Immunoglobulins: Local list of indications for sub-regional use

Below is the list of indications that are approved by the London sub regional immunoglobulin assessment panels (SR-IAPs), where prior panel approval is not required for the first dose and therefore, patients diagnosed with any of the indications listed below can be administered **ONE dose of immunoglobulin only**. Retrospective feedback must be provided by the local IAP to the SR-IAP within an appropriate agreed time frame. Subsequent doses will be at the discretion of the SR-IAP based on the evidence provided. This is to ensure appropriate stewardship of immunoglobulin and compliance with the NHSE KPIs.

Condition	Designation	Selection criteria	Outcome measures (must provide baseline and subsequent follow up values)	Dosing (based on IBW)
Haematology				
Haemophagocytic syndrome	Commissioned	• Diagnosis by consultant haematologist based on bone marrow biopsy, AND OR • Pancytopenia, AND • Non-response to conventional treatment (e.g. corticosteroids, immunosuppressive agents, chemotherapy), OR • Conventional treatment is contra-indicated or inappropriate	Improvement of cytopenias Survival Improvement of HLH markers – ferritin/soluble CD25	Up to 2g/kg in two to five divided doses

Condition	Designation	Selection criteria	Outcome measures (must provide baseline and subsequent follow up values)	Dosing (based on IBW)
Haematology				
Acquired red cell aplasia associated with chronic parvovirus B19 infection	Commissioned	Parvovirus B19 infection: • Parvovirus B19 infection confirmed by PCR, AND • Evidence of high viral load, usually above 10^9 IU/ml In cases of foetal hydrops: • Likely to be associated with parvovirus B19	Rise in haemoglobin Transfusion independence Reticulocyte count	1-1.2g/kg in divided doses
Coagulation factor inhibitors* (alloantibodies and autoantibodies) – short term use:	Commissioned	<u>Acquired von Willebrand disease (VWD):</u> • Life- or limb-threatening haemorrhage, AND • Failure to respond to other treatments, AND/OR • Prior to invasive procedure • Treatment directed by the haemophilia centre at which the patient is registered	Rise of factor level Resolution of bleeding Number of bleeding episodes	Either 0.4g/kg for five days or 1g/Kg for two days

Condition	Designation	Selection criteria	Outcome measures (must provide baseline and subsequent follow up values)	Dosing (based on IBW)
Neurology				
Acute disseminated encephalomyelitis/ idiopathic transverse myelitis	Commissioned (left-hand grey)	• Diagnosis confirmed by a neurologist; • Reduced level of consciousness (GCS<14) • Plasma exchange not available or contra- indicated • Failure to respond to IV steroids and plasma-exchange.	Improvement in level of consciousness (GCS) Improvement in Expanded Disability Status Score (EDSS)	2g/kg
Auto-immune encephalitis	Commissioned (left-hand grey)	• Diagnosis by a neurologist • Probable/definite autoimmune encephalitic syndrome associated with autoantibodies where plasma exchange is contra-indicatedUnexplained limbic encephalitis (LE) • Unresponsive to acyclovir. • Relapse in a patient with known LE inaccessible or contra-indicated. • Unexplained limbic encephalitis LE • Unresponsive to aciclovir. • Relapse in a patient with known LE.	Improvement in cognitive function Resolution of seizures Improvement in level of consciousness (GCS)	2g/kg

Condition	Designation	Selection criteria	Outcome measures (must provide baseline and subsequent follow up values)	Dosing (based on IBW)
Infectious Diseases				
Necrotising (PVL-associated) sepsis Staphylococcal or streptococcal toxic shock syndrome	Commissioned	• Diagnosis of streptococcal or staphylococcal toxic shock syndrome, preferably with isolation of organism; • AND failure to achieve rapid improvement with antibiotic therapy and other supportive measures; • AND life threatening.	Improvement of FBC, ALK and CPK Reduction in hospital in-patient stay Survival (yes/no)	2g/kg as a single dose
Severe or recurrent Clostridium difficile colitis	Commissioned	• Severe cases (WCC >15, acute rising creatinine and/or signs/symptoms of colitis) not responding to oral vancomycin 125 mg qds, high-dosage oral vancomycin +/- iv metronidazole 500 mg tds is recommended; the addition of oral rifampicin (300 mg bd) or IVIg may be considered. • If multiple **recurrences**, especially if evidence of malnutrition, wasting etc., consider IVIg.	Any significant clearance of *c.diff.* Duration of hospital in-patient stay	0.4g/kg in one dose

Condition	Designation	Selection criteria	Outcome measures (must provide baseline and subsequent follow up	Dosing (based on IBW)
Infectious Diseases				
Measles (immunosuppressed individuals)	Commissioned	Immunosuppressed individuals (Group A and Group B based on level of immunosuppression: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/637003/Guidance_for_measles_post-exposure_prophylaxsis.pdf) who have had a significant exposure to measles and are known to be susceptible (based on vaccine history and /or IgG testing).	Prevention of measles	0.15g/kg of IVIg recommended ideally within 72 hours of exposure although can be given up to 6 days. Where exposure recognised late or found to be antibody negative between 6 and 18 days after exposure, IVIg may be considered following discussion with specialist clinician.

Condition	Designation	Selection criteria	Outcome measures (must provide baseline and subsequent follow up values)	Dosing (based on IBW)
Measles (pregnant women and infants)	Commissioned	Pregnant women who have identified as susceptible based on vaccine history and /or antibody testing who have had a significant exposure to measles Infants under 9 months of age with a significant exposure to measles.	Prevention of measles	• For pregnant contacts approximately 2250mg – equivalent to 3 vials of Subgam • Infants 0.6ml/kg up to a maximum of 1 vial (750mg) Subgam Subgam to be given within 6 days of exposure in pregnant women and infants.

Condition	Designation	Selection criteria	Outcome measures (must provide baseline and subsequent follow up values)	Dosing (based on IBW)
Infectious Diseases				
Varicella zoster	Commissioned	Individuals for whom intra-muscular injections are contra-indicated (e.g. those with bleeding disorders) and thus cannot receive prophylaxis with VZIG IVIg is indicated for these Individuals who fulfil all of the following three criteria: 1) Significant exposure to chickenpox (varicella) or shingles (zoster) during the infectious period 2) At increased risk of severe chickenpox i.e. immunosuppressed individuals, neonates and pregnant women 3) No antibodies to varicella-zoster virus (based on VZV antibody testing) Immunosuppressed individuals are assessed at time of exposure into Group A & Group B based on likely level of immunosuppression Revised restrictions have been in place since August 2018 with VZIG currently being advised for women exposed in first 20 weeks of pregnancy and neonates. It is not clear how long these restrictions will be in place and when VZIG supplies will return to expected levels. Advice is available at: https://www.gov.uk/government/publications/varicella-zoster-immunoglobulin	Prevention of chicken pox infection Prevention of severe chicken pox	0.2g IVIG per kg body weight (i.e. 4ml/kg for a 5% solution) Brands have not been specified as no formal testing of products has been undertaken. VZIG (or IVIg when VZIG contraindicated) should be administered ideally within 7 days of exposure in susceptible immunosuppressed individuals. Where the exposure has been identified beyond 7 days, VZIG can be offered up to 14 days after exposure. Beyond this time for patients in both groups A & B, a discussion with the specialist caring for the individual should take place and IVIg (0.2g/body weight) may be considered in susceptible individuals for up to 21 days to attenuate infection.

Condition	Designation	Selection criteria	Outcome measures (must provide baseline and subsequent follow up values)	Dosing (based on IBW)
Rheumatology (adults and children)				
Catastrophic antiphospholipid syndrome	Commissioned (left-hand grey)	Diagnosis confirmed by haematologist or rheumatologist based on: • Demonstration of multiple small vessel thromboses • Presence of one or more phospholipid antibodies (ACL, anti-B_2GPI, LA) Plasmapheresis not available or contra-indicated; Unresponsive to plasmapheresis or conventional anti-thrombotic	Survival	2g/kg

Condition	Designation	Selection criteria	Outcome measures (must provide baseline and subsequent follow up values)	Dosing (based on IBW)
Others				

Solid organ transplant	Commissioned	Steroid resistant rejection where other therapies are contraindicated post heart, lung or renal transplant	Renal
			• Patient survival
			• Graft survival
			• Renal function
			• HLA class DSA
			• Further rejection episodes
			Cardiothoracic
			• Patient survival
			• Graft survival
			• Graft function
			  ○ Heart: ejection fraction
			  ○ Lung: spirometry
			• Length of ITU / hospital stay
				2g/kg

Condition	Designation	Selection criteria	Outcome measures (must provide baseline and subsequent follow up values)	Dosing (based on IBW)
Others				
Kawasaki disease	Commissioned	Clinical diagnosis of Kawasaki disease by a paediatrician or an immunologist	Resolution of fever	2g/kg single dose, given over 10–12 hours, in conjunction with high-dose aspirin; a second dose may be given if no response, or if relapse within 48hours