Amanita phalloides (Death Cap)

Ingestion of one *Amanita phalloides* mushroom is potentially fatal. Early risk assessment and initiation of Rx in cases of possible exposure is paramount.

Risk Assessment

Amanita phalloides typically grows near oak trees

- *White gills and volva*
- *One mushroom may result in toxicity leading to death*
- *Found in Victoria, SA and ACT, rarely other states*
- *Toxins are heat stable: not inactivated by cooking/drying*

Clinical Presentation

The typical presentation outlined below may vary due to:

- *Mixed ingestions: other mushrooms may produce early GI symptoms*
- *Large ingestions: large, ingested doses of Amanita may produce early GI symptoms*

0-5 hours: Asymptomatic

5-24 hours: Nausea, vomiting, diarrhoea, abdominal pain, mild elevation LFTs and renal dysfunction

1 to 7 days: Fulminant hepatic failure, renal failure, encephalopathy, death

Investigations:

Liver transaminases: may take 24hrs to become abnormal

Renal function, lactate, INR

Management:

Management requires expert advice. PLEASE DISCUSS ALL CASES WITH A CLINICAL TOXICOLOGIST

Mushroom ID may be possible. *See separate "Identification of fungi in Victoria"* guideline

Retain samples of mushroom if available. Photographs with size marker may help with identification.

Supportive care: aggressive early IV fluid resuscitation to correct GI losses, which may be significant (4-6 liters of IV fluid are typically required in the first 24 hours in patients with severe symptoms)

Decontamination: 50g activated charcoal single dose and 25g every 2 hours if no contraindications. AC may be beneficial up to 72 hours post ingestion.

Specific treatments:

Treat with BOTH **Acetylcysteine:** Utilize same infusion protocol as for paracetamol toxicity **AND**

Silibinin: See separate *Silibinin* guideline. If silibinin is not available immediately, alternative antidotes to silibinin that may have a beneficial interim role include:

- *Rifampicin*: 600 mg IV daily (child 15mg/kg up to 600 mg) **OR**
- *Benzylpenicillin*: 3 g IV 4 hourly (Child: 60 mg/kg up to 2.4 g)

Liver transplant: discuss with liver transplant unit in cases who develop acute liver injury (ALT>250)

Disposition:

If asymptomatic at 24 hours post ingestion with normal liver / renal function, then can be discharged

If symptomatic, but LFTs / renal function normal at 48-hours post exposure, then this excludes amatoxin-related mushroom poisoning

Continue therapy (NAC + silibinin) until down-trending LFTs and asymptomatic OR for at least 6 days

Version 5: Published 5/2025. Review 5/2028