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NICE food allergy and anaphylaxis quality standards:

a review of the 2016 quality standards

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NICE FOOD ALLERGY AND ANAPHYLAXIS QUALITY STANDARDS

The National Institute for Health and Care Excellence (NICE) has in the last 5 years published guidance on several aspects of clinical allergy. In March 2016 they published quality standards on food allergy (QS 118)[1] and anaphylaxis (QS 119).[2]

Despite the recent increase in allergy guidance, not only from NICE but also in the form of a Department of Health Commissioned Pathway Project with the Royal College of Paediatrics and Child Health (RCPCH),[3] and several NICE-accredited guidelines from the British Society for Allergy and Clinical Immunology (BSACI), inconsistencies remain in the management of food allergy and anaphylaxis. The *National Review of Asthma Deaths* highlights that some deaths may have been prevented had there been better management of those with asthma and allergies. Recognition that in uncontrolled asthma, allergic triggers such as food allergy should be considered and also acknowledging that having asthma increases the risk of life-threatening reactions in, for example, those with food allergies, may have prevented some of the deaths.[4]

It is hoped that these quality standards, accompanied by their performance measures, may drive a further awareness of ideal care of those with suspected food allergy and/or anaphylaxis.

The quality standards are divided into six statements for food allergy and four for anaphylaxis. They are based on the corresponding NICE guidelines.

QUALITY STANDARD ON FOOD ALLERGY

Quality statement 1: history

Identifying the possibility of food allergy comes from taking what NICE terms an allergy-focused clinical history.[5] This history needs to be taken whenever food allergy is suspected by a healthcare professional.[1] It should seek to determine, first, if the symptoms are likely to be allergy. It then helps to establish the severity of the suspected clinical reaction and also determine the likely mechanism, either IgE mediated or non-IgE mediated. It is the likely mechanism that determines what testing is needed. Both IgE- and non-IgE-mediated disease results from a reaction by the immune system, hence the term 'allergic disease'. The symptoms are however different, with those of IgE-mediated disease principally occurring within minutes of consumption of the food, whereas the non-IgE-mediated symptoms may only be evident several hours or even days later.[5]

Quality statements 2 and 3: testing to confirm diagnosis

If the allergy-focused history suggests IgE-mediated food allergy, with, as well as anaphylaxis, the most likely symptoms being urticaria, angioedema, and gastrointestinal symptoms such as diarrhoea and vomiting occurring within minutes and up to 2 hours after exposure to a certain food, then NICE states that specific IgE antibodies should be tested for, either by skin prick tests or blood tests.[5] It is important that this testing is specific for the food thought to be causing the symptoms.[5]

If the competences are not present to both carry out and interpret these tests then referral should be made to appropriate specialist care.[5,6] If more than one food is suspected, referral needs to be made in all such cases.[5]

If non-IgE-mediated disease is suspected, most commonly seen in infants with milk allergy, the way to confirm the diagnosis is by initially eliminating the suspected food from the diet.[5] In a formula-fed infant, this will require substitution with an extensively hydrolysed formula or much less commonly, in severe cases, an amino acid formula. Dairy products will need to be eliminated if weaning onto solid foods has commenced. In a totally breast-fed infant it would involve elimination of milk from the mother's diet.[5–7]

REFERENCES

1. National Institute for Health and Care Excellence. *Food allergy. QS118.* 2016. https://www.nice.org.uk/guidance/qs118 (accessed 27 Jan 2017).
2. National Institute for Health and Care Excellence. *Anaphylaxis. QS119.* 2016. https://www.nice.org.uk/guidance/qs119 (accessed 27 Jan 2017).
3. Royal College of Paediatrics and Child Health. Care pathways for children with allergies. 2014. http://www.rcpch.ac.uk/allergy (accessed 27 Jan 2017).
4. Levy ML, Andrews R, Buckingham R, *et al. Why asthma still kills: the National Review of Asthma Deaths (NRAD) Confidential Enquiry report.* 2014. https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills (accessed 27 Jan 2017).
5. National Institute for Health and Care Excellence. *Food allergy in under 19s: assessment and diagnosis. CG116.* 2011. https://www.nice.org.uk/guidance/CG116 (accessed 27 Jan 2017).
6. National Institute for Health and Care Excellence. Cow's milk protein allergy in children. Clinical Knowledge Series. 2014. https://cks.nice.org.uk/cows-milk-protein-allergy-in-children (accessed 27 Jan 2017).
7. Venter C, Brown T, Shah N, *et al.* Diagnosis and management of non-IgE-mediated cow's milk allergy in infancy — a UK primary care practical guide. *Clin Transl Allergy* 2013; **3(1):** 23. DOI: 10.1186/2045-7022-3-23.
8. National Institute for Health and Care Excellence. *Anaphylaxis: assessment and referral after emergency treatment. CG134.* 2011. https://www.nice.org.uk/guidance/CG134 (accessed 27 Jan 2017).

Provenance

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The third quality statement insists that not only is this trial elimination diet offered but also to then prove this diagnosis. Unless the symptoms have been severe, there must be a planned home reintroduction to determine if the symptoms return when the food is reintroduced and settle again when back on the elimination diet.[1,5–7] This is usually performed between 2 and 4 weeks of starting the elimination diet.[5–7]

Statement 4: referral

This statement relates to referring appropriately those with suspected food allergy.[1] Some referrals will be made following the history and before any testing, for example, for patients with:

- acute systemic reactions or severe delayed reactions;
- faltering growth and gastrointestinal symptoms;
- significant atopic eczema with suspicion of multiple food allergies; or
- possible multiple food allergies.[5]

Ideally, some should have initial investigations in primary care but be referred following this, for example, for patients with:

- any proven IgE–mediated reaction and asthma;
- tests negative but history gives strong clinical suspicion of IgE-mediated allergy;
- symptoms that do not respond to single allergen elimination diet; or
- persisting parental suspicion of food allergy but unconvincing history.[5]

Statements 5 and 6

Quality statements 5 and 6 were added as placeholder statements as areas where evidence-based guidance needs to be developed.[1] They relate to diagnosing food allergy in adults and nutritional support in both adults and children who have food allergies.

QUALITY STANDARD ON ANAPHYLAXIS

Implementation of these statements will depend on the provision of appropriate services in primary, secondary, and tertiary care.

Statement 1: referral

All people treated for suspected anaphylaxis are to be referred to a specialist allergy service.[2] Ideally this referral should be made by secondary care before discharge,[8] but this will depend on local pathways and may need to be made by primary care.

Statement 2: education

It is expected that all those treated for suspected anaphylaxis (with the exception of drug-triggered anaphylaxis) will be promptly supplied with an adrenaline device, ideally before discharge.[8] The statement requires training to be provided to the patient and/or carer in how and when to use such a device.[2]

Statement 3: referral for venom reactions

This relates to bee or wasp venom reactions and is dependent on determining the severity of the reaction. Again, this could be instigated with appropriate local pathways from the emergency department. Because of the success of venom immunotherapy, those with systemic reactions to bee or wasp stings should be referred for consideration of desensitisation. NICE emphasises that the referral should be to an allergy service experienced and skilled in such immunotherapy.[2]

Statement 4

This statement was made to acknowledge the importance of ensuring research in the area that those prescribed adrenaline receive ongoing, regular re-training in how to use their devices.[2]

These statements refer to both adults and children.

RESOURCES FOR GPs

For those interested in learning more about allergy, the BSACI website (http://www.bsaci.org/professionals/primarycare) provides links to many resources. NICE has produced a learning module based on these standards (http://elearning.nice.org.uk/).

The Royal College of General Practitioners has produced three 30-minute learning modules on allergy, accessible through its website (http://elearning.rcgp.org.uk/).

It is worth looking out for local study days resourced by BSACI. The Allergy Academy (http://www.allergyacademy.org) (Guy's and St Thomas' Hospital) runs study days. The websites of Allergy UK (http://www.allergyuk.org) and Anaphylaxis Campaign (http://www.anaphylaxis.org.uk) provide information for professionals and patients, and the latter also has online training (AllergyWise courses: http://www.anaphylaxis.org.uk/information-resources/allergywise-training/) for patients and professionals.