

key points

SELECTED BY

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Suspected adverse drug reactions may be subdivided

on the basis of mechanism e.g. immunological (requiring sensitisation by previous exposure) versus non-immunological; timing (e.g. immediate or delayed), or whether the phenomenon is dose dependent or not. In the recent NICE guideline the main approach is to classify the adverse event according to whether it: is immediate (within an hour of drug administration) or delayed (hours or days); affects a single system or multiple systems; is clinically severe/life threatening or not.

An immediate, immunologically mediated, multisystem,

life-threatening reaction would for example include anaphylaxis (type 1 or typically IgE-mediated hypersensitivity) especially if the clinical features (e.g. bronchospasm, hypotension) are suggestive. Serum mast cell tryptase should be tested ideally within two hours and certainly before four hours post reaction. Detailed investigation of suspected cases in a specialist clinic is ideally delayed for 4-6 weeks after the event, and skin testing is the main test modality used.

Adverse drug reactions need to be meticulously recorded

and the patient and their family should be fully informed. Documentation should include: date of reaction; drug name (chemical and generic); route of administration; time interval between first dose and event; and nature and severity of symptoms. Written guidance should be provided on which other chemically related drugs also need to be avoided.

Patients with mild reactions (e.g. isolated urticaria)

following a non-selective NSAID who have an ongoing need for anti-inflammatory medication could be considered for a trial of a selective COX-2 inhibitor, which carries a lower risk of further urticaria, started at a low dose, without specialist referral. However, this approach would not be recommended when the previous adverse NSAID reaction was more severe (e.g. an asthma episode requiring nebuliser treatment).

Specialist referral is indicated for the following: all cases

of suspected anaphylaxis; all severe/life-threatening episodes e.g. Stevens-Johnson syndrome; severe NSAID reactions with ongoing need for NSAID therapy; suspected penicillin allergy (but only where alternative antibiotics are not available); and problems related to general and local anaesthesia.