National Institute for Health and Clinical Excellence

Short Clinical Guideline:

Anaphylactic episode

Scoping Workshop

Room: Bollin | Level 1A | City Tower | Piccadilly Plaza | Manchester M1 4BD

2nd August (9.45 – 12.30pm)

Minutes from the workshop

Item 1 Introduction and welcome (Sharon Summers-Ma)

SS Associate Director for the Centre for Clinical Practice at NICE welcomed the group and attendees and outlined the purpose and agenda for the workshop

Item 2 The NICE Short Clinical Guideline Programme (Caroline Keir)

CK (NICE commissioning manger) presented the group with an overview of the short clinical guidelines programme

Item 3 Patient & Public Involvement Programme – NICE (Sarah Chalmers)

SC (NICE PPIP Project Manager) presented to the group the role of the PPIP in developing short clinical guidelines

Item 4 Draft guideline scope (Beth Shaw)

BS (NICE Technical Advisor, Short Clinical Guidelines) presented the scope

Item 5 – Health Economics (Prashanth Kandaswamy)

PK (NICE Technical Advisor, Short Clinical Guidelines) presented an overview of health economics and the potential questions to answer in development

Item 6 Questions for the breakout session (Sharon Summers-Ma)

SS outlined the questions for discussion in the breakout session:

Population

Health Care Setting

Key Clinical Issues

Main Outcomes

Health Economics

Equalities Issues

GDG composition

Item 7 Breakout Session

General Discussions

Table 1

The group discussed the correct definition of anaphylaxis and agreed the definition as stated in the scope.

Group members highlighted the difficulties of diagnosing in hospital anaphylaxis

Table 2

The group discussed the definition of Anaphylaxis and felt the scope definition was suitable

Table 3

The group noted that anaphylaxis is often misdiagnosed and treated incorrectly. The group estimated about 50% of cases are diagnosed incorrectly.

POPULATION

Table 1

The group agreed it was important to define children and adults with asthma as a sub group.

The group also highlighted children with congential heart disease or lung disease as a potential sub group.

Table 2

The group noted that adults and children could be merged into one population

The group noted children (0-18 years) could be defined as a subgroup

Table 3

The group were in agreement with the population

HEALTH CARE SETTING

Table 1

The group were in agreement with the stated settings

Table 2

The group wanted to define emergency departments or remove as it would be covered under secondary care

Table 3

The group were in agreement with the current settings but noted that paramedics could be included.

KEY CLINICAL ISSUES.

Table 1

The group felt the list of clinical assessments should be re-ordered in order of how they would occur.

The group agreed with the rest of the covered issues

The group noted that assessment of risk for future episodes should be included.

Table 2

.The group wanted the list of clinical assessments to be re-ordered in accordance with standard procedure

The group asked if the provision and training in the use of auto injectors could be included as part of the covered clinical issues

The group noted that assessment of risk for future episodes should be included

Table 3

The group noted that tests may not be available in all settings, nor be able to be interpreted.

The group also noted that patients should be given adrenaline auto injectors and appropriate support and information about that treatment

OUTCOMES

Table 1

The group agreed with the current list

Table 2

The group agreed with the current list

Table 3

The group did not discuss this section in detail but did note that recurrence of anaphylaxis could be better defined

HEALTH ECONOMIC QUESTION

Table 1

The group agreed that the question should focus on the cost benefit of referring to allergy services

Table 2

The group agreed that the question should focus on the cost of referral to specialist teams

Table 3

The group highlighted that the key issue is the referral to appropriate services and how this impacts on quality of life. The group noted that the number of referrals to specialist centres differ regionally depending on the availability

EQUALITY ISSUES

Table 1

Noted that emerging evidence suggests.that non-white male children could be more susceptible to anaphylaxis –

Table 2

None identified

Table 3

Identified older people, those who don't speak English, people with learning disabilities and teenagers (due to drugs, peer pressure, individual responsibility etc) as being at greater risk of anaphylaxis

COMPOSITION OF GDG

Table 1

Recommended an A&E physician, nurse lead for either setting (primary or secondary care) specialist services representative eg allergy specialist or organ based specialist, Anaesthesiologist and a respiratory physician

Table 2

Recommended a dermatologist, Immunologist, respiratory physician, asthma nurse, GP with specialist interest and a health visitor.

Table 3

Recommended a Paramedics, Commissioner, and a school nurse in addition to those outlined at the workshop

Item 8 Feedback

Table 1 key themes inlcuded the health economics question on referral to specialist allergy clinics, the order of assessment and assessment of risk of prophylaxis and the various identified sub groups

Table 2 also noted the key messages raised with Table 1

Table 3 raised the issues of settings which could include paramedics. They also noted that a commissioner should be included on the GDG

The group as a whole then discussed together the various items and noted that although paramedic services vary regionally they would not administer adrenaline without admitting to hospital therefore this would not be added to the scope

Item 9 Next steps (Scope consultation & GDG recruitment

SM thanked the workshop attendees and noted that details of recruitment to the GDG and the dates for the GDG meetings will be available on the NICE website from 1st September.2010