Delabelling penicillin allergy revisited

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Correcting (or delabelling) inaccurate penicillin allergy labels is an important component of antimicrobial stewardship. Over recent years, there has been greater recognition of the harms associated with having penicillin allergy wrongly noted in medical records, as well as development of tools to support delabelling initiatives. The proportion of incorrect penicillin allergy labels has been reported to be about 95% following subsequent testing. People who have a label of penicillin allergy are more likely to be treated with alternative antibacterials that have a broader spectrum of activity, which may impact on antimicrobial resistance patterns. In addition, there is growing resistance to last-line antibiotics, which is associated with a higher risk of mortality disproportionately affecting deprived or non-white populations, and increasing resistance to alternative antibiotics in primary care.

Delabelling penicillin allergy by non-allergists is supported by national and international guidelines. The British Society for Allergy and Clinical Immunology (BSACI) guideline includes a checklist to identify patients at low risk of allergy and a framework for drug provocation testing by non-allergists. A systematic review of 69 studies reporting on the successful delabelling of 5019 patients delivered by non-allergists provides further evidence for this intervention. In the review, the methods of delabelling included direct delabel (removal of allergy record on history alone), direct drug provocation testing (most often using a single dose of oral amoxicillin) and skin testing followed by direct drug provocation testing. These were delivered, mainly in inpatient settings, by pharmacists, doctors, nurses, physician associates, medical students and pharmacy students. Rates of allergy delabelling varied from 14% to 41% depending on the method of assessment. Once assessed as suitable for testing, 95% or more of patients tested were successfully delabelled with only 1.7% reporting harm (non-serious).

Within a hospital setting and with the involvement of non-allergists, a clear pathway is being developed as to how such delabelling should take place. This typically involves: obtaining a structured allergy history from the patient, risk stratification and deciding on the testing method. If the test result is positive, the reaction is treated, and the allergy label remains in place. If the test result is negative, the patient’s health record is amended, and the significance of the result discussed with the patient and the change in allergy status communicated across care providers. Though some work is underway in a primary care setting, also with the involvement of non-allergists, this appears to be less well reported in the literature than delabelling in hospital and targets a very low-risk patient group.

There are encouraging signs that delabelling penicillin allergy by non-allergy specialists is possible. Further work is underway to provide evidence to support implementation of the BSACI guideline and this will be made available across health and social care services. Nevertheless, as others have argued, patients and clinicians will ‘need to be supported to use penicillin allergy services and be provided with the skills and information to prescribe and use penicillins appropriately after a negative test result.”

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References


