Post-exposure Pathway for Human Rabies Immune globulin (HRIG) administration if HRIG is indicated following Risk Assessment.

For details of the rabies prone exposure risk assessment process please see summary risk assessment. For full details on HRIG please refer to NIAC Rabies Guidance

HRIG may be administered at the same time as the first rabies vaccine dose, or as soon as possible thereafter, within 7 days of the first dose of rabies vaccine. In general, HRIG should be given as soon as possible, and within 12 hours if the incident is high risk. Urgent administration of HRIG is especially important if the patient has not been previously immunised or is immunosuppressed, regardless of vaccine status. HRIG should only be used in combination with rabies vaccine.

HRIG should be administered in a hospital-based setting. To ensure that the hospital can meet the necessary service requirements for administration of HRIG, each hospital should have:

1. Identified suitable location(s) for administration of immunoglobulin.

2. Assigned the appropriate medical and nursing team to undertake this task with appropriate training.

This service is required 7 days a week.

1. **Accessing HRIG**
   - See Process for ordering HRIG and Rabies vaccine

2. **Medical and Nursing Team**
   - A senior member of the team should be available to medically review, and risk assess patients who require HRIG and to prescribe these medicines.
   - Guidelines should be available on the risk assessment, medical management of these patients as well as on rabies post exposure treatment (PET) prescribing.
     Education and training as required.
3. **Administration of HRIG**
   - See NIAC Rabies Guidance
   - The dose is 20 IU/kg
   - After thorough wound cleansing, HRIG should be infiltrated into the depth of the wound and around the wound as much as anatomically feasible. Any remainder should be injected IM at a site distant from that of the vaccine, e.g. if vaccination given in anterolateral thigh, then give remaining HRIG in deltoid, or vice versa.
   - Primary wound suturing should be avoided or postponed, as it may increase the risk of inoculation of rabies virus into nerves. If unavoidable,

suturing should be performed loosely and with the minimum number of sutures required to approximate wound edges, to facilitate optimal HRIG diffusion.

- Tetanus prophylaxis and measures to control bacterial infection should be administered as indicated. See here for AMRIC advice on management and antibiotic treatment following bites.

4. **Administration of vaccine**

- Rabies vaccination is a safe and effective intervention, and its use should be considered in all RPEs. Clinical rabies is invariably fatal, and PET should never be withheld if clinically indicated post risk assessment.
  - **Contraindications**
    - Anaphylaxis to any of the vaccine constituents. ***However, as rabies infection is generally fatal, there are no contraindications to post exposure vaccination***. Facilities should be in place to monitor the vaccinated person and recognise and treat severe allergic reactions.
    - **Precautions**
      - Acute severe febrile illness – defer until recovery, unless used for post-exposure management.
    - **Pregnancy.**
      - Pre-exposure vaccine may be given to pregnant women if the risk of exposure to rabies is high and rapid access to post exposure prophylaxis will be limited. Post exposure treatment should be given when indicated. Rabies vaccines and rabies immunoglobulin are considered safe to use in pregnant and lactating women, HIV-infected and other potentially immunocompromised individuals.

5. **Discharge planning and escalation plan**
   - Each patient should have a discharge plan in place. If post exposure treatment is provided in ED, the patient is to be referred to the ID service who will coordinate follow up and liaise with the patient's GP. All patients should be provided with a GP letter providing information on their treatment.