Women's & Children's Hospital

Paediatric Allergy and Clinical Immunology Referral guidelines

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Summary of Service

The WCHN Allergy and Clinical Immunology service provides care to children who have IgE mediated and Non-IgE mediated food allergy, anaphylaxis, venom allergy, chronic urticaria (>6 weeks), latex allergy, adverse drug reactions, complicated allergic rhinitis , eczema in the context of food allergy or that is poorly responsive to recommended treatments, suspected Primary Immunodeficiency Disorders and children who have had serious adverse events following immunisation, are considered at high risk of an immunisation reaction or who have complex immunisation problems. This service offers a 7 day, 24 hour on call consultative service to health providers and welcomes contact regarding urgent or complicated referrals.

All referrals should be faxed to the Administration Hub on 8161 6246 or Dept 8161 9295.

Mandatory referral content

Demographic

- Childs name
- Date of birth **(please note that due to our waiting times patients over the age of 17 years should be referred to an adult facility)**
- Family contact details including mobile and email if available
- Referrer details including mobile and email if available
- Interpreter requirements and if so what language

Clinical

- Reason for referral
- Clinical urgency
- Duration of symptoms
- Management to date and response to treatment
- Relevant pathology i.e. Serum Specific IgE, previous skin prick testing results if available
- Past medical history
- Current medications
- Family history of atopy

***refer to individual guidelines for more specific information ***

Women's & Children's Hospital

TRIAGE GUIDELINES FOR REFERRING DOCTORS

TRIAGE CATEGORIES

These are maximum recommended triage categories as determined by national consensus.

Currently the service is experiencing excessive demand and actual waiting times may be considerably in excess of the recommended waits. If the referring doctor believes a patient requires earlier review please contact the on call allergist to discuss the patients' needs further on 8161 7000. We are happy to provide interim management advice and recommend appropriate diagnostic tests.

Priority 1	**6/52**
Priority 2	**<4/12**
Priority 3	**<8/12**
Decline Referral (DR) (Consultant decision only)	**Letter sent back to referring doctor and parent with interim advice as appropriate.**

Information for our consumers (clinicians and the community):

Who do we see?

We provide a general allergy service to the Central, Western and Northern regions of metropolitan Adelaide, country South Australia and near areas of NSW and Victoria. We are the state service and accept referrals (from any region) for children with suspected immunodeficiency or special immunisation problems (see referral guidelines).Flinders Medical Centre also has a Paediatric Allergy Service for consumers living in the southern region and accepts direct referrals to their service. There are also a number of private allergy services in metropolitan Adelaide. Information on specialists providing private allergy services can be found at the Australasian Society of Allergy and Clinical Immunology website at: http://www.allergy.org.au/patients/allergy-and-clinical-immunology-services/how-to-locate-a-specialist.

Prescriptions

We rely on our GP colleagues to assist with the provision of prescriptions that may include Adrenaline auto-injector devices or elemental formulas. If you are unclear about whether you can prescribe/re-prescribe an item please contact the service.

Anaphylaxis *is the most severe form of allergic reaction and requires* ***urgent medical treatment.***

Symptom Definition:

*• Any acute onset illness with typical skin features (urticarial rash or erythema/flushing, and/or angioedema**), PLUS** involvement of respiratory and/or cardiovascular and/or persistent severe gastrointestinal symptoms.*

OR

• Any acute onset of hypotension or bronchospasm or upper airway obstruction where anaphylaxis is considered possible, even if typical skin features are not present. ALWAYS refer confirmed or suspected anaphylaxis for specialist assessment and targeted interventions E.g. desensitisation to insect venom (Immunotherapy).

Anaphylaxis	
Idiopathic/trigger unclear	**P1**
Bee/Wasp Venom/Jumper ant	**P1**
Foods (staple or non- staple)	**P1**
Latex	**P1**
Drug	**P1**

Initial pre-referral work up	**GP management**	**Comments**
Clinical History • Identification of likely trigger (food/medicine/ venom/idiopathic/ exercise) if possible • Co-morbidities and current medications • Clinical symptoms • Treatment required: o Adrenaline o Antihistamines o Salbutamol o Fluid resuscitation o Corticosteroids **Investigations** • Mast cell tryptase if diagnosis in doubt and within 3 hours of the onset of symptoms.	**Emergency –** All patients presenting to a primary care setting with symptoms of anaphylaxis should be treated according to the Australian Prescriber guidelines (see link below). Intramuscular adrenaline is safe and should be administered as first line treatment for anaphylaxis. The patient should be transported by ambulance to the nearest hospital for further management and observation. **All patients presenting with a anaphylaxis should have:** • An Adrenaline Auto-injector (AAI) • An Anaphylaxis Action Plan	**All patients with anaphylaxis will be categorised as C1.** **Red Flags! Service should be contacted for advice if the patient has had:** • **Idiopathic anaphylaxis** • **Required multiple doses of adrenaline (> 3)** • **Required ICU admission** Comments: Patients with anaphylaxis to medication do not normally require an AAI as medication can/should be avoided. A MedicAlert medical ID is recommended.

Initial pre-referral work up	GP management	Comments
	Further information about AAI prescription guidelines: PBS guidelines state that script can be organised IN CONSULTATION with an allergist/paediatrician/ respiratory physician. **GP's can also issue continuing supply** <u>Doses:</u> **150mcg (>10kg)** **300mcg(>20kg)** ***Phone*** WCHN Allergy/Clinical Immunology Registrar or Consultant on call to discuss PBS subsidised approval for initial Adrenaline Autoinjector (EpiPen®) via switchboard 8161 7000 **AAI should be prescribed with:** • Anaphylaxis Management Plan: www.allergy.org.au **Please also provide the following:** >use of the device >When to use device >MedicAlert/ case note alert if appropriate >Psychological support: Alleviate alarm; assist in communication to children's services >Ensure any asthma is well controlled.	

Initial pre-referral work up	GP management	Comments
	>Educate on strict avoidance of allergen if trigger identified to prevent further allergic reactions. **<u>Medical Guidelines:</u>** **Australian Prescriber Emergency Management of Anaphylaxis** https://www.nps.org.au/australian-prescriber/articles/anaphylaxis-wallchart **For emergency management of anaphylaxis in a primary care or rural setting these guidelines are intended for emergency department staff, ambulance staff, rural and remote GP's and nurse providing emergency care):** **http://www.allergy.org.au/health-professionals/papers** **For additional medical/patient resources:** **http://www.allergy.org.au/health-professionals/anaphylaxis-resources** o Action plans and AAI prescription guidelines o Anaphylaxis checklist for GP's o Dietary avoidance information sheets o Fact sheet for parents o First aid – other	

Initial pre-referral work up	GP management	Comments
	languages	

Food Allergy:

- Food allergies are IgE, non-IgE or mixed immune mediated hypersensitivity reactions.

• **Common food triggers:**

- egg, cow's milk protein, soy, wheat, nuts (peanut and tree nuts), fish, shellfish, sesame.

• **Food allergy reaction patterns** may be broadly grouped into:

- **acute reactions,** occurring soon after exposure to the allergen.
- **chronic allergic reactions**, due to **regular ingestion** of allergen**,** through breast milk, formula or solid diet and includes progressively intensifying generalised eczema and gastrointestinal symptoms.

Food Allergy – Not Anaphylaxis	
Associated Feeding Disorder	**P1**
Associated FTT	**P1**
Multiple Foods (including at least two staple foods)	**P1**
FPIES	**P1**
Eosinophilic Esophagitis < 12 months	**P1**
Non-staple food (Peanut/Nuts/Seeds/Seafood)	**P2**
Eosinophilic Esophagitis > 12 months	**P2**
Positive screening sIgE tests to staple foods and foods excluded[1]	**P2**
One staple food < 12 months	**P2**
One staple food > 12 months	**P3**
Positive screening sIgE tests to non-staple foods and foods excluded	**P3**
Positive screening sIgE Tests to foods and unclear if foods excluded	**DR**
Positive screening sIgE Tests to foods and food remains in diet	**DR**
Sibling of child with food allergy/Parent has food allergy	**DR**
Carbohydrate Malabsorption (i.e. lactose intolerance)	**DR**

Initial pre-referral work up	**GP management**	**Comments**
Clinical History • Identification of trigger foods (list each food) and what form reaction occurred i.e. cooked, raw. • Description of symptoms including timeline • Previous anaphylaxis • Presence of any skin manifestations, gastrointestinal symptoms, respiratory symptoms • Identify any concerns about feeding disorders or failure to thrive	• Reassure parents • Provision of action plan for Allergic reactions (for patients with reactions that are not consistent with anaphylaxis): http://www.allergy.org.au/health-professionals/ascia-plans-action-and-treatment • Consideration of elemental formula for children with cow's milk/ soy	**Red Flags! Service should be contacted if you are:** **Referring patients who have food allergies and/or intolerances who have:** >Persistent vomiting, pallor and unresponsiveness after food (up to 6 hours) FPIES (see link) > Failure to Thrive >Markedly limited diet on the basis of perceived adverse reactions to foods or

• Detail current height and weight • Type of foods/formula already in diet **Investigations Required:** • Staple food mix and nut mix specific IgE have poor specificity and are therefore NOT recommended. Specific IgE to individual foods may be useful but interpretation in the context of clinical history is important – please contact us for advice. • Failure to thrive investigations – (CBP, ECU, LFT including albumin, CaMgPhos, Immunoglobulins, Vitamin D, ESR, Fe Studies, B12, Folate, Zinc, Thyroid function.	allergy (Contact Allergist on call 8161 8638 for advice) *Please note that risk of vaccination reactions is not increased by having food allergy.* **Medical/Patient information:** General information on Food Allergy: **http://www.allergy.org.au/patients/food-allergy** Dietary avoidance information: **http://www.allergy.org.au/patients/food-allergy/ascia-dietary-avoidance-for-food-allergy** Allergic reactions to seafood: http://www.allergy.org.au/patients/food-allergy/allergic-and-toxic-reactions-to-seafood Cow's milk allergy: http://www.allergy.org.au/patients/food-allergy/cows-milk-dairy-allergy Peanut/tree nut and seed allergy: http://www.allergy.org.au/patients/food-allergy/peanut-tree-nut-and-seed-allergy	additives >dysphagia >food impaction >Feeding disorder – unable to ingest solids in any form after 8 months of age >severe recalcitrant eczema <5 years Comments: Inappropriately delayed introduction of staple foods may lead to failure to develop tolerance; inappropriate avoidance may lead to a break in tolerance. There is also the potential for unnecessary cost and anxiety and for delay in appropriate treatment of associated disorders (i.e. eczema). **FPIES (Food Protein Induced Enterocolitis Syndrome)-** consider this diagnosis if patient presents with persistent vomiting, diarrhoea, pallor or collapse 2-4 hours after ingestion of food (typically weaning foods). This is a complex diagnosis, often requires supervision of introduction of staple foods, and there is a risk of feeding disorders. **Eosinophilic oesophagitis - food**

	Management of Food Allergy: https://www.allergy.org.au/patients/food-allergy/ascia-dietary-avoidance-for-food-allergy Management of FPIES: http://www.allergy.org.au/patients/food-other-adverse-reactions/food-protein-induced-enterocolitis-syndrome-fpies?highlight=WyJmcGllcyJd Management of Eosinophilic Oesophagitis: http://www.allergy.org.au/patients/food-other-adverse-reactions/eosinophilic-oesophagitis Management of Food intolerance: http://www.allergy.org.au/patients/food-other-adverse-reactions/food-intolerance	sticking, choking on foods, regurgitation ***note that these patients should be referred to a paediatric gastroenterologist in the first instance for diagnosis.** **Severe failure to thrive -** Early intervention is likely to avoid long term health consequences – these patients require urgent assessment by a General Paediatrician.

Adverse Drug reactions- most occur due to non-immunological or unknown mechanisms with allergic or immunological mechanisms accounting for only a small number of these reactions (ASCIA 2015).

Drug allergy	
Complex - – multiple drugs, co-morbidity, no alternates available, drug required for treatment i.e. CF **(refer Drug Allergy clinic)**	**P2**
Simple – single drug, no co-morbidity, alternates available **(refer General Allergy Clinic)**	**P3**

Initial pre-referral work up	**GP management**	**Comments**
Clinical History • Type of medication/s including brand name, dosage, dose at which reaction was elicited. • Patients with a history of reactions to local anaesthetics or induction agents. • Document symptoms and severity and interval between exposure and reaction • Any underlying medical condition at the time that could explain the symptoms • Was the adverse reaction to the drug in keeping with known adverse reactions to the drug • Medication list at time of event, including over the counter, illicit and homeopathic drugs • Past medical history (including asthma) • Reason for prescribed drug use, and likelihood that it or related	**Medical Guidelines:** Adverse drug reactions: http://www.allergy.org.au/health-professionals/hp-information/asthma-and-allergy/allergic-reactions-to-antibiotics Antibiotic Allergy: http://www.allergy.org.au/health-professionals/hp-information/asthma-and-allergy/allergic-reactions-to-antibiotics Further information: http://www.allergy.org.au/images/stories/hp/info/ASCIA_HP_Clinical_Update_Antibiotic_Allergy_2014.	Red Flag! Please ring service: ***If drug urgently required call on- call Allergist on 8161 7000.*** Comments: **Patients with complex drug allergy are triaged higher as there is:** High risk for serious adverse reactions to incorrect drug chosen, potential for unnecessary use of expensive alternate drugs, drug choice can be complex (i.e. side chain allergy). **Consideration is also given to those patients with:** • Penicillin allergy who have significant co-morbidities (such as cystic fibrosis) or who have had adverse symptoms (rash) following multiple antibiotics from different families. **Do not refer:** • Patients who have had delayed rash (after 48 hours) following Penicillin and who are able to tolerate other antibiotics.

drugs will be required again. • Known prior drug allergies **Investigations** • If available - Mast cell tryptase within 3 hours if reaction anaphylaxis		

Atopic Eczema: Eczema is a chronic, pruritic skin condition which is commonly associated with elevated IgE antibodies. If eczema presents in infancy it is a marker for the presence of food allergy (refer to food allergy guidelines).
Major features include:
- Pruritus
- Rash - location and extent of disease varies according to age and trigger.
- A personal or family history of atopy or allergic disease

Eczema	
With suspected food allergy (based on reaction or IgE) and < 12 months of age	**P1**
With suspected food allergy (based on reaction or IgE) and >12 months of age	**P2**
Apparently severe < 5 years of age where appropriate treatment has been implemented and failed	**P2**
Apparently severe and > 5 years of age where appropriate treatment has been implemented and failed	**P2**
Any severity referred by dermatology clinic WCHN	**P2**
Apparently mild – any age	**DR**

Initial pre-referral work up	**GP management**	**Comments**
Clinical History • Medical History (Including any other allergies such as allergic rhinitis, asthma and or suspected or confirmed food allergies • Duration and severity of symptoms • Effects on day to day living, including any failure to thrive issues. • In infants – list current diet, weight and height and any gastrointestinal symptoms • Current treatment and response to	• Reassure parents • Optimise skin management through use of emollient therapy and topical corticosteroids • Consideration of role of food allergy • Check compliance with recommended treatments **Medical/Patient information:** https://www.allergy.org.au/patients/skin-allergy **Eczema Action Plan:**http://www.allergy.org.au/patients/skin-allergy/eczema-action-plan?highlight=WyJhY3Rpb24iLCJwbGFuIiwiYWN0aW9uIHBsYW4iXQ	**Red Flags:** Severe eczema that involves most (>50%) of the body and is associated with significant morbidity. Eczema associated with failure to thrive, recurrent infection, generalised erythroderma (redness of whole skin). Comments: Eczema should be considered a skin disease rather than an allergy though some children with eczema do have associated food allergy. Food allergy is not the cause of eczema. **Do not refer:** • Uncomplicated and mild- moderate eczema. Atopic eczema is not

treatment – use of emollients and list of topical corticosteroids or other topical treatments used or anti-infective measures.		caused by food allergy or aeroallergen allergy. **Consider Dermatology referral.** • Refer patients with contact dermatitis to Dermatology.

Allergy to Insect venom refers to a clinical reaction to one or more stings that is greater than would be expected in the general population and results from specific sensitization to that venom (Golden, WAO 2015).

Insect venom allergy	
Systemic reaction (not anaphylaxis)	**P2**
Local reactions	**DR**

Initial pre-referral work up	**GP management**	**Comments**
Clinical History • Determine whether patient had anaphylaxis, a generalised reaction or local reaction only. Important to identify signs of hypotension. • Check if stinger identified • Co-morbid conditions including asthma • Previous stings **Investigations:** • If appropriate perform Specific IgE to Honey Bee venom including Total IgE and Mast cell tryptase • If appropriate Specific IgE can also be ordered for Jack Jumper ant (SA Pathology only) and European wasp and paper wasp.	• If anaphylaxis needs EpiPen – see anaphylaxis guideline • Provision of allergen avoidance advice: http://www.allergy.org.au/patients/insect-allergy-bites-and-stings/allergic-reactions-to-bites-and-stings?highlight=WyJ2ZW5vbSJd	**I**mmunotherapy **(**desensitisation) treatment is available for bee and wasp venom. Jumper ant immunotherapy has been successfully used in clinical trials and may be available in the near future. **Systemic reactions – without anaphylaxis** (generalised rash and/or angioedema without respiratory/cardiovascular or GIT involvement. *Risk of anaphylaxis, with subsequent bee/wasp stings is low and this is not an indication for immunotherapy. These children should be referred for consideration of an AAI.* **Do not refer:** **Local reactions only** Low risk of anaphylaxis, simple

		management with non-sedating antihistamines and TCS may be required.

Asthma is defined by the presence of both the following:

- Excessive variation in lung function i.e. variation in expiratory airflow that is greater than that as seen in healthy people.
- Respiratory symptoms (e.g. wheeze, shortness of breath, cough., chest tightness) that vary over time and may be present or absent at any point in time(National Asthma Council Australia 2015)

Asthma	
Persistent, uncontrolled, and multiple admissions	**P2**
Any severity referred by respiratory physician at WCHN	**P2**
Any severity referred by Paediatrician	**P3**
Persistent and stable	**P3**
Intermittent	**DR**
Unknown severity	**DR**
Any severity referred by GP	**DR**

Initial pre-referral work up	**GP management**	**Comments**
Clinical History • Clinical symptoms • Likely triggers • Comorbid conditions such as allergic rhinitis and eczema • Family history **Physical Examination** • FEV 1 or PEF lower than predicted without any other explanation • Wheeze on auscultation • Symptoms responsive to bronchodilator **Investigations** • Pulmonary	• Confirming diagnosis • Ensuring good asthma management by assessing pattern and severity. • Provision of action plan • Ensure proper use of medications – puffer technique and spacer use • Managing comorbid conditions that may impact on asthma like allergic rhinitis • Manage flare ups as they occur • Assessing triggers **Medical/Patient information:** **Allergy and Asthma:** http://www.allergy.org.au/patients/asthma-and-allergy **Asthma handbook:**	Red Flags!- please contact service: ➢ a severe episode of asthma (ICU admission) in an individual with a known food allergy. ➢ An acute and severe (ICU admission) respiratory episode in which diagnosis is unclear and anaphylaxis is considered. ➢ Comments: Patients with asthma are only accepted into the allergy clinic by direct referral from a Respiratory Physician or General Paediatrician. **These specialties should** consider referral for allergen immunotherapy for asthmatic patients if there is one or more of the following:

function testing pre and post bronchodilator	http://www.asthmahandbook.org.au/uploads/555143d72c3e3.pdf	• a clear relationship between asthma and exposure to an unavoidable aeroallergen to which specific IgE antibodies have been demonstrated • Co-existing allergic rhinitis which is inadequately controlled on symptomatic treatment • Poor response to asthma pharmacotherapy (despite good compliance) and appropriate allergen avoidance • Unacceptable side effects of medications • Desire to avoid long term pharmacotherapy • questions around immunotherapy or systemic immunomodulation See **General Medicine** or **Respiratory Medicine** Referral Guidelines for further information **<u>Do not refer:</u>** ➢ Persistent asthma which does not meet referral criteria. The vast majority of asthmatics will be atopic (positive Specific IgE to an aero-allergen) and this is not a reason for referral.

Allergic Rhinitis/Conjunctivitis

Is caused by the nose or the eyes coming into contact with environmental allergens such as pollens, dust mite, moulds and animal hair. Symptoms include:

- Runny / itchy /congested nose
- Sneezing
- Itchy watery eyes

Allergic rhinitis and conjunctivitis	
Severe VKC	**P1**
Persistent, uncontrolled, seasonal/perennial rhinitis	**P2**
Any severity referred by ENT physician	**P2**
Any severity referred by Paediatrician	**P3**
Any severity referred by GP where treatment has been implemented but failed	**P3**
Any severity referred by GP without good evidence of treatment implementation	**DR**
Persistent and controlled seasonal/perennial rhinitis	**DR**
Intermittent (seasonal) rhinitis	**DR**
Unknown severity	**DR**

Initial pre-referral work up	**GP management**	**Comments**
Clinical History • Establish if chronic – persistent symptoms (more than 8 weeks, recurrent or more than 6 episodes per year) • Clinical symptoms – nasal obstruction, nasal discharge, facial pain/frontal headaches/ disturbance of smell or taste/ impacts on quality of life • Details of treatment given and effectiveness • Establish co-morbid conditions **Physical Examination** • Swollen mucosa • Secretions • Ensure symptoms are not due to nasal foreign body	• Outline of trial of ASCIA Allergic Rhinitis Management plan (see under Medical Guidelines) and patients response to it:- • Allergy testing if indicated to likely triggers i.e. pollen mix, mould mix, cat, dust mites etc • Manage environmental factors – i.e. if patient is house dust mite sensitised on SpIgE testing then house dust mite measures	Red Flags! Please contact service: **Vernal KeratoConjunctivitis (VKC)** Potential for corneal scarring and loss of sight. May require immunotherapy. This should be considered an urgent referral – **also refer to Eye clinic** Comments: Allergic rhinitis is a common condition affecting up to 10% of the population and should largely be managed in primary care. The allergy service only accepts patients with prolonged or severe

Investigations Total IgE and Specific IgE – to suspect allergen triggers	should be implemented i.e. covers (see link below). • Consider topical nasal corticosteroids and antihistamine therapy **Medical/Patient Guidelines:** General information on allergic rhinitis including action plan: http://www.allergy.org.au/patients/allergic-rhinitis-hay-fever-and-sinusitis Allergen minimisation (includes house dust mite): http://www.allergy.org.au/patients/allergy-treatment/allergen-minimisation	manifestations of rhinitis with comorbid conditions e.g. asthma and where symptoms interfere with quality of life and/or ability to function, or have found medications to be ineffective. These patients are likely to benefit from immunotherapy.

Urticaria is a distressing but usually self- limiting and benign condition that can be treated with explanation, symptomatic treatment and clinical follow up. Urticarial lesions may be flat, raised, itchy or asymptomatic, of variable size and last minutes to hours. Investigation is recommended when symptoms are prolonged, refractory or atypical or when underlying disease is suspected. **Angioedema** may occur in conjunction with urticaria – swellings may burn or hurt, be less demarcated and often last longer than 24 hours. The face and larynx are most often involved.

Hereditary Angioedema (HAE) should be considered if the patient presents with angioedema only and where its onset is preceded by trauma and is associated with recurrent abdominal pain and upper airway swelling (ASCIA 2015).

Urticaria and/or Angioedema	
Angioedema – suspected HAE	**P1**
Angioedema – HAE not suspected	**P2**
Idiopathic urticaria > 6 weeks duration	**P2**
Idiopathic urticaria < 6 weeks duration	**DR**
Physical urticaria (e.g. cold urticaria)	**DR**

Initial pre-referral work up	**GP management**	**Comments**
Clinical history • Duration of symptoms • Is the urticaria associated with angioedema • Site of swelling or urticaria • Review possible etiologic factors (medications/supplements/ dietary factors, animal exposures, physical factors). • Family history • Consider vasculitis – lesions lasting longer than 24 hours, purpuric, painful or burning, signs of systemic	**Idiopathic urticaria <6 weeks** Likely self-limiting and can be managed with high dose non-sedating antihistamines: Zyrtec 0.25mg/Kg/dose BD Singulair 4mg or 5mg	Red Flags! Please contact service: **Possible Hereditary angioedema:** Potentially life-threatening condition, significant morbidity. The diagnosis is suggested by the following: • Family history • Recurrent episodes of angioedema without urticaria • Associated abdominal pain and vomiting Associated upper airway obstruction (stridor Comments: Angioedema occurs in 40% of patients with chronic urticaria and usually affects the lips, peri orbital regions, extremities and genitals (seldom the tongue, throat

illness • Consider autoimmune pathogenesis • Patients with chronically recurring angioedema without urticaria should be considered for HAE • Systemic mastocytosis should be considered **Investigations:** **Idiopathic urticaria >6 weeks:** CBP, ESR, Complement function, ANA **Recurrent angioedema without urticaria:** C4 and refer.		or airway) Chronic urticaria with or without angioedema is very rarely associated with food allergy. Allergy testing (including skin testing) and/or dietary restriction is rarely indicated. **Idiopathic urticaria >6 weeks will only be accepted by this clinic** **<u>Do not refer:</u>** Acute episodes of urticaria and/or angioedema. In a child under 5 years viral infection is the most likely cause.

Consider PRIMARY IMMUNODEFICIENCY (PID) if any of the following: -
Recurrent and/or unusual infections (opportunistic infections, recurrent invasive infections, recurrent upper respiratory tract infections). These conditions have significant morbidity and therefore **consultant discussion is REQUIRED** prior to referral – contact via switchboard on 8161 7000.

Immunodeficiency (to be triaged by Consultant only)	
High probability PID	**P1**
Low probability PID	**P2**

Initial pre-referral work up	**GP management**	**Comments**
Clinical History Any of the following warning signs: • 8 or more new infections within one year • 2 or more serious sinus infections within one year • 2 or more months on antibiotics with little or no effect • 2 or more pneumonias within a year • Failure of an infant to gain weight or grow normally • Recurrent deep skin or organ abscesses • Persistent thrush in the mouth or elsewhere on skin after age 1 year • Need for IV antibiotics to clear infections • 2 or more deep-seated infections • A family history of immunodeficiency **Investigations:** Call the Allergy Service	**Contact ACI consultant on 8161 7000 for advice prior to referral.**	Red Flag! Contact service: PID has potential for serious morbidity and mortality, multiple admissions and significant risk if diagnosis is delayed. Comments: All referrals must be by initial phone call to the on-call Immunologist. This is to- • Determine the likelihood of a Primary Immunodeficiency • To facilitate any testing required that will expedite diagnosis. Referrals within the hospital: • Inpatient consultation if appropriate

Miscellaneous	
Adverse events following immunisation/ High risk immunisation/ complex immunisation issues (see guidelines below)	**P1/P2**
Auto-inflammatory condition/Periodic Fever Syndrome	**P1**
Latex Allergy – not anaphylaxis	**P2**
Suspected Food Chemical Intolerance with evidence of significant morbidity	**P3**
Suspected Food Chemical Intolerance without evidence of significant morbidity	**DR**
Non-specific rashes	**DR**
Large local reactions to mosquito bites	**DR**
Current patients due for review	**P2**
Patients with eosinophilia, High Total IgE, positive IgE to aeroallergens but **no documented clinical symptoms.**	**DR**

Initial pre-referral work up Adverse Events Following Immunisation	**GP management**	**Comments**
Clinical History • Previous vaccines and adverse events • Background medical/social issues • Vaccines associated with event • Time interval between vaccine and onset of symptoms • Treatment required • Resolution of symptoms	**All Adverse Events Following Immunisation to be notified to the Department of Health (SA).** • **phone** 1300 232 272 during business hours • complete the Vaccine Reaction Reporting Form o **email** - healthvaccinesafety@sa.gov.au o **fax** - (08) 8226 7197. • For general immunisation advice (for example catch-up schedules) **phone** 1300 232 272 during business hours	**Red Flags! Contact service if:** The following events occurred post-vaccination; • Anaphylaxis • Hyporesponsive Hypotonic Episode (HHE) • Seizures Comments: This is not a routine immunisation service. This service is for children who have had severe adverse events following immunisation or those who have medical risk factors that may result in an increased likelihood of an adverse reaction or those that have complex immunisation needs that have not

		been addressed in primary care. **Do not refer:** Children with egg allergy who require the MMR or MMR-V vaccines (these vaccines do not contain egg). Children with egg allergy who tolerate egg in baked goods and require the seasonal influenza vaccine. This vaccine can be given in the community in these egg allergic children. For information on egg allergy and influenza vaccination please see (http://www.allergy.org.au/health-professionals/papers/influenza-vaccination-of-the-egg-allergic-individual)

WCHN Department of Allergy and Clinical Immunology Referral Guidelines – QUICK GUIDE

TRIAGE CATEGORIES *please note these are maximum recommended waiting times. Currently the service is experiencing excessive demand and actual waiting times may be considerably in excess of the recommended waits. If the referring doctor believes a patient requires earlier review please contact the on call allergist to discuss the patients' needs further on 8161 7000.

Priority 1	**6/52**
Priority 2	**<4/12**
Priority 3	**<8/12**
Decline Referral (DR) (Consultant/ Nurse Practitioner decision only)	**Letter sent back to referring doctor and parent with interim advice as appropriate.**

Anaphylaxis	
Idiopathic/trigger unclear	**P1**
Bee/Wasp Venom/Jumper ant	**P1**
Foods (staple or non- staple)	**P1**
Latex	**P1**
Drug	**P1**
Food Allergy – Not Anaphylaxis	
Associated Feeding Disorder	**P1**
Associated or FTT	**P1**
Multiple Foods (including at least two staple foods)	**P1**
FPIES	**P1**
Eosinophilic Esophagitis < 12 months	**P1**
Non-staple food (Peanut/Nuts/Seeds/Seafood)	**P2**
Eosinophilic Esophagitis > 12 months	**P2**
Positive screening sIgE tests to staple foods and foods excluded[2]	**P2**
One staple food < 12 months	**P2**
One staple food > 12 months	**P3**
Positive screening sIgE tests to non-staple foods and foods excluded	**P3**
Positive screening sIgE Tests to foods and unclear if foods excluded	**DR**
Positive screening sIgE Tests to foods and food remains in diet	**DR**
Sibling of child with food allergy/Parent has food allergy	**DR**
Carbohydrate Malabsorption	**DR**
Drug allergy	
Complex - – multiple drugs, co-morbidity, no alternates available, drug required for treatment i.e. CF **(refer Drug Allergy clinic)**	**P2**
Simple – single drug, no co-morbidity, alternates available **(refer GAC)**	**P3**
Eczema	
With suspected food allergy (based on reaction or IgE) and < 12 months of	**P1**

age	
With suspected food allergy (based on reaction or IgE) and >12 months of age	**P2**
Apparently severe < 5 years of age where appropriate treatment has been implemented and failed	**P2**
Apparently severe and > 5 years of age where appropriate treatment has been implemented and failed	**P3**
Any severity referred by dermatology clinic WCHN **(book for Eczema clinic)**	**P2**
Apparently mild – any age	**DR**
Insect venom allergy	
Systemic reaction (not anaphylaxis)	**P2**
Local reactions	**DR**
Asthma	
Persistent, uncontrolled, and multiple admissions	**P2**
Any severity referred by respiratory physician at WCHN	**P2**
Any severity referred by Paediatrician	**P3**
Persistent and stable	**P3**
Intermittent	**DR**
Unknown severity	**DR**
Any severity referred by GP	**DR**
Allergic rhinitis and conjunctivitis	
Severe VKC	**P1**
Persistent, uncontrolled, seasonal/perennial rhinitis	**P2**
Any severity referred by ENT physician	**P2**
Any severity referred by Paediatrician	**P3**
Any severity referred by GP where treatment has been implemented but failed	**P3**
Any severity referred by GP without good evidence of treatment implementation	**DR**
Persistent and controlled seasonal/perennial rhinitis	**DR**
Intermittent (seasonal) rhinitis	**DR**
Unknown severity	**DR**
Urticaria and/or Angioedema	
Angioedema – suspected HAE	**P1**
Angioedema – HAE not suspected	**P2**
Idiopathic urticaria > 6 weeks duration	**P2**
Idiopathic urticaria < 6 weeks duration	**DR**
Physical urticaria (e.g. cold urticaria)	**DR**
Immunodeficiency (to be triaged by Consultant only)	
High probability PID	**P1**
Low probability PID	**P2**
Miscellaneous	
Auto-inflammatory condition/Periodic Fever Syndrome	**P1**
Latex – not anaphylaxis	**P2**
Suspected Food Chemical Intolerance with evidence of significant morbidity	**P3**
Suspected Food Chemical Intolerance without evidence of significant morbidity	**DR**
Non-specific Rashes	**DR**
Large local reactions to mosquito bites	**DR**
Patients with eosinophilia, High Total IgE, positive IgE to aeroallergens but no documented clinical symptoms.	**DR**

References

Leung, D & Schatz, M 2006, 'Consultation and referral guidelines citing the evidence: How the allergist-immunologist can help', *Journal of Allergy and Clinical Immunology,* no. 117, pp. S495 – 523.

FMC Referral Guidelines: Dr Anthony Smith & Sue Mattschoss (SALHN project support officer) 2014

WHCN Paediatric Allergy/Immunology Triage Survey 2013

WCHN Referral guidelines 2009/2013

For further information about management of children and adults with allergic conditions:

www.allergy.org.au

http://www.bsaci.org/guidelines/paediatric-guidelines

For more information

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