



SUTTER PHYSICIANS ALLIANCE (SPA)
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SPA PCP Treatment & Referral Guideline
Allergy

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I.	Allergic Rhinitis.....	Page 2
II.	Anaphylaxis	Page 2
III.	Hymenoptera Sensitivity.....	Page 2
IV.	Urticaria/Angioedema.....	Page 2 - 3
V.	Medication Allergy	Page 3
VI.	Consideration Of Immunodeficiency.....	Page 3
VII.	Chronic Cough and/or Wheezing.....	Page 3 - 4
VIII.	Asthma Management	Page 4
IX.	Indications for Limited Sinus CT	Page 4

Note: This guideline is designed to assist clinicians in the evaluation and treatment process, but is not intended either to replace a clinician's judgement or to establish a protocol for treatment of all patients with a particular condition. Individual referral decisions may be patient and physician specific.

I. Allergic Rhinitis

The Primary Care Physician should try routine basic treatment first. Referral should be considered for the following:

- A) Unsuccessful trial (2-3 weeks for each agent) of medication therapy (poor response or medication intolerance) using nasal steroids, oral or nasal antihistamines \pm decongestants, as indicated by persisting interference with normal activities including sleep, work or school performance.
- B) Significant comorbid conditions including eczema, sinusitis, and asthma.
- C) Significant complications not responding to treatment of the underlying condition, including otitis media, sinusitis, nasal polyposis, and hyposmia/anosmia.
- E) Recurring requirement for IM or oral corticosteroids.
- F) Need to identify allergic/environmental triggers in order to provide education on trigger avoidance and medication use.
- G) Multiple medications over a prolonged period (i.e., 4-6 months) needed to maintain control of symptoms.
- H) Consider early referral for children requiring constant or intermittent use of nasal steroids.

II. Anaphylaxis

Anaphylaxis is a symptom complex that may present with severity ranging from mild (e.g., urticaria only) to severe with life threatening hypotension and respiratory compromise. Repeat exposure may result in a more severe reaction. The precipitating factor(s) should be identified as definitively as possible. Patient self-assessment of the potential allergen may not be accurate. Referral is indicated when, in the judgment of the PCP, assistance is needed in diagnosis, treatment, or prevention planning. Patients who have presented with potentially life threatening anaphylactic reactions should be subsequently referred. It is important to consider ACE inhibitors as the source of this problem in patients who are taking them.

III. Hymenoptera Sensitivity

Large local reactions (i.e., swelling at the site of the sting) to the stings of hymenoptera can be treated appropriately with antihistamines and local measures; in certain instances, oral steroids may be required to control symptoms. Referral is indicated for patients who experience any reaction other than locally at the sting site.

IV. Urticaria/Angioedema

Urticaria that only involves the cutaneous tissues and does not involve the airway or represent a symptom of a systemic disorder should be evaluated by the PCP with emphasis on defining the etiology. Referral should be considered under the following conditions:

- A) The etiology is unclear and the condition persists more than six weeks
- B) Response to conventional medication is inadequate.

Angioedema, particularly involving mouth and face, may be referred immediately if obvious causes such as ACE inhibitor or aspirin use have been ruled out. NSAID sensitivity should be referred.

V. Medication Allergy

Generally, these patients do not need to be referred for Allergist evaluation, as alternative medication treatments are available.

Referral is indicated:

- A) For specific skin testing to penicillin or cephalosporins. This may be helpful in identifying the responsible agent in patients with a history of multiple drug reactions or when the patient is expected to require subsequent treatment with beta lactams.
- B) Local anesthetic testing and challenge.
- C) For evaluation of sensitivity to nonsteroidal anti-inflammatory medications.

VI. Consideration of Immunodeficiency

Unexplained recurrent infections that are unusually severe, do not respond well to antibiotic treatment or are caused by unusual organisms may be an indication for an immunodeficiency evaluation. Most patients with Immunodeficiency present with chronic sinus infections.

VII. Chronic Cough and/or Wheezing

Accurate diagnosis is crucial for successful treatment of patients with chronic cough and wheezing. Allergy-related asthma and isolated reactive airway disease are not the only disorders that can cause these symptoms. Other conditions leading to this symptom complex with some frequency include sinusitis and other respiratory infections, gastroesophageal reflux, congestive heart failure, and COPD. Cough is also a common side effect of certain medications. To the extent possible, these etiologies should be ruled out prior to referral. Evaluation prior to referral should include the following:

- A) Rule out medication reaction, particularly secondary to ACE inhibitors, even angiotensin receptor antagonist.
- B) Chest x-ray: findings suggestive of acute infection or other non-allergy disorder should be treated accordingly. Findings consistent with COPD and a history of significant smoking should lead to a pulmonary referral for patients needing further evaluation.
- C) Evaluation of GI symptoms: patients having significant upper gastrointestinal symptoms in conjunction with chronic respiratory complaints should be evaluated for gastroesophageal reflux, including a trial of therapy. The index of suspicion for this etiology is higher in obese patients, those with nocturnal symptoms, and those over 50 years of age.
- D) Consider a limited sinus CT for patients having significant upper respiratory symptoms.
- E) Where spirometry is performed, in the absence of other findings patients having an FEV₁ < 80% of predicted or an FEV₁/FVC ratio of less than 75% can be referred immediately.
- F) In the absence of other findings, a cough persisting for over 2 months should be referred for evaluation to an allergist or pulmonologist.

VIII. Asthma Management

Many patients with chronic Asthma can be managed by the Primary Care Physician. Patients already fully evaluated and having a well-established diagnosis of asthma should be considered for referral to an Allergist or Pulmonologist if the patient:

- A) Requires systemic steroids with any frequency (e.g., > 2/ yr).
- B) Has persistent symptoms that are moderate or severe on inhaled steroids or leukotriene antagonists.
- C) Has labile symptomatology that is difficult to control.
- D) Pre-bariatric Surgery Work-up needs further evaluation for disease etiology, e.g., inhalant sensitivities or chronic infection.
- E) Has a recent history of hospitalization or multiple ER visits.

IX. Indications for Limited Sinus CT Include:

In patients over 12 years of age recurrent upper respiratory tract infections (presumed sinusitis,) requiring antibiotics occurring more than 3x/12 months. In children less than 12 years of age, obtain limited sinus CT if on antibiotics more than 5x/12months.

- A) New onset anosmia or significant hyposmia.
- B) Definite nasal polyps identified on physical exam.
- C) History of recurrent asthma associated with upper respiratory tract infections.
- D) History of fever/facial pain/periorbital swelling/nasal purulence for which the presumptive diagnosis is acute bacterial sinusitis.

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