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WE’RE FIGHTING THE SAME FIGHT

I HAVE A SEVERE RESPIRATORY ALLERGY
I’M AN IMMUNOTHERAPY RESEARCHER

The biopharmaceutical company Stallergenes has been driving research and collaboration with the medical community for 50 years now and is at the forefront of allergen immunotherapy.
Commissioning - a new opportunity!

Dr Lee Noimark, Paediatric Allergist, Barts and the London Children’s Hospital

As I am sure you have all realised, Allergy Update has moved from its previous April publication to June, this is in keeping with the annual conference in September. We hope September will offer many more people the opportunity to attend both the BSACI Annual Meeting as well as EAACI meeting, and as Claudia Gore summarises in her report there is much to look forward to in Telford this year, where I hope many of you will be able to come.

In this issue we have really focused on the recently published SOCC cow’s milk allergy guideline which is in the centre pages of this publication and can be pulled out and used as a poster. We encourage you to hang it up in your clinic. David Luyt and the SOCC team have done a wonderful job and hopefully it will inspire many of us to follow in his footsteps.

Whilst commissioning remains very important and steps are taken leading us forward the future of allergy training is also taking shape. Chris Corrigan describes where we are at the moment with trainees and whether there may be joint allergy and immunology training or possibly even wider training requirements. There is also a KBA at this year’s annual conference with thanks to Alex Croom which will be the final one before it is made compulsory.

Well done to the Anaphylaxis Campaign on receiving a GSK IMPACT award for their services to allergy and in continuing to give the wonderful service that they provide.

It has been three years’ since Professor Anthony Frew was elected by the membership to be President of BSACI. Therefore BSACI shall be looking for a new president to start in September 2015, a nomination paper is enclosed in this publication. In addition to electing a new President, we are also electing a new Honourary Treasurer and have enclosed a nomination form for this also, the deadline for nominations is 21 July.

Lastly our 7 elected Council members outline their plans for the second half of their tenure and relate some of the challenges they have faced. I hope you all have a wonderful summer and enjoy the football and I look forward to seeing you all at the BSACI 2014 Annual Meeting in the autumn!

Contributions should be e-mailed to: inoimark@hotmail.com
President's message

Message from the President

Top priority at our recent Council meeting was a discussion of progress with the commissioning of allergy services. It is now 12 months since NHS England came into being, and a lot of effort has gone into defining what aspects of allergy and immunology are highly specialised, and which are regarded as local services. I think it is fair to say that things remain a bit unclear, but some useful elements are emerging from the mist. The key for allergy services is that units must be logging their activity, and making a distinction between local secondary care and anything that meets the definition of highly specialised allergy. Tariffs have not yet been agreed but we need to be in a position to tell NHE what we are doing before they will agree to pay for it. Services wishing to bill NHSE will need to be registered with the IQAS scheme.

Interest in BSACI membership remains strong, and we now have well over 800 members. We have reviewed the benefits of membership and hope that we can continue to attract all those involved in clinical allergy and those involved in relevant research. We have compared our membership fees with other related societies and we feel we offer good value – as ever please let us know if there is something more you feel we should be doing. Council is here to help members, not the other way around!

I was delighted to learn that the Parliamentary Office for Science and Technology (POST) has decided to develop a report on the causes and extent of allergic disease in childhood – we sometimes complain that politicians don’t take allergy seriously and it is very welcome news that POST is going to address this.

BSACI recently cosponsored a workshop organised at the Royal Society by the Food Standards Agency. This looked at possible areas for funding research into food allergy in adults (as distinct from their current programme which largely looks at food allergy in childhood). The meeting was well attended and came up with a number of topics which we hope are going to be developed into future funding streams.

Finally, preparations are well under way for our next annual scientific meeting, to be held in Telford at the end of September. In response to BSACI members’ feedback, the timing of the meeting has been altered to avoid the summer holidays and allow more people to attend. We hope to see you there, and please invite your friends and colleagues, especially those that haven’t been to a BSACI meeting before.

Tony Frew,
President, BSACI

Are you part of it?

ALLERNI

Improving the care of infants with cow's milk allergy

www.allerni.co.uk
I am pleased to report that the progress of all our Allergy trainees nationally is well up to scratch. We had largely favourable reports from the latest GMC trainee survey and no major issues to report to the GMC in the most recent Annual Speciality Report sent to the GMC late last year. Our thanks are due to Tina Dixon for leading on this.

We are still shackled by Health Education England to national Allergy and Immunology recruitment which takes place at present in London in the spring. There has been a gratifying response to this year’s advertisements for new Allergy and Immunology posts, with a successful round of interviews in April. Our thanks are due to Alex Croom and Matthew Helbert for leading the Allergy and Immunology processes respectively, and to those of you who kindly helped with the interviewing and/or composed some of the interviewee questions and answers. The profile of Allergy as a career has been somewhat raised by the inclusion of Allergy on the RCP/JRCPTB sites, but we still have a long way to go in terms of increased teaching and awareness of Allergy in medical schools and “taster” initiatives for core trainees. The ongoing shortage of Allergy consultant posts continues to deter prospective Allergy trainees, a point the BSACI must continually address on behalf of its members.

The Allergy training curriculum has not been updated since 2010: a revision is planned soon, not least to mandate compulsory participation in Knowledge Based Assessment for all trainees. Another group of Allergy trainees will be sitting the pilot examination at this year’s BSACI meeting in September and this is planned to be the final pilot prior to its incorporation into the curriculum. Thanks are due to Alex Croom again for coordinating this exercise, to all of you who contributed questions and to the BSACI which has coordinated the examiners’ meetings and provided the examination logistics. We must accumulate a question bank, so this is not the end! I have also advertised, via the BSACI, for views on any other additions or omissions from the existing curriculum but have had no concrete proposals. I do urge the Allergy trainers and other interested parties amongst you to please respond and contribute by sending me your suggestions at chris.corrigan@kcl.ac.uk.

There has been a move from our Immunology colleagues on the SAC, backed by some, but not all of the Allergists, to produce a joint Allergy and Immunology training programme. Immunology colleagues have put forward proposals which are being considered by the SAC and which have also been sent out to the current Allergy trainers and trainees for their views. A board consensus is that this may be a positive move in that it will offer Immunology trainees the opportunity to undergo comprehensive training in Allergy, but that it should not come at any cost: services should reflect local and national caseload and societal needs, and Allergy training must take place substantially in centres offering comprehensive, specialised allergy services. In this regard there is ongoing consultation with Dr Vicky Osgood of the GMC, who has oversight of the speciality training curricula, as Continued on p9

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News

Allergy update
Once again, it is my pleasure to tell you about the upcoming BSACI Annual Meeting 2014. After the successful move to Telford, where we had a great meeting (and an even greater social programme!), we listened to your views on the timing of the conference and moved it to September.

Our 2014 theme “Allergy – towards true multidisciplinary care” was inspired by the multidisciplinary delegates we welcomed last year. It is exciting to see the field of clinical and translational allergy develop towards multisystem and multidisciplinary care. Within the programme, we have a strong respiratory focus with a world renowned faculty – kicking things off with the WAO supported Presidential Plenary Symposium to open the conference.

This year, we have developed sessions with other societies:

- “Allergy and the Gut” again, features world leading speakers and is co-hosted by The British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN). It will be fascinating to find out about the gut-brain link and the latest on eosinophilic gut disorders.
- Another exciting session is co-hosted by the British Association of Dermatologists (BAD) and will explore the latest science of Stevens Johnson Syndrome.

We have introduced some Pro-Con sessions, which should be entertaining, as well as scientifically informative – and stimulate debate on some of the topics, which are perpetually debated!

We have worked hard to make the meeting even more inclusive – reflecting the multidisciplinary nature of allergy research and clinical care. You will, once again, find specific strands for basic scientists, adult and paediatric clinicians, trainees, nurses, dietitians and primary care teams. We would like to give a big “Thank you!” to all our colleagues in the various settings, who contributed to putting this exciting programme together.

The “Allied Health Day” will be held on the 28th September 2014, to allow those with tight study leave allowance to attend and enjoy the fabulous sessions, embedded within this day. The annual “Primary Care Day” will be held on Monday 29th September and we are hoping to attract plenty of local, interested primary care professionals to this varied and hands on day.

You will find that the programme highlights of previous meetings have been retained:

Unopposed poster sessions, with abstracts being presented as posters throughout the conference; Grand Rounds; Review of the Year; Hands on Workshops.

The Barry Kay Awards for best original work will again be in the categories of basic science, adult clinical, paediatric clinical, primary care, allied health - and a prize for the best undergraduate submission. We are looking forward to seeing your excellent work once again! We shall be expanding our “Hands on Workshops”, which will run on both the Sunday and Monday - demonstrating (and encouraging you to get your hand on) “Sprays & Pumps”, “Messy Play” (eczema creams) and other practical procedures.

To celebrate our second year in the new, spacious venue, we have - once again - a fantastic, fun and inclusive Welcome Evening planned at the Conference Centre for Sunday Night. The Monday night Gala Dinner will be held in the Enginuity Iron Bridge Gorge Museum set within the beautiful UNESCO world heritage site, with the pre-dinner drinks reception in the interactive Design and Technology Centre.

Despite the change in date, to a very popular time of the year, the conference remains competitively priced - and travel fellowships are available for junior/student and allied health members as well as non-members this year! Applications can be submitted from Monday June 23rd. The closing day for Travel Fellowship applications is Monday August 11th.

The deadline for the early bird registration is Monday 7th July.
We look forward to seeing you in Telford.
Dr Ewan is a Consultant Allergist at Addenbrooke’s Hospital, University of Cambridge Clinical School. Her research into nut allergy, anaphylaxis and venom allergy has led to improvements in patient care as well as public awareness.

She has played a major role in the development of allergy as a specialty and influenced public policy on the development of allergy services. She led the national campaign to highlight the need to improve NHS allergy services. She is past President of the BSACI, and co-founder and co-chair of the National Allergy Strategy Group. She co-produced the Royal College of Physicians Report ‘Allergy: the unmet need’ and was advisor to the House of Commons Health Committee inquiry into Allergy Services and to the DH Allergy inquiry.

More recently with Dr Andrew Clark, she developed a programme of oral immunotherapy for peanut allergy.

Dr Skypala is a specialist allergy dietitian and Clinical Lead for Food Allergy at the Royal Brompton and Harefield NHS Foundation Trust. Isabel completed her PhD on Pollen-Food cross reactivity syndrome (oral allergy syndrome) in 2009. She is a national authority on the diagnosis and management of adult food allergy and was responsible for the restructuring of the food allergy services at The Royal Brompton Hospital with the inception of an award-winning bespoke Adult Food Allergy Clinic. She is a key member of faculty on the Allergy MSc at Imperial College, co-leading the module on food allergy. Isabel has supported food allergy development world-wide, being a founder member and inaugural chair of the Food Allergy & Intolerance Specialist Group (FAISG) of the British Dietetic Association (BDA) as well as the first dietetic member on BSACI Council. Isabel chairs the International Network of Diet and Nutrition in Allergy (INDANA) which she co-founded in 2009. Isabel is also the current chair of the Allied Health Interest Group of EAACI.

Professor Warner has been Professor of Paediatrics, Imperial College based at St Mary’s Hospital, London since September 2006. His research has focused on the early life origins of asthma and related allergic and respiratory disorders. He has published over 400 papers in scientific journals on these topics.

Professor Warner is currently “Early years” theme lead in the NIHR CLAHRRC NW London programme and is implementing integrated care pathways for children with allergic diseases. He was awarded an OBE in 2013 for services to food allergy research.
Dymista® Nasal Spray, suspension. Prescribing Information.

Presentation: Nasal spray suspension. Each gram of suspension contains 1000 micrograms of azelastine hydrochloride and 365 micrograms of fluticasone propionate.

Indications: Relief of symptoms of moderate to severe seasonal and perennial allergic rhinitis if treatment with intranasal antihistamine or glucocorticoid alone is not considered sufficient. Dosage and administration: Adults and Children over the age of 12. One actuation into each nostril twice daily. Contra-indications: Hypersensitivity to azelastine hydrochloride or fluticasone propionate or any of the other ingredients in this medicine. Warnings and precautions: Avoid concomitant use with systemic corticosteroids. Systemic effects of nasal corticosteroids may occur. Systemic exposure in severe liver disease may be increased. Dymista may result in clinically significant adrenal suppression. Monitor patients who experience changes in vision or have a history of ocular pressure, glaucoma and/or cataract. If adrenal function is impaired, take care when changing medication to Dymista. In patients with infections, recent surgery or injury to nose or mouth, weight benefits against risks of use. Contains benzalkonium chloride. Experience of use in pregnancy and lactation is limited. Dymista should only be used if the potential benefit justifies the potential risk. Dymista has minor influence on ability to drive and use machines. Undesirable effects: Epistaxis, headache, dizziness, unpleasant smell, hypersensitivity reactions including anaphylactic reactions, angioedema, bronchospasm, glaucoma, increased intraocular pressure, cataract, septal perforation, growth retardation may be possible in adolescents receiving prolonged treatment and growth should be monitored regularly. Consult the Summary of Product Characteristics for other side effects. Package Quantities and Basic Price (UK): £18.91 for 23g bottle. Each spray (0.14 g) contains 1.57 mcg of azelastine hydrochloride and 50 mcg of fluticasone propionate. Legal category: POM. Product Licence Holder: Meda Pharmaceuticals Ltd, Slyway House, Pamphagoe Road, Taunton, Somerset, TA1 5PE. Marketing Authorisation Number: PL 15142/0258. Date of preparation: April 2013. UK/2121/11200072.

Dymista® is indicated for the relief of symptoms of moderate to severe seasonal and perennial allergic rhinitis if monotherapy with either intranasal antihistamine or glucocorticoid is not considered sufficient.

We have been amazed by the generosity this year of our industry partners who have kindly supported the BSACI Travel Fellowship Scheme once again, as a result we would like to share this generosity with you! The scheme offers members, and for the first time, non-members the opportunity to apply for a BSACI Travel Fellowship to the BSACI 2014 Annual Meeting in Telford. To be eligible colleagues will need to submit an abstract and have it accepted.

The abstract deadline has been and gone. However if you submitted an abstract this year, you will be notified around July 2nd whether your abstract has been accepted or not. We wish you luck! If you are a Junior Member, Student, Trainee, Nurse or Dietician that has had your abstract accepted, you should apply for a BSACI Travel Fellowship.

BSACI can offer the following:
If you are attending the conference and staying over for;
One night = £250
Two nights = £350
Three nights = £450

To apply applicants will need to submit the following by email to Fiona Rayner at Fiona@bsaci.org no later than 5pm on Monday 11th August.
• A covering letter from yourself (please include the number of nights stay)
• Brief curriculum vitae
• The abstract that has been accepted
• A supporting letter from your Head of Department.

If you wish to discuss the application process with me my number is 0207 501 3910. Alternatively you can email me at Fiona@bsaci.org

Lastly, BSACI are grateful to the following companies for supporting the scheme: DANONE Baby Nutrition (UK), MEDA Pharmaceuticals Ltd, Stallergenes (UK) Limited, Diagenics Ltd and Mead Johnson Nutrition (MJN). There will be a ‘meet and greet’ session just before the ‘Welcome Reception’ on Sunday evening where Travel Fellowship Awardees will be able to meet those who have supported the Scheme.

Fiona Rayner, BSACI Chief Executive

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to whether all Immunology training centres can deliver Allergy training and experience to WAO Grade 3 standard (i.e. a fully independent and suitably experienced Allergist capable of independent practise in all the specialist fields of Allergy) as is stipulated in the latest iteration of the Immunology training curriculum which has yet to be approved by the GMC.

Finally, the Shape of Training is upon us. For those of you not in the mainstream of this, it is a further revision of the NHS grand plan to produce trainees of sufficient experience to cope with the changing NHS workload, in particular the increasing numbers of elderly patients and those with psychosocial problems such as dementia, and restore the balance on hospital floors of “general” medical registrars and senior registrars which have been virtually wiped out by “Modernising Medical Careers”. Initial proposals have envisaged that specialist trainees will spend more training in general medicine, with less time for specialist training. There have been mixed responses to this. The official RCP response may be found at http://www.jrcptb.org.uk/SiteCollectionDocuments/Shape-of-training_joint_statement_April_2014_FINAL.pdf, while the Government mandate can be found at https://www.gov.uk/government/publications/health-education-england-mandate-april-2014-to-march-2015. With regard to the future of Allergy training, a key proposal is that “in the case of smaller specialties and professions, planning for smaller specialties will be led on a national basis by an individual LETB, with HEE ensuring that overall training numbers in the plans reflect the national demand. HEE should use the consolidated responses from all the LETBs to inform the production of a national 5-year workforce plan”. Again the BSACI must monitor developments, particularly as to how influence may be brought to bear on this individual proposed LTEB (presumably not identified yet) through HEE or otherwise to assure that this matter is given full and proportionate attention. Commissioning for both Allergy clinical services and training is still woefully inadequate. Please watch this space.
There is much talk of networks currently in the context of Specialist commissioning, but like most good ideas this one was conceived over a drink in the bar, rather than at a management meeting. The Network involves four hospitals/Trusts – Barts Health (London Chest Hospital), Homerton, North Middlesex and Mid Essex (Broomfield, Chelmsford). It covers two SHA areas and covers a population of at least two million.

The initial idea was to arrange meetings quarterly for peer support, continuing education and service development. This started in 2007. Immediately it was clear to all members that the meetings were fulfilling a clear need, to help with the difficulties of developing and maintaining a successful Allergy service, in the face of growing demand. We found common ideals, difficulties and solutions, although each trust has its own particular issues.

So what was achieved at Network meetings? Initial meetings focussed on education, with each site hosting a meeting in rotation, with themes including nasal disease, immunotherapy, skin allergy and drug allergy. During meetings there has been opportunity for informal discussion and networking, and gradually we have evolved a ‘business agenda’. We decided that we wished to make progress in several key areas, including education, training, research, service development and protocol/guideline development. So how successful have we been?

**Education**

Our meetings always have an educational component, involving case presentations, topic reviews and guest speakers. This was contributed to by all members’ Allergy CPD, which was complimentary to larger meetings, such as BSACI and EAACI. As yet these meetings are not CME registered. In addition, we agreed a clear agenda to improve Primary Care Allergy Training. With some input from BSACI bursaries, we put together two hugely successful Primary Care training days in 2012, one in Chelmsford and one at Barts with further study days planned within the next year.

**Service Development**

The Network has helped us to coordinate ideas and best practice for service development. Three of the four sites offer immunotherapy, and we have been able to discuss indications, assessment of response and practical issues. We have discussed extensively how best to fund and administer sublingual immunotherapy. These peer support discussions have undoubtedly helped each service to move forward and develop for the overall benefit of patients. Similarly, facilities for food and drug challenges have evolved and improved over time, and as a Network we have reviewed best practice, discussed protocols, and shared results. The key aspect to this is that each unit has been able to develop at its own pace, with peer support, but without the isolation that can occur with small independent units.

During this period we have seen an explosion in referrals from GPs, with Choose and Book and Payment by Results key factors. All of our services have had to respond to this increasing demand, by increasing capacity, innovation (eg nurse-led clinics) and increased turnover, whilst not affecting other services. Early discussions focussed on
achieving an appropriate tariff and income for Allergy activity.

Research
Three of the centres participate in research and clinical trials. The Network has allowed us to coordinate activity and plan research priorities. In particular, we have been able to refer patients from one centre to another to be assessed for inclusion. Studies have included immunotherapy studies, anti-IL 5 in nasal polyposis, and the genetics of adverse drug reactions.

Protocol/Guideline development
Shared development of protocols, SOPs and guidelines was an area we identified early on in the development of the Network. Progress was made in certain areas, particularly in discussions surrounding different challenge protocols. However, the real spur for progress in this area has been the requirements for RCP IQAS registration. There is a huge but important workload needed for preparation of the appropriate working documents for this process. Early on we agreed to share expertise and knowledge, and also the workload, with a view to developing common, Network-wide protocols on which we would agree by consensus. This hopefully will go a long way to standardising and locking in best practice.

The Future
Within this network, we have achieved a significant amount so far, and, as our practices are growing, the benefits of networking will grow. I am sure I can speak for all members in saying that this Network has played a huge role in allowing us develop Allergy services for the benefit of patients, in a way that has allowed us all to feel supported personally and professionally. The effect of Specialist commissioning may mean that we will need also to Network with other centres, which is undoubtedly a good thing and the next step in the process.

There is no doubt, from speaking to colleagues at meetings, that Allergy can be a lonely specialty for some. Often single-handed practitioners, either in adult or paediatric practice, can be faced with a huge workload and unmet demand, despite negativity and scepticism from colleagues, plus pressures from other areas of the service. We would encourage those of you in this situation to look for your closest neighbours (try the BSACI Website), and GET NETWORKING!

BSACI Guideline on the diagnosis and management of cow’s milk allergy

May 2014 saw the publication of the BSACI Guideline on the diagnosis and management of cow’s milk allergy in Clinical and Experimental Allergy (pages 642-672). It follows the decision taken in 2011 by the Standards of Care Committee (SOCC) for the need to develop a national guideline for cow’s milk allergy. The committee co-opted David Luyt to lead a team to develop this document. The authors and indeed the SOCC committee members were very grateful to the society members for their interest and contributions. Thanks also to Pia Huber, BSACI Research Officer, who provided us with support for our all administrative needs and kept us in line to try to achieve deadlines.

Cow’s milk allergy is unique amongst food allergies and presents specific challenges when developing management guidance that is acceptable and inclusive to local practice.

Features distinctive to cow’s milk allergy are that:

• as affected individuals are effectively allergic to their entire diet, not only does dietary avoidance not suffice, but a suitable dietary solution is urgent;

• the consequent scenario of an infant with feeding problems means that many different health workers with differing levels of expertise (e.g. health visitors, midwives, dietitians and doctors) can potentially be asked to provide parents with feeding advice;

• considering the diagnosis is made difficult as presentation varies widely, more widely than most other food allergies, and may mimic other common conditions in infancy such as reflux and colic;

• confirming the diagnosis can also be difficult particularly in clinical practice as the available tests lack sensitivity in IgE-mediated allergy (as they do with most food allergies), and are not of any use in non IgE-mediated gastrointestinal and skin presentations; and

• the substitute milks available to clinicians (dietitians, doctors and

Continued on p12
From p11
nurses) to recommend are all commercial products (with new introductions to that selection during the development of this guideline) where often many may be a suitable choice. In no other food allergy do clinicians prescribe alternative foods. These features of cow’s milk allergy, as well as other subheadings relevant to all food allergies (e.g. epidemiology and natural history) deserved careful consideration for the guideline to achieve its goal of a useful inclusive reference for the management of all cow’s milk allergy by all.

The current ‘buzz’ word in the management of food allergy is the reintroduction of allergens back into affected individuals’ diets. This is supported by a growing literature demonstrating that early introduction of foods can prevent allergy, and where already present, early reintroduction can enhance and accelerate the development of tolerance. This is certainly true for cow’s milk allergy. Reintroduction is thus a key component (together with dietary avoidance, choice of milk substitute and calcium supplementation) in the management of cow’s milk allergy and was consequently addressed in detail, providing the reader with ‘how to’ and ‘where to’ guidance. The guideline details step-by-step advice of baked milk reintroduction, considerations as to whether reintroduction could be conducted unsupervised at home or needed to be conducted with medical supervision in hospital, and a ‘milk ladder’ (in line with the ‘egg ladder’ in the Egg Allergy Guideline) for guidance on further introduction where individuals freely tolerated baked milk biscuits. There is limited ‘hard’ literature to support unsupervised reintroduction or the ‘milk ladder’, but the guidance provided is in line with expert opinion and widespread local practice. Whilst these recommendations were vigorously challenged in the preparation of the document, by society members at consultation and by referees on presentation to the journal, the authors felt that these were important principals. The advantages of home reintroduction are that they are consistent with the notion of early reintroduction of cow’s milk into an allergic individual’s diet, and, perhaps more importantly, they provide clinicians with the opportunity to progress with managing the allergic infant without being constrained by local hospital resource limitations. Careful guidance with cautions hopefully provides practicing clinicians with information for safer practice.

The object of guidelines is to improve the standard of the management of allergy throughout the country. This is currently being addressed by SOCC, led by MT Krishna, through a process of audit and re-audit of BSACI members’ practice before and after the publication of guidelines. The next stage for this guideline, indeed for all, will therefore be their implementation. This will only be achieved by publicity not only by the SOCC but also by the BSACI at large. We thank Allergy Update for this opportunity to commend them to you.

Knowledge Based Assessment

Alexandra Croom, Consultant Allergist, Glenfield Hospital, Leicester

The allergy KBA is back. After a 26 month hiatus it will take place during the BSACI Telford Meeting in September. For the uninitiated the Allergy Knowledge Based Assessment (KBA) is aimed at specialist trainees. It comprises 12 questions based around the contents of the 2010 Allergy Curriculum. It looks like an exam, is sat like an exam, but it isn’t an exam. No actual marks are given; candidates are issued a feedback sheet for their ARCP and educational supervision meetings. It’s aimed at anyone in their third year of Allergy training onwards, but can be sat earlier if desired. Whether you revise for it is optional. It’s a formative assessment, so if it reveals something you don’t know, you just go back to the books.

So far, so good and I would encourage all Allergy trainees who haven’t taken it to seriously consider sitting it this year. Why? Well a lot of effort has been made to devise the questions, it’s going to be compulsory in the next iteration of the curriculum and even now we are encouraging educational supervisors to incorporate it into PDPs. Most importantly this process is monitored by the JRCPTB and poor take-up will reflect badly on the speciality. It’s not too late to enrol; contact Fiona Rayner at the BSACI. For those of you who have, see you on the 30th September at 2pm; the exact venue will be confirmed.
Guideline for the diagnosis and management of cow’s milk allergy

David Luyt, Heidi Ball, Nick Makwana, Michael Green, Kristian Bravin, Shuaib Nasser, Andy Clark.

View all clinical guidelines of the British Society for Allergy and Clinical Immunology (BSACI) Standards of Care Committee on the open section of the society website at www.bsaci.org
bsaci guideline for the diagnosis and management of cow’s milk allergy

Definition and mechanism
CMPA is defined as a **reproducible adverse reaction** to one or more milk proteins mediated by an immune mechanism.
An underlying immunological mechanism distinguishes CMPA from other adverse reactions to milk, e.g. lactose intolerance.

CMPA is classified as:
1. **Immediate onset** (usually IgE mediated) typically with skin, respiratory, gastrointestinal and rarely cardiovascular symptoms.
2. **Delayed onset** (non-IgE or combined IgE/non-IgE) with gastrointestinal symptoms and/or eczema.

Prevalence, onset and evolution
CMPA affects 2-3% of children, presenting typically at 3-6 months (rarely after 12 months).
Presentation can be **delayed** for weeks to months.
CMPA has a favourable outcome, resolving in most children with 2/3 tolerant by school age. Predictors of persistence are:
1. Immediate onset symptoms vs delayed onset symptoms.
2. Reactivity to baked milk on first challenge or exposure.
3. Presence of other food allergies, especially egg allergy.
4. Concomitant asthma and/or allergic rhinitis.
5. Large SPT weal size or higher sIgE level at diagnosis.

Clinical presentation and diagnostic evaluation

**Immediate onset** (within minutes to two hours)
Presenting with symptoms affecting the:
1. **Skin:** urticaria, pruritis and angioedema.
2. **Gut:** abdominal pain, vomiting (repeated or profuse), diarrhoea.
3. **Respiratory tract:** red/itchy eyes, blocked/runny nose, sneezing, cough, wheeze, breathlessness.
4. **Cardiovascular system:** drowsiness, dizziness, pallor, collapse.

**Wide range in severity** from skin symptoms only, to life-threatening or fatal anaphylaxis. Presentation mild in the majority.

**Diagnostic evaluation** (confirmation of suggestive history)
Immediate onset: **typical** symptoms confirmed by SPT >3mm.
**Atypical** or **absent** symptoms need SPT >5mm.
Delayed onset: **GI symptoms:** milk exclusion and assess symptoms.
**Eczema:** milk exclusion 2-6wks, then reintroduction.

Delayed onset (frequently delayed - hours to days)
Presenting with:
1. **Gastrointestinal symptoms** (range of symptoms and severity).
   - **Blood in stool** in otherwise well child.
   - **Vomiting** in irritable child with back arching and screaming.
   - **Feed refusal** and aversion to lumps.
   - **Dysphagia** (possible oesophageal eosinophilia; warrants biopsy).
   - **Diarrhoea:** often protracted with propensity to faltering growth.
   - **Constipation:** straining with defecation, but producing soft stools.
   - **Unwell child:** delayed onset protracted vomiting and diarrhoea.

**Wide range in severity** from well child with bloody stools to unwell shocked child after profuse vomiting and diarrhoea (FPIES).

**2. Eczema:** 3 different patterns of clinical reactions:
   - **Immediate onset** (non-eczematous reactions).
   - **Isolated eczematous reactions** (flare ups) after hours or days.
   - **Mixed reactions:** eczematous flares following acute reaction.

Treatment

**Dietary avoidance** (avoidance advice)
**Choice of substitute milks** (replacing cow’s milk in diet)
How to read a label for a milk-free diet

Look out on labels for any of the following ingredients:

- Butter, butter fat, oil, acid, ester or milk
- Casein, casein hydrolysate, sodium or calcium caseinate
- Cow’s milk (fresh, UHT, dried, powdered, condensed)
- Cheese, cottage cheese
- Cream, artificial cream
- Curds, ghee, custard
- Lactalbumin, lactoglobulin, lactoferrin margarine
- Milk solids (non-fat milk solids milk sugar or protein)
- Animal milks (goat’s milk)
- Sour cream or milk solids
- Whey, whey powder or syrup sweetener, hydrolysed whey
- Yogurt, fromage frais

Milk is sometimes found hidden in the following:

- Biscuits / baked goods
- Processed meat
- Savoury snacks, soup, gravy
- Pastry, batter

*In EU all pre-packaged must declare milk on allergy list if it is an ingredient

Suitable milk substitutes

- **Breast milk** (suitable for most with CMPA).
- **Hypoallergenic formulas** (first choice; AAF for severe CMPA).
  
  Extensively hydrolysed formulas
  - Aptamil Pepti 1, Alithera
  - Nutramigen lipil, Similac Alimentum
  - Pepti Junior, Pregestimil
  - Pepdite, MCT pepdite
- **Amino-acid formulas**
  - Neocate LCP
  - Nutramigen AA
  - Neocate active (>12mo)
  - Neocate advance (>12mo)
- **Soya based fortified drink** (not recommended in infants <6mo).

Unsuitable (U) or less desirable (L) milk substitutes

- U - Heated or processed fresh cow’s milk.
- U - Other mammalian milks (e.g. goat’s, donkey’s, etc.).
- L - Alternative milk ‘beverages’ (e.g. almond, coconut, rice, soya) to be used under dietetic guidance in older children.

Reintroduction (rate of resolution varies so timing and location (home or hospital) must be individually assessed)

Guidance for reintroduction of cow’s milk

1. Consider reintroduction from **12 months**.
2. Review every **6-12 months** (repeat SPT if IgE mediated).
3. Start with **baked** milk as less allergenic.
4. **Home reintroduction may be attempted** where:
   - Mild symptoms on noteworthy exposure.
   - No reaction in past 6 months.
   - Significant reduction in SPT (in IgE mediated).
5. **Hospital reintroduction recommended in**:
   - Any previous moderate to severe reaction (incl. FPIES).
   - Less severe reaction to trace exposure.
   - Regular asthma preventative treatment.
   - Multiple or complex allergies.
   - Parents unable to understand protocol

Once tolerance is established, encourage greater exposure of **less processed** milk as in ‘Milk Ladder’

Milk Ladder

Factors considered:

1. **Volume or quantity**
2. Effect of heating – degree and duration
3. Wheat matrix effect

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
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| Small crumb of biscuit with <1g of CMP per biscuit. Build up whole biscuit over 5 weeks. | Other baked products containing CMP, e.g. biscuits, cakes, muffins, waffles, scotch pancakes. Butter, margarine Cheese powder flavouring | Products containing cooked cheese or whole cow’s milk as heated ingredient e.g. custard, cheese sauce, pizza, rice pudding. Chocolate, chocolate coated items. Fermented chocolate yoghurt. | NOTES (all stages):
   - Proceed with caution
   - Classification not perfect, so step-up may be bigger than expected, esp. in Stage 3.
   - If reacting, stop and go back to lower stage |

Less denatured / High protein dose
More allergenic

More denatured / Lower protein dose
Less allergenic

Developed by the bsaci standards of care committee
Cow's milk allergy may be defined as a reproducible adverse reaction of an immunological nature induced by cow's milk protein. (A)

Cow's milk allergy can be classified into IgE mediated immediate-onset and non-IgE mediated delayed-onset types according to the timing of symptoms and organ involvement. (A)

The prevalence of cow's milk allergy is between 1.8% and 7.5% of infants during the first year of life. (B)

Cow's milk allergy commonly presents in infancy, with most affected children presenting with symptoms by 6 months of age. Onset is rare after 12 months. (B)

Cow's milk allergy has a favourable prognosis, as most children will outgrow their allergy by adulthood. (B)

Cow's milk allergy is more likely to persist in IgE mediated disease and where there is greater sensitivity (higher specific IgE levels), multiple food allergies and/or concomitant asthma and allergic rhinitis. (B)

The clinical diagnosis in IgE mediated disease is made by a combination of typically presenting symptoms, e.g. urticaria and/or angio-oedema with vomiting and/or wheeze, soon after ingestion of cow's milk, and evidence of sensitisation (presence of specific IgE). The spectrum of clinical severity ranges from skin symptoms only to life-threatening anaphylaxis. Clinical assessment should include a severity evaluation to ensure affected individuals are managed at the appropriate level. (B)

The clinical diagnosis of non-IgE mediated disease is suspected by the development of delayed gastrointestinal or cutaneous symptoms that improve or resolve with exclusion and reappear with reintroduction of cow's milk. As with IgE mediated disease, non-IgE mediated disease varies widely in clinical presentation from eczema exacerbations to life-threatening shock from gastrointestinal fluid loss secondary to inflammation (Food Protein Induced Enterocolitis Syndrome (FPIES)). (B)

Gastrointestinal symptoms of non-IgE mediated cow's milk allergy are variable and affect the entire gastrointestinal tract. There are some well recognised more easily identifiable conditions (e.g. eosinophilic proctitis) but symptoms are more commonly non-specific. Cow's milk allergy should be considered in these circumstances where symptoms fail to respond to standard therapy or where other features of allergy are present. (B)

Lactose intolerance can be confused with non-IgE mediated cow's milk allergy as symptoms overlap. The terms are thus frequently mistakenly used interchangeably. Lactose intolerance should be considered where patients present only with typical gastrointestinal symptoms. (B)

The reported levels of IgE required to support a diagnosis of IgE mediated cow's milk allergy varies between studies and depends on the research population. A skin prick test (SPT) weal size ≥5mm (≥2mm in younger infants) is strongly predictive of cow's milk allergy. (C)

A food challenge may be necessary to confirm the diagnosis either in IgE mediated disease where there is conflict between the history and diagnostic tests. (D)

Food elimination and reintroduction is recommended for the assessment of non-IgE mediated cow's milk allergy where there is diagnostic uncertainty. (C)

The management of cow's milk allergy comprises the avoidance of cow's milk and cow's milk products and dietary substitution with an allergenically and nutritionally suitable milk alternative. (D)

The choice of cow's milk substitute should take into account the age of the child, the severity of the allergy and the nutritional composition of the substitute. Nutritionally incomplete substitutes can lead to faltering growth and specific nutritional deficiencies. (D)

As cow's milk is the major source of calcium in infant diets, children on milk exclusion diets are at risk of a deficient calcium intake. A diettian should assess calcium intake and dietary or pharmaceutical supplementation advised where appropriate. (D)

Cow's milk allergy will resolve in the majority of children. Individuals should be reassessed at 6-12 monthly intervals from 12 months of age to assess for suitability of reintroduction. (B)

The reintroduction of cow's milk may be graded according to the 'milk ladder' with less allergenic forms offered initially. More allergenic forms are then eaten sequentially as tolerated. Reintroduction can be performed at home or may need to be supervised in hospital. (D)

Oral tolerance induction offers a novel treatment option to the small but clinically significant proportion of affected individuals whose cow's milk allergy persists. (C)

Cow's milk allergy in adults more commonly arises in adulthood but may persist from childhood. This is frequently a severe form of allergy where up to 25% have experienced anaphylaxis. (C)
Council Members half way through their tenure

Hasan Arshad

I joined BSACI council at the recommendation of my friend and colleague, Dr John Holloway who had just completed his tenure at the Council. I don’t know if the Council has found my presence useful, but it has certainly been an enjoyable and very informative experience for me. The first thing I noticed was that the Council is extremely well organised. All members knew what was expected of them and took this responsibility seriously. The amount of effort that various council members put into their respective duties voluntarily and happily is amazing and heart-warming. I found the reports from the president and various committee were extremely useful and informative. Paediatric allergist and Dietetic groups seem very active and organised. However, there was very little talk of adult allergy services and training. I spoke about this at one of the Council meetings and inevitably, I was given the task of organising an adult allergy group of which I am in the process of doing. In essence, although BSACI is a small society in comparison to several other specialties, given the enthusiastic and energetic academics and clinicians at the helm and the growing Society membership, I am certain that it has a bright future.

Rubaiyat Haque

The Challenge of Change

The theme that has dominated the allergy landscape for the first half of my tenure as council member has been one of change. The biggest single change was The Health and Social Care Act 2012. The Act essentially a vehicle for the facilitation of private providers to gain access to NHS patients, all in the guise of a massive and unnecessary structural reorganisation! gave rise to a dizzying array of new bodies with confusing acronyms: CCGs, LATS, CSUs, CRGs, CPAC, RDAG and HNBs to name only a few. I played my part in adding to the confusion (for a limited time) in my role as chair of the Local Commissioning Working Group and as an ongoing member of the Clinical Reference Group (one of the aforementioned acronyms). A more enjoyable role of mine has been on the Standards of Care Committee. With the help of my distinguished co-writers, our local anesthetic allergy guideline should be with you shortly. The ‘change’ theme will no doubt continue for the remainder of my tenure. There are many important debates to be had about the future shape of allergy training. Should allergy and immunology training programmes be merged? Or should we simply try and maintain the status quo.

Sophie Farooque

The BSACI website continues to maintain a steady flow of traffic, with the Guidelines and Annual Meeting pages being visited the most. However, in the last few months, the BSACI has been looking at ways to make the website an even more useful resource for our membership and this has resulted in two new projects: Firstly, the BSACI Standard of Care Committee (SOCC) will now be providing short updates, highlighting relevant papers that members may wish to read. These will often tie in with guidelines that are in the pipeline or just published. These updates will be found on-line under the title of “SOCC Recommends”. Till last of this series, is now available to members (go to publications and resources and click on the “SOCC Recommends” tab), and you will find an update by David Luyt on Milk Allergy. Secondly, the role of the website, as a tool to both support researchers and also to engage the public in Asthma and Allergy research is presently being evaluated. One idea that has been discussed at BSACI Council, is collating simple information about all the latest Charitable and Research Council Funded Projects that members are involved in. This information would then be accessible to both the public and members via the website. Before using the website as a research hub, it is important to know if this is something that the membership would support. Therefore if you have not already done so, please take 5 minutes to reply to our Survey Monkey Questionnaire which explores these ideas in further detail.

Finally, I would like to thank Stephen Till and Andy Clarke for their support with these projects and David Luyt for kicking off the first SOCC Recommends series. I hope that by the time the next AU is published, there will have been significant progress in developing the website as a resource for researchers.

Clive Grattan

As a Dermatologist, with an abiding interest in Allergy, I saw an opportunity to strengthen the bridge between the two specialties in Cutaneous Allergy at all levels of training, practice, research and accreditation.

The goal for sharing and achieving mutual standards remains but the reality of two separate specialties with different priorities converging is more complex than I expected. Dermatologists with an interest in Allergy are trained and accredited primarily in contact dermatitis involving delayed hypersensitivity reactions whereas Allergists are trained and accredited in skin diseases primarily involving IgE-driven, mast cell-mediated illness. Specialists from Dermatology and Allergy are good at the polar ends of this spectrum but the difficult stuff in the middle may go under-diagnosed and undertreated. There remains a clear need for Dermatologists and Allergists to think and work alike in the overlap areas with the added benefit of understanding illness and disease mechanisms outside their usual scope.

Steve Till

My first 18 months on the council has been mainly a period of watching and listening. Not that it has been a quiet period: there has been vigorous debate ongoing about the future form of Adult Allergy training and accreditation.

As one of a tiny number of senior lecturer clinical Adult Allergists I remain concerned about the few clinical academics emerging in our speciality, which has, until now, been heavily research led. Finally, with Sophie Farooque I have been thinking of a few ideas for how the BSACI can promote and raise awareness of Allergy research. As a result, we have sent out a survey to all members asking how best we can facilitate research amongst the BSACI members. If you have not completed this, please could I ask you to do so as soon as possible, but don’t worry if you can’t find it, the survey will be re-circulated shortly.

Mark Wilkinson

As a dermatologist with an interest in contact allergy and patch testing, I was delighted to be appointed to the council of the BSACI to try to improve awareness and interaction between our various groups. At the start of my term, the allergy accreditation scheme through the RCP was being developed and it felt inappropriate to exclude contact allergy. I hoped that by broadening the scope it might improve interaction and benefit patient care. Although initial discussions were encouraging it was subsequently decided to keep the specialisms separate. It is now intended that cutaneous allergy will be accredited through a NICE approved process by the British Association of Dermatologists. Although this feels like a missed opportunity, I’m sure others will arise. Currently the British Society for Cutaneous Allergy is feeding back to NICE on their draft drug allergy guidelines.

Andrew Williams

In my first year as a council member I have been mainly engaged in promoting IOAS to District General hospitals who are sometimes taking a share of the allergy load with little support or link with a more developed tertiary centre. If the unmet need is going to be met then it would be best that centres are staffed and equipped appropriately and have ready access to a supportive hub allergy centre and not be sideline. I am hoping that IOAS will be implemented over a time scale that gives all allergy centres the opportunity to “up their game” in terms of quality, safety, governance and availability of services. I have supported the on-going roll out of standard operating procedures developed by the BSACI Nurses committee and have been exploring the utility of Twitter as a means of raising our profile.
Allergy Diagnostics & Therapeutics

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Our partners Allergopharma are one of Europe’s principal allergy companies. We supply and support their products in the UK and Ireland through our experienced and dedicated local team.
Primary Care Committee Update

The Primary Care Committee continues to develop with a strong membership and increasing contacts from GPs and other health professionals wishing to develop and improve their knowledge of allergic disease. As well as GPs we have representation from our nursing colleagues, dietetics, health visiting and charities.

Primary Care interest in learning about allergy seems to be steadily increasing. We have received a good number of applications to host Primary Care Days (for which funding can be made available) across the country and have started a LinkedIn group with slow but increasing membership.

Our primary focus this year has been the development of the main BSACI Primary Care Day at Telford on Monday 29th September. We have constructed a broad programme to help primary care teams develop a good basis of understanding with great support from our colleagues in both primary and secondary care. I’m pleased to report that our programme this year has been accredited by the RCGP for CPD. For 2015 we are looking at the possibility of a stand-alone BSACI Primary Care conference and will be examining this over the next few months.

At last year’s conference we recorded some webinars on Cow’s Milk Protein Allergy and history taking which have recently been posted to YouTube. We hope to repeat this in September and plan to record a new webinar on Urticaria. These learning resources are aimed at Primary Care and can be extremely helpful in focussing on common presentations to GPs, Nurses and Health Visitors.

One of the common themes raised with us is the GP with Specialist Interest (GPwSI) in Allergy. At present the RCGP and NHS England have no formal competency framework for Allergy as a specific field, nor are there current plans to develop one. Our vice-chair, Dr Steve Holmes has written a short information leaflet detailing the current and future situation which will soon be widely available.

Nurses in Allergy Committee

We are pleased to report that the Allergy Nursing Competency Document based on the Department of Health, Skills for Health competences, for all bands of nurses working in allergy clinical practice has been completed and submitted for review.

Recently we welcomed three new committee members: Lucy Common, Clinical Nurse Specialist in Immunology/Allergy at Salford Royal, Kathryn Powrie, Clinical Nurse Specialist in Allergy at Broomfield Hospital, Essex and Gemma Scanlan, Paediatric Allergy Clinical Nurse Specialist, Kings College Hospital, London, which takes us to full committee membership.

The Nursing Standard has commissioned the Nurses in Allergy Committee to write a series of allergy articles over the summer. We felt this was both an excellent opportunity to support nurse education and to raise the profile of allergy nursing. Watch this space, notification of publishing dates will be circulated to members when known.

We are all very much looking forward to this year’s annual BSACI conference in Telford, which I am delighted to report includes an Allied Health Day. Please consider submitting an abstract, as we are looking for nurses to share their work. There will be a prize for best AHP abstract, all those whose abstract has been accepted can apply for a travel grant to support costs to attend September’s conference.

We hope as many nurses as possible can attend the conference to make it the best attendance yet! The entire programme looks excellent and there is something for everyone, visit the link www.bsacimeeting.org.
The National Allergy Strategy Group postcard campaign is now nearing its final stages with nearly 50,000 postcards having been distributed over the last year. Thank you so much to everyone who has helped with this; we have had great support and as a result we have had responses from all three main parties which have helped us shape the next phase of campaigning. Additionally, we have heard from hundreds of people living with allergic disease, or who have allergic children, who are wanting to tell their story.

These stories have now been compiled into a report which we are hopeful will be endorsed by the All Party Parliamentary Group for Allergy which is chaired by Jon Cruddas MP with Baroness Finlay as vice-chair. The report is due to be launched later this term before the House rises for the summer recess and will be supported by a number of relevant Parliamentary Questions and debate. These questions will continue into the autumn term when we will be holding a round table meeting in the House of Commons to highlight the fact it is a decade on from the original Health Select Committee inquiry of 2004.

As always we are keen to hear from anyone interested in the work of the NASG and are always looking for new supporters. Come and see us on the first night of the BSACI conference (Sunday) when we will be hosting a session looking at how allergy impacts of quality of life with an invited patient speaker as well as giving an update on our work and, as always, feel free to contact us at any time mandy@nasgu.org

**Junior Members Update**

Dr Chris Rutkowski,
Allergy SpR,
Addenbrooke's Hospital,
Cambridge.

The world of allergy trainees has been as active as ever. In January, a well attended training day on rhinitis, sinusitis and rhinoconjunctivitis took place at the RNTNEH in London. In May, we discussed the intricacies of the laboratory diagnostics in Sheffield. That’s not all - two more national training days are planned. I am particularly excited about seeing you all in my neck of the woods around October (date TBC) to discuss anaphylaxis and drug/vaccine allergy. The 2014 educational season will finish in December with a day devoted to atopic dermatitis - a condition we all need to expertly manage (London). A few weeks ago, many of us met at the EAACI 2014 conference in Copenhagen, hopefully we shall all meet again at the BSACI Annual Meeting in Telford in September. If you have an interesting case you would like to present at the Adult or Paediatric Grand Round (30th Sept) please let me know. This is a unique opportunity to practice your presentation skills and share you knowledge with a large audience of allergists and immunologist. It will look really good on your CV and count as ‘teaching experience’ in our ‘beloved’ allergy e-portofolio. If you have submitted your abstract and you have been successful, you will be able to apply for the BSACI travel grant (www.bsaci.org/meetings-and-events/travel-fellowships-and-bursaries). The good news is that this year’s pot of money is really big so all of us should be able to attend BSACI 2014. I strongly believe that submitting an abstract is definitely worth our while!

Later this year we will be welcoming three new adult allergy SpRs but also saying ‘good luck’ to three colleagues finishing their training. Let’s keep our fingers crossed that they all secure full allergy consultant posts very quickly. There is a Trainees’ Meeting in Telford on Sunday, 28th September, 18:20-19:00, it will be a great opportunity for all trainees (including paediatricians) to meet. Hope you can make it! In the meantime, please email your suggestions, questions and concerns to juniormembers@bsaci.org

Mandy East,
National Allergy Strategy Group (NASG)
Parliamentary Officer

National Allergy Strategy Group (NASG)
Support the National Allergy Strategy Group postcard campaign
Update from the Standards of Care Committee (SOCC)

Dr Andrew Clark, Chair of SOCC, Consultant in Paediatric Allergy, Addenbrooke's Hospital, Cambridge

The Standards of Care Committee (SOCC) are pleased to announce the publication of the highly anticipated milk allergy guidelines in this month's edition of Clinical And Experimental Allergy (Clin Exp Allergy 2014;44:642). The authors (Ms Heidi Ball, Dr Nick Makwana, Dr Michael Green, Mr Kristian Bravin, Dr Shuaib Nasser and Dr Andrew Clark) and lead (Dr David Luyt) are congratulated on producing an excellent guideline summarising the state of the art in milk allergy management. As well as pragmatic guidance for specialists in areas of diagnosis and treatment, the guideline advises on if, when and how to reintroduce cow’s milk back into the diet. To help make the guideline easy to implement we have included standalone protocols for hospital challenge and home reintroduction, as well as guidance on which protocol is most suitable for individual patients. Also in this edition of Allergy Update you will find a poster containing a summary of the guideline (also available as a pdf on the BSACI SOCC website (http://www.bsaci.org/Guidelines/milk-allergy), and an article written by Dr Luyt introducing the new guideline.

We were pleased to receive CEA reviewers’ comments on the beta lactam guideline, led by Dr Rita Mirakian. We are currently responding, and hope to publish this guideline shortly. Professor Richard Powell and Dr Susan Leech have comprehensively re-written the Urticaria guideline, originally published in 2007. This is currently under consultation with the BSACI membership, and will shortly be submitted for publication. The peanut/nut allergy and adrenaline guidelines are at an advanced stage of preparation.

Writing each guideline is a huge task for all those involved. It is important that they reach as wide an audience as possible, so that we can improve national allergy care and maintain our excellent international reputation. To this end, at our April SOCC meeting, I convened an implementation workshop where we brainstormed various approaches. These will be developed into an implementation policy for SOCC with the aim that all guidelines are exploited to their full potential. BSACI members with particular skills or experience in guideline implementation are encouraged to contact SOCC. Results of recent national audits (management of milk allergy and Immunotherapy for rhinitis and venom) will be presented in the SOCC session of the BSACI Annual Meeting in Telford (2pm on Monday 29th September 2014).

The Food Allergy and Intolerance Support Group of the British Dietetic Association

Dr Carina Venter, Chair of the Food Allergy and Intolerance Support Group (FAISG)

The Food Allergy Group of the BDA is continuing with producing diet sheets and other material to support dietitians dealing with food allergies and intolerances. Group members have been involved in the recent publication of the BSACI Cow’s milk allergy guidelines (Heidi Ball and Kristian Bravin) and a number of EAACI guidelines on Allergy Prevention and Food Allergy Prevalence (Dr Isabel Skypala, Dr Rosan Meyer and Dr Carina Venter). The FAISG had a very successful study day on 9 May 2014 organised by Ruth Chalmers. The day was oversubscribed and included a list of excellent speakers. Dr Rosan Meyer started the day with an overview of infant formulas used in the management of cow’s milk allergy. Prof Hasan Arshad gave a thought-provoking talk on possible interventions (some surprising) for the prevention of food allergy. Dr Efrem Eren gave a detailed talk about the possible role of nutritional factors in the management of Chronic Urticaria which was followed by an overview of all the new labelling issues by Dr Paul Turner. After lunch, Dr Imran Aziz discussed gluten sensitivities followed by and excellent overview of adult food allergies by Dr Isabel Skypala. The day was concluded by two Allergy Dietitians, Tanya Wright and Heidi Ball on the topic of allergen ‘ladders’: Milk, and egg.

The BDA is re-designing their website and branding. The FAISG now has updated the public and members sections, which we will be adding to in the coming months. The group has also been chosen as one of a few dietetic specialist groups to be involved in phase one of new logo designs.
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Aptamil Pepti is the only extensively hydrolysed formula range to contain galacto- and fructo-oligosaccharides (GOS/FOS), which have been shown to significantly reduce the incidence of allergic manifestations among infants at high risk of allergy up to five years of age\(^1\), as well as reduce the incidence of infections up to 2 years\(^2\).

It’s tolerated by 97% of infants with proven CMA in clinical trials\(^3\), so you can be sure your patients are receiving a product with proven efficacy.

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I'm delighted to be able to announce that the Specialist Paediatric Medicine CRG have accepted the Specialised allergy service specification for 2014-15. This describes the composition of a specialised (tertiary) allergy service, led by at least two consultant paediatric allergists, providing a full range of allergy investigations and services.

Paediatric allergy has been chosen as one of the first service specifications to be implemented, and will be 'going live' from October 2014. We were asked to propose a number of quality indicators for specialised allergy services, and agreed the following:

- All children should be seen within 18 weeks of referral
- Children with anaphylaxis requiring intensive care, should have an allergy review before discharge
- Children with anaphylaxis requiring PICU admission should be seen in an allergy clinic within 6 weeks
- Children with systemic reactions to insect venom should be seen in a specialist clinic within 6 weeks of referral
- Children requiring review by a specialist paediatric allergy dietician should be seen within 2 weeks of their paediatric allergy clinic appointment
- Children undergoing oral food challenges and drug provocation tests in a specialist centre should be challenged in a facility with access to a PICU
- Subcutaneous immunotherapy should be administered on a unit with access to a PICU

Having spent so long in putting this document together, we're anxiously waiting to see how this will work in practice.

I'm also delighted to announce that the Parliamentary Office for Science and Technology has approved the following topic for their future work programme: childhood allergy: a discussion of the causes and extent of allergic disease in childhood, giving an overview of recent epidemiological studies in paediatric populations and examining the links between allergy, genetic and environmental factors. It will summarise new clinical research and discuss issues relating to clinical care for children and young people. We are looking forward to see how this will progress.

Mich Lajeunesse and Paul Turner have been co-ordinating a multicentre safety study of Fluenz (intranasal influenza vaccine) in egg allergic children. They intend to increase the number of study centres for a second year from September 2014.

Paul Turner has taken over as allergy representative on the BPAIIG committee. We wish him luck with the appointment.

Disappointingly there was a lack of applicants for the national grid training programme in paediatric allergy starting September 2014. The next round of applications will start in September 2014 for the 2015 round. If you have any bright, enthusiastic trainees who would like to apply, please do encourage them. The future looks very promising for paediatric allergy.

Contact Gillian.vance@nuth.nhs.uk for further details.

Dr Susan Leech, Consultant Paediatric Allergist, Kings College Hospital and Chair of the Paediatric Group.

The BSACI Clinical Immunology subcommittee continues to have meetings held 4-6-monthly. There has been a recent change in chairmanship, with Dr Yousuf Karim taking over from Dr Philip Doré. The committee wishes to thank Dr Doré for his hard work during his time as chairman.

Discussions of the committee have focused on Immunology and Allergy training, the KBA in Allergy, the relationship between Immunology and Allergy, and Immunology contribution to the Annual Meeting.

The committee is keen for both Allergy and Immunology SpRs to attend the Allergy Training Days (subject to being a member of BSACI).

The committee will continue to help provide questions for the KBA in Allergy. We will assist in the Clinical Immunology part of the BSACI 2014 Annual Meeting. This year, talks on immunodeficiency are planned.

A major challenge facing the Allergy and Clinical Immunology committee will be the approach to IQAS registration and accreditation for the Allergy services which are provided throughout the UK. This is a major opportunity for close interaction between the Allergy and Immunology communities.

Dr Yousuf Karim, Chair of BSACI Clinical Immunology Committee

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Dr Yousuf Karim, Chair of BSACI Clinical Immunology Committee
Jennifer Mitchell, who died in her home town of Edinburgh in December 2013, was the devoted and highly respected Editorial Assistant of Clinical and Experimental Allergy. After appointments in Edinburgh she moved to London in 1980 as the Secretary/PA to the Department of Allergy and Clinical Immunology, National Heart and Lung Institute, Royal Brompton Hospital. During that time Jennifer was the Editorial Assistant of several monographs and a textbook on Asthma and Allergy. She also organised the annual Basic Clinical Allergy course and several international scientific meetings.

Jennifer began with the Journal in 1983 when Barry Kay and Stephen Holgate became co-editors. At first it was a part-time appointment but as the Journal grew and published monthly Jennifer became more involved. Her numerous tasks involved tracking the progress of manuscripts, assigning manuscripts to editors and providing suggestions for appropriate reviewers, liaising with the editors, the publisher and the journal production office about all matters concerned with processing and publication of manuscripts, assisting authors/reviewers who have difficulty with the online system, corresponding with authors on all other matters regarding their manuscripts, preparing contents lists of papers and editor’s choice for monthly issues, updating database of potential reviewers and updating reports for editors and for editorial board meetings.

In terms of long hours and devotion to duty Jennifer became a legend in her own time. With her low-profile style she moved mountains. It was not just hard work, far beyond the call of duty, which earned Jennifer the respect of a generation of colleagues, but her high standards, attention to details and accuracy in the multiplicity of tasks she was called on to perform. Nothing has ever been too much trouble for her. She was one of the first secretaries to use word processing and always kept up with the technology of the day. It is particularly sad that after over 30 years of service to the Department and the Journal Jennifer enjoyed only two years of retirement.

Jennifer was a private person who didn’t particularly like social situations and large gatherings. However, on a one-to-one basis, she was friendly, cheerful and had a lovely sense of humour. She went out of her way to help others and earned the gratitude of a procession of doctors and scientists who came through the department. By her industry and commitment Jennifer enhanced research and teaching in the field of allergic diseases for which we owe her a huge debt of gratitude.

Professor Barry Kay
Southampton Allergy Centre - A WAO Centre of Excellence

Our mission is to provide excellence in clinical care, research for patient benefit and education for all.

Southampton has been named a WAO Centre of Excellence for achievement in Clinical Innovation and Research. It is currently the only service in the world to hold this status. The centre has an international reputation for scientific and patient based research in Allergy, Asthma and Clinical Immunology. We have expertise in the clinical trials, epidemiology, diagnostic laboratory and scientific basis of food, drug, skin, eye, airway and paediatric allergies and have established cross disciplinary research programmes that examine Life Course Immunity.

The department boasts a number of world leading physicians and scientists in asthma and allergy. The Southampton Allergy, Asthma and Clinical Immunology service is a regional Comprehensive Care Centre for the evaluation, diagnosis and treatment of patients with suspected allergic diseases. The Consultant team consists of 6 adult and 5 Paediatric physicians. All members of the Consultant team, plus those in dietetics and nursing, are actively involved in both teaching and research. The MSc Allergy programme provides a formal teaching programme at certificate, diploma, MSc or standalone module level for UK and international students. We also run courses and training days for allergy trainees and GPs.

In collaboration with WAO, the Southampton Allergy department would like to improve allergy education for patients, families and healthcare practitioners across the world. We would like to work with allergy ‘champions for change’ in emerging nations where exposure to high quality educational resources are limited, but where improved education can translate into positive clinical transformation of allergy provision. To achieve this we will use the existing MSc Allergy educational resources, we have refined and extended over the last 10 years, to initiate a fit for purpose and designed to deliver "e resource" for distance on line allergy education.

Hasan Arshad, Professor of Allergy and Clinical Immunology, Southampton University Hospital Trust

Anaphylaxis Campaign wins GSK Impact Award

The Anaphylaxis Campaign is a national charity which aims to improve awareness of anaphylaxis and access to NHS allergy services. It was recently announced as one of the ten winners of a GSK IMPACT Award, completing with over 400 charities to achieve this status. The awards, run in partnership with The King’s Fund and now in their seventeenth year, are seen as a mark of achievement in the healthcare charity sector. In addition to the £30,000 they receive, winning organisations are able to access training, development, and networking opportunities through a dedicated programme hosted by The King’s Fund.

The award judges were impressed by many aspects of the charity’s work, not least its reach with 32 local support groups and 5,700 members. It provides a wide range of patient information on medical facts, food labelling, risk reduction and allergen management, supported by a panel of scientific and clinical advisors and health professionals. Its online training programme, Allergywise, which has been accredited by Royal College of Nursing, the Royal College of GPs and endorsed by the British Society of Allergy and Clinical Immunology (BSACI) has different courses tailored to a range of health professionals as well as ones for families and carers.

The organisation has developed creative ways of raising awareness of allergy risks, is influential, represents the patient perspective on allergy issues and has developed many strong partnerships to support its work. For example when food companies announce an error that may put allergy sufferers at risk, the organisation sends out product alerts by text and email within an hour of announcement; last year it sent out 40,000 such texts and emails relating to 53 alerts.

The Anaphylaxis Campaign has been working for 20 years to support allergy sufferers. It is an impressive independent organisation carrying out targeted activity that protects people with allergies in a particularly effective way and its award is well-earned.

Sarah Bereford, Anaphylaxis Campaign, Communications Manager
Announcements/News

DIARY DATES
See www.bsaci.org for a comprehensive list of meetings, courses and workshops.

2014

28-30 September 2014
BSACI 2014 Annual Meeting
Telford, UK

6-10 September 2014
European Respiratory Society (ERS) Annual Congress
Munich, Germany

6-10 November 2014
American College of Allergy, Asthma and Immunology (ACAAI) 2014 Annual Meeting
Atlanta, USA

6-9 December 2014
World Allergy Organization (WAO) International Scientific Conference
Rio de Janeiro, Brazil

Allergy Academy Courses
BSACI Junior members go free! All other BSACI members are entitled to a 15% discount. See www.Allergyacademy.org for an update on meetings.

STOP PRESS!!
BSACI would like to thank Nestle Nutrition for supporting the BSACI stand at EAACI 2014.

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Prescribing Information

(Please refer to the full Summary of Product Characteristics before prescribing)

Avamys® Nasal Spray Suspension (fluticasone furoate 27.5 micrograms/spray).

Uses: Treatment of symptoms of allergic rhinitis in adults and children aged 6 years and over.Dosage and Administration: For intranasal use only. Adults and adolescents (12 years and older): Two sprays per nostril once daily (total daily dose, 110 micrograms). Once symptoms controlled, use maintenance dose of one spray per nostril once daily (total daily dose, 55 micrograms). Reduce to lowest dose at which effective control of symptoms is maintained. Children aged 6 to 11 years: One spray per nostril once daily (total daily dose, 55 micrograms). If patient is not adequately responding, increase daily dose to 110 micrograms (two sprays per nostril, once daily) and reduce back down to 55 micrograms daily dose once control is achieved. Contraindications: Hypersensitivity to active substance or excipients. Special warnings and precautions: Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. These effects are much less likely to occur than with oral corticosteroids and may vary in individual patients and between different corticosteroid preparations. Potential systemic effects may include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, cataract, glaucoma and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children). Treatment with higher than recommended doses of nasal corticosteroids may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Caution when prescribing concurrently with other corticosteroids. A reduction in growth velocity has been observed in children treated with fluticasone furoate 110 micrograms daily for one year. Therefore, children should be maintained on the lowest possible efficacious dose which delivers adequate symptom control. It is recommended that growth of children receiving prolonged treatment with nasal corticosteroids is regularly monitored. Consider referring to a paediatric specialist. May cause irritation of the nasal mucosa. Caution when treating patients with severe liver disease, systemic exposure likely to be increased. Nasal and inhaled corticosteroids may result in the development of glaucoma and/or cataracts. Close monitoring is warranted in patients with a change in vision or with a history of increased intraocular pressure, glaucoma and/or cataracts. Drug interactions: Caution is recommended when co-administering with potent CYP3A4 inhibitors e.g. ketoconazole and co-administration with ritonavir is not recommended because of the risk of increased systemic exposure of fluticasone furoate. Pregnancy and Lactation: No adequate data available. Recommended nasal doses result in minimal systemic exposure. It is unknown if fluticasone furoate nasal spray is excreted in breast milk. Only use if the expected benefits to the mother outweigh the possible risks to the foetus or child. Side Effects: Very common (≥1/10): epistaxis. Epistaxis was generally mild to moderate, with incidences in adults and adolescents higher in longer-term use (more than 9 weeks). Common (≥1/100 and <1/10): headache, nasal ulceration. Uncommon (≥1/1000 and <1/100): rhinorrhea, nasal discomfort (including nasal burning, nasal irritation, and nasal sneezing), nasal oedema. Rare (<1/10000 and <1/1000): hypersensitivity reactions including anaphylaxis, angioedema, rash, and urticaria. Not known: transient ocular changes, growth retardation. Presentation and Basic NHS cost: Avamys Nasal Spray Suspension: 120 sprays: £5.44 Marketing Authorisation Number: EU/1/07/434/003 Legal category: POM PL holder: Glaxo Group Ltd, 960 Great West Road, Brentford, Middlesex, United Kingdom, TW8 9SS. Last date of revision: December 2013 For the UK, further information is available from Customer Contact Centre, GlaxoSmithKline, Stockley Park West, Uxbridge, Middlesex UB11 1BT; customercontact@glaxo.com; Freephone: 0800 221 441. For Ireland, please contact 1800 244 255.

Adverse events should be reported. For the UK, reporting forms and information can be found at www.mhra.gov.uk/yellowcard. For Ireland, adverse events should be reported directly to the HSE; Pharmacovigilance Section, Irish Medicines Board, Kevin O'Malley House, Earlsfort Terrace, Dublin 2. Tel: +353 1 6764971. Adverse events should also be reported to GlaxoSmithKline on 0800 221 441 in the UK or 1800 244 255 in Ireland.

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References: