Allergy and asthma update for community clinics

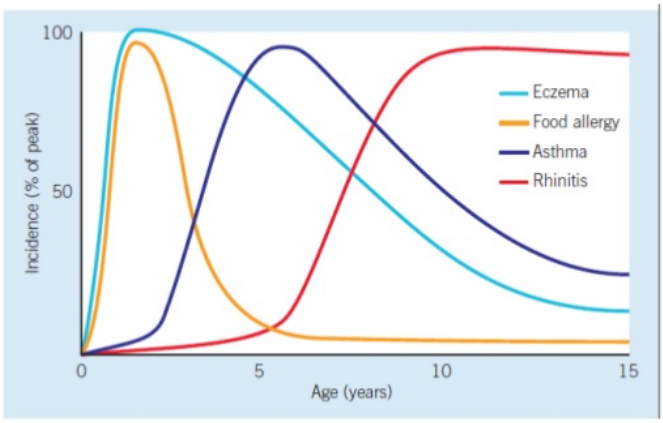
1

Topics suggested

- Food allergy
- RAST testing
- Severe eczema, practical eczema
- CMPA (reintroduction of dairy)

2

THE ATOPIC MARCH



- Atopic Dermatitis

3

Case 1

Thank you for seeing this 3 month old infant with eczema that has not improved with regular emollients (cetraban) and 1% hydrocortisone.

4

Case 1 - background

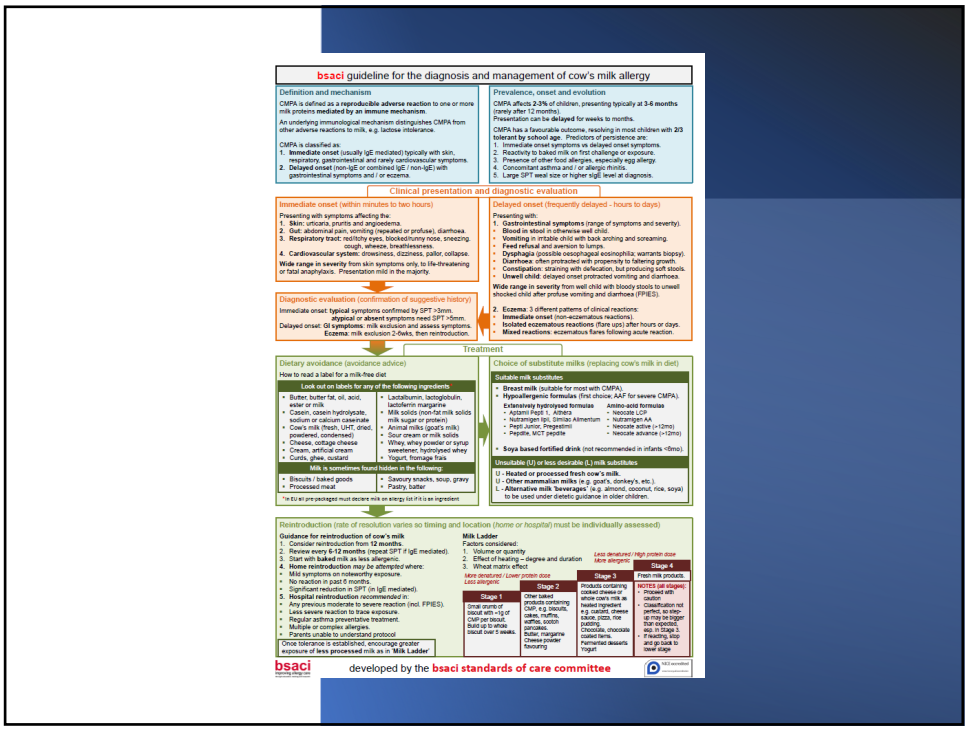
3 month old infant
Bottle fed SMA from birth
Early onset eczema from 1st few weeks
Irritable fussy feeder, vomits, refluxy
Blood in stools
Maternal eczema
Diagnosis: Delayed cows milk allergy

5

Case 1 - learning points

Immediate vs delayed allergy
Mx cows milk allergy
Signpost to BSACI cows milk guidelines
Milk ladder and reintroduction of dairy

6



7

Case 2

Thank you for seeing this 24 month old boy whose mother is concerned about rashes on the face after certain foods. His mixed food RAST was positive.

8

Case 2 - background

Urticaria, angioedema and coughing after
- eating nutella
- touching peanuts

Urticaria after raw egg contact

Background of recurrent viral induced wheeze

9

Case 2 – learning points

Importance of allergy focused history

Use of allergy tests - skin tests vs RASTs

Recognition of anaphylaxis in history

Use of adrenaline auto-injectors

10

Case 3

Thank you for seeing this 5 year old with recurrent cough at night and a background of eczema.

11

Case 3 - background

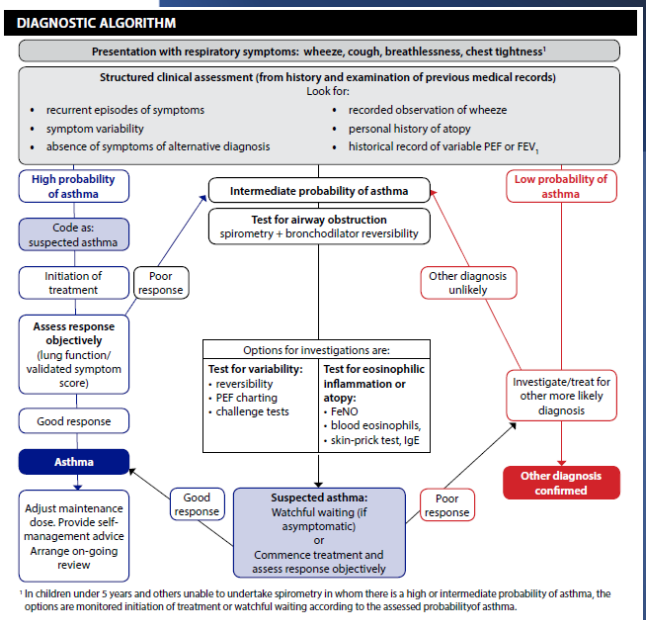
- Otherwise well child
- Persistent nocturnal cough
- Multi-trigger wheeze (URTI's, change in weather, cold drinks and foods, exercise)
- Responds well to salbutamol
- Presented twice to A+E with acute wheeze
- Parents non-smokers
- Ezcema as an infant – improving
- No food allergy

12

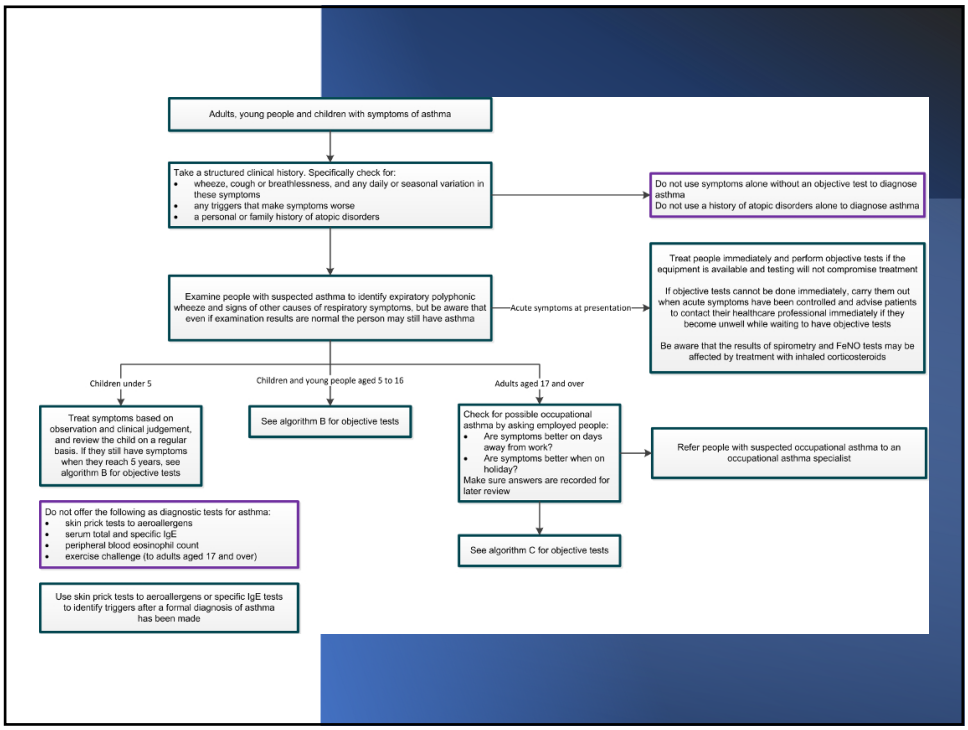
- Asthma history
- Inhaler technique check (volumatic +_ mask)
- BTS step wise treatment- starting steroids
- Asthma management plans
- Community asthma clinic pathways

Case 3 – Learning points

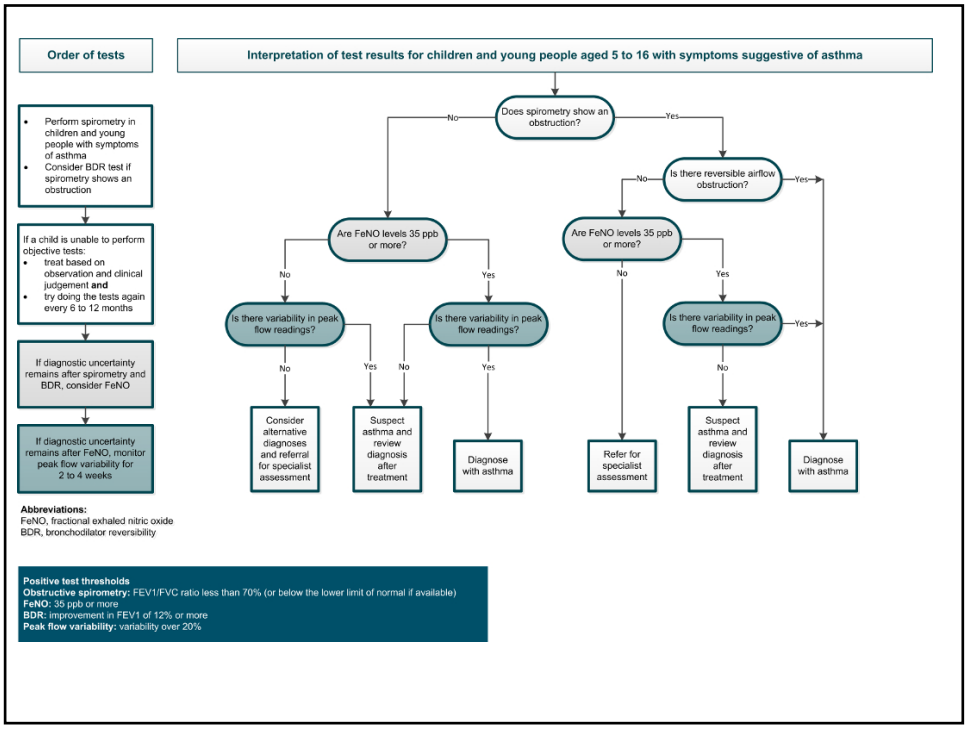
13



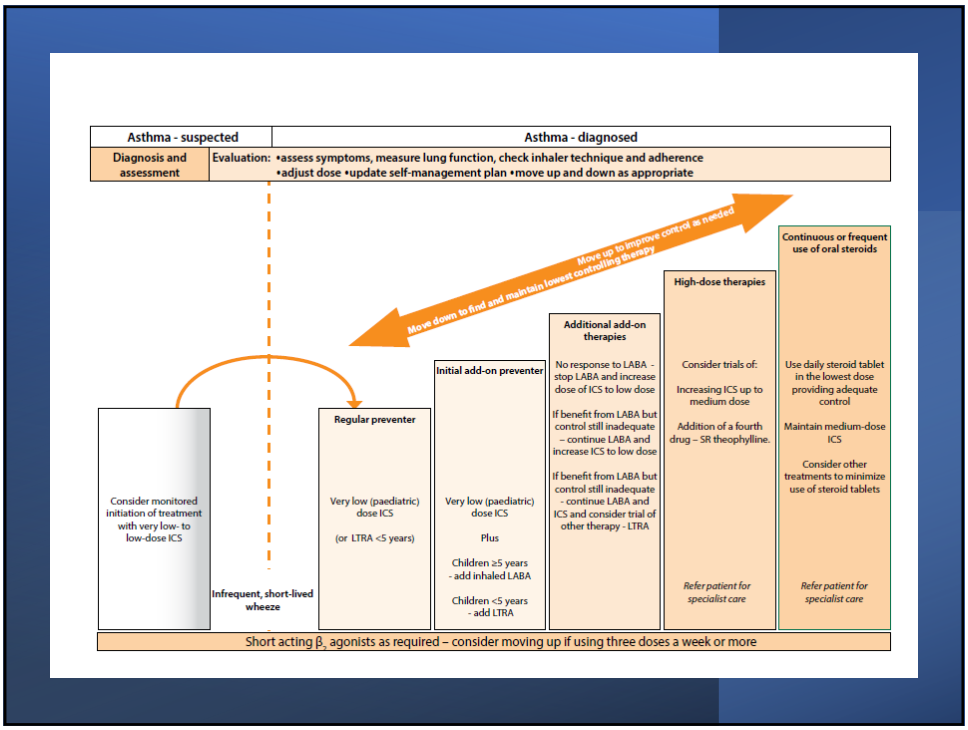
14


Adults, young people and children with symptoms of asthma
Take a structured clinical history. Specifically check for:
wheeze, cough or breathlessness, and any daily or seasonal variation in these symptoms
any triggers that make symptoms worse
a personal or family history of atopic disorders
Do not use symptoms alone without an objective test to diagnose asthma
Do not use a history of atopic disorders alone to diagnose asthma
Examine people with suspected asthma to identify expiratory polyphonic wheeze and signs of other causes of respiratory symptoms, but be aware that even if examination results are normal the person may still have asthma
Acute symptoms at presentation
Treat people immediately and perform objective tests if the equipment is available and testing will not compromise treatment
If objective tests cannot be done immediately, carry them out when acute symptoms have been controlled and advise patients to contact their healthcare professional immediately if they become unwell while waiting to have objective tests
Be aware that the results of spirometry and FeNO tests may be affected by treatment with inhaled corticosteroids
Children under 5
Children and young people aged 5 to 16
Adults aged 17 and over
Treat symptoms based on observation and clinical judgement, and review the child on a regular basis. If they still have symptoms when they reach 5 years, see algorithm B for objective tests
See algorithm B for objective tests
Check for possible occupational asthma by asking employed people:
Are symptoms better on days away from work?
Are symptoms better when on holiday?
Make sure answers are recorded for later review
Refer people with suspected occupational asthma to an occupational asthma specialist
See algorithm C for objective tests
Do not offer the following as diagnostic tests for asthma:
skin prick tests to aeroallergens
serum total and specific IgE
peripheral blood eosinophil count
exercise challenge (to adults aged 17 and over)
Use skin prick tests to aeroallergens or specific IgE tests to identify triggers after a formal diagnosis of asthma has been made

15


Order of tests
Interpretation of test results for children and young people aged 5 to 16 with symptoms suggestive of asthma
Perform spirometry in children and young people with symptoms of asthma
Consider BDR test if spirometry shows an obstruction
If a child is unable to perform objective tests:
treat based on observation and clinical judgement and
try doing the tests again every 6 to 12 months
If diagnostic uncertainty remains after spirometry and BDR, consider FeNO
If diagnostic uncertainty remains after FeNO, monitor peak flow variability for 2 to 4 weeks
Does spirometry show an obstruction?
No
Yes
Is there reversible airflow obstruction?
No
Yes
Are FeNO levels 35 ppb or more?
No
Yes
Are FeNO levels 35 ppb or more?
No
Yes
Is there variability in peak flow readings?
No
Yes
Is there variability in peak flow readings?
No
Yes
Is there variability in peak flow readings?
No
Yes
Consider alternative diagnoses and referral for specialist assessment
Suspect asthma and review diagnosis after treatment
Diagnose with asthma
Refer for specialist assessment
Suspect asthma and review diagnosis after treatment
Diagnose with asthma
Abbreviations:
FeNO, fractional exhaled nitric oxide
BDR, bronchodilator reversibility
Positive test thresholds
Obstructive spirometry: FEV1/FVC ratio less than 70% (or below the lower limit of normal if available)
FeNO: 35 ppb or more
BDR: improvement in FEV1 of 12% or more
Peak flow variability: variability over 20%

16



17

Case 4

Thank you for seeing this 13 year old boy with asthma and hayfever, not controlled on regular inhaled steroids and antihistamines.

18

Case 4 - background

Asthma – multi-trigger, poorly controlled

Rhinitis – perennial early morning sneezing and itching with worsening in spring and summer.

Unrecognised peanut allergy – reaction with difficulty breathing/ cough

Eczema ++

Not adherent to Rx (clenil 100 bd via spacer and daily cetrizine and nasal steroid)

Needs appropriate device and training for asthma

Needs adrenaline autoinjector

Needs education +++

Needs plan

19

Case 4 – learning points

Multisystem allergic disease history

Recognition of anaphylaxis and need for adrenaline autoinjector

Education and training key

20

Case 5

Thank you for seeing this 13 year old girl with a long standing itchy rash, not improving on regular antihistamines.

21

Case 5 - Background

Idiopathic urticaria for > 6 weeks

No physical or other cause

No evidence mastocystosis

22

Case 5 - Learning points

- Role of skin tests – can be useful if immediate IgE mediated allergy/ rhinitis suspected
- Chronic urticaria screen
- Doses of antihistamines – can increase significantly
- BSACI guideline

23

doi: 10.1111/cea.12494

Clinical & Experimental Allergy, 45, 547–565
© 2015 John Wiley & Sons Ltd

BSACI GUIDELINE

BSACI guideline for the management of chronic urticaria and angioedema

R. J. Powell[1], S. C. Leech[2], S. Till[3], P. A. J. Huber[4], S. M. Nasser[5] and A. T. Clark[6]

[1]Department of Clinical Immunology and Allergy, Nottingham University, Nottingham, UK, [2]Department of Child Health, Kings College Hospital, London, UK, [3]Division of Asthma, Allergy and Lung Biology, Kings College London, London, UK, [4]BSACI, British Society for Allergy & Clinical Immunology, London, UK, [5]Department of Allergy & Clinical Immunology, Addenbrooke's NHS Trust, Cambridge, UK and [6]Department of Allergy, Addenbrooke NHS Trust, Cambridge, UK

Clinical & Experimental Allergy

Correspondence:
Dr A. T. Clark, Allergy Clinic, Cambridge University Hospitals NHS Foundation Trust, Box 40, Cambridge CB2 2QQ, UK.
E-mail: atclark@doctors.org.uk

Cite this as: R. J. Powell, S. C. Leech, S. Till, P. A. J. Huber, S. M. Nasser and A. T. Clark, Clinical & Experimental Allergy, 2015 (45) 547–565.

Summary

This guidance for the management of patients with chronic urticaria and angioedema has been prepared by the Standards of Care Committee of the British Society for Allergy and Clinical Immunology (BSACI). The guideline is based on evidence as well as on expert opinion and is aimed at both adult physicians and paediatricians practising in allergy. The recommendations are evidence graded. During the development of these guidelines, all BSACI members were included in the consultation process using a Web-based system. Their comments and suggestions were carefully considered by the Standards of Care Committee. Where evidence was lacking, a consensus was reached by the experts on the committee. Included in this management guideline are clinical classification, aetiology, diagnosis, investigations, treatment guidance with special sections on children with urticaria and the use of antihistamines in women who are pregnant or breastfeeding. Finally, we have made recommendations for potential areas of future research.

Keywords adult, allergy, angioedema, antihistamine, anti-IgE, auto-antibody, autoimmune, breastfeeding, BSACI, child, epidemiology, guideline, hypothyroidism, IgE, management, paraprotein, pregnancy, pregnancy, Urticaria

Submitted 6 October 2014; revised 11 December 2014; accepted 9 January 2015

Introduction

This guidance for the management of patients with chronic urticaria/angioedema is intended for use by physicians treating allergic conditions. It should be recognized that patients referred to an allergy clinic often have a different pattern of presentation (e.g. intermittent acute) from those referred elsewhere and both the patient and referring practitioners often wish to determine whether allergy is involved.

Evidence for the recommendations was collected by electronic literature searches of MEDLINE and EMBASE using these primary key words: urticaria, angioedema, angioneurotic oedema, allergy, allergic, antihistamines, auto-antibody, autoimmune, hypothyroidism, IgE, paraprotein, pregnancy, breastfeeding, child, epidemiology, management, psychology. In addition, hand searches were performed and the Cochrane library and NHS evidence were also searched. Each article was reviewed for suitability by the first and second author of this guideline. The recommendations were evidence graded at the time of preparation of these guidelines (Appendix Tables B1 and B2). During the development of these guidelines, all BSACI members were consulted using a Web-based system and their comments and suggestions were carefully considered by the Standards of Care Committee (SOCC). Where evidence was lacking, a consensus was reached among the experts on the committee. Conflict of interests were recorded by the SOCC. None jeopardized unbiased guideline development.

Executive summary and recommendations

(Grades of recommendations are described in Appendix Tables B1 and B2)

- Chronic urticaria/angioedema has traditionally been defined as weals, angioedema or both with daily or almost daily symptoms lasting for more than 6 weeks. In these guidelines, we have also included patients with episodic acute intermittent urticaria/angioedema lasting for hours or days and recurring over months or years.
- Weals and angioedema commonly occur together, but may also occur separately.

24