Clinical guideline. Diagnosis and management of drug allergy in adults, children and young people. CG183.

Defining drug allergy as ‘any reaction caused by a drug with clinical features compatible with an immunological mechanism’, NICE acknowledges that diagnosis can be challenging and management and access to specialist services are variable. The guideline is in four parts, covering assessment, sharing information, providing information and support to patients, and nonspecialist management and referral.

Assessment includes the differential diagnosis of a drug reaction, for which tables of definitions are provided. Serum tryptase should be measured after a suspected anaphylactic reaction but IgE should not be measured in a nonspecialist setting. Detailed guidance is included on what to document about suspected drug allergy. All records should be updated with allergy status (separate from information about adverse drug reactions) and this information should be included in all letters. Prescriptions should be amended to include statements on which drugs to avoid. Allergy specialists should provide unequivocal information about allergy status and how it was diagnosed.

Drug allergy should be discussed with the patient and their family/carers and supported by written information. They should always carry information about the allergy, know which medicines they should avoid and check with pharmacists when obtaining medicines.

When a drug allergy is suspected, nonspecialist management includes stopping the drug, treating the acute symptoms (or, if severe, sending the patient to hospital), documenting the details and informing the patient, and referring severe cases to a specialist. The allergic response to an NSAID is mediated through COX-1 and many, but not all, individuals with a mild reaction may tolerate a COX-2 selective agent. In such cases, treatment should start with a low once-daily dose. However, all NSAIDs should be avoided if the allergic reaction is severe. Individuals who need an NSAID despite their allergy should be referred.

People who are allergic to beta-lactam antibiotics (e.g. penicillins and cephalosporins) should be referred if they can only be treated with such an agent or they may need to be treated in the future. Patients who are allergic to beta-lactams and one other class of antibiotic should also be referred. Referral is recommended for people who may be allergic to local anaesthetics but need to undergo a procedure, and for those who have an allergic reaction after general anaesthesia.

Clinical guideline. Investigation and management of dyspepsia, symptoms suggestive of gastro-oesophageal reflux disease, or both. CG184.

This update to the 2004 guideline (CG17) includes new advice and many amendments to recommendations for investigation and referral, eradicating Helicobacter pylori, specialist management and surveillance of Barrett’s oesophagus in people with dyspepsia.

Patients with uninvestigated dyspepsia who have been treated with a proton pump inhibitor (PPI) should allow two weeks before a breath test or stool antigen test for H. pylori is carried out. Patients with a gastric or duodenal ulcer who have H. pylori should be offered a retest six to eight weeks after beginning treatment. The patient should be referred if H. pylori infection does not respond to second-line therapy.

New recommendations cover the use of full-dose PPIs. Individuals with severe oesophagitis should be offered a full-dose PPI both as an eight-week healing course and as maintenance therapy, taking personal preferences and clinical factors into account. If the first healing course or maintenance therapy fails, a different PPI should be considered. Endoscopy to diagnose Barrett’s oesophagitis should not be routine but should be considered for patients with GORD in light of their risk factors. Endoscopic surveillance should be considered when Barrett’s is diagnosed and individuals should be informed that its benefits may outweigh the harms in those with a low risk of progression to cancer.

The choice of first-line eradication therapy should now be the least costly and take into account prior exposure to clarithromycin or metronidazole. Individuals allergic to penicillin should now be offered a PPI, clarithromycin plus metronidazole or, in the case of prior use of clarithromycin, a PPI, bismuth, metronidazole and tetracycline. Options for second-line eradication therapy now include the antibiotics not used initially and levofloxacin.

Laparoscopic fundoplication should now be considered for patients with a confirmed diagnosis of acid reflux and symptoms that are responding to a PPI but who cannot tolerate acid suppression therapy, or do not want to take it in the long term.

Clinical guideline. The assessment and management of bipolar disorder in adults, children and young people in primary and secondary care. CG185.

This guideline replaces all parts of the 2006 guideline (CG38). Most of the guideline covers the assessment and treatment of adults in secondary care prior to recovery and a return to primary care. A section covering the management of children and young people recommends referral to child and adolescent mental health services (CAMHS). In this age group, the diagnosis should be made only by a suitably experienced individual or team. Valproate should be avoided in girls of childbearing age. Treatment for mania may be based on adult care with adjustment in dosage whereas bipolar depression should initially be managed with psychological therapies, adding pharmacological approaches when depression is moderate or severe.

When bipolar disorder is suspected in primary care, referral for specialist mental health assessment should be considered — urgently if mania or severe depression is suspected or there is a risk of harm. Initial management should be a psychological therapy. Lithium should not be initiated for the first time in primary care except under a shared-care arrangement.
and valproate should not be initiated in primary care at all. The guideline includes criteria for re-referral to secondary care and advice on managing physical health.

Recommendations for secondary care cover assessment, managing crisis and challenging behaviour, managing mania and depression acutely and in the long term, and the use of medication. Drug treatment requires a concordant approach supported by appropriate information about risks and benefits and regular review. The special needs of older people should be considered.

The guideline includes detailed advice on starting, monitoring and stopping treatment with an antipsychotic, lithium, valproate and lamotrigine. Treatment with an antipsychotic should remain the responsibility of the secondary-care team for 12 months or until the condition has stabilised, whichever is longer, before transferring responsibility to primary care under a shared-care arrangement. Gabapentin and topiramate are not recommended for bipolar disorder.


The 2005 clinical guideline on long-acting reversible contraception (LARC) included recommendations to encourage wider use of intrauterine devices, progestogen intrauterine systems, injectable progestogens and progestogen implants. It referred specifically to Implanon, a long-acting implant of etonogestrel that has since been discontinued. Its replacement, Nexplanon, is similar but has slightly different licensed indications. One section of the guideline has been updated to account for the differences.

The new information states that women should be informed of the low failure rate of the etonogestrel implant (<1 pregnancy per 1000 implants over three years) and that vaginal bleeding may stop, become more or less frequent or be prolonged during use. Dysmenorrhoea may improve and there is no evidence showing a delay in return to fertility after removal. Complications associated with implant insertion and removal are uncommon.