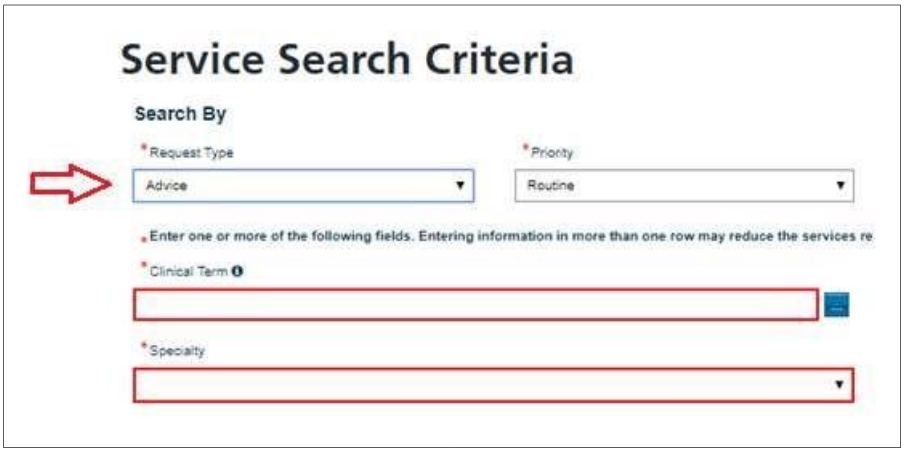
Homerton Healthcare
NHS Foundation Trust

# Advice and referral (A&R) at Homerton Healthcare NHS Trust

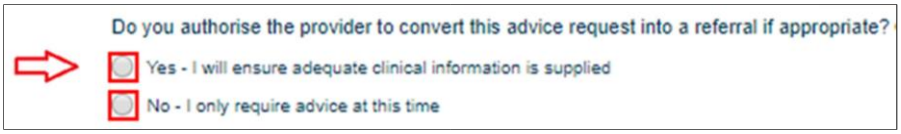
Homerton Healthcare NHS Trust are piloting advice and referral as the sole referral process, for the **Allergy** specialty, using the advice and guidance functionality on eRS (electronic referral service).

To refer to A&R, whether seeking advice or referral, you need to:

1. Change the default Request Type 'refer' to 'advice' on eRS and search for the service you are looking for:




2. Tick the box authorising conversion to referral like this:




'Good Practice' for GPs when referring/asking for advice via eRS

- Tell a story - Write in the freetext box (or task admin team to do so) a few sentences about the patient, the salient points and what question you have
- Attach any imaging that has been performed outside of Homerton Health e.g. in health images
- Check the directory of services (DOS) carefully to pick the correct one
- Continue to ask questions back to the consultant if you need to using the same UBRN

If you need help:

- Check if the information you need is in the Advice & Refer GP handbook:
- If you would like face to face training on how to use e-RS for Advice & Refer please contact nelcsu.gpittraining@nhs.net to arrange a training session

# Allergy referral Guide

## Conditions we can help with

- Food allergy / Oral allergy syndrome
- Allergic rhinitis
- Chronic spontaneous urticaria and angioedema
- Drug allergy
- Latex allergy
- Venom allergy
- Unexplained allergy / anaphylaxis

## Conditions we do not see

- Food intolerances (please refer to gastroenterology and dietitian).
- Difficult asthma (please refer to respiratory)
- Eczema / Dermatitis & other rashes (please refer to dermatology)
- Contact dermatitis (please refer to dermatology for patch testing).
- Mast cell activation syndrome (please refer to immunologist or dermatologist within interest in mast cell conditions)
- Immunodeficiency (please refer to immunology)
- Chronic fatigue syndrome / Fibromyalgia (please refer to rheumatology).
- multiple chemical sensitivity'

## Advice on common conditions

**Urticaria:**

if the patient has recurrent daily migratory generalised hives, this is most probably chronic (>6 weeks) or acute (<6weeks) spontaneous urticaria. This is not an allergic disease. The acute version can be commonly triggered by vaccines, infections, stress, surgery etc.. and can last for days to weeks.

The chronic version is an autoimmune skin condition that tends to burn out and resolve within 1 year (>90% cases), but it can recur. Treatment should be with second generation antihistamines (i.e. Fexofenadine 180mg once daily) which can be increased up to a four times daily regimen if needed, and montelukast 10mg nocte can also be added on in antihistamines resistant cases. Prednisolone can be useful as a short courses for severe flares (i.e. 30mg once daily for 3-5 days maximum). This can all be initiated in primary care. Allergy testing has no benefit in the management of this condition. NSAIDs can flare the condition so should be discontinued and avoided during periods of active urticaria.

When the patient has 3 months of fully controlled chronic urticaria, then antihistamines can be weaned off at a rate of 1 tablet every 4-6 weeks. It is important to be certain the condition is hives (i.e. rash vanishes within 24 hours), and not a dermatitis / eczema. For the latter please seek dermatology opinion. Allergy services

are happy to see poorly controlled antihistamine resistant chronic urticaria for consideration of Omalizumab (biologic) therapy.

**Rhinitis:**

Please send specific IgE blood test to the inhalants (grass pollen, tree pollen, house dust mite, animal dander, moulds), as this can be very helpful for us later on to expedite treatment decisions, and will help you diagnose whether they have a perennial or seasonal allergic rhinitis. If these are all entirely negative, please consider an ENT referral.

Please ensure all patients will severe allergic rhinitis are optimised to the following treatment before referral to us:

Dymista nasal spray 1 squirt both nostrils twice daily, Fexofenadine 180mg once daily, Azelastine/Olopatadine eye drops (if needed) and saline nasal douches.

**Rashes:**

Please confirm whether the rashes the patient experience are eczema/dermatitis, urticaria or another dermatosis. As per advice above, chronic recurrent hives is not allergy. For eczema/dermatitis please refer to dermatology, as we cannot undertake allergy testing in these cases. Please do NOT order allergy testing in patient with eczema or chronic rashes. Dermatology can consider patch testing if deemed relevant.

Please note that facial swelling that evolves into an eczema (i.e. periorbital dermatitis), is also not Type 1 allergy, and again they will benefit from dermatology input (i.e. for patch testing).

**Food allergy:**

Please prescribe x2 adrenaline autoinjectors if you feel the patient has had a convincing history of a reaction to a food (i.e. suggestive of Type 1 food allergy) or convincing history of anaphylaxis (i.e. unexplained). You do not need to wait for allergy clinic review to prescribe this.

Please avoid ordering food allergy specific IgE blood tests in primary care. Due to their hugely variable sensitivity and specificity they are best interpreted by an allergy specialist. In general, allergy blood tests should only be ordered if there is a clear convincing history suggestive of Type 1 allergy, and they are NOT a screening tool for unexplained symptoms or chronic rashes.

Please note that a raised Total serum IgE does not automatically mean they have underlying allergy and is quite commonly elevated in atopic individuals. Raised total IgE therefore on its own is not a reason for an allergy referral.

**Drug allergy:**

We need detailed information on the exact drugs implicated, clinical presentation, timings, onset and recovery information, as this helps us tailor the correct drug allergy investigations. Screening for drug allergy is not possible, so therefore not knowing the drugs involved unfortunately means we cannot accept the referral.

For general anaesthetic (peri-operative anaphylaxis), we need anaesthetic charts / notes and a completed NAP6 anaphylaxis referral form providing extensive detail on the suspected drug reaction to proceed with testing. The responsible anaesthetist should complete this. We can send over to you the required referral form once requested. Unfortunately, general anaesthetic allergy screening is not possible or useful, and we rely on knowing all drugs involving, clinical presentation, onset times to conduct accurate testing.