

KISS: Allergy Testing in Primary Care

Reference - [BSACI Primary Care Guideline 2025](#)

Background/key principles:

- References to 'allergy' in this guideline refer to immediate/type 1 (IgE-mediated) hypersensitivity reactions.
- **Symptoms occur within minutes/max 1 hour of exposure and include:**
 - Rash (urticaria, angioedema or erythema), wheeze, hypotension, vomiting and diarrhoea.
- Symptoms are REPRODUCIBLE and occur with EVERY subsequent exposure and do NOT occur without exposure to the allergen.
- Allergy is a CLINICAL diagnosis, and testing should be strictly guided by the clinical history, with tests limited to relevant triggers only; 'Screening' allergy testing is not indicated.

Assessment:

- **History is KEY - Use the STAR principles:**
 - Are **S**ymptoms consistent with an IgE-mediated mechanism?
 - Is **T**iming consistent with an IgE-mediated mechanism?
 - Can symptoms be attributed to a likely **A**llergen?
 - Are symptoms **R**e producible?
- **IgE testing should only be undertaken if the answer is 'yes' to ALL 4 of the STAR questions above.**
- In most cases, it is rarely necessary to test for more than 5 individual allergy-specific IgEs.

General guidance for allergy testing:

- Measurement of total IgE is not helpful in allergy testing.
- **Food testing:**
 - Do not use bundles of tests, e.g. food mixes - test only the specific food compatible with the allergy.
 - Any suspected food that has been consumed and tolerated after the event can be excluded without testing.
 - Isolated delayed (>1 hour) GI features are generally not consistent with allergy.
- **Inhalant allergies:**
 - Always consider non-allergic respiratory disease, including perennial rhinitis, before considering allergy/testing.
 - Timing and duration of symptoms can help identify allergens ([click here](#) for a seasonal guide to allergy patterns).
 - **Only test if it will change management:**
 - If an allergen can't be avoided (e.g. a pollen), testing may not be helpful, but if avoidance is possible (e.g. testing for dog dander), then it probably is helpful.
 - This would include testing if required by local pathways prior to referral to either ENT or allergy clinics.
- **Drug allergies** - do not test in primary care; refer to allergy services as per [NICE guidance](#) if:
 - Severe reaction, e.g. anaphylaxis, Stevens-Johnson syndrome, toxic epidermal necrolysis, severe angioedema or asthmatic reaction.
 - Suspected antibiotic allergy and likely to need that antibiotic in the future, especially beta-lactam antibiotics.
- **Bee and wasp venom:**
 - Do not test for local reactions, even if large.
 - If systemic features are present, refer to the allergy clinic; consider baseline mast cell tryptase and IgE wasp and bee venom levels at the point of referral.

Referral:

- If referring to an allergy clinic, check your local referral guidelines, but information to include in referral:
 - History based on STAR assessment above.
 - Examination findings at the time of the acute event (if available), e.g. RR, pulse, BP.
 - Treatments given and response.
 - Also consider mast cell tryptase levels.