



Issue 2  
Autumn 2003

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2003

[www.bsaci.org](http://www.bsaci.org)

# Allergy Update

The Newsletter of the British Society for Allergy & Clinical Immunology

## Parliamentary Debate on Paediatric Allergy

Dr Helen Cox

Dept Paediatric Allergy and Immunology  
St Mary's Hospital

On 14th October 2003, Jon Cruddas, the Hon member for Dagenham, secured the debate on Paediatric allergy services within the House of Parliament. He outlined the issues facing our service with great clarity. He was able to highlight the Royal College of Physician's report, "Allergy: the unmet need" in which a number of excellent proposals were made for the way forward. He requested that the Department of Health show some commitment to the development of allergy services through investment in the establishment of regional allergy centres with funding for additional consultants, training posts in allergy and clinical research. He requested a willingness by the Minister to meet a representative group of campaigners and medical experts.

The response from The Under-Secretary of State for Health, Melanie Johnson, was a complete obfuscation. Whilst in agreement that NHS allergy services needed improvement, she offered no commitment to specific funding of this service. As solutions she mentioned the annual increase in NHS expenditure in real terms, which she stated had already led to "significant increases in the number of health professionals, increases in capacity, prescribing of new and better drugs, shorter waiting times and greater choice for patients."

The real terms increase in NHS spending however is not finding its way into allergy, despite an increase in disease prevalence, patient demand and waiting times. There has been no extra funding for paediatric allergy consultant posts in the UK and no new training posts in allergy. Despite our best efforts to establish a 3 year paediatric training post in allergy in the North West Thames region, we have been unable to do so due to lack of funding. Additional

funding for waiting lists has been available with attendant severe penalties for breaching these targets. Our own experience with waiting list targets at St Mary's has been far from favourable. In an effort to reduce waiting times for new patients we have had to limit referrals to the most complex cases and refuse referrals from primary care which fall out of area. As a result, the delivery of paediatric allergy care has become even more of a post-code lottery.

Credence was paid to the work of the Food Standards Association (FSA), an organisation which functions independently of the Department of Health. Their work on food labelling and prevalence of allergies does not however address the grassroots issues surrounding provision of allergy care to the patients who need it. This is solely the remit of the Department of Health to whom the question was addressed.

Thus, whilst acknowledging the problem facing paediatric allergy services in the UK, she offers no ideas or mechanisms to reach a solution. Specifically she chooses to ignore the excellent recommendations of the RCP. She implies that it is sufficient to rely on growth of spending, reduced waiting times and a general sense of optimism for the problem to go away. She describes this wholly ineffective approach as "taking the provision of allergy services very seriously indeed".

But not all is lost, she invites members of our organisation to meet Dr Ladyman, the Under-Secretary of State for Health responsible for allergy, to discuss provision of allergy services in the UK. The allergic march continues!



British Society for Allergy  
& Clinical Immunology

**Annual Meeting**

Monday July 12th – Wednesday July 14th 2004  
Burleigh Court, Loughborough

See [www.bsaci.org](http://www.bsaci.org) for details

# Collaborative approach

Dr Glenis Scadding

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Welcome to the second edition of *Allergy Update*. Thanks to many of you for positive comments about the first edition – even if it did include mis-spellings!

As with much of the BSACI structure changes are afoot – intended to broaden input into Society affairs. The newsletter is now the product of an editorial committee, with different individuals taking responsibility for writing or commissioning articles within their area of interest. We hope that this will reduce the burden on one or two people and enable a wider-ranging and more interesting magazine which should appear in Spring and Autumn.

I have decided to step down as Editor (to spend more time with my research interests) and have handed the reins to Nasreen Khan, who has worked with me on producing this issue. If any reader would like to contribute then please contact Nasreen or the relevant commissioning editor – details appear opposite.

I shall continue to be responsible for Personal View – which in this edition features a fascinating reminiscence by Mary Brydon on her career as an allergy nurse. Other articles have a paediatric emphasis: the lack of evidence for feeding practices is noted by Kate Grimshaw and the need for attention to the psychological effects of food allergy and anaphylaxis by David Reading. Angela Simpson describes her research on the Manchester birth cohort; Robin Gore tells of some of the pitfalls that occur during the bedside to bench years.

Journal Watch includes summaries of recent important articles detailing the lack of evidence for some allergen avoidance measures in asthma. Readers are also invited to contribute to this section.

There are also summaries of important BSACI initiatives arising from the Council meeting on 3rd October and the Think Tank held at Leicester on 4th October. A major need is for guidelines for allergy investigation and treatment. At present those suggested for production are drug allergy; an update on immunotherapy; anaphylaxis; urticaria and angioedema and egg and milk allergy. Again suggestions and help will be gratefully received. Shuaib Nasser is leading for the society on this work.



Finally, I think that all those who attended the Annual Conference at Nottingham will agree that it was a very high quality educational meeting. It cost us £50,000 – not an amount that we as a small organization can afford to pay annually. Please help by making sure that you attend next year and by recruiting a colleague/friend to join the BSACI and to come as well – to Loughborough on July 12th –14th, 2004. See you there!

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# National Allergy Strategy Group (NASG)

## Professor Andrew Wardlaw

Chair in Respiratory Medicine, Glenfield Hospital, Leicester

The NASG is an umbrella grouping of all stakeholders with an interest in allergy and acts as a forum through which we can integrate and co-ordinate a sustained and long-term effort to improve allergy services. Our aim is to exert pressure, using the resources of both the BSACI and patient groups, with the RCP report "Allergy the unmet need" as our blue print for what we wish to achieve. The priority is to create more Consultant Allergists in regional centres, to support and develop allergy services in the secondary care sector, to get more allergy trainees and to encourage improved allergy awareness in primary care.

One of my aims as president is to make the BSACI more in touch with what is happening on the ground in terms of who delivers allergy services not least so we can identify opportunities for expansion. I intend creating a network of BSACI regional representatives to act as a source of local information, as champions for the development of allergy services and as contact points for the

organisation of regional allergy meetings.

### New sub-committees of the Council

We are creating a number of standing sub-committees of council which will take forward business between meetings. These are:

- Scientific Meetings Committee (chaired by Andrew Bentley)
- Communications Committee (Nasreen Khan)
- Standards of Care Committee (Shuaib Nasser)
- Allergy Services Committee (Andy Wardlaw)
- A paediatric sub-committee is under consideration.

If you would like to get involved in the work of any of the committees please contact the relevant chair. If these committees are successful we will recommend formalising them at the AGM.

Copies of NASG prospectus are available from [gail.fretter@uhl-tr.nhs.uk](mailto:gail.fretter@uhl-tr.nhs.uk)

## Diary dates

### 2003

**The British Society for Immunology - Annual Meeting**  
2-5 December  
Harrogate International Centre, UK  
[www.immunology.org](http://www.immunology.org)

### 2004

**Allergy and Eczema, A CME Accreditation event in cooperation with ACAAI in Milan.**

January 23-24.

*Main theme:* Adverse reactions to food proteins, the changing patterns, the mechanisms and treatment.

[www.mcaevents.org](http://www.mcaevents.org)

### AAAAI Annual Meeting

March 19-23  
San Francisco, California  
[www.aaaai.org](http://www.aaaai.org)

### Allergy for non- experts

April 19th  
Royal College of Physicians  
[www.rcplondon.ac.uk](http://www.rcplondon.ac.uk)

### British Society for Allergy & Clinical Immunology, Annual Meeting 2004

12-14th July  
Burleigh Court, Loughborough, Leicestershire

#### *Details and registration:*

Website: Visit [www.bsaci.org](http://www.bsaci.org) for details and a booking form.

Email: [Conference@bsaci.org](mailto:Conference@bsaci.org) with your name and address details

Tel/Fax: +44 (020) 8859 6118

Post: Conference 2004, BSACI, PO Box 35649, London SE9 1WA

## BSACI Annual Meeting

30th June  
- 2nd July 2003

Congratulations to Andrew Bentley for organising such a successful event. Those who gathered at the East Midlands Conference Centre had the opportunity to partake of a wide variety of educational sessions. Paediatric, clinical, scientific and immunology matters were all equally represented.

The meeting began with an emphasis on the development of allergic disease. The role of early life influences from pets to probiotics was discussed and vigorous debate followed. The jury remains on a very long lunch break (nut free obviously!). Consideration of the function of epithelium, immune regulation and neuro-immuno-endocrine links in allergic disease provided a surfeit of scientific matter. Clinical sessions on the state of immunotherapy, diagnostics and management practice were relevant to delegates needs. The issues surrounding anaphylaxis also received appropriate attention. Difficult asthma for the allergist remains difficult for the patient despite our ability to measure inflammatory markers. The role of allergen avoidance (a recurring theme in this edition of Allergy Update) was again aired. Current trends in clinical laboratory immunology and developments in immunity to mycobacteria rounded off a wide-ranging subject base.

Professor Tim Williams delivered the annual and prestigious Jack Pepys Lecture this year with characteristic equanimity. His address entitled 'Eosinophil migration to the lung; what's the attraction?' took the audience on a journey that was smooth, concise and ultimately fascinating.



Professor Tim Williams (l) being congratulated by Professor Mark Pepys

# The weaning dilemma: which solids to introduce and when

Kate EC Grimshaw and Jonathan O'B Hourihane

Food allergy awareness is increasing in the general population and with it comes an increasing demand for more information from health professionals. Pregnant women and the mothers of young children are particularly interested in obtaining information, mainly to reduce the likelihood of their child developing allergies. Articles in lay magazines reflect this interest.<sup>1,2</sup>

Mothers and health professionals may be aware of the existence of hypoallergenic formulae but not of the rationale and indications of their use. Similarly many seem aware of the concept delaying the introduction of solids into an infant's diet, but the advice given to mothers can be extremely varied and is not detailed enough to enable execution of the proposed strategies. Confusion about weaning is also apparent in the medical world. A carefully prepared review on the subject published earlier this year highlights the need for more research in this area and recommends caution when advocating early allergen avoidance,<sup>3</sup> whilst research amongst paediatric nurses has highlighted that weaning guidelines are not widely understood.<sup>4</sup> Add to this the latest Department of Health guidelines embracing the WHO advice for mothers to exclusively breastfeed until 6 months of age and the picture is further confused.

As there has been no research into the relationship between when solids are introduced into an infants diet and the development of allergic disease, (apart from a single study of a single disease outcome-eczema- that reported results at 10 years in 1994<sup>5</sup>), it is very difficult to know what advice to give to mothers, particularly when the infant is at risk of developing allergies. The European Society for Paediatric Allergology and Clinical Immunology (ESPACI) and the European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPHAN) published a joint statement advising no solid foods to be introduced before 5 months of age, with no further recommendations given as to when to introduce allergenic food.<sup>6</sup> The American Academy of Paediatrics recommends no solids before 6 months, no cow's milk before 1 year, no eggs before 2 years and no peanuts, tree nuts or fish before 3 years.<sup>7</sup> Further conflicting advice can be found in texts regularly used in the clinical setting.<sup>8,9</sup>

It is clear that the delayed introduction of solids is now considered a fundamental, uncontested component of many complex intervention studies (either as part of the

intervention with other prevention strategies<sup>10, 11</sup> or as advice for all study groups<sup>12</sup>) as well as being part of standard weaning advice given to the general public.<sup>1,13</sup> This is despite there being very little evidence base for such recommendations.

In this age of evidence-based practice, it is not appropriate that recommendations for care are being made without the evidence base to support them. There is a need for the formal evaluation of weaning as a single intervention. It appears on a practical level, more important to emphasise the need to delay the introduction of any solids until at least four months of age than delaying the introduction of allergenic solids because 85% of infants in the UK receive solids by the age of four months.<sup>14</sup>

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# Functional in vitro tests for allergy diagnosis

HC Bourne, GP Spickett and D Barge

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The 'holy grail' of clinical diagnostic allergy is the identification of the ideal diagnostic tool with optimum sensitivity and specificity while minimising any inherent risk to the patient. The gold standard is currently the double-blind placebo controlled challenge. However these are extremely labour intensive to perform and carry an intrinsic risk of inducing anaphylaxis. Skin prick tests (SPT) are fraught with difficulties, they may not always be possible, may be contraindicated and may result in false positive or negative results. Specific IgE can be measured if SPTs are contraindicated but they lack sensitivity and there is a limited range of allergens. A number of in-vitro functional assays are now available for the investigation of suspected allergic disease, using both ELISA and flow cytometry as test systems.

## Types of assay available

Assays available include the basophil histamine release test, leukotriene release test and the basophil activation tests (BAT) also called flow cytometric allergen stimulation tests (FAST).

The histamine release test was the first approach to basophil functional studies. However its clinical benefit has remained controversial due to insufficient sensitivity and specificity. Tests for basophil histamine release have been used for many years, but these are time consuming assays appropriate to a research setting only.

The basis of the basophil activation tests is the demonstration of altered membrane phenotypes on activated basophils. The most commonly used marker in basophil activation studies is CD63. CD63 correlates strongly with degranulation making it an ideal surrogate and robust marker of basophil activation when plotted against anti-IgE-FITC. Basophil activation tests are also commercially available under the name of Flow CAST (Bühlmann Laboratories) and BASOTEST (Becton-Dickinson). Recently CD203c has been shown to have a higher sensitivity compared to CD63 using a similar methodology.

Leukotriene release tests are performed using an ELISA to measure leukotriene

production in the supernatant. They are also manufactured commercially under the name of CAST-ELISA (Bühlmann Laboratories)

## Clinical utility

The assays have been used for diagnosis of inhalant allergens, food allergens, insect venom, drugs and latex. These assays are expensive and therefore not likely to be of significant value where cheaper, quicker tests are available such as SPT for the diagnosis of inhalant allergies. However the assays may be useful in the diagnosis of drug allergies and NSAID/additive reaction where alternative tests are impractical, represent a significant risk to the patient or are not available. Despite the wide availability of commercial kits the majority of published data has not used an 'off the shelf kit' but a similar methodology and allergen titrations to optimise performance.

In the author's preliminary experience using a kit and confirmed by published data the Flow-CAST assay has shown to have a high specificity but appears to lack sensitivity. The CAST-ELISA is a complex assay, with stringent requirements in respect to timing and sampling. While it gives similar results to the Flow-CAST, it is certainly not appropriate to a routine laboratory due to the labour intensive nature of the assay and the length of time from start to finish. In summary these tests clearly require further development but have the potential to improve our diagnostic armamentarium.

## Rhinitis and Asthma guidelines

Dear Editor,

It has come to our attention that a set of united guidelines encompassing rhinitis and asthma is proposed, possibly for internet publication. Unfortunately there is little evidence from therapeutic trials considering both conditions simultaneously.

However should an amalgam of GINA and ARIA be formed, rather than labelling this with the acronym GINARIA (which sounds like a cocktail) or ARIAGIN (something out of Lord of the Rings) we propose the following title: Virtual Integration of All Guidelines for Rhinitis and Asthma (VIAGRA). These should be able to stand up for themselves.

Yours sincerely,

*Martin Church and Glenis Scadding*

## Further Reading

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# From bedside to bench... and back again

Robin Gore

What follows is some sound advice for those of you contemplating the world of research for the first time ... so read and learn

“Research experience improves confidence, especially when assessing new therapies for common diseases and unusual therapies for rare disorders”



‘Research will change you’, I was told. Whatever did they mean? Was this a good thing? Nobody ever explained in more detail; it just seemed to be understood. As I now wait for my PhD viva, a few things seem a little clearer. ‘Young Allergy’ within the BSACI is full of people who are in the process of conducting research, or are contemplating it, so I decided to share some thoughts. Whether this column becomes a message board for similarly bewildered research-types depends on you, the reader.

## Why do research?

You may want a research career. You may just want a change. Whether you start from a scientific or a medical career track, the transferable skills are numerous; your honed powers of deduction, tenacity and creativity will be attractive to many employers. Specifically from a medical stand point, research experience improves confidence, especially when assessing new therapies for common diseases and unusual therapies for rare disorders. This ability is central to the role of a specialist and is unlikely to be rendered obsolete by the current proliferation of guidelines.

## Journal watch

Journal watch is designed to summarize studies relevant to allergy which are not published in the allergy journals. All suggestions gratefully received!

### Enzyme potentiated desensitisation in treatment of seasonal allergic rhinitis: double blind randomised controlled study

Radcliffe MJ, Lewith GT, Turner RG *et al*  
*BMJ* 2003; **327**: 251–257

A UK study of adults (n=183) with seasonal rhinitis refractory to antihistamines and topical steroids, (without asthma requiring regular inhaled steroids) randomised to 2 injections of placebo or enzyme potentiated mixed inhaled allergen extract.

## Where to do it

Research opportunities do not grow on trees. If one does have some say in the matter, a useful exercise is to determine the abstract or paper output of junior researchers in the department of interest. This may reflect the opportunities you are likely to have. A busy department affiliated to a medical school will have BSc or medical students engaged on related research projects. Well-planned co-operation is mutually beneficial. Some departments have links with laboratories abroad. Once you’ve found your feet, a few weeks in a different laboratory can expand your horizons and be really good fun. Be wary of embarking upon a research programme requiring a particular technique or expertise in a department without the necessary track record. For clinical studies, ensure that you will have unfettered access to the correct numbers and types of patient. Determine that there will be no conflict of interest here with other researchers.

## Which degree?

If you’re unsure how far to take it, an MPhil degree gives a one-year rigorous research training. You can then extend your work if you wish by subsequently enrolling for a two-year PhD. Medical researchers are increasingly enrolling for PhD programmes. There are no absolute rules to help choose between a PhD and MD, although if you are committed to a research career, you will find yourself increasingly persuaded to enrol for a PhD.

No difference was found in problem free days or rhinoconjunctivitis scores during the following pollen season, with 80% power at 5% significance of detecting a 13% difference.

### Evaluation of impermeable covers for bedding in patients with allergic rhinitis.

Terreehorst I, Hak E, Oosting AJ *et al*  
*N Engl J Med* 2003; **349**: 237–46

A Dutch study of adults and children (n=232) with allergic rhinitis, positive skin test or IgE to mite and a positive nasal allergen-provocation test to mite were randomly assigned mite impermeable covers for mattress, duvet and pillows or control covers. Both groups were given advice on hot washing bedding and ventilating the home. Mite allergen levels fell

## Supervision

What is effective supervision? Old hands not infrequently tell you they were shown their 1m<sup>2</sup> bench area by their supervisor on day one and were instructed to report back in three years after completing their studies. Universities now try to avoid this, although as a result some students find they are too 'led'. It may be possible to get an idea about this from talking to present incumbents in your prospective department, although in reality this is difficult to evaluate until you're actually in the thick of it. Supervisors should not (and generally do not) hold your hand. However, exchanging ideas with many other people is a key part of the research experience: such people provide surrogate intellectual supervision and are usually other professors or post-docs. I never met an academic who was not prepared to donate some time for this purpose. However, a supervisor should supervise you to the extent that you are encouraged or coerced into submitting abstracts and writing papers. The supervisor should also critically review your manuscript towards the end of your period of research. Choosing two co-supervisors can help, especially if your field bridges two areas. Delaying university registration by a few weeks at the beginning of your research to sort out your supervision properly is well worth it.

## Presenting and organising your work

'Abstracts are just wallpaper.' Another miserable quote from the land of research designed for maximum personal deflation. All right, papers are more important, although having your abstracts reviewed at a conference helps you to write the paper later on. Where else

will you have a handful of experts in the same room criticising your work, other than at a conference (or in your viva)? The BSACI annual conference is an excellent forum for presenting research and junior members pay very attractive conference rates. The BSACI offers travel grants which can be applied for at any time of year. The European Academy (EAACI) similarly offers many generous grants to young researchers to enable them to attend the European meeting (Venue 2004: Amsterdam). We Brits are backwards in applying for these grants. If we don't use the money, we'll lose it.

A thesis effectively consists of back-to-back papers. If you are in a position to write papers as you go along, then thesis writing becomes much easier. Your work will have been peer-reviewed and you will be on firmer ground for the viva. Try to write your introduction by the end of year one (I didn't) and try not to be in a position where most of your writing is done once you've returned to a full-time job (this can be very unpleasant). Allow yourself some 'down-time' too. If you don't, you'll grind to a halt and end up taking some anyway.

## Life after research

If all goes roughly according to plan, you will have proceeded thus: survived the initial period of total confusion; isolated some fascinating (but completely invisible) blobs of organic material; thought hard about why you decided to do this in the first place; determined what you would have done, had you had the knowledge in the beginning that you now have acquired. Congratulations. You will have slotted your piece into the universal jigsaw.

"A supervisor should supervise you to the extent that you are encouraged or coerced into submitting abstracts and writing papers"

significantly in the impermeable cover group over the 12 month period. Despite this there was no change in allergen provocation test score in either group at 12 months. Rhinitis symptoms scores improved in both groups at 12 months, but there was no difference between groups, nor did sub-group analysis of those with high level exposure at baseline reveal any clinical effect.

## Control of exposure to mite allergen and allergen impermeable bed covers for adults with asthma

Woodcock A, Forster L, Matthews E *et al*

*N Engl J Med* 2003; **349**: 225–36

A UK double blind study of adults with asthma (n=1122) were randomised to a single intervention of allergen impermeable covers for the

duvet, pillows and mattress or placebo covers. Mite allergen levels were lower in the impermeable cover group at 6 months, but not at 12 months in the random 10% of homes selected. Due to the study's size, allergen levels could only be calculated as a concentration rather than total allergen recovered, so the difference in mite allergen exposure may have been underestimated. Both groups showed a significant improvement in peak flow and approximately 17% of participants in each group were able to reduce their dose of inhaled steroid in the 2nd 6 month phase of the study. Sub-group analysis of those sensitised to mite or those exposed to high levels of allergen did not change the results. Mite impermeable covers as a single intervention are ineffective in adults with asthma.

# Reflections of an allergy nurse: 20 years of a Nurse-Led Allergy Service in Primary Care

Mary Brydon

The concept of nurses and/or general practitioners running an allergy/skin testing clinic in primary care is not new, having been undertaken in the 1960s when nurses undertook skin prick tests which were then read by the GP.

Between the 70s and the 80s manufacturers of desensitising solutions began to offer GPs a skin prick testing service, with many of the tests being carried out by sales representatives. Whilst saving GP time there was undoubtedly pressure for the sales representatives to complete as many orders as possible in order that patients might undertake a desensitising programme.

In the early 1980s the late David Hide recognised that it would take many years to train even a minimum number of allergy specialists and in the meantime many GPs would continue to provide most of the advice to those with asthma, eczema, and hay fever. He further emphasised that allergy skin tests are not difficult to perform but the best results are obtained when an experienced individual, whose technique does not vary, performs them.

In late 1979 E Merck Ltd decided to train registered nurses to fulfil the role of allergy assessment and skin prick testing. I became a Merck Nurse in 1984 and was a member of a team of 34 nurses throughout the UK providing an allergy service to GPs and their patients.

Training was intense: a two week induction course of basic allergy, immunology, history taking and skin prick testing, followed by a two week period of being "shadowed" within the clinical setting before being deemed fit to practice on one's own. In addition we had regional seminars every three months, which off set any professional isolation and kept us abreast of current thinking. There was also an allergy consultant at the company whom we could contact directly if any difficulties or questions arose within the clinical setting. At no time was I ever under pressure to suggest or obtain orders for desensitising if it was not clinically justified. I saw the GP after each session and discussed each case and it was his or her decision whether or not to prescribe. Merck also organised regular GP weekend allergy training courses.

A part of my work was to meet GPs in order to introduce the Merck Nurse Service. During some of my visits I discovered that allergy testing was already being carried out by the surgery and I became increasingly concerned on three accounts. There appeared to be no designated nurse or doctor, virtually anyone carried out the skin testing procedure, some having very limited training and supervision, thus not maintaining consistency in obtaining results. Some of the skin prick test kits were not stored correctly in fridges when not in use, they were left sitting on a radiator shelf or in direct sunlight. Of major concern was the fact that a different professional (district nurses, practice nurse or whichever GP was available) gave the desensitising vaccine each week, without specific training. As a consequence some patients were not being asked about any side effects from the previous week's injection. I lodged these concerns with the company and talks were underway for the Merck Allergy Nurses to possibly develop further training so

as to undertake specific clinics at various centers in order to administrate the vaccines more safely.

However, matters were, quite rightly, taken out of our hands when the Committee on Safety of Medicines in 1986 imposed constraints on desensitising injections. Merck had no option but to call a halt to the entire nurse led allergy clinics and within 24 hours we were all out of work.

My reaction was two fold: one of relief, because of the above concerns, and a great sadness and frustration as I loved the work I was doing and felt that the 'baby was being thrown out with the bath water'. The Committee on Safety of Medicines letter sent out to all GPs clearly stated 'The CSM is not aware of such problems relating to skin testing when these allergens are used for diagnostic purposes only'. I strongly believed that there was validity in continuing with an allergy service based on the principle that patient selection for desensitisation was: a) if avoidance measures could not be implemented, b) treatment such as anti histamines and nasal sprays were not helpful. In my two and half year experience a high percentage of patients did not meet these criteria.

## Identifying a need

It was with this notion in mind that I set up The Norfolk Allergy Diagnostic and Advisory Service (NADAAS) in 1986/7. Initially the service had to be private because I needed to prove to the Health Authorities that there was a need to continue with an allergy service and more importantly the need to get allergy recognised within the NHS. This took a lot of hard work, preparing data, talking to doctors and administrators, and in November 1987 I was awarded funding to set up a pilot study at three surgeries. The outcome of this study demonstrated cost effectiveness and patient benefits, and resulted in an increase of funding on an annual basis.

Each year since I have had to submit a report of my work (financial and professional accountability) together with an application for further funding. The responsible 'body' has changed its title seemingly as often as the number of years I have been applying, from Norfolk Family Practitioner Services, Norfolk Family Health Service Authority, East Norfolk

Health Commission, East Norfolk Health Authority and now Primary Care Trusts. Fortunately each year I have been successful and currently there are steps underway to offer a three yearly contract.

The allergy service has been designed to be a 'One Stop Shop'. Assessment involves looking at the patient holistically: recording and addressing all their symptoms, together with skin prick testing, education and advice on management strategies. A recent survey within NADAAS, has shown that less than 3% of patients needed to be referred on to a district / regional allergy center or local organ based specialist.

In the early days I carried out a peripatetic service visiting surgeries, but I became conscious of wasting professional time travelling and now the majority of clinics held at a large medical centre with 10 GPs, 2 Nurse Practitioners, 4 part time practice nurses and a paramedic unit. The majority of patients referred are pleased to travel to the centre from all over Norfolk. Those few who are unable to travel, are usually seen at their respective surgery once there is a sufficient number of patients there to merit a visit.

This service has been running well under the NHS umbrella for 17 years and is supported on a regular basis by over eighty surgeries and 12 hospital consultants and dietitians. It has proved to be one of the first 'seamless' services to have been developed between primary and secondary care. The allergy service has also served to provide

awareness, dissemination of knowledge and education to my primary care colleagues, and the assistance in developing local study days for the primary and secondary care professionals in Norfolk. In addition, I have been able to offer clinical experience to both doctors and nurses either in their own work environment or by them sitting in on my clinics. My role has also involved a degree of research, in particular looking at the relationship of allergy, asthma and rhinitis.

### Achieving success

I was exceedingly fortunate to have the great support and encouragement from many of the BSACI consultants and to be the first nurse invited to join the society in 1986, and gain a place at the first BSACI Allergy School, Edinburgh in 1989.

For me the twenty years in allergy has been and continues to be challenging and very rewarding, a stimulating and worthwhile career. In essence the model of service which I set up is currently being advocated within primary care. It is now up to other nurses and GPs to grasp the nettle and provide the allergy service so badly required, to 'sell the service concept' to the local providers by knocking on their doors and making presentations. This approach from primary care together with that of the consultant allergists should lead to better provision of allergy services. There is no doubt that there has to be a bottom up, top down combined approach, only then will we be truly meeting the need of the allergic patient.



*"Twenty years in allergy has been, and continues to be, a stimulating and worthwhile career"*

## Suspected anaphylactic reactions associated with anaesthesia

In August 2003 the AAGBI and BSACI produced joint guidelines with the following objectives:

- Reviewing the incidence of anaphylactic reactions associated with anaesthesia
- Recognising and treating anaphylactic reactions
- Making recommendations about the investigation of anaphylactic reactions
- Considering the role of screening for the risk of anaphylactic reactions before anaesthesia
- To make recommendations about the reporting and collection of data on anaphylactic reactions

- To list major allergy centres able to help with investigations

The document is essential reading for those involved in the planning and administration of anaesthetics. It gives practical advice and answers to 'frequently asked questions'. Importantly it emphasises the need for all patients to be referred to an experienced allergist for investigation following a presumed reaction. Guidelines for allergists to follow from the Standards of Care Committee.

Visit [www.aagbi.org](http://www.aagbi.org) for full details

# Helping to lower the anxiety levels

David Reading

**Aiding parents in getting the balance right and enabling children to take ownership of their allergy is no easy task. Here we discover how it is possible with appropriate support**

When a child is diagnosed with a potentially life-threatening allergy, there is a tendency within the family to control every aspect of that child's life. The parents may be terrified their child will never reach adulthood and will do everything in their power to exclude the problem foods or substances from the environment.

This is understandable, of course, but can this quest for absolute safety go too far? The Anaphylaxis Campaign – a national charity with 7,400 members – has found that sometimes the fear of an allergy is as destructive as the allergy itself. There is a real danger that such children will grow up fearful, timid and unwilling to partake in life's challenges.

This deep anxiety is often expressed in calls to our telephone helpline. We spend much time and energy educating parents by helping them to get allergies into perspective and preparing for the moment when they will have to let go.

## **Anaphylaxis is serious but manageable**

The following excerpt from a letter written by the mother of a nut-allergic child is fairly typical: 'I am going out of my mind with worry and have been told I must wait three months before I see a consultant. My GP knows very little and would rather say nothing. Please, please can you help me?'

Ignorance of the facts is often at the root of parental anxiety and a lot of productive work can be done simply by passing on high-quality, reliable information in factsheets and newsletters and over the telephone. The clear message is that anaphylaxis is serious but it's manageable. There is plenty that those affected can do to take control of difficult situations, protect the person at risk and – if it is a child – raise them in a calm, stable atmosphere.

We provide a wealth of practical information, but the basic messages are simple: Get a proper diagnosis, carry your epinephrine at all times (if prescribed), formulate a management plan for when things go wrong and – if it is a food allergy – be vigilant and proactive whenever food is around.

Importantly, there are many myths that have to be dispelled. People have heard that peanut

allergy is always life-threatening; that vegetable oil is dangerous; that the smell of peanut butter will kill an allergic child; that each reaction will become increasingly severe; that epinephrine is more hazardous than the symptoms it treats. Countering misinformation with some hard facts is the routine part of a medical charity's work.

Providing guidance for teenagers is just as crucial. We run a programme of interactive workshops for allergic teenagers right across the country, taking up to 20 people for each event.

The objective is to show allergic teenagers how to assess risk and manage it safely. Topics covered include:

- Signs and symptoms of an allergic reaction
- How to use an epinephrine injector
- How to read food labels and assess risks
- What do "may contain nuts" warnings mean?
- Handling situations such as eating at restaurants, friends' houses and parties

Factual information is covered in a lecture or video, and there are sessions on risk assessment, teenage attitudes, and encounters with difficult people.

In addition, there is an urgent need to inform and educate the food industry, schools and health professionals. Deaths can be avoided, but families need to be well-informed. Many are not receiving proper medical guidance due to the inadequate training in allergy that GPs receive and the poor allergy services across the country. People's anxiety is exacerbated by confusing food labelling and lack of awareness in many restaurants. The Anaphylaxis Campaign is working with other groups to seek improvements in all these areas, but progress is slow.

Ultimately the answers lie in research. While those affected are watching the horizon for the elusive 'cure', scientists are grappling with the many questions surrounding allergy: What are the causes of allergic sensitisation? Might it be possible to predict who will have only mild allergy and who will suffer life-threatening reactions? Why is the peanut so notoriously hard to fathom? While patient care will remain an important part of the Campaign's work, we will no doubt be moving in the direction of helping science to answer these and many other questions.

The Anaphylaxis Campaign is a registered charity that represents people with life-threatening allergies by providing education, information and support, campaigning on their behalf and promoting research.

Website:  
[www.anaphylaxis.org.uk](http://www.anaphylaxis.org.uk)

# The National Asthma Campaign Manchester Asthma and Allergy Study

Angela Simpson

The National Asthma Campaign Manchester Asthma and Allergy Study (NACMAAS) is a single centre prospective population-based birth cohort study of the risk factors for the development of asthma and allergies.

MAAS was born in 1995 when Professors Woodcock and Custovic (both humble doctors then) secured funding from the NAC and recruitment began. In order to recruit the ~1000 children at different relative risks of allergy, we (myself, Adnan, Bridget Simpson and a team of nurses) attended 654 antenatal clinics over a two year period. The pregnant women and their partners were screened by questionnaire and then skin tested to inhalant allergens.

The expected child was then assigned a risk group based on parental atopic status: high risk – both parents atopic, medium risk – 1 parent atopic, low risk – neither parent atopic. Pet (cat and dog) ownership was recorded at recruitment and those at high risk with no pets were randomly allocated to follow stringent environmental control or normal regime.

## Methods and preliminary results

The environmental control regime included the fitting of mite proof encasings to the parental mattress, duvet and pillows by 16 weeks of pregnancy, advice to hot wash bedding at >55°C, supply of a high filtration vacuum cleaner and Acarosan to apply to dust reservoirs where a high mite allergen level had been identified. Just before the birth of the child, custom made cot and carrycot mattresses (made of mite allergen proof fabric) were supplied to the family and carpets were removed from nursery and a vinyl cushion floor was fitted. A hot washable toy was also supplied. As the child progressed from cot to bed, mite impermeable covers were supplied for the bed. No attempt was made to introduce placebo devices into the control homes. The control group knew they were taking part in an allergen avoidance study and compliance with the regime was measured in the active group and any use of allergen avoidance measures by the control group was recorded.

The environmental control measures were

very effective in reducing exposure to mite, cat and dog allergens.<sup>1</sup> Compliance with the environmental control measures exceeded our expectations; at age 3 years, 87% of the children still had mite proof encasings on the bed.<sup>2</sup>

Lung function was measured at age 3 years, using a novel measure of specific airways resistance, and this together with Spirometry and dry air challenge has been repeated at age 5 years. At age 3 years, lung function was poorer in the high-risk groups and amongst those whose parents reported wheeze.<sup>3</sup> The effects of the intervention at age 3 years are as yet unpublished. The full data set at age 5 years is now collected and is being analysed. DNA has been collected from most of the children and they have been genotyped for *ADAM33*, in collaboration with Professor Holgate.

Questions which we hope the cohort will answer over the coming years include

- Can asthma and allergies be prevented by raising a child in a low allergen environment?
- Does the presence of cats and dogs in the home increase (or decrease) the risk of sensitisation to the pet, wheeze and asthma?
- Does the development of asthma relate to the levels of inhalant allergens or endotoxin within the home?
- Can we design future cohort studies where environmental modifications are introduced based on genotype rather than parental history of allergic disease?

Wish us luck.

## References

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“Compliance with the environmental control measures exceeded our expectations - at 3 years, 87% of the children still had mite proof encasings on the bed”

# BSACI Think Tank - 4th October 2003

Thirty five delegates attended Highpoint Conference Centre in Leicester with the object of thrashing out a 3-year plan for the BSACI under its new presidency. The converted convent provided a deferential backdrop for what was, at times, heated discussion.

Andy Wardlaw began proceedings by giving an account of BSACI history and structure. Tony Frew then reported on BSACI finances stimulating lively debate. The issues of membership numbers and fees, corporate sponsorship and shape of the annual meeting were all discussed. Indeed, delegates were to return to these issues again and again during the proceedings. BSACI membership by organ based specialists who practice allergy and immunology is low. It became evident that many of these potential members are unaware of the existence of the society.

Widespread support was given to the idea of annual 'co-badged' sessions at appropriate national chest, dermatology, immunology, paediatric and ENT meetings in order to raise the profile and stimulate interest in the society. Allied health professional membership was also seen as an opportunity for expansion with the main restriction being fees and joint membership with other societies. Opinion was divided as to the future of the annual meeting with opposing views on whether the aim should be for a larger/smaller, more or less frequent event. Consideration of a UK bid for EAACI 2009 also received an enthusiastic response.

Barry Kay reported on the status of '*Clinical and Experimental Allergy (CEA)*'. Delegates were encouraged to produce guidelines for publication in CEA since these tend to be widely quoted and raise the

journal's impact factor.

Allergy services were the next focus for discussion. Andy Wardlaw conducted a virtual tour of allergy services in Scotland and North England. Chronic underfunding resulting in excessive demand on services is clearly an issue there as in much of the UK. Chris Corrigan has been instrumental in the development of a training programme for Allergy SpRs but as yet provision of funding and the allocation of numbers does not tally with the current "epidemic" in allergic disease. Pam Ewan suggested a letter writing campaign (via lay societies) to keep the plight of allergy sufferers in the media and governmental eye. The need for close liaison with commissioning PCTs was highlighted.

Sophie Farooque provided valuable feedback from the trainee point of view and returned to the subject of tacit antagonism between allergist and immunologist. Whilst there remain areas of friction, all present (of both denominations) were keen for the society to move forward as one. The exciting phenomenon of GPSI (General Practitioners with a Special Interest) was introduced by Mark Levy. The eventual provision of these is regarded as an excellent opportunity to enhance allergy services and to improve relations between primary, secondary and tertiary care.

Shuaib Nasser consulted with delegates as to the focus and aims of the planned guidelines. He has requested a wider forum for this discussion — comments to him from members are welcome.

Children's allergy services were debated. Jonathan Hourihane was keen to aim for a purely paediatric service whilst Glenis Scadding reported local success of joint clinics (paediatricians plus adult allergists) and suggested this as a pragmatic measure while the numbers of paediatric allergists were so low.

The meeting concluded with further emphasis on the issue of interprofessional relationships. Gavin Spickett, Sam Walker and Robin Gore eloquently summarised the need for consideration of all members/potential members.

Let us hope that this excellent meeting will have provided the necessary momentum to carry these ideas forward!

## Evidence-based Guidelines in Preparation

BSACI's new Standards of Care Committee plans as its first task to oversee the production of a first generation of guidelines for allergy practice.

Initially the Committee will develop evidence based guidelines on:

- Drug Allergy
- An update on existing immunotherapy guidelines
- Anaphylaxis
- Urticaria and angioedema
- Egg and milk allergy

We plan extensive consultations to support the work, using our website. Correspondence is invited from those involved in allergy practice to enable committee to produce guidelines that are relevant to YOUR needs.

Suggestions gratefully received at [guidelines@bsaci.org](mailto:guidelines@bsaci.org)