

Clinical Immunology and Allergy Referral Guidelines

Services available and accessing services

Outpatient clinics are based at the Royal Victoria Infirmary (RVI). Clinics are held Monday – Friday. Referrals from GPs should be sent by e-referral. Referrals are screened by a Consultant and patients are booked to be seen in problem-based clinics according to the identified clinical question.

Referrals from within the Trust or other hospitals should be sent to the Immunology Department, Royal Victoria Infirmary, Newcastle upon Tyne, NE1 4LP or may be emailed to nuth.immunology.allergy@nhs.net.

The secretaries can be contacted on 0191 2820669. Most initial appointments are now booked as telephone consultations. Please advise if this is not going to be appropriate eg. needs interpreting services, learning difficulties, speech or hearing impairment, patient preference

For details of what to refer please see page 2.

Referral for children (<16) are not accepted and should be sent to Paediatric Allergy or Paediatric Immunology teams at the Great North Children's Hospital depending on the clinical condition.

Advice and guidance can also be accessed via e-referral and most enquiries would be answered in 2 working days. For advice on patients already known to our service please contact the department directly.

Outreach clinics

Clinics are currently only being held in the RVI. However we hope to be able to offer outreach services in the near future.

Who we are

We are a team of consultants, specialist nurses, junior doctors and nursing staff supported by a dietitian, health care assistant, receptionists and secretarial staff. Details of key staff members are available on the Newcastle Hospitals Allergy and Immunology webpage:

<https://www.newcastle-hospitals.nhs.uk/services/immunology-and-allergy-unit/>

Helpful information

The following Websites may be of value:

www.aaaai.org/professionals.stm
www.allergyuk.org
www.jext.co.uk
<https://www.nice.org.uk>

www.anaphylaxis.org.uk
www.bsaci.org
www.epipen.co.uk

What to refer

For examples please see the table below – numbers in brackets refer to the numbered notes

What to refer*	What not to refer*
Immunodeficiency	
Known or suspected primary immunodeficiency (1)	HIV/AIDS (2)
Recurrent major infection (3)	Recurrent minor infection (4)
Recurrent severe boils [failed initial therapy; deep seated abscesses] (5)	Recurrent superficial abscess /boil; hidradenitis suppurativa (5)
Unexplained periodic fevers / autoinflammatory conditions	Vasculitis/Connective tissue disease (6); Arthritis (7)
Congenital asplenia (8)	Non-congenital asplenia (8)
Hereditary angioedema / acquired angioedema secondary to C1 esterase inhibitor deficiency	Recurrent shingles (9)
Allergy	
Anaphylaxis (10)	Asthma (11) Recurrent sensation of throat swelling without other features of allergy (12)
Recurrent angioedema in people NOT on ACE Inhibitors (13)	Angioedema in people taking ACE Inhibitors / Angiotensin receptor blockers (14); single episode of self-limiting angioedema
Seasonal or perennial rhinoconjunctivitis resistant to maximal conventional therapy (14)	Eczema (15); Periorbital oedema with scaly rash (15)



What to refer*	What not to refer*
Venom allergy (16)	
Drug allergy including immediate reactions to local anaesthetic & vaccines (17)	
General Anaesthetic allergy (18)	
Latex allergy (19)	
Food allergy (20)	Food intolerance; irritable bowel syndrome (21)
Urticaria if severe and prolonged (21)	Urticaria if single episode, recent onset and/or mild (23)

* See below for details and advice. If unsure whether to refer, please contact Department by telephone, fax or email or request Advice and Guidance via e-referral.

Notes

- 1) Known or suspected primary immunodeficiency: all need to be under care of Immunologist.
- 2) Refer all HIV/AIDS to Adult Infectious Disease Service at Royal Victoria Infirmary (or to local Infectious Disease or GUM Service, outside of Newcastle)
- 3) Recurrent Major infection: please refer all of the following:
 - Two major infections in 12 months (major = requires hospital admission).
 - One major + 2 minor (minor = microbiologically proven and needs oral antibiotic) in 12 months.
 - Second episode of bacterial meningitis ever.
 - Infections (major or minor) in relative of patient with known primary immunodeficiency.
 - Patients with unexplained bronchiectasis and/or sinusitis.
 - Unusual, recurrent or persistent fungal infections
- 4) Recurrent minor viral infections will not be due to immunodeficiency and referral is not necessary: exclude stress, inadequate diet, iron deficiency. Recurrent vaginal thrush is common and not an indicator of immunodeficiency.
- 5) Recurrent boils/abscesses: most are due to staphylococcal carriage or local disease (hidradenitis suppurativa – refer to dermatology or plastic surgery). Rarely may be due to neutrophil or antibody deficiency. Check blood glucose, TFTs and nasal swabs for staphylococci. The Department has a regime for decontamination of staphylococcal carriers, available on request. Refer only those carriers who fail decontamination. Refer all patients with deep-seated abscesses (liver, brain).
- 6) Acute vasculitis or connective tissue disease should be referred to Rheumatology.
- 7) Acute arthritis should be referred to Rheumatology.

- 8) Guidelines for the management of asplenia are available from our Department. Refer only those patients who fail to respond to recommended vaccines, who cannot or will not tolerate continuous antibiotics, and those with congenital asplenia. Practices should maintain their own practice register of asplenic patients for annual follow-up.
- 9) Recurrent 'shingles' is very rare in the absence of severe and obvious immunodeficiency (e.g. lymphoma, leukaemia, AIDS, chemotherapy) and the usual cause of recurrent lesions similar to shingles (VZV) is actually recurrent Herpes simplex infection. Treat with oral aciclovir (not topical). If episodes are very frequent, consider prophylaxis with aciclovir 200mg bd for 6 months.
- 10) Refer all patients with anaphylaxis (= allergic reaction with systemic features, hypotension, laryngospasm, bronchospasm). See NICE Guideline: <http://guidance.nice.org.uk/CG134>
- 11) Refer difficult to control asthma to Respiratory Medicine. Severe asthma is an exclusion criterion for immunotherapy.
- 12) Refer recurrent sensation of throat swelling/ closing to ENT.
- 13) Angioedema may be caused by ACE inhibitors and Angiotensin II blockers (up to 5% of patients): stop drug and wait 3 months. Refer if angioedema persists. Other drugs causing angioedema include NSAIDs, PPIs and statins.
- 14) Refer only patients with allergic rhinconjunctivitis who fail to respond to maximal medical therapy (oral anti-histamines + nasal steroid + eye drops). Ensure that nasal steroids are used with head forward looking at feet. For management in primary care see BSACI primary care guideline: <https://www.bsaci.org/Guidelines/allergic-non-allergic-rhinitis>
- 15) Refer eczema and persistent periorbital oedema with scaling to Dermatology. In adults, food allergy rarely has a role to play in the generation of eczema. Investigation of dermatitis is by patch testing (available in Dermatology).
- 16) Venom immunotherapy should be offered to patients who have had a severe systemic reaction to a sting, or who have had a moderate reaction with one or more risk factors (raised mast cell tryptase, significant anxiety about further stings or high risk of further stings). www.nice.org.uk/guidance/ta246
- 17) Refer patients with drug allergy only if clinically relevant and where testing will alter treatment. See NICE Guidelines on referring drug allergy from primary care: <http://www.nice.org.uk/guidance/cg183/chapter/1-Recommendations#nonspecialist-management-and-referral-to-specialist-services-2>

Patients with penicillin allergy should only be referred where there is an ongoing need for a penicillin antibiotic or where the allergy is associated with allergy to other antibiotics.

Refer patients with reactions to NSAIDS only where there is a clear ongoing need for this class of drugs.

True IgE-mediated allergy to local anaesthetics is very rare.

Patients with immediate onset of allergic symptoms after vaccine administration should be referred for consideration of testing where this is possible.

We do not normally recommend the carriage of adrenaline autoinjectors in drug-related reactions as medications can be avoided. A medic-Alert bracelet (or equivalent) is advisable.

- 18) General Anaesthetic allergy. The anaesthetist involved in the patient's care at the time of reaction should refer the patient. The following documents and a copy of the anaesthetic chart should be completed and sent to Dr Henrietta Dawson, Consultant Anaesthetist, Anaesthetic Drug Allergy Clinic, Anaesthetic Department, Royal Victoria Infirmary or email to henrietta.dawson@nhs.net



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- 19) Refer all patients with significant immediate allergy to latex. Contact eczema to rubber should be referred to Dermatology for patch testing.
- 20) Refer all patients with known or suspected allergic reactions to foods. Some patients may have been told that they have multiple food allergies after high street 'allergy' tests: many of these tests are unscientific: refer for further testing only those in whom correct testing will help them come to terms with chronic symptoms e.g. irritable bowel. Non-specific symptoms are virtually never due to true food allergy.
- 21) Chronic urticaria is **rarely** due to allergy. Most is due to physical urticaria (pressure, heat etc.), stress, chronic infection (dental, sinus, helicobacter, cholecystitis), and thyroid dysfunction; some may be spontaneous and can be affected by the former conditions. Vitamin & mineral deficiency (B12, folate, ferritin, vitamin D can all exacerbate symptoms in some patients. Exclude these before referral. Do not refer patients with a single or short-lived episode of urticaria. Management of urticaria may require use of doses of anti-histamines in excess of those normally recommended in the BNF: use cetirizine in doses up to 40 mg per day or fexofenadine 360 mg bd in resistant cases; addition of monteleukast 10 mg od is also recommended in Guidelines. Do not use continuous steroids. Do not use Piriton (chlorphenamine) during the daytime or for acute use (weak anti-histamine, short duration of action and sedating). BSACI guidelines on managing Chronic spontaneous urticaria can be found at:- <https://www.bsaci.org/guidelines/chronic-urticaria-and-angioedema>

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