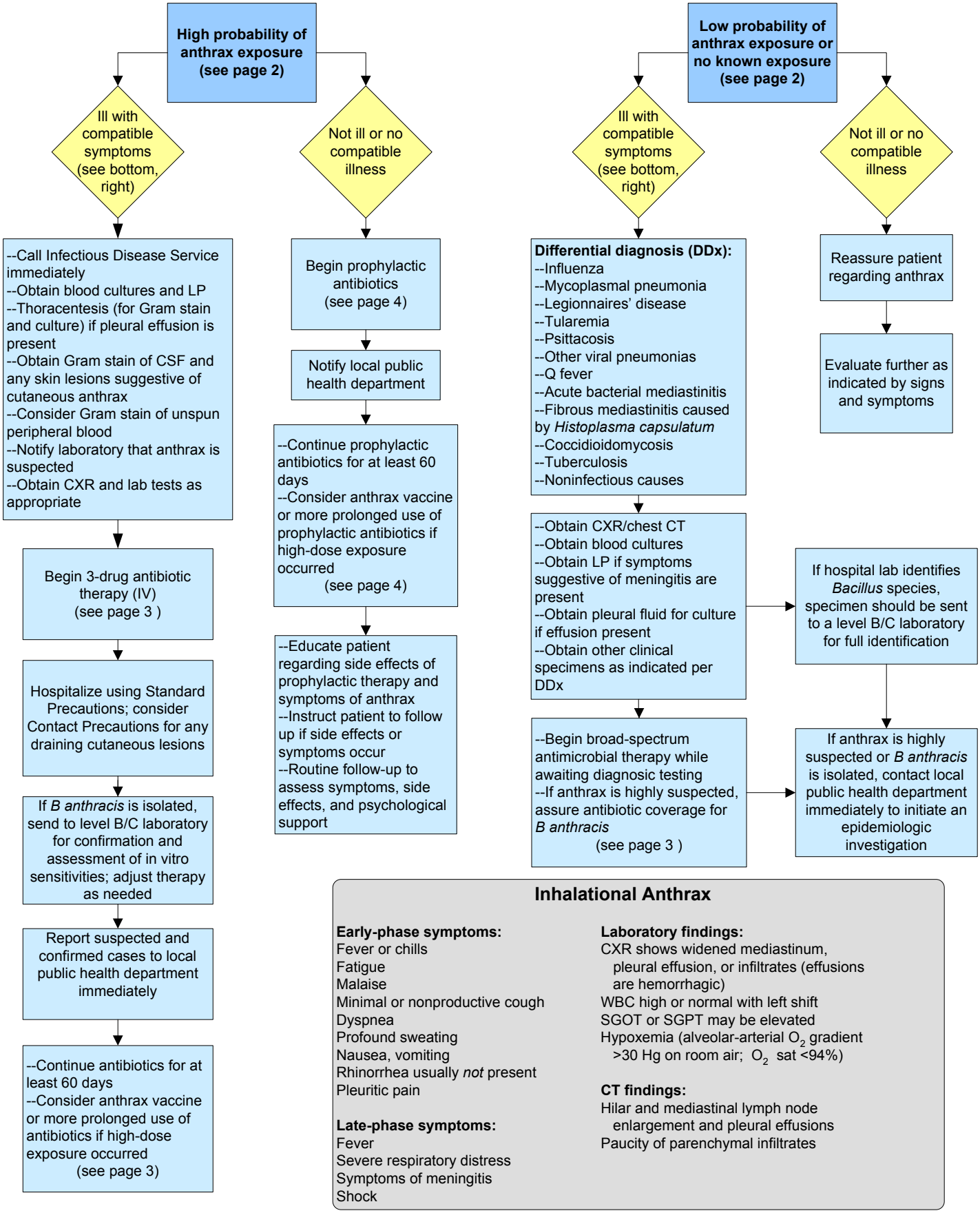
Clinical Pathway: Anthrax Inhalational Exposure



Inhalational Anthrax

Early-phase symptoms:
Fever or chills
Fatigue
Malaise
Minimal or nonproductive cough
Dyspnea
Profound sweating
Nausea, vomiting
Rhinorrhea usually *not* present
Pleuritic pain

Late-phase symptoms:
Fever
Severe respiratory distress
Symptoms of meningitis
Shock

Laboratory findings:
CXR shows widened mediastinum, pleural effusion, or infiltrates (effusions are hemorrhagic)
WBC high or normal with left shift
SGOT or SGPT may be elevated
Hypoxemia (alveolar-arterial O_2 gradient >30 Hg on room air; O_2 sat <94%)

CT findings:
Hilar and mediastinal lymph node enlargement and pleural effusions
Paucity of parenchymal infiltrates

Assessing the Probability of Anthrax Exposure

High Probability	***During a known anthrax event:*** • Persons exposed to an air space where a suspicious material may have been aerosolized (eg, near a suspicious powder-containing letter during opening) • Persons who shared an air space likely to be the source of an inhalational anthrax case (eg, being exposed to a shared ventilation system) • Persons who may have been exposed to an item contaminated with *Bacillus anthracis* (eg, an envelope or other vehicle) along the transit path of the item (eg, a postal sorting facility in which an envelope containing *B anthracis* was processed)
	In situations where anthrax has not previously been identified*: • Persons who opened a suspicious letter or package that was found to contain a white powder suspected to be a source of *B anthracis* • Persons exposed to an air space where suspicious material may have been aerosolized (eg, near a suspicious powder-containing letter during opening)
Low Probability	• No history of exposure to an item (eg, an envelope or other vehicle) or powder confirmed or suspected to harbor *B anthracis* spores • No history of exposure to an air space where a suspicious material could have been aerosolized (eg, being present at the time a powder-containing letter was opened) • No history of exposure to an air space likely to have been the source for a confirmed case of inhalational anthrax

*In situations where anthrax exposure is suspected but no prior cases of anthrax have been confirmed, a risk assessment should be conducted by local public health and law enforcement officials. If the probability of anthrax exposure is considered high on the basis of the risk assessment, prophylactic antimicrobial therapy should be initiated for asymptomatic exposed persons while the suspect material is being tested for *B anthracis*. Any persons who have symptoms compatible with anthrax should be treated with appropriate antibiotics, according to the clinical pathway (see page 1), until anthrax can be confirmed or ruled out.