How the Allergist-Immunologist Can Help:

Consultation and Referral Guidelines Citing the Evidence

Executive Summary

Allergists-Immunologists can provide expert consultation for a number of diseases and conditions. These can be divided into two broad categories: 1) chronic diseases frequently followed by primary care physicians or another specialist/sub-specialist, and 2) conditions in which allergist-immunologist consultation is usually necessary for definitive diagnosis and treatment.

Chronic diseases frequently followed by primary care physicians or another specialist/sub-specialist:

These conditions include asthma, conjunctivitis, cough, dermatitis, rhinitis, and sinusitis. In general, the following referral considerations apply to these conditions: *Single consultation* may be useful for confirmation of diagnosis, identification of allergic triggers, provision of avoidance advice, and other recommendations for therapy. *Co-management or specialty follow-up:* 1) Referring physician or patient desires additional expertise, 2) Patients with more severe or difficult to control disease manifestations, 3) Outcomes of care have not met patient or physician expectations, 4) Patients with co-morbid conditions such as rhinitis or sinusitis, or 5) Patients interested in inhalant immunotherapy (asthma, conjunctivitis, rhinitis).

More specific referral considerations for these diseases, based on diagnostic value or improved outcomes, include, but may not be limited to, the following:

Asthma

Diagnosis: Challenge testing (e.g. methacholine, exercise) for confirmation of airway reactivity, role of allergy (correlation of specific IgE with history), role of occupational exposure

Improved outcomes in the following categories of patients:

1. Patients with asthma emergency department visits or hospitalizations
2. Patients with potentially fatal asthma (prior severe life-threatening episodes)
3. Patients with moderate-severe persistent asthma
4. Patients with uncontrolled asthma in spite of therapy
5. Patients who use excessive amounts of reliever medications (1 canister per month or more)
6. Patients in whom adherence or self-management appears to be sub-optimal
7. Patients with associated rhinitis or sinusitis

Dermatitis

1. To confirm the diagnosis of atopic or contact dermatitis
2. To identify the etiology of contact dermatitis (patch testing)
3. To identify the role of environmental allergy (e.g. dust mite) in patients with atopic dermatitis
4. To identify the role of food allergy in patients with atopic dermatitis
5. Management of patients who are poorly responsive to treatment

Rhinitis or Conjunctivitis

Diagnosis: Allergy testing and correlation of specific IgE with history

Management: Improved outcomes due to

1. Environmental management
2. Optimal pharmacotherapy
3. Immunotherapy (in properly selected patients)

Sinusitis

Diagnosis:

1. Associated allergic rhinitis
2. Associated immunodeficiency
3. Allergic fungal sinusitis

Management: Improved outcomes due to

1. Treatment of associated allergic rhinitis (avoidance, pharmacotherapy, immunotherapy)
2. Treatment of associated immunodeficiency
3. Medical treatment of allergic fungal sinusitis
4. Pharmacologic treatment of associated eosinophilic inflammation or nasal polyps

Conditions in which allergist-immunologist consultation is usually necessary for definitive diagnosis and treatment.

These conditions include allergic bronchopulmonary aspergillosis, anaphylaxis, aspirin exacerbated respiratory disease, drug allergy, food allergy, hypersensitivity pneumonitis,

insect hypersensitivity, latex allergy, occupational allergic diseases, primary immune deficiency, and urticaria/angioedema. For these conditions, the allergist-immunologist often provides unique diagnostic information (skin testing, in vitro testing, provocative challenges) or therapeutic interventions (avoidance, drug desensitization, other immunologic therapy).