EMERGENCY PROTOCOL

# Suspected HA Filler Vascular Occlusion

HARLEY STREET INSTITUTE

Recognition first. Then choose the correct emergency pathway. Updated teaching summary for trained healthcare professionals.

## AFTER FILLER: IS PERFUSION COMPROMISED?

Stop injecting immediately • keep the patient with you

### LOOK FOR

- **BLANCHING / PALLOR**
  persistent or extending beyond injection site
- **CAPILLARY REFILL**
  delayed or absent compared with surrounding skin
- **PAIN**
  sudden, severe or increasing — but pain may be absent
- **COLOUR CHANGE**
  livedo / mottling / dusky change; cool skin

### DOCUMENT NOW

Good light: photograph or video the whole area.

Compare capillary refill along the suspected arterial territory and with normal skin.

Mark the full area of ischaemia — not only the injection point.

## ANY VISUAL / NEUROLOGICAL SYMPTOMS?

YES

NO

### VISION / CNS EMERGENCY

Examples: visual loss or blur, ocular pain, diplopia, ptosis, ophthalmoplegia, severe headache, weakness, speech change.

**TRANSFER TO NEAREST ED WITHOUT DELAY**

Call emergency services. Do not let clinic measures delay transfer. Best practice: clinician accompanies patient and brings emergency information / hyaluronidase.

### CUTANEOUS ISCHAEMIA PATHWAY

Treat a suspected HA filler vascular occlusion promptly. Coverage of the entire compromised territory matters more than chasing the vessel lumen.

**GO TO PAGE 2 → HIGH-DOSE HYALURONIDASE**

Reassess clinically after treatment and repeat until perfusion is restored. Escalate if response is incomplete or tissue injury evolves.

### DO NOT WAIT FOR NECROSIS

The original 2019 poster emphasised pallor, sluggish refill and pain. Modern guidance keeps these signs, but prioritises rapid treatment and a separate time-critical vision/CNS pathway.

Clinical note: this is a teaching aid, not a substitute for local medicines governance, SmPCs, emergency training or individual clinical judgement.

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# Cutaneous Vascular Occlusion — Action Tree

High-dose pulsed hyaluronidase pathway for suspected HA filler-related ischaemia. Treat the tissue at risk, reassess, repeat.

1

## STOP + MAP

Stop filler injection. Photograph/video, assess colour, temperature, pain and capillary refill. Mark the entire ischaemic territory.

2

## PREPARE

Disinfect. Reconstitute 1,500 IU hyaluronidase in 1 mL bacteriostatic 0.9% NaCl or 1–2% lidocaine / suitable compatible alternative.

3

## INFILTRATE

Infiltrate 1,500 IU across the course of the affected artery and the wider area of ischaemia. Use additional vials when needed for full coverage.

4

## MASSAGE + REASSESS

Firm massage, then reassess perfusion clinically. Follow colour, warmth, pain and capillary refill rather than a fixed total dose.

5

## STILL COMPROMISED?

Repeat high-dose hyaluronidase at approximately 15–20 minute intervals, or as practical, guided by reassessment. Continue until perfusion is restored.

6

## FOLLOW THROUGH

Face-to-face follow-up. If skin breakdown develops, manage as a wound and escalate appropriately. Maintain records, photographs and patient contact.

### NO ROUTINE SKIN TEST IN AN EMERGENCY

Current CMAC guidance advises against delaying treatment for hyaluronidase skin testing in established vascular occlusion. Be prepared to manage anaphylaxis.

### ADJUNCTS ≠ THE CORE TREATMENT

Aspirin, vasodilators, steroids and antibiotics are not substitutes for prompt hyaluronidase and reassessment. Use only where indicated and within local protocol.

**VISION / CNS RED FLAG AT ANY POINT → stop this pathway and arrange immediate transfer to the nearest Emergency Department.**

Evidence basis: adapted and updated from the supplied 2019 emergency reversal poster; aligned to CMAC vascular-occlusion / hyaluronidase guidance and 2026 UK consensus on filler-induced vision loss.

# ADJUNCTIVE OPTIONS

After immediate hyaluronidase management of suspected HA vascular occlusion

## THE PRINCIPLE

Adjuncts must never delay hyaluronidase, reassessment of perfusion, or emergency transfer for visual or neurological symptoms.

### ASPIRIN

CONSIDER IF SAFE

**300 mg oral stat; CMAC suggests 75 mg daily until the occlusion is dissolved and tissue reperfused.**

Rationale is extrapolated from antiplatelet use elsewhere; direct evidence in HA occlusion is lacking. Check contraindications and interactions.

### GTN / NITROGLYCERIN PASTE

NOT ROUTINE

**Older protocols used topical GTN for vasodilation.**

Current CMAC guidance does not recommend it: benefit is unproven and vasodilation may theoretically propagate embolic material or worsen venous congestion.

### SILDENAFIL / PDE-5 INHIBITORS

NOT ROUTINE

**Older protocols proposed sildenafil 50 mg/day as a vasodilator.**

CMAC advises against routine use. No comparative efficacy data; hypotension and ocular adverse effects are relevant, and it must not be combined with nitrates.

### SYSTEMIC CORTICOSTEROID

ONLY IF INDICATED

**Prednisolone/prednisone has appeared in older protocols to reduce inflammation and oedema.**

Current CMAC guidance advises avoiding routine steroids unless there is a separate clinical indication because they may impair wound healing or worsen early infection.

### ANTIBIOTICS

ONLY IF INDICATED

**Do not prescribe prophylactically simply because an occlusion occurred.**

Use when infection is clinically suspected or wound breakdown creates a specific indication. Established tissue breakdown needs structured wound care and close review.

### TOPICAL STEROID CREAM

NOT FOR ACUTE ISCHAEMIA

**Not a treatment for the obstructed vessel and not part of current CMAC acute reperfusion management.**

Avoid routine application to threatened or broken-down skin. A topical steroid could mask inflammation, increase local infection risk and does not restore perfusion.

### HSI TEACHING POINT

**The endpoint is restored perfusion - not completion of a drug checklist. Adjuncts are secondary to rapid recognition, high-dose pulsed hyaluronidase and repeated clinical reassessment.**

Evidence note: CMAC vascular occlusion guidance (Murray et al., 2021) and subsequent review literature.