IMMUNOLOGY and ALLERGY - Introduction

North Bristol NHS Trust

Overview

North Bristol Trust provides a secondary and tertiary Immunology and Allergy service.

The service specialises in the investigation and management of patients with antibody deficiency, other immunodeficiency, and ***allergy that cannot be managed in primary care.***

Many GPs refer to the service and waiting lists are long. Please use these guidelines to help refer patients appropriately. Referrals on e-RS must be specifically to ***Allergy*** or to ***Immunology*** as incorrectly directed referrals may be rejected.

On e-RS, an ***Advice and Guidance*** option is now available. Please make use of this.

CONDITION SMAIN MENU

CLINICS

MORE ON ADVICE and GUIDANCE

What NOT to refer

Please read guidelines carefully for treatments, actions, alternative services and exclusions, prior to making a referral.

Please note :

- For patch testing (e.g. for contact hypersensitivity) or eczema - **REFER TO DERMATOLOGY**
- We do not have expertise in lactose intolerance or food "intolerance"
- We have no expertise in ME/chronic fatigue or fibromyalgia
- We do not have expertise in the management of mast cell activation disorders

Many symptoms are commonly attributed to allergy which are not actually due to this.

ECZEMA

WHAT IS NOT ALLERGY?

ADVICE and GUIDANCE option for Immunology and Allergy e-referrals

Overview

An e-RS Advice and Guidance option is now available for the NBT Immunology and Allergy service.

This allows all referrers to seek advice from the NBT team and for the team to support GPs in managing a patient's condition.

GPs may wish to use this option to seek advice on:

- Diagnosis and treatment plan
- Other issues in the management of the patient's care
- Test results
- Whether to refer, or what the most appropriate alternative care pathway might be

The NBT team will respond promptly to A&G requests. They will seek to support GP in the management of the patient in primary care wherever possible.

Using A&G may make a referral and a long wait for an appointment unnecessary.

Use of A&G can help to reduce avoidable hospital referrals and free up capacity for other appointments.

Given the current pressures, GPs may consider using A&G ahead of a referral, if this is appropriate.

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These guidelines contain hyperlinks to pages that you want to view. To return to the last page viewed please use the ***last page viewed button*** *on your pdf reader*

WHAT IS NOT ALLERGY? Patients who present with symptoms/signs/tests fitting with the categories below rarely benefit from referral to specialist allergy services. These patients should only be referred after careful consideration +/- discussion with the Clinical Immunology/Allergy service.

Patients frequently attribute a wide variety of symptoms to allergy. This perception has often been reinforced by "information" in the press and other popular media, and by the results of privately available "diagnostic allergy tests" which are not only inherently implausible but have no established validity. In many cases, the patients' beliefs that their symptoms are due to allergy are deeply entrenched and may not be amenable to rational debate.

The following should be borne in mind when considering whether such patients should be referred:

- **Weight loss, weight gain, headache** (including migraine)**, confusion, depression, lack of concentration, vertigo, tiredness** (including chronic fatigue syndrome) and **hair loss** can never be explained in terms of allergy. The same is almost always true of isolated vague abdominal symptoms such as bloating (these can, however, be due to irritable bowel syndrome, undiagnosed coeliac disease or other organic pathologies). Even if **"food intolerance"** (e.g. to wheat) does exist as a diagnostic entity, there are **no validated diagnostic tests or therapies other than avoidance**.
- **Some substances are simply not recognised allergens**, e.g. tap water, sugar, caffeine, dental amalgam. There is no evidence that patients who consider themselves intolerant of various scents or odours (e.g. bleach, "chemical smells", potpourri, air freshener, perfumes) are suffering from allergy to these substances. Asthma should be excluded.
- **Positive results obtained by unorthodox techniques**, such as electrodermal testing (e.g. the *Vega* test), are irrelevant to the diagnosis of food allergy and are best ignored — they do not justify referral to the allergy service. In addition, IgG antibodies to food allergens, as measured by some private laboratories, have not been shown to be of diagnostic value.
- There is no good evidence that "**systemic candidiasis syndrome", "multiple chemical sensitivity syndrome" or "amalgam sensitivity"** are discrete physical entities, or that they are actually due to those agents from which they derive their name. There are no validated diagnostic tests or therapies.
- **Mast cell activation syndrome**: We do not see patients with either suspected or confirmed mast cell activation syndrome. This is a syndrome with many non-specific reported symptoms and without robust diagnostic criteria. True mastocytosis should be excluded by sending a mast cell tryptase (plain clotted sample).
- **Histamine sensitivity syndrome**: We do not see patients with suspected histamine sensitivity syndrome. Evidence for this condition is questionable and there are no well-validated diagnostic criteria. A trial of a low histamine diet may be helpful.

ANAPHYLAXIS

Anaphylaxis is a severe allergic-type reaction, usually of rapid onset, with either airway involvement (e.g. bronchospasm, pharyngeal oedema) or cardiovascular compromise (e.g. hypotension, collapse), typically with cutaneous features (e.g. urticaria, angioedema)

Red Flags

Any patient with a history of anaphylaxis should be referred to eithe the 'Adult Allergy Service' Clinic' via e-referral.

*Please use the **last page viewed button** on your pdf reader to get back to the last page viewed*

HOW TO IDENTIFY A FOOD ALLERGY

True (IgE-mediated) food allergy results in a reaction which is:

1. REPRODUCIBLE on exposure to a food or group of foods (and does not occur if not exposed)
2. RAPID in onset (i.e. usually within 30 minutes, and nearly always within 60 minutes)
3. ALLERGIC in character (e.g. urticaria/rash, angioedema, itch, wheeze, dizziness, collapse, gastrointestinal symptoms, feeling of 'impending doom')

MANAGEMENT OF SUSPECTED FOOD ALLERGY

ANAPHYLAXIS

The presence of any of the following features suggests symptoms are **NOT due to food allergy**:

- Symptoms occurring more than 2 hours from ingestion (rare exceptions if fit other criteria)
- No consistent relationship to a particular food trigger, either by ingestion, or contact (in the case of localised contact urticaria)
- Spontaneous symptoms, without any apparent triggering factor (e.g. come on overnight or first thing in the morning prior to eating/drinking) – see links below in relation to urticaria and/or angioedema
- Symptoms having physical triggers, such as minor trauma, temperature change, sweating or exposure to water
- Symptoms persist for several days at a time

Such patients should NOT be referred as a food allergy patient

MANAGEMENT OF NON-ALLERGIC URTICARIA +/- ANGIOEDEMA

MANAGEMENT OF NON-ALLERGIC ANGIOEDEMA WITHOUT URTICARIA

MANAGEMENT OF SUSPECTED FOOD ALLERGY

Overview

Please consider first reading HOW TO IDENTIFY A FOOD ALLERGY.

Principles of management for suspected food allergy

If a food allergy is suspected please consider the following actions:

- Consider sending specific IgE testing for suspected allergens – do not send specific IgE tests for allergens which are not suspected of being causative of reactions
- Advise absolute avoidance of the suspected allergen
- Supply the patient with an oral antihistamine (e.g. Cetirizine 20-30mg) to be used acutely for mild reactions
- Consider the prescription of 1-2 adrenaline autoinjectors if perceived risk of anaphylaxis merits this (https://www.bsaci.org/Guidelines/adrenaline-auto-injector) and patient is in agreement, with appropriate training in their use
- Target good asthma control (if relevant)

This should be enough for simple, single food allergens with few episodes of anaphylaxis.

Referral

If patients are **complex** and there are further questions about management or diagnosis then consider either asking for advice (see below) or referring to the 'Adult Allergy' services via e-referral.

Advice

Requests for routine advice should be made through the Advice and Guidance option via e-referral. Urgent advice is available for GPs via the Southmead Hospital Switchboard – ask for the Immunology or Allergy Registrar/Specialist.

URTICARIA and ANGIOEDEMA

Overview

URTICARIA (hives, wheals or "nettle rash") and **ANGIOEDEMA** (soft tissue swelling) can occur alone or together.

Key points:

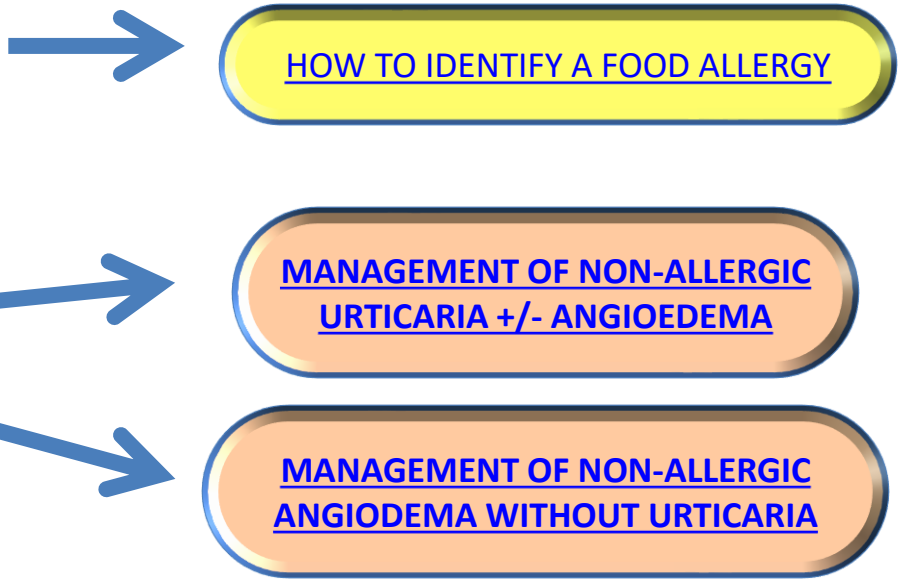
- Urticaria/Angioedema can be allergic or non-allergic in aetiology.
- The majority of patients have spontaneous urticaria/angioedema, for which extended antihistamine treatment is often necessary
- Spontaneous urticaria/angioedema is **NOT** an allergy
- In the majority of cases, food allergy is **NOT** the cause and can be excluded on the basis of the clinical history alone, without the need for any investigation.

Referral via e-referral:

- **Patients with suspected complex food allergy should be referred**
- **Patients with chronic spontaneous urticaria and/or angioedema should only be referred if symptoms are intolerable despite treatment – see management recommendations**

ACE INHIBITORS and NSAIDS (e.g. Ibuprofen)

- Urticaria and angioedema are well-documented side-effects of **ACE inhibitors and NSAIDs**
- The mechanism for this is non-allergic and is a pharmacological effect
- Urticaria and/or angioedema can occur for the **first time even after prolonged treatment**
- Please **consider stopping** these medications for at least a few weeks (if possible) and seeing if this is effective prior to referral



MANAGEMENT OF NON-ALLERGIC URTICARIA +/- ANGIOEDEMA

- Check that symptomatic episodes have not followed ingestion of a non-steroidal anti-inflammatory drug (e.g. aspirin/ibuprofen). Stop use of NSAIDs and monitor if suggestive history.

  Note: There is no need to stop treatment in patients who have been stabilised on long term maintenance NSAID therapy.
- **Give an oral long-acting non-sedating antihistamine**, such as fexofenadine 180 mg, cetirizine 10 mg or Loratadine 10mg once daily (*prn*, if symptoms are infrequent)
- If necessary, increase the dose of antihistamine (guidelines on this topic are available at https://www.bsaci.org/guidelines/chronic-urticaria-and-angioedema) up to a maximum dose of 40mg/day of Cetirizine, 40mg/day of Loratadine or 360mg/day of Fexofenadine

  Note: In pregnancy, Chlorpheniramine *(Piriton)* has the most evidence for safety, although Loratadine may also be used.
- A typical time to see a response would be up to 2 weeks.

Referral

Only refer via e-referral to **'Adult Allergy'** if:

- Symptoms do not respond to these measures. Please indicate clearly in your referral that above measures have been ineffective.
- History suggests underlying allergy (immediate hypersensitivity)

REFER TO **DERMATOLOGY** if history suggests delayed hypersensitivity or eczematous rash
Refer to **DERMATOLOGY** urgently if cutaneous urticaria associated with a vasculitis is suspected.

Advice

Requests for routine advice should be made through the Advice and Guidance option via e-referral. Urgent advice is available for GPs via the Southmead Hospital Switchboard – ask for Immunology Allergy Registrar/Specialist

MANAGEMENT OF NON-ALLERGIC ANGIOEDEMA WITHOUT URTICARIA

Treat as per MANAGEMENT OF NON-ALLERGIC URTICARIA +/- ANGIODEMA
but with the following additional considerations:

1. **If the patient is taking an ACE inhibitor, this should be stopped (no patient should be referred until they have been shown not to respond to this intervention).** We would suggest a switch to an angiotensin II receptor antagonist. Although angioedema has also been reported with these, the risk appears to be much less. Alternative antihypertensives may also be used.
2. Even if the patient is not taking an ACE inhibitor, these should be avoided in the future.
3. In patients with angioedema without urticaria exclude C1-inhibitor deficiency (check complement C4 — values above 0.15 g/l virtually exclude this condition). If C4 low then refer as below. Please do consider referral if there is a strong family of isolated angiodema (without urticaria) even with a normal C4.

MANAGEMENT OF NON-ALLERGIC URTICARIA +/- ANGIOEDEMA

C1-INHIBITOR DEFICIENCY

Referral

Refer to **'Adult Allergy'**services via e-referral if:

- Antihistamines and drug avoidance measures above have failed to gain adequate control of symptoms
- Involvement of the tongue or throat/upper respiratory tract (unless this only happened whilst on an ACE inhibitor)

Refer to **'Adult Immunology'** via e-referral if low C4 in the context of angioedema/family history
In your referral you will need to indicate **failure of treatment, severity** and the **result of C4 testing**.

Requesting advice

Requests for routine advice should be made through the Advice and Guidance option via e-referral. Urgent advice is available for GPs via the Southmead Hospital Switchboard – ask for Immunology Allergy Registrar/Specialist

RHINITIS – PAGE 1

Overview

Key points

- Rhinitis can be allergic or non-allergic, although both forms can coexist.
- Allergic rhinitis is likely if symptoms are seasonal or episodic, and obviously coincide with exposure to known aero-allergens, such as pollens and animal danders.
- Allergic rhinitis due to house dust mite antigen (relatively ubiquitous and tends to cause perennial symptoms) is the least easy to distinguish clinically from non-allergic rhinitis.
- To a variable degree, patients with allergic rhinitis may also have ocular symptoms; sometimes these are the main feature.
- Nasal polyps are not always an allergic phenomenon (as these patients sometimes have pharmacological hypersensitivity to NSAIDs), but it is often useful to know whether there is an *additional* allergic component to the rhinitis.

Optimise medical treatment in primary care prior to referral:

Combined treatment with

- Topical or **oral antihistamine** (e.g. Cetirizine 10mg daily / Loratadine 10mg daily) AND
- A **nasal steroid spray** (e.g. Fluticasone/Mometasone) AND
- Consideration of nasal ipratropium bromide (particularly effective if rhinorrhoea is a major symptom) AND
- Consideration of eye drops (e.g. Azelastine, Sodium Cromoglycate or Nedocromil)

MORE

RHINITIS – PAGE 2

Referral

For advice on management of nasal polyps in primary care (including red flags) then please see ENT Remedy page on nasal treatment at https://remedy.bnssgccg.nhs.uk/adults/ent/nasal-treatment/. Referrals for surgical treatment of nasal polyps without red flags is subject to the BNSSG CCG Nasal treatment policy at https://bnssgccg.nhs.uk/individual-funding-requests-ifr/individual-funding-requests-directory/nasal-treatment-non-cosmetic/. Patients must have a documented failure to improve after a trial of maximal medical treatment for a period of at least 6 months AND significant functional impairment (as defined by BNSSG).

Referral via e-referral of patients with **rhinitis** to **'Adult Allergy'** is justified if:

- It is to **confirm the agent(s) responsible** for allergic rhinitis so that advice can be given on avoidance. If the allergen is already obvious clinically (e.g. pollen/cats) and/or if **testing can be performed in primary care** (e.g. specific IgE (previously known as 'RAST') to house dust mite/tree/grass/cat/dog etc), then referral for confirmation may not be necessary. Referrers will be expected to have undertaken this and referrals may not be accepted if not accompanied by these results.
- **Attempts to treat rhinitis in primary care as per '**RHINITIS – PAGE 1' guidance have not been successful or are genuinely not tolerated.
- For the **consideration of allergen desensitisation** therapy.
- For assessment for aspirin desensitisation if Samter's triad

RHINITIS ALLERGEN DESENSITISATION

Back to Rhinitis first page

Requesting advice

Requests for routine advice should be made through the Advice and Guidance option via e-referral. Urgent advice is available for GPs via the Southmead Hospital Switchboard – ask for Immunology Allergy Registrar/Specialist

RHINITIS ALLERGEN DESENSITISATION

Overview

Allergen desensitisation may be considered for patients whose symptoms of allergic RHINITIS cannot be adequately controlled in primary care and for those who genuinely cannot tolerate medical treatment.

Before referral for possible desensitisation, patients should to be aware that:

- The treatment involves a 3-year course of subcutaneous injections (weekly for the first 9 to 15 weeks depending on allergen, monthly thereafter) or daily treatment under the tongue
- The injectable treatment can only be given in the hospital clinic, at a set time during the week and there is a mandatory period of at least one hour after each injection, during which the patient must wait behind in the clinic for observation
- The first dose of under the tongue treatment needs to be given in hospital, and thereafter is given at home
- Fatal anaphylaxis is one possible outcome of the desensitisation treatment, although the risk of this is extremely small.

The following exclusion criteria for allergen desensitisation apply:

- Asthma which is severe enough to require long-term maintenance treatment with an oral steroid
- Patients on Beta-blocker therapy/Significant other co-morbidities

It should be noted that desensitisation, with its attendant risks, cannot be offered as a “lifestyle” treatment in cases where the allergen could reasonably be avoided without this having a devastating effect on the patient’s daily activities or employment (e.g. cat allergy in someone who does not meet cats during the course of their employment).

Referral via e-referral for consideration of allergen desensitisation

Should only be considered for patients whose symptoms of allergic rhinitis cannot be adequately controlled by the measures suggested in RHINITIS and for those who genuinely cannot tolerate the treatment.

Allergy Testing in Asthmatics

Testing of asthmatics for allergy can be a useful guide to help advise on allergen avoidance (i.e. 5mls of clotted blood for specific IgE (previously known as RAST) to suspected allergens).

A total IgE result can be useful to guide interpretation of specific IgE results, as a very elevated total IgE can result in non-specific low-level positivity to specific IgEs (i.e. a false positive). Please get in contact for advice if you suspect this may be the case and there is a clinical query.

The majority of asthma is intrinsic and therefore not helped by allergen avoidance. Extrinsic asthma may be diagnosed by the history and may be helped by allergen avoidance.

Referrals

The allergy service do not have expertise in the management of asthma – recommend referral to RESPIRATORY

Desensitisation therapy is not recommended as a treatment for asthma *per se*, because of a lack of efficacy in this context and concerns over safety in this clinical context .

REFERRALS WITH ASTHMA AS THE REASON FOR REFERRAL WILL NOT BE ACCEPTED

ECZEMA

Overview

Key points

- Patients with troublesome eczema are often keen to discover some avoidable dietary cause of their symptoms.
- Allergy testing does not reliably predict response to dietary avoidance.
- Many patients with eczema will demonstrate apparent sensitisation (positive skin prick test and/or circulating IgE) to dietary antigens which they know they can tolerate — this can lead to unnecessary food avoidance/anxiety.
- Please see hyperlinks for advice on identification and management of suspected food allergy.

HOW TO IDENTIFY A FOOD ALLERGY

MANAGEMENT OF SUSPECTED FOOD ALLERGY

Principles of management

If the history suggests *contact* eczema, skin *patch* testing may be worthwhile — patch testing is performed by DERMATOLOGY (e.g. at the Bristol Royal Infirmary).

If foods are suspected of exacerbating eczema then exclusion diets may be tried, and are sometimes of clinical benefit.

Referral

In the absence of symptoms of true food allergy, there is little to be gained by referring patients with eczema to an allergy clinic, but **REFERRAL TO DERMATOLOGY** may be helpful if their eczema merits this.

Referrals without a history suggestive of food allergy will not be accepted.

SUSPECTED DRUG ALLERGY

Overview

Antibiotics are the commonest cause of suspected drug allergy. When considering whether to refer a patient for investigation of possible drug allergy please be aware:

- Diagnostic tests are only available/recommended for those cases where the symptoms (urticaria, angioedema, bronchospasm, acute collapse) suggest the possibility of an IgE-mediated reaction (i.e. type I or immediate-type hypersensitivity)
- Even in these cases, although positive tests are informative, negative tests do not guarantee that a drug can be administered safely in the future
- The absolute standard for diagnosis is direct drug challenge — many patients will prefer simply to avoid future exposure than to undergo this

ADDITIONAL INFORMATION

- When the symptoms are other than those described above (e.g. **vasculitic or purpuric rashes** etc.), the diagnosis is purely clinical and avoidance is advised if the history suggests a drug reaction — there is unlikely to be any additional benefit from referral to the allergy clinic
- Although **NSAIDs** can cause symptoms indistinguishable from those of IgE-mediated allergy (up to and including anaphylaxis), the "hypersensitivity" is pharmacological rather than immunological. The diagnosis is clinical, there is no diagnostic test, and these drugs should be avoided if there is a strong index of suspicion. Most of these patients can take paracetamol without issue.
- Similarly to NSAIDs, **opioids** (e.g. morphine, codeine) may cause pharmacological rather than immunological hypersensitivity resulting in direct histamine release in a dose-dependent manner. Skin testing in this context is often unhelpful. If possible, alternative painkillers should be used. Some opioids are less prone to cause direct histamine release and may be tried (e.g. Fentanyl).
- **ACE-inhibitors** are well known to cause or exacerbate angioedema - please see This reaction is not immunologically mediated and there is no diagnostic test.

MANAGEMENT OF NON-ALLERGIC ANGIODEMA WITHOUT URTICARIA

Referral – Should be to the 'Adult Allergy' service

Referral (subject to the above information) via e-referral **should only be considered** when:

- There is an ongoing need for treatment with a drug (or related drug) suspected of causing an allergic reaction OR
- There is doubt as to which drug caused a severe allergic reaction and identification is important

For **penicillin/beta-lactam allergy** referral via e-referral is indicated only if:

- Patients need treatment for a disease or condition that can only be treated by a beta-lactam antibiotic OR
- Patients are likely to need beta-lactam antibiotics frequently in the future (e.g. people with recurrent bacterial infections or immune deficiency) OR
- Patients are unable to take beta-lactam antibiotics and at least 1 other class of antibiotic because of suspected allergy

Patients who do not fulfil these criteria should avoid beta-lactam antibiotics and use alternative agents

ANAESTHETIC ALLERGY

Overview

We provide a regional service for investigation.
Patients should be referred to the ‘Adult Allergy’ service.

Referral

Referrals usually originate from a Consultant Anaesthetist or Dentist, and GPs should not be expected to refer patients following hospital discharge. It is the responsibility of the anaesthetic team.
Please ensure that patients fit NICE guidelines for referral
https://www.nice.org.uk/guidance/cg183/resources/drug-allergy-diagnosis-and-management-pdf-35109811022821

ALLERGY TO BEE OR WASP VENOM

Overview

- Any patient with a history of respiratory symptoms or a systemic allergic reaction (generalised urticaria, angioedema, bronchospasm or anaphylaxis) following a bee or wasp sting *should* be referred for assessment.
- Many of these patients will need their own supply of adrenaline for emergency use. Please consider supplying prior to the patients review in allergy clinic.
- Venom allergen desensitisation will be appropriate for some.

It is *NOT* necessary to refer patients:

- For "screening" because they have other allergies
- Who have only had local reactions to stings (even though these can be quite severe)
- Because another family member is allergic to bee or wasp venom

If there is anxiety because of these situations, please consider asking for advice.

Advice

Requests for routine advice should be made through the Advice and Guidance option via e-referral. Urgent advice is available for GPs via the Southmead Hospital Switchboard – ask for Immunology Allergy Registrar/Specialist

Referral

Refer patients with a history of respiratory symptoms or a systemic allergic reaction following a bee or wasp sting to **'Adult Allergy'** services via e-referral.

C1-INHIBITOR DEFICIENCY

Overview

This rare problem, which can be hereditary or acquired, is likely to present as angioedema (without urticaria) and be considered under the 'URTICARIA and ANGIOEDEMA' section (see hyperlink) and should be managed as per the advice in 'MANAGEMENT OF NON-ALLERGIC ANGIOEDEMA WITHOUT URTICARIA' (see hyperlink below).

URTICARIA and ANGIOEDEMA

MANAGEMENT OF NON ALLERGIC ANGIODEMA WITHOUT URTICARIA

However, it deserves special mention as the presentation may be atypical and, in some cases, a patient with a known family history of hereditary angioedema may not yet have experienced symptoms.

Referral

Referral via e-referral is appropriate for exclusion of C1-inhibitor deficiency in any patient with:

Unexplained episodic angioedema and/or abdominal pain **OR**
a family history of the above (or of known hereditary angioedema)

AND

Complement component C4 measured at less than 0.15g/l (a normal C4 virtually excludes the diagnosis unless on treatment). Referral will not be accepted without the C4 result, unless there is a family history.

It is not necessary to measure C1- inhibitor level/function in general practice as there are subtle problems associated with this.

Refer to **'Adult Immunology'** service. Refer all members of an affected family for screening as reactions can be fatal.

IMMUNODEFICIENCY

Referral – Refer to 'Adult Immunology' service

Please consider referral in ***adult*** patients who have:

A recent or ongoing high infection frequency:

a. 4 or more infections requiring antibiotics within 1 year
b. 4 or more ear infections in 1 year
c. 2 or more serious sinus infections in one year
d. Two or more pneumonias in one year, or two or more radiologically proven pneumonias within 3 years
e. Two or more deep seated infections (e.g. sepsis, cellulitis, osteomyelitis, meningitis)

Unusual infections:

a. Recurrent deep skin or organ abscesses
b. Unusual infective organism or unusual location
c. Persistent thrush in mouth or fungal infection on skin

Poor response to treatment:

a. Requirement for prolonged antibiotic therapy
b. Two or more months on appropriate antibiotics with little effect
c. Need for intravenous antibiotics to clear infections
d. Surgical intervention for chronic infection, such as lobectomy for bronchiectasis, recurrent insertion of grommets or recurrent incision of boils

Family history of immunodeficiency

History of recurrent infection more than 6 months following chemotherapy/immunotherapy for cancer

Advice

Requests for routine advice should be made through the Advice and Guidance option via e-referral. Urgent advice is available for GPs via the Southmead Hospital Switchboard – ask for Immunology Allergy Registrar/Specialist

IMMUNOLOGY – PERIODIC FEVERS

Overview

- These conditions cause **recurrent fevers / inflammation** without obvious cause
- Patients typically present with intermittent fever, rash, abdominal pain, chest pain and/or diarrhoea, and a strong inflammatory response (e.g. **rise in CRP**).
- A **family history** is present in about 60% of cases and cases typically present in early childhood.
- These conditions are extremely rare and it is far more common that patients have a rheumatological, infective or haematological cause for recurrent fevers.

Referral

Please consider whether referral to an Immunology service is more appropriate than referral to rheumatology, infectious diseases or haematology.

In your referral, you should clearly demonstrate why you feel an autoinflammatory syndrome is likely – particularly by demonstration of an inflammatory response in the absence of infection.

Advice

Requests for routine advice should be made through the Advice and Guidance option via e-referral. Urgent advice is available for GPs via the Southmead Hospital Switchboard – ask for Immunology Allergy Registrar/Specialist

WHICH CLINICS TO REFER TO

- **'Adult Allergy Service – Southmead – RVJ'**
  - Urticaria and/or angioedema
  - Complex food allergy
  - Bee/Wasp venom allergy
  - Severe rhinitis not responding to antihistamines/topical steroids
  - Anaphylaxis
  - Drug Allergy
  - Anaesthetic Allergy – should be referred from secondary/tertiary care
  - Occupational Allergy
- **'Adult Immunology – Southmead – RVJ'**
  - Suspected or confirmed primary or secondary immunodeficiency
  - Suspected or confirmed C1 esterase inhibitor deficiency / hereditary angioedema
  - Suspected Periodic Fever Syndromes

Advice

Requests for routine advice should be made through the Advice and Guidance option via e-referral. Urgent advice is available for GPs via the Southmead Hospital Switchboard – ask for Immunology Allergy Registrar/Specialist

USEFUL REFERENCES

BSACI guidance on the management of chronic spontaneous urticaria and angioedema - https://www.bsaci.org/guidelines/chronic-urticaria-and-angioedema

BSACI guidance on the provision of an adrenaline autoinjector for allergy - https://www.bsaci.org/Guidelines/adrenaline-auto-injector

PATIENT RESOURCES

Patient information:

- Allergy UK: https://www.allergyuk.org/information-and-advice/conditions-and-symptoms
- Anaphylaxis campaign: https://www.anaphylaxis.org.uk/information-training/our-factsheets/
- Hereditary angioedema: https://www.haeuk.org/advice-support/links-resources/