NICE National Institute for Health and Care Excellence

Appendix A: Stakeholder consultation responses table

2026 surveillance of CG134 Anaphylaxis: assessment and referral after emergency treatment

Consultation dates: 21st January to 3rd February 2026

Proposed new recommendations 1.3.1 to 1.3.4 post-anaphylaxis observation periods for children and adults. Do you agree with the proposal to update CG134 recommendations about post-anaphylaxis observation periods with the Resuscitation Council UK's recommendations? Yes/no. Please provide a rationale for your decision		
Stakeholder	**Responses**	**NICE response**
Resuscitation Council UK	Yes. It is important to align this recommendation with the RCUK guideline (which is widely used in UK hospitals). With the arrival of non-injectable forms of adrenaline in the UK (e.g. EURneffy, now licensed by MHRA), recommendation 1.3.2 should be changed to "2 doses of adrenaline" (rather than IM adrenaline).	Thank you for your response. We have adapted the recommendation from the Resuscitation Council's guideline which specifies IM adrenaline. We are aware of EURneffy's licensing for anaphylaxis in people weighing 30kg or more. We considered this issue in a surveillance review and do not propose to update recommendations about this

Responses received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The responses are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees

		at this time because of a lack of evidence. We have highlighted intranasal adrenaline to the NIHR as an area for research.
Resuscitation Council UK	The wording in 1.3.4 might be misleading. This refers to a scenario where someone has undergo intentional allergen exposure e.g. following a supervised allergy challenge in a specialist setting. The RCUK guidelines states that "It may be reasonable for some patients to be discharged after 2 hours despite needing two doses of IM adrenaline" under such circumstances, while the proposed change to CG134 says "should consider". This should be changed to "can consider" to align with RCUK, and prevent implying that such patients should be discharged after 2 hours.	Thank you for your response. We disagree that the wording could be misleading. The recommendation says 'should consider' which we think is the most active language we can use to indicate that the most appropriate course of action for a clinician is to assess someone for their suitability for 2 hour discharge because anaphylaxis was induced and resolved under controlled conditions.
Royal College of Anaesthetists	Yes. This makes the guidance consistent with the Resuscitation Council UK's advice and thus avoids any confusion over discrepant guidance.	Thank you for your response.
College of General Dentistry	Yes to bring in to line with other recommendations.	Thank you for your response.
South Eastern Health and Social Care Trust	It is necessary for all children who have had anaphylaxis to be admitted. Perhaps adding "Consider" admitting children.....is more appropriate.	Thank you for your response. Considering your comments and those of other stakeholders, and following consultation with a clinical colleague at NICE, we have amended the wording of the recommendation to recommend to admit young people and children under 16 years under the care of an inpatient paediatric medical team if they cannot be discharged in accordance with the criteria for 2 hour discharge. This is to help ensure that a child accesses the

		most appropriate care pathway and to free up capacity in emergency departments.
South Eastern Health and Social Care Trust	There are families who are competent in managing anaphylaxis and a period of observation of between 6-12 hours, like in adults I think is more than reasonable. More importantly, an urgent outpatient patient referral to the local allergy team should be made and a member of medical team training the family how to use an AAI and providing them with an AAI prior to discharge is more appropriate.	We have amended observation times to include a fast track 2 hour discharge in line with the Resuscitation Council's recommendations. Re your comment 'More importantly an urgent outpatient referral…' this is covered by the recommendation to refer to a specialist allergy service which recommends 1.5.1 After emergency treatment for suspected anaphylaxis, offer people a referral to a specialist allergy service (age-appropriate where possible) consisting of healthcare professionals with the skills and competencies necessary to accurately investigate, diagnose, monitor and provide ongoing management of, and patient education about anaphylaxis. Re your comment 'medical team training the family how to use an AAI…' this is covered by the discharge recommendation which recommends 'At discharge following emergency treatment for suspected or known anaphylaxis, ensure the adult, young person or child has 2 in-date adrenaline auto-injectors (via a prescription, if needed) and knows when and how to use them, unless the anaphylaxis was due to a drug allergy and the drug can be easily avoided.' It is also covered by the recommendation that recommends before discharge that the adult, young person or child (or their parent or

		carer as appropriate) should be offered a brand-specific demonstration of the correct use of the adrenaline auto-injector and when to use it.
The Royal College of Pathologists	Yes – this would result in the various guidelines being consistent.	Thank you for your response.
Association of Paediatric Emergency Medicine	Yes, these are pragmatic and realistic	Thank you for your response.
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	Yes it is important to align this recommendation with RCUK for consistency of practice across the UK and to ensure NICE audits reflect RCUK recommendations which have been widely implemented. However some specific feedback: 1.3.1: • the person already has a supply of prescribed adrenaline auto-injectors and knows how to use them, To ensure healthcare professionals don't accidentally assume that if they prescribe adrenaline devices for the first time in hospital this then qualifies as "already has a supply" perhaps consider rewording to: • the person already has a pre-existing supply of prescribed adrenaline auto-injectors prior to this presentation and knows how to use them Or add: not suitable for those being prescribed adrenaline devices on the first occasion. i.e. those getting a first time diagnosis and don't have adrenaline already from a previous prescription are not	Thank you for your responses. We agree with your suggestion and your rationale which will act to better align recommendation 1.3.1 with the Resuscitation Council's original recommendation. We have amended the wording to clarify that a supply is 2 in date AAIs in line with MHRA guidance. We also agree with adding the words 'and when' to the recommendation and will amend it to 'knows how and when to use them.'

	eligible for 2hr discharge. Also the wording of "…knows how to use them" misses the requirement that the patient should know "when to use them". Please consider changing to "how and when to use them". It may be helpful to consider whether a final "AND" bullet point should be added of: • The patient/carer feels comfortable and confident with discharge after 2 hours of observation.	Adding 'And the patient carer feels comfortable…etc' is going beyond what the Resuscitation Council explicitly recommends. Patient confidence as you highlight is very important however we feel it is implicit in the accompanying bullets about symptom resolution, access to, and familiarity with adrenaline auto injectors, and having adequate supervision from an appropriate adult. It is also implicit in the guideline. The guideline your responsibility section notes that health care practitioners 'are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service.'
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	Also the wording "a supply of" may be too generic given there are clear MHRA recommendations on how many should be prescribed. Please consider rewording to make it clearer how many is a "supply". In most instances this is enough for them to have 2 within date devices with them at	We have amended 1.3.1 to make it clear that a supply is 2 in date AAIs in line with MHRA guidance. We will also amend discharge recommendations to align them more clearly with MHRA guidance that people should be prescribed 2 AAIs if they do not already have 2 in date devices.

	all times. In rare instances a patient may be recommended to have more than that.	
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	1.3.2 - • Observe the adult, young person or child for a minimum of 6 hours after resolution of all symptoms if:… The "after resolution of all symptoms" may not be most appropriate here and doesn't match with the structure of 1.3.1 which times discharge from resolution of "anaphylaxis symptoms". The reason for raising this is sometimes waiting for resolution of ALL symptoms leads to patients being kept in A+E for very long periods to await resolution of face or lip or eye swelling. Sometimes signs like eye or face swelling can take days to resolve. A clarifying sentence may be beneficial here.	The wording 'Resolution of symptoms' in 1.3.2 as distinct from resolution of anaphylaxis used in 1.3.1 is intentional. This is in line with the Resuscitation Council's guidance which recommends to 'Consider fast-track discharge (after 2 hours observation from resolution of anaphylaxis) if…' and observation for a 'Minimum (of) 6 hours observation after resolution of symptoms (is) recommended if…' (see table on p.43 of Emergency treatment of anaphylaxis Guidelines for healthcare providers.).
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	• 2 doses of intramuscular (IM) adrenaline were needed to treat the anaphylaxis or "intramuscular (IM) is not specified in 1.3.1 which simply refers to "to a single dose of adrenaline". Given that different routes of adrenaline administration are now available on the NHS/MHRA approved for use for treating anaphylaxis and other devices on the way e.g. sublingual tablets, perhaps this is better future-proofed by simply using the phrase "2 doses of adrenaline"	Thank you for your response about 1.3.1 not specifying intramuscular (IM) adrenaline. We will amend this to ensure consistency with 1.3.1 and the Resuscitation Council's treatment algorithm which refer to IM adrenaline (fig.6 p.25 of Emergency treatment of anaphylaxis Guidelines for healthcare providers). We are aware of the licensing of intranasal adrenaline. We considered the issue in a surveillance review and do not propose to update recommendations on this at this time because of a lack of evidence. We have highlighted intranasal adrenaline to the NIHR as an area for research.

	An explanation of what is meant by the term "dose of adrenaline" can then be specified in the glossary to include all options available e.g. adrenaline autoinjector, needle and syringe IM injection, nasal spray.	Thank you for your response about the dose of adrenaline in 1.3.1. Emergency treatment is not within the scope of CG134 and by extension neither is defining adrenaline dosages. CG134 covers the correct identification and referral of anaphylaxis. Emergency treatment of anaphylaxis including dosages is covered by the Resuscitation Council's Emergency treatment of anaphylaxis Guidelines for healthcare providers which is linked to from CG134's introduction page.
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	1.3.3: • the person has severe asthma or had anaphylaxis that involved severe respiratory compromise, or To flag, "anaphylaxis that involved significant cardiovascular compromise" or "anaphylaxis that resulted in significant postural hypotension" have not been covered in the recommendations. Is there a default recommendation statement required to guide healthcare professionals of the default duration of observation when in doubt or unlisted scenarios? • the person presents out-of-hours, or may not be able to seek help in response to a deterioration in their condition, or The way this is written may be confusing – I think it should be referring to "…seek rapid/acute emergency response if a deterioration or recurrence of symptoms."	The Resuscitation Council's Emergency treatment of anaphylaxis Guidelines for healthcare providers which is linked to from CG134's introduction page, also covers the treatment of patients with significant cardiovascular compromise and significant postural hypotension. We agree with your responses about 1.3.3 bullet point 5 'the person presents out-of-hours'. We have made 'out-of-hours' a separate bullet point and bring the remaining wording into line with the Resuscitation Council's wording including 'may not be able to respond to any deterioration' to ensure it covers the groups you highlight.

	One element of the assessment that is missing from what is listed in Resus Council UK recommendations is " the patient may not be able to respond to any deterioration". This is intended to cover the physically disabled adult or young person without a carer present e.g. not being able to self-administer another dose of adrenaline should they have a recurrence of anaphylaxis once discharged in the acute time window in which a biphasic reaction may occur. Please consider adding the bullet point to address this.	
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	• Observe the adult, young person or child for a minimum of 12 hours after resolution of all symptoms if: Similar to the response above re: considering aligning the resolution wording here to that of 1.3.1 i.e. ...."after resolution of anaphylaxis symptoms" or adding a sentence guiding HCPs that "mild skin symptoms or nasal congestion may persist for several hours/days. However, do no preclude discharge if these minor symptoms remain on stable or improving trajectories.	Thank you for your response re 'Observe the adult...for a minimum of 12 hours'. This is in line with the Resuscitation Council's recommendations about observation periods which recommends 'Observation for at least 12 hours following resolution of symptoms if any one of the following...etc'. It is intentional that 1.3.3 says resolution of symptoms as distinct from resolution of anaphylaxis as per 2 hour discharge. (see table on p.43 of Emergency treatment of anaphylaxis Guidelines for healthcare providers.). The RCUK clarified with us that resolution of symptoms (rather than the 'ABC' symptoms of anaphylaxis) is used for the longer observation periods because it is a more cautious and conservative management strategy for people who may be at higher risk of a secondary reaction.
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	1.3.4 – The wording may be confusing. Especially the "should consider discharging" as this is based on clinician experience and expertise of anaphylaxis management. This	Thank you for your response. We disagree that the wording could be misleading. The recommendation says 'should consider' which we think is the most active language to indicate that the most

	should be reworded. Consider: If anaphylaxis occurs at a hospital-supervised allergen challenge, even if 2 doses of adrenaline were required to treat the reaction, a suitably qualified and experienced healthcare professional may consider discharging the adult, young person or child after 2 hours of observation from the time of resolution of the anaphylaxis if all other features of presentation are reassuring and training on reaction management has occurred. .	appropriate course of action in this situation is that a clinician should assess someone for their suitability for 2 hour discharge because anaphylaxis was induced and resolved under controlled conditions.
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	Additionally, again the statement uses the term “IM adrenaline”. Consider changing to “2 doses of adrenaline”	Thank you for your response. We are aware of other routes of adrenaline administration including the recent licensing of EURneffy, for anaphylaxis in people weighing 30kg or more. We considered this issue in a surveillance review and do not propose to update recommendations on this at this time because of a lack of evidence. We have highlighted intranasal adrenaline to the NIHR as an area for research.

British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	It is also likely to be beneficial to add “Supervised allergen challenge” to the glossary as this is not a procedure that is widely known and may confuse people who don’t practice in this area and therefore don’t know that this is an allergy day case procedure. Consider something like. Hospital supervised allergen challenge: A day-case or outpatient procedure often undertaken by allergy departments where a supervised exposure to an allergen in undertaken to investigate whether an allergic reaction is provoked by the exposure. This is a diagnostic investigation to confirm or de-label an allergy	Thank you for the suggestion. We have added a definition of supervised allergy challenge to the glossary of terms taking into consideration your suggested wording.
NHS England	Agree with these updates in line with resus council recommendations. For 1.34 - what is the definition of a suitably qualified clinician and should this be stated? For 1.34 - if you have a food challenge - should you only be discharged after 2 hours if you also don't have any of the preceding other high risk criteria?	Thank you for your responses. It is the remit of a health care practitioners’ particular professional body to set standards of ‘suitably qualified’. This is not within NICE’s remit and so we have not specified a definition. Yes, that is correct, only if the other criteria in recommendation 1.3.1 apply and high-risk criteria do not apply.
Proposed new recommendation 1.4.1 admission of children who cannot be safely discharged. This recommendation has been added to make it clear how children who do not meet criteria in proposed recommendations 1.3.1 to 1.3.4 should be cared for. Do you agree with the proposal to recommend that children younger than 16 years who cannot be discharged using the discharge criteria recommended by new proposed recommendations 1.3.1 to 1.3.4 should be admitted under the care of a paediatric medical team?		

Yes/no. Please provide a rationale for your decision			
Stakeholder	**Overall response**	**Responses**	**NICE response**
Resuscitation Council UK		Yes, although the wording could be improved to make it clearer that this is with respect to children who do not meet criteria in proposed recommendations 1.3.1 to 1.3.4, i.e. "Children who cannot be discharged under the above recommendations should be admitted under the care of a paediatric medical team".	Thank you for your response. Considering your comments and those of other stakeholders, and following consultation with a clinical colleague at NICE, we have amended the wording so that the recommendations recommends admitting young people and children under 16 years under the care of an inpatient paediatric medical team if they cannot be discharged in accordance with the criteria for 2 hour discharge. This is to help ensure that a child accesses the most appropriate care pathway and to free up capacity in emergency departments.
Royal College of Anaesthetists		Yes. This makes the guidance consistent with the Resuscitation Council UK's advice and thus avoids any confusion over discrepant guidance.	Thank you for your response.
College of General Dentistry		Yes would make sense and cover potential loop hole in current recommendations.	Thank you for your response.
South Eastern Health and Social Care Trust		I do not think it is necessary for all children who have had anaphylaxis to be admitted. Perhaps adding "Consider" admitting children.....is more appropriate. There are families who are competent in managing anaphylaxis and a period of observation of between 6-12 hours, like in adults I think is more than reasonable. More	Thank you for your response. Considering your comments and those of other stakeholders, and following consultation with a clinical colleague at NICE, we have amended the wording of the recommendation so that it recommends admitting young people and children under 16 years under the care of an inpatient paediatric medical team if they cannot be discharged in accordance with the criteria for 2 hour discharge. This is to help ensure that a child

	importantly, an urgent outpatient patient referral to the local allergy team should be made and a member of medical team training the family how to use an AAI and providing them with an AAI prior to discharge is more appropriate.	accesses the most appropriate care pathway and to free up capacity in emergency departments. We think that your comments about referral and access to AAIs are covered by the discharge recommendations. These recommendations recommend: referral to a specialist allergy service, equipping people with 2 in date AAIs, a brand specific demonstration of their use and advice to carry them at all times.
The Royal College of Pathologists	Yes, that is reasonable. Should there also be a similar recommendation for people 16 and over?	Thank you for your comment. Recommendation 1.4.1 was made by the committee at the time of guideline development and is specifically aimed at children. The committee agreed that children younger than 16 years should be treated differently to people older than 16 years as a suspected anaphylactic reaction can be a traumatic experience and will raise many different issues. It was made to ensure that children receive paediatric assessment. This update focuses specifically on incorporating the recommendations of the UK Resuscitation Council and so did not consider whether to make a similar recommendation for people over 16. However, considering comments from stakeholders, and following consultation with a clinical colleague at NICE, we have amended the wording of the recommendation so that it recommends admitting young people and children under 16 years under the care of an inpatient paediatric medical team if they cannot be discharged in accordance with the criteria for 2 hour discharge. . This is to help ensure that a child accesses the most appropriate care pathway and to free up capacity in emergency departments.

Association of Paediatric Emergency Medicine	Yes. Could you consider admission to a short stay or observation ward as an addition to the options?	Thank you for your response. Considering your comments and those of other stakeholders, and following consultation with a clinical colleague at NICE, we have amended the wording of the recommendation so that it recommends admitting young people and children under 16 years under the care of an inpatient paediatric medical team if they cannot be discharged in accordance with the criteria for 2 hour discharge. This is to help ensure that a child accesses the most appropriate care pathway and to free up capacity in emergency departments.
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	Yes. It may be helpful to specify or link back to those not meeting 1.3.1 to 1.3.4 (which is stated in the question here but not actually in the recommendation in the guideline)	Thank you for your comment. Considering your comments and those of other stakeholders, and following consultation with a clinical colleague at NICE, we have amended the wording to recommend admitting all children who require observation for 6 hours or longer. Thus the amended recommendation recommends to: 'Admit children under 16 years under the care of an inpatient paediatric medical team if they cannot be discharged in accordance with the criteria for 2 hour discharge.' We felt that this will help ensure that a child accesses the most appropriate care pathway and will also help to free up capacity in emergency departments.
NHS England	Yes - I agree with this proposal.	Thank you for your response.

Proposed new recommendation 1.4.3 offer of adrenaline auto-injectors following emergency treatment for suspected anaphylaxis and when they should be offered. This recommendation has been updated to reflect advice from the MHRA on adrenaline autoinjectors and to align with British Society for Allergy and Clinical Immunology and Resuscitation Council UK guidance about when they should be offered. Do you agree that people should be offered 2 adrenaline auto-injectors as an interim measure before they attend for a specialist allergy appointment, unless the suspected anaphylaxis was due to a drug allergy that can be easily avoided. Yes/no. Please provide a rationale for your decision		
Stakeholder	**Responses**	**NICE response**
Resuscitation Council UK	Yes - as this should be aligned with official MHRA guidance.	Thank you for your response. Following this consultation we have created 1 recommendation which consolidates recommendations about when to offer 2 AAIs contained in 1.4.3 and 1.5.1 into one recommendation. We feel this makes recommendations about when to offer AAIs and how many to offer clearer and fully aligned with MHRA guidance.
Royal College of Anaesthetists	This appears to refer to 1.4.2 rather than 1.4.3 but yes. This makes the guidance consistent with other guidance and thus avoids confusion over discrepancies.	Thank you for your response. During upload draft recommendation 1.4.3 temporarily lost its number - apologies for any confusion caused. Following this consultation we have created 1 recommendation which consolidates recommendations about when to offer 2 AAIs contained in 1.4.3 and 1.5.1 into one recommendation. We feel this makes recommendations about when to offer AAIs and how many to offer clearer and fully aligned with MHRA guidance.

College of General Dentistry	Yes. Uncertain how quickly a specialist allergy appointment would be made available and how easily the patient could access this from their location.	Thank you for your response. Following this consultation we have created 1 recommendation which consolidates recommendations about when to offer 2 AAIs into one recommendation. We feel this makes recommendations about when to offer AAIs and how many to offer clearer and fully aligned with MHRA guidance.
South Eastern Health and Social Care Trust	I would like to add the at patient/family must be informed of the risk of a biphasic reaction and what to do if symptoms return. They must be provided with 2 adrenaline autoinjectors for home and trained on how to use them before being discharged. Ideally they should also be given a BSACI action plan if available (this is easily downloaded from their website and is in the resus council guidance on anaphylaxis). They should be referred urgently to their local allergy clinic.	Thank you for your response. Your comments are addressed by the discharge recommendation which recommends that 'Before discharge a healthcare professional with the appropriate skills and competencies should offer the adult, young person or child (or their parent or carer, as appropriate) the following: information about anaphylaxis, including the signs and symptoms of anaphylaxis information about the risk of a biphasic reaction advice about how to avoid the suspected trigger (if known) information about the need for referral to a specialist allergy service and the referral process information on what to do if anaphylaxis occurs (use the adrenaline auto-injector and call emergency services) a brand-specific demonstration of the correct use of the adrenaline auto-injector and when to use it, including advice that the person should lie down after using the injector (or sit up if they are struggling to breathe) and should not stand up or change position suddenly, even if they feel better information about patient support groups.'

		Following this consultation we have created 1 recommendation which consolidates recommendations about when to offer 2 AAIs. We feel this makes recommendations about when to offer AAIs and how many to offer clearer and fully aligned with MHRA guidance. We will add a link to BSACI's emergency action plans from CG134's tools and resources section.
The Royal College of Pathologists	Yes, this would be appropriate and means that patient's will have access to emergency medication should anaphylaxis recur before the specialist appointment. It may be worth highlighting as well that the AAIs should be offered even if the cause of the anaphylaxis is not identified (unless it was due to drug allergy).	Thank you for your response. AAIs are recommended in all circumstances including idiopathic anaphylaxis with the one exception of a known, easily avoided drug allergy. We feel this acts to make the recommendation clearer than trying to list all circumstances for when AAIs should be given. Following this consultation we have created a recommendation which consolidates recommendations about when to offer 2 AAIs. We feel this makes recommendations about when to offer AAIs and how many to offer clearer and fully aligned with MHRA guidance.
Association of Paediatric Emergency Medicine	This may be difficult for every urgent and emergency care environment, especially out of hours e.g. smaller departments or at the weekend when pharmacies may be closed. Would this necessitate AAI to be available as a TTO drug? It also has implications for AAI training which will need to be provided by emergency department staff - historically this has been of mixed success. Robust examples of training packages or good practice might be considered as an addendum to the guidance?	Thank you for your response. The amendment to the recommendation is to bring it in line with MHRA recommendations and does not change the requirement of the original recommendation for AAIs to be available as a 'to take out' (TTO) drug. We accept that some NICE recommendations may be aspirational for some smaller centres and we will investigate adding a link to an appropriate training package from CG134's Tools and resources page. Following this consultation we have created 1 recommendation which consolidates recommendations about when to offer 2 AAIs

		contained into one recommendation. We feel this makes recommendations about when to offer AAIs and how many to offer clearer and fully aligned with MHRA guidance.
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	Yes – although 2 elements of the statement could be clearer. • After emergency treatment for suspected anaphylaxis, offer the adult, young person or child (or their parent or carer, as appropriate) 2 adrenaline auto-injectors to use if needed and as a safety measure before the specialist allergy service appointment, unless the anaphylaxis was due to a drug allergy and the drug can be easily avoided (see NICE's guideline on drug allergy). [2026] - "if needed" – could be read and interpreted incorrectly to sound like there are no clear indications for prescribing. - "before the specialist allergy service appointment" could result in patients being discharged and asked to seek prescription from primary care before the allergy appointment which is not appropriate. This should be changed to "before discharge from hospital" Consider re-wording to: "After emergency treatment for suspected anaphylaxis, unless the anaphylaxis was due to a drug allergy and the	Thank you for your response. We agree that 'if needed' is open to misinterpretation as it use of 'before the specialist allergy service.' We also note that there was some duplication of recommendations in the consultation version. Following this consultation we have created 1 recommendation which consolidates recommendations about when to offer 2 AAIs into one recommendation. We feel this makes recommendations about when to offer AAIs and how many to offer clearer and fully aligned with MHRA guidance.

	drug can be easily avoided (see NICE's guideline on drug allergy), offer the adult, young person or child (or their parent or carer, as appropriate) a prescription and supply of 2 adrenaline auto-injectors prior to discharge as a safety measure. These are for their use if needed in the event of anaphylaxis recurrence after discharge, while they await a specialist allergy service appointment.	
NHS England	Yes I agree with this recommendation	Thank you for your response. Following this consultation we have created 1 recommendation which consolidates recommendations about when to offer 2 AAIs into one recommendation. We feel this makes recommendations about when to offer AAIs and how many to offer clearer and fully aligned with MHRA guidance.
Amended recommendation 1.5.1 discharge practice. This recommendation has been amended for consistency with proposed recommendations 1.3.1 to 1.3.4, including the addition of a new bullet which clarifies discharge recommendations for people who have experienced suspected anaphylaxis due to a drug allergy where the drug is subsequently easily avoided. Do you agree with the amended bulleted recommendation? Yes/No. Please provide a rationale for your decision.		
Stakeholder	**Responses**	**NICE response**
Resuscitation Council UK	Yes, as this makes it consistent with 1.4.3 and will prevent inappropriate prescription of rescue adrenaline to those with drug allergies who do not need this.	Thank you for your response.

Responses received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The responses are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees

Royal College of Anaesthetists	Yes. This makes the guidance internally consistent.	Thank you for your response.
College of General Dentistry	Yes	Thank you for your response.
The Royal College of Pathologists	Yes, that is fine.	Thank you for your response.
Association of Paediatric Emergency Medicine	Yes. It might be helpful to add resources for providing information e.g. allergy action plan from the British Society for Allergy & Clinical Immunology (BSACI)	Thank you for your response. We will add a link to action plans from the British Society for Allergy & Clinical Immunology (BSACI) from CG134's Tools and resources page.
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	Yes - although additional clarification of some of the recommendations may be helpful: • a prescription for 2 further adrenaline auto-injectors with advice to carry the injectors with them at all times, unless the anaphylaxis was due to a drug allergy and the drug can be easily avoided (see recommendation 1.4.3) The "further" is superfluous and may confuse prescribers. Additionally consider changing injectors to devices to future proof for other devices becoming available in the NHS. Perhaps consider rewording to: "a prescription for 2 adrenaline devices (unless the adult, young person, child already has 2 in-date, correct dose	Thank you for your comments. We agree that 'further' is superfluous. Following this consultation we have created 1 recommendation which consolidates recommendations about when to offer 2 AAIs into one recommendation. We feel this makes recommendations about when to offer AAIs and how many to offer clearer and fully aligned with MHRA guidance. We are aware of alternative routes of administration including the licensing of EURNeffy intranasal adrenaline for anaphylaxis in people weighing 30kg or more. We considered this issue in a surveillance review and do not propose to update recommendations at this time because of a lack of evidence. We have highlighted intranasal adrenaline to the NIHR as an area for research.

	devices with them, on their person) with advice to carry the injectors with them at all times, unless the anaphylaxis was due to a drug allergy and the drug can be easily avoided (see recommendation 1.4.3)"	
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	Yes - although additional clarification of some of the recommendations may be helpful: information on what to do if anaphylaxis occurs (use the adrenaline auto-injector and call emergency services) There is an important statement missing which is in the resus council UK recommendations and should be considered to be added here: "Patients should be provided with an emergency management or action plan. For children, these are available at bsaci.org or sparepensinschools.uk." If the reference URLs cannot be added please consider adding a bullet: "Patients should be provided with an emergency management or action plan prior to discharge."	Thank you for your comment about emergency action plans. We will link to examples of good quality action plans (e.g., from BSACI) from CG134's tools and resources page.

British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	Yes - although additional clarification of some of the recommendations may be helpful: • a brand-specific demonstration of the correct use of the adrenaline auto-injector and when to use it, including advice that the person should lie down after using the injector (or sit up if they are struggling to breathe) and should not stand up or change position suddenly, even if they feel better and should not stand up or change position suddenly, even if they feel better" it is not clear how long this applies for. For this section of the sentence "and should not stand up or change position suddenly, even if they feel better" it is not clear how long this applies for. Guidance is not provided in Resus Council guideline either but perhaps consider adding "until further assessment has occurred in hospital".	Thank you for your comment about changing position when self-administering AAIs. This update focused on incorporating the recommendations from the UK Resuscitation Council on discharge following anaphylaxis and so did not consider this area.
NHS England	Yes I agree with all the bullet points. Again - do we need to state what a suitably qualified clinician is?	Thank you for your responses. It is the remit of a health care practitioners' particular professional body to set standards of 'suitably qualified'. This is not within NICE's remit and so we have not specified this.

Are there any health inequalities issues related to the draft recommendations that you think need to be considered?		
Stakeholder	**Responses**	**NICE response**
Resuscitation Council UK	Yes - with respect to discharge recommendation 1.5.1, it is important that patients/caregivers prescribed rescue adrenaline know how to use it - this may require provision of information/training in languages other than English. In addition, the recent approval of non-injectable adrenaline - yet its limited availability in the NHS (resulting in health inequalities whereby only those who can afford a private prescription can obtain this) should be flagged as an area which needs addressing.	Thank you for your response. The guideline recommendations are covered by the your responsibility statement which says: 'When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service.' Thank you for flagging non-injectable adrenaline. We are aware of the 2025 licensing of EURneffy for anaphylaxis in people weighing over 30kg. We will continue to monitor for evidence as it emerges. We have also highlighted to the NIHR that this as an area to consider for research.
Royal College of Anaesthetists	No. Additional responses: The guideline does not address perioperative anaphylaxis at all, and this is understandable as it is a specialised area. The fact that a patient may have had both anaphylaxis and an anaesthetic +/- and operation may complicate how they are then managed/the period of observation. The guideline emphasises tachycardia associated with hypotension - in the Royal College of Anaesthetists' 6th	Thank you for your response and for providing evidence. Anaesthesia, Surgery and Life-Threatening Allergic Reactions: Report and findings of the 6th National Audit Project: perioperative anaphylaxis reports that the commonest presenting features of anaphylaxis were *'hypotension (46%), bronchospasm (particularly in patients with morbid obesity and asthma) (18%), tachycardia (9.8%), oxygen desaturation (4.7%), bradycardia (3%), and reduced/absent capnography trace (2.3%).'* That was in a sample of N=266 cases of grade 3-5 anaphylaxis, which is equivalent to n=8 people with bradycardia. CG134 recommendation 1.1.1 recommends to: Document the acute clinical features of the suspected anaphylactic reaction (rapidly developing, life-threatening problems involving the airway [pharyngeal or

	National Audit Project we also say severe bradycardias with hypotension as a presenting feature of anaphylaxis. https://www.rcoa.ac.uk/research/research-projects/national-audit-projects-naps/nap6-perioperative-anaphylaxis	laryngeal oedema] and/or breathing [bronchospasm with tachypnoea] and/or circulation [hypotension and/or tachycardia] and, in most cases, associated skin and mucosal changes). While we acknowledge that some people will present with bradycardia it is not possible for the recommendation to list all possible presentations, and diagnosis is without the scope of CG134. Instead, recommendation 1.1.1 lists the most common clinical features of the suspected anaphylaxis in order to ensure proper onward referral and testing.
College of General Dentistry	I think patient's ability to access specialty allergy services appointments needs to be considered especially in rural locations	Thank you for your response. These are operational issues are outside of NICE's remit which is to make evidence based recommendations to ensure equality of care.
The Royal College of Pathologists	No specific issues.	Thank you for your response.
Association of Paediatric Emergency Medicine	Access to allergy clinic for poorer resourced areas, especially paediatrics Access to out of hours pharmacy for provision of AAI	Thank you for your response. These are operational issues outside of NICE's remit which is to make evidence based recommendations to ensure equality of care.
British Paediatric Allergy, Immunity and Infection Group (BPAIIG)	Reaction training is a key part of pre-discharge criteria. Access to this training in a suitable language for the patient's communication language to effectively train the patient/carer is required. Non-injected routes of adrenaline are now available (EURneffy - MHRA approved, in NHS). Guidance needs to	We think this is covered by CG134's your responsibility section which notes that health care practitioners: 'are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service.' We are aware of EURneffy licensing for anaphylaxis in people over 30kg. We have highlighted this to the NIHR as a possible area for

	reflect this so that whatever device patients have and use, an aligned management approach is taken.	research and we will continue to monitor for emerging evidence about EURneffy.
NHS England	No	Thank you for your response.

ISBN: 978-1-4731-9535-6