DRUG ALLERGY GUIDELINE

Stakeholders Workshop - Group Discussion Notes

Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, Regent's Park, London, NW1 4RG.

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Group 1 Membership

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Group 1 Summary of Discussions

Facilitator Question	Group response
Any thoughts on a definition for Drug Allergy?	1. The group thought a definition would be very challenging as it was difficult to describe the complexity of drug allergy in one sentence. The technical team was referred to the recently published BSACI guideline which provides a useful definition. 2. The team was asked to note that allergic reactions could cover: Immunologically mediated or non-immunologically mediated and non IGE mediated events. Clinicians have a tendency to group reactions into the gell coombs classification Types 1, 2, 3, and 4 and 5 so the different categories of allergic type reactions would need to be considered when defining drug allergy for the scope. 3. The definition would be affected by whether the guideline is pharmacology driven or immunology driven. 4. The clinical features that clinicians look for in identifying drug allergy, may need to be mentioned in the definition for clarity. 5. Misconceptions that affect referrals may need to be addressed through the definition. Specifically stating: the signs symptoms needing to be considered angioedema, anaphylaxis, rash (which could then be split into several different types of rash). Important to ask patients if they are allergic. 6. The group discussed the merit of including symptoms that may present as drug allergy but more than likely be ADRs.
Current practice	7. The clinical need for the guideline has not been included in this part of the scope. Self reported and reported drug allergies are common but poorly addressed by the NHS, lots of self diagnosis, miss diagnosis and incorrect labelling of patients with allergies and variations of care across the country need to be mentioned. 8. The service provided by specialist centres are vastly inconsistent, there is variability in access to specialist centres, and upon the types of drugs that may be tested for allergy at these centres therefore with primary care, GPs, emergency services, pharmacies as the referral pathway is currently varied? 9. Current issues in practice with collection and dissemination of information which is sometimes affected by patient's inability to communicate for a range of reasons including, dementia or other cognitive difficulties, or clinicians encountering patients who do not speack english. 10. It was felt that it was odd to list cancer drugs at the top of this list as referrals for allergies to these drugs are rare and generally dealth with by cancer sepcialists
Population? Appropriate or specific subgroups that have not been mentioned.	11. What about people with allergy to general anaesthetic? 12. Maybe special consideration should be given to immuno surpressed groups. (HIV etc.) 13. Patients with multiple drug allergies were mentioned by the group as needing special consideration.
Healthcare setting	14. There is no simple test that can be done in primary care settings that could identify drug allergy, so the services provided in specialist centres are key to the very complex process. Some tests

Facilitator Question	Group response
	done in primary care are also inappropriate and should not be done speciifcially skin testing for drug allergy and penicillin specific IgE
Clinical issues that will be covered	15. Local anaesthetics and general anaesthesia and penicillin and hypersensitivity to NSAIDS should remain included. 16. Penecillin was felt to be too narrow. Beta lactams may be more appropriate although this still doesn't take into account cross reactivity with cephalosporins 17. . 18. Documentation of symptoms so that primary and secondary care practitioners have access to information. The potential challenges faced with documentation would include: • putting systems in place to update documentation and finding a way to ensure that clinicians have access to allergy details outside of GP hours. • Dealing with patient ignorance, as patient may not be aware of the name or brand of the drug used. • Addressing patients who may not have the cognitive ability to communicate details related to their drug reaction. • Possibly encouraging patients to photograph topical reactions to drugs to aide documentation (this was, however highlighted as a possible equalities issue as not all patients may have access to mobile technology). 19. Would topical drugs be covered by the guideline? 20. Would other related allergies be considered, for example Latex allergies in vaccines where syringes are made from latex. 21. It was also considered that egg allergies in the make up of certain vaccines may be an issue 22. Biologics was highlighted as an area where increasingly more referrals are seen in specialist centres.
Clinical issues that will not be covered	23. Allergic parents and child's potential for allergy to same drug. (there is no evidence, but it is a common question) – would this be addressed in the guideline. 24. Excluding (ruling out of) drug allergy is an important issue, and relevant to economics. 25. The identification of suitable drugs is key, and relevant to economics.
Main outcomes	26. Documentation/Initial event should be number one outcome. Documentation vs. No documentation. Maybe audits specific to documentation would help with searching for this question. 27. Recording suspicion of event – to assist with referral for testing. 28. Health professionals to check allergies before prescribing. 29. How often are GP electronic records checked. 30. Standards for documentation and testing. 31. Items 4.4 c, d, e and f should take priority in health care settings. 32. Possibly no data available for health related quality of life. Quality of life affects parents for example, who need to take children to paediatric clinics for every jab. 33. Should morbidity be added to the list of outcomes?
Service Delivery	34. The group agreed that a national database similar to the one used in France to capture drug allergy data at the national level, would

Facilitator Question	Group response
	be useful, their discussion on the challenges this would present included: • The possibility in a database that presented two sets of data: perceived allergies and proven allergies, with great variance in numbers. Currently perceived are incorrectly labelled or under-reported. Diagnosis also poor as there are insufficient specialist centres conducting tests. 35. Currently GPs must mandatorily report drug allergies, but there are questions surrounding the accuracy of that data. 36. There is no national collaboration between speicialsit allergy clinics. 37. Currently an unpublished audit shows large variations in practice. 38. Standards for documentation could be improved by including allergy information on prescription forms. 39. Appropriate referral to a suitable centre.
Economic aspects	40. The group agreed that there would be difficulty collecting HE related information as there was little data available on QALYs. 41. Exclusion of drug allergy and identification of suitable drugs have the biggest implications for health economics.
GDG membership	42. Suggestions included: • Dentist as a co-optee would answer questions on what this group of clinicians would find useful. This may help the GDG understand how the guideline would be used? • Add Pharmacist to list, possibly a community pharmacist. • Should non medical prescribers need to be represented on the group?

Group Summary

- General approach to developing guideline preferred.
- Definition, what drug allergy is, define common clinical features – this will be helpful to all users in the community: GP, district nurses and other prescribers.
- Identification of drug allergy as opposed to diagnosis.
- Appropriate referral.
- Documentation and the need for a national system that link service providers.

Group 2 Membership

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Group 2 Summary of discussions

Facilitator question	Group response
Definitions	43. Clinicians and non clinicians have views on what drug allergy refers to. Will topical medicines be included? The group had concerns that this group of allergies could be hidden in the guideline or not sufficiently addressed. 44. A comprehensive guideline may be incredibly complicated. 45. In defining drug allergy, it would be wrong to focus on IGE mediated drug allergy which is just one aspect of the spectrum. 46. Should be Immune mediated allergies only , which includes type 1 sensitivities, and cell mediated hyper-sensitivities or severe delayed hyper-sensitivity. 47. The group thought it would be impossible to provide specialist clinicians with a protocol for each existing drug. So will need a broad definition to include all reactions, but the guideline will not be able to provide detailed specialist guidance for every single drug. 48. May be better to do guideline on presented symptoms as may be a more useful guide and a simpler approach for developers. This may be best in the allergy field with is largely complicated and little understood.
Clinical need for the guideline	49. The quality of information across services is poor, little details on drug, little context, if labelled as having an allergy, no details available on diagnosis or source of labelling. 50. Quality of allergy information available is poor.
Current practice	51. Very little follow-up on suspected allergy in existing practice, and very few referrals for allergy testing. 52. In some services, recording of an allergy is pretty straight forward, the nature of the reaction must also be recorded along with how the allergy has been confirmed, but there is variation in services nationwide. 53. Intolerance needs to be separated from immune based reactions. 54. Care records currently don't provide forms for collection of data on both, so the one box approach to collecting data on drug allergy is insufficient. 55. There is currently a prevalence of uninformed patients and carers. Comparisons were made to nut allergy sufferers who are educated and aware of the consequences and dangers of their allergy. 56. Different geographical levels of care were highlighted by the group, along with a seeming lack of interest about drug allergy nationwide. 57. The group suggested that tracking information would be helped by more details on summary care records. 58. Cross contaminants were mentioned as a concerns, e.g. drug coated devices, antiseptics used in surgery. (the chair joined the group at this point and mentioned that this issue would be looked at when reviewing reactions during general

Facilitator question	Group response
	anaesthesia) 59. Concerns about how we go about ensuring that guidelines are followed were expressed, the groups wants to see clear guides on who patients get referred to. 60. Incorrect labelling of patients as penicillin is approximately 10% of the population. The testing is complex and extensive. Starts with skin prick test, once positive no further investigation needed. In 20% of cases, the skin prick test is not enough, so further testing is required after negative results. 61. Human factor: safe health care cannot be delivered if we are not acting on the information provided. Dispensing drugs that patients are allergic to. 62. Fears that guideline would focus on great diagnosis and not address patient care. 63. The label of drug allergy is not taken seriously.
Population	64. Are there specialist considerations for children and women. Most paediatricians do some testing for allergy. But for pregnancies, no challenging tests should be done due to risk to child. 65. Criteria for referral different for children.
Healthcare setting	66. What constitutes a specialist allergy service varies across the service. Its important to understand the services offered in these services.
Clinical issues that will be covered	67. Details about the desensitisation process should not be provided. Mentioning it as a treatment option would be ok. Same for challenge testing exists. Make recommendations as in what type of patient the criteria for considering for referral. 68. Avoidance should be included. 69. Sulphur containing drugs should be added to the list of drugs on which specific guidance will be provided. NSAIDS should be included on this list as well. 70. Predictive testing for non anaphylasix type reactions should be included. General consensus now that gene testing could help to identify allergies in advance. It would be helpful to recommend research in this field. 71. General anaesthesia, allergy guidelines already
Clinical issues that will not be covered	72. Agreed that guideline should not cover acute management (symptomatic treatment of anaphylaxis)
Main outcomes	73. Concerns about sub-optimal service should be highlighted as a key outcome.
Economic aspects	74. Allergy testing.
GDG Membership	75. Add pharmacist, preferably someone familiar with a systems approach to documentation - medical safety pharmacists (common in secondary care setting). 76. Pharmacologist – as it may be rare to find one with an interest in drug allergy. 77. Cooptee in electronic records.

Facilitator question	Group response
	78. Non special responsible for acute medical. 79. Strive for balance between generalist and specialist. 80. Need for more primary care representation on the group.

Group Summary

- Documentation a strong theme throughout discussions, but the group stressed the need for patient responsibility and the role that service delivery would play in ensuring that documentation is used in an accurate and timely fashion. The group thought that prompts were needed on relevant forms to guide the collection of information and diagnosis.

- The group thought that the separation of drug allergy and intolerance would be key in refining the definition of drug allergies for the scope and explored ideas on which clinicians would be responsible for diagnosis of either.

- Focus on general issues related to drug allergy and not touch on what gets done after referral to specialist as this will be covered by specialist remits. Possibly remove radiocontrasts, chemotherapeutic drugs and biologics from list of excluded clinical topics as the group thought it would be inappropriate to eliminate any medicine group from the general issues being covered.

- Information collection key, challenges identified with patient not having information about the drugs they have had reactions to, or details related to their reaction.

- Human errors a strong theme coming out of discussions.