



Issue 1  
Summer 2003

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

# Allergy Update

The Newsletter of the British Society for Allergy & Clinical Immunology

## Allergy Services: The unmet need

### COMING SOON - COLLEGE OF PHYSICIANS REPORT

#### 25th June – a turning point?

A new report from the Royal College of Physicians on Allergy Services will be released at a press conference on 25th June. This should be important in shaping the future provision of allergy services.

The report was produced by a Working Party, chaired by Stephen Holgate and Pam Ewan, with a wide membership most of whom were BSACI members. Included were allergists, paediatric allergists, respiratory physicians, dermatologists, immunologists, GPs and a dietician plus a number of physicians representing the Royal College of Physicians. Many other experts were consulted, and some of these made major contributions.

In addition to clinical analysis, the report brings the patient perspective to bear and backs its conclusions with new evidence on the epidemiology of allergy.

To inform the Working Party BSACI commissioned two research projects. The first, on the prevalence of allergy in the UK was conducted by Professor Ross Anderson's group at St George's, and the second, into General Practitioners' attitudes to and knowledge of allergy, by Dr Mark Levy and his colleagues. Key findings from both of these studies will be included in the Report.

The Report will review current provision of allergy services in the UK, outline need and make detailed proposals for development of the service, at all levels from primary through to specialist care.

The Executive Summary of the Working Party's findings, together with the key findings from the new research, will be available on the bsaci website ( [www.bsaci.org](http://www.bsaci.org) ).

On the same day the Report is released, the National Allergy Strategy Group (NASG) launches its parliamentary campaign at the House of Commons. The NASG brings together all those interested in improving allergy services including the profession represented through the BSACI, and patient groups, particularly the Anaphylaxis Campaign and Allergy UK. The aim is to involve MPs and explain the need for allergy services, so that pressure will be brought to bear on Health Ministers, Health Departments, NHS Commissioners and primary care and hospital trusts.

We shall need the help of all our Members, both at the time of the launch and later. The launch of the report should attract considerable press interest and members may need to be prepared to speak to the press and appear on local radio and TV to explain the situation for allergy services and make the local case for service improvement. Over the longer term NASG will need your support to keep momentum behind a campaign for improvement in allergy care.

The College Report will be an important first step. Perhaps, with your help, allergy might at last develop from being a Cinderella subject.

**Pam Ewan**



British Society for Allergy  
& Clinical Immunology

### Annual Meeting

Monday June 30th – Wednesday July 2nd 2003

East Midlands Conference Centre,  
Nottingham

Details and registration forms from  
0115 915 1383 or  
email: [julie@confnottingham.co.uk](mailto:julie@confnottingham.co.uk)

# All change at the BSACI

Dr Glenis Scadding

Consultant Physician in Rhinology, Immunology and Allergy, Royal National Throat, Nose and Ear Hospital, London

Welcome to this new look edition of the BSACI Newsletter, compiled with the help of INQ Design.

This is not the only change at the BSACI. Sue Duff who ran the Society like clockwork for many years has retired. She is much missed and in this edition is a eulogy from a past President, Pam Ewan. An expanded organisational role has been bravely taken on by Jack Barnes, whom some of you will know from his work with the National Asthma Campaign. Jack has recently been joined by Fiona Head. We have also had a change of President: with Pam Ewan stepping down to be replaced by Professor Andy Wardlaw from Leicester. There are also some changes in Council, whose composition is detailed in the accompanying panel.

During Pam's Presidency, she, through her work on JCHMT, was instrumental in getting allergy recognised as a specialist subject with a CCST (greatly supported by Chris Corrigan who helped to develop the curriculum). The implications for the National Health Service of the dramatic increase in allergy in recent years is now the subject of a Royal College of Physicians working party on improving the provision of clinical services in the UK. This is due to publish its report *Allergy: The Unmet Need – A blueprint for better patient care* on the 25 June 2003. Pam has written a brief preview of the report in this edition of *Allergy Update*.

Adequate allergy care requires trained health care professionals at all levels. In this edition there are articles on training for nurses, primary care practitioners and other health care professionals by Monica Fletcher, an article on training for physicians by Chris Corrigan and one from Jill Warner about the MSc in Allergy at Southampton University. Please pass these details on to colleagues and friends who show an interest. Many of you who are trained will be interested in undertaking immunotherapy and the present state of play is noted in the letter from Tony Frew which is reproduced here.

We also have some personal views: Harry Morrow Brown's delightful article on his adventures with a microscope, one by the mother of a severely allergic child who has coped so well that he is now an international sportsman, one from my own department about our paediatric rhinitis clinic. The catarrhal child is a very common and often a frustrating problem, so I hope these articles gives encouragement.

The BSACI is your Society and feedback on this newsletter, particularly on this new look, would be very welcome, either by letter or directly to [info@bsaci.org](mailto:info@bsaci.org). Short articles for publication in the personal view or practice observed sections are welcome.

I look forward to hearing from you and hope to see most of you in Nottingham,



*Glenis.*

Contributions should be sent on disk accompanied by a hard copy to Dr Glenis Scadding c/o RNTNE Hospital, Gray's Inn Road, London, WC1X 8DA, or emailed directly to [g.scadding@ucl.ac.uk](mailto:g.scadding@ucl.ac.uk)

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# Welcome from your new President

## Professor Andrew Wardlaw

Chair in Respiratory Medicine, Glenfield Hospital, Leicester

I have been fascinated by diseases of the immune system since I embarked on my research career with Professor Barry Kay in the mid 1980s. I was therefore delighted to be elected president of the BSACI last December taking over from Pam Ewan who did such an excellent and tireless job during her presidency in promoting allergy services in the UK.

A key recent initiative was the formation of the National Allergy Strategy Group (NASG), a forum in which all the stakeholders could work together to promote allergy services. In partnership with the Royal College of Physicians the NASG will be launching the RCP report on allergy services on June 25th. This seminal report clearly sets out the need for a dramatic improvement in the quality of care for people with allergic disease through the creation of more consultant posts, more trainees, more specialist nurses and better training in primary care.

Following on from this we need a long term plan which will deliver on the aspirations set out in the report. The implementation of such a plan is one of the key priorities of my presidency.

Our annual meeting in Nottingham remains one of the flagship activities of the society. As ever the organising committee led by Andrew Bentley has put together an outstanding programme with an exciting blend of science and clinical updates. As well as being informative it is an opportunity to meet fellow allergists and clinical immunologists over a drink and a game of archery so I hope you will make every effort to make time in your busy schedules to help make the meeting a success.

More than any other aspect of our work what sets BSACI members apart from alternative allergy practitioners is the rigour with which we manage allergic disease according to an evidence base. It is therefore beholden on the society to develop clear and comprehensive guidelines and protocols that will standardise best practice. This is another important priority for the society in the next couple of years.

Although in recent years the strategy of the BSACI has been to emphasise the need for more fully trained specialists in allergy, the majority of allergy care in the UK has been, and will continue to be, delivered by enthusiasts who were trained in another speciality. It is important that the society takes an inclusive approach in order to harness and engage all those people with an interest in allergy. The society is a small one and we are always looking for new people to support the activities and functions of the society so if you are interested do get in touch.

The newsletter is an important forum for interaction within the society and we are indebted to Glenis Scadding for all her hard work as editor in putting together such an excellent edition.

I look forward to seeing you in Nottingham.

## Diary dates

### British Society for Allergy & Clinical Immunology Annual Meeting 2003

June 30th – July 2nd 2003  
East Midlands Conference Centre,  
Nottingham

*Details and registration forms from*  
0115 915 1383 or email:  
julie@confnottingham.co.uk

### 11th British Academic Conference in Otolaryngology and ENT Expo

2 - 5th July 2003  
The International Convention Centre,  
Birmingham UK  
*Secretariat:* Rachel Powell, BACO  
Conference Co-ordinator, BAO-HNS  
The Royal College of Surgeons of  
England, 35-43 Lincoln's Inn Fields  
London, WC2A 3PE  
Tel 00 44 (0)207 404 8373  
Fax 00 44 (0)207 404 4200  
E-Mail baco@bao-hns.demon.co.uk

### ERS 13th Annual Congress

September 27 - October 1 2003  
Vienna Austria  
*For more information on registration please contact*  
Congrex Sweden AB  
c/o ERS 2003  
P.O. Box 5619  
SE-114 86, Stockholm  
SWEDEN  
Tel: +46 8 459 66 00  
Fax: +46 8 661 91 25  
ers2003@congreg.se

### World Allergy Organisation Congress – XVIII ICACI

September 7 - 12 2003  
*WAO Secretariat:*  
WAO Congress – XVIII ICACI  
Attn: Congress Registration  
611 East Wells Street  
Milwaukee,  
WI 53202  
USA  
[www.worldallergy.org/  
congresses/vancouver03](http://www.worldallergy.org/congresses/vancouver03)

# The Paediatric Rhinitis Clinic at the RNTNE Hospital

Glenis Scadding and Yvonne Darby

Establishing a paediatric rhinitis clinic is an excellent way to deal with ENT problems in children efficiently. Glenis Scadding and Yvonne Darby explain how their clinic runs

“Most children with ENT problems suffer from disease in other areas - thus a multispecialist holistic approach is sensible”

Imagine you are an ENT surgeon sitting in a general outpatient clinic full of waiting patients and the next is a six year old boy accompanied by his recently arrived in UK Turkish mother who speaks very little English with her three year old son in tow. The one line referral letter suggests that the child has chronic nasal discharge and obstruction. Where do you start?

Quite a good starting point is to establish a paediatric rhinitis clinic with medical colleagues, such as a paediatrician and/or an allergist. Most children with ENT problems are atopic or immune deficient and suffer from disease in other areas such as chest skin or gut – thus a multispeciality holistic approach is sensible.

Triage of the referral letters can be established so that urgent problems such as severe sleep apnoea are seen quickly and translators are immediately available. Our clinic was set up when I first arrived at Gray's Inn Road as a clinical immunologist and allergist in 1987. Our aim was to see children in a dedicated clinic efficiently, wherever possible making this a one-stop visit.

Once assigned to the clinic the notes are reviewed on the day before by my nurse Yvonne Darby and necessary immediate investigations are entered. This means that children have weight, height, peak flow (best of 3), skin prick tests (inhalant only) and if relevant : hearing tests, nitric oxide, spirometry, acoustic rhinometry undertaken before they are seen by the relevant Doctor.

The clinic is multispecialist: served by an ENT surgeon, an audiologist, a paediatrician (when possible) and myself plus my allergy nurse, outpatient nurses and a play specialist. The waiting area is well supplied with (largely) unbreakable toys, colouring pencils and colouring sheets, plus a video showing cartoons. Whilst the child is occupied the accompanying adult is asked to fill in a history questionnaire so that when they are seen by the first (most relevant, as determined by the referral letter)

doctor the major features have already been rehearsed. The doctor then fills in any gaps in the history, examines the child, not only ears, nose and throat but also the chest for any evidence for asthma or other lower respiratory tract disease plus the skin for any evidence for eczema. Initial nasal examination is made with the auriscope or head mirror; endoscopy may also be employed in older children.

A provisional diagnosis is reached and further tests for saccharin clearance, food allergen skin prick testing, imaging, or nitric oxide measurements with or without decongestant can be organised at the same visit as necessary. A history of recurrent infections, especially at different sites may suggest blood tests for haemoglobin, differential white cell count, iron studies, immunoglobulins and IgG subclasses. In recent years I have decreased the use of these-preferring to alter environmental factors such as day care, parental smoking and allergens first, combined with simple therapy such as douching, topical corticosteroids and adequate courses of antibiotics (2 bottles rather than one, in real terms a week's course, not 3 days). This reduces the need for blood letting which is unpopular with children, even with local anaesthetic (EMLA) cream.

## Diagnostic aids

Recently we have used analysis of nitric oxide in the nose as a diagnostic aid. Low levels of nitric oxide, less than 100 parts per billion, suggest primary ciliary dyskinesia, but can also be due to severe nasal obstruction from other causes. Decongestion may resolve the issue by resulting in a rise in nitric oxide. However in some children a couple of weeks of treatment



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with oral steroids plus topical steroids may be necessary before the nasal airways are sufficiently open for normal levels to register. Using this approach reduces the number of referrals to a tertiary centres for ciliary beat frequency and electroscopic analysis of cilia, an expensive and complex procedure. Raised nitric oxide levels (over 900 ppb) suggest nasal inflammation-in children on therapy this implies that compliance is a problem. However high levels also suggest that the ostiomeatal complex is patent, reducing the need for CT or MRI scans. In fact we employ imaging very rarely in this clinic-usually only after treatment failure in chronic rhinosinusitis when surgery is considered –this is in under 5 children per year. Raised levels of expired nitric oxide from the chest mean that lower respiratory tract inflammation is present and can be helpful in distinguishing the cause of a chronic cough.

If a simple definitive diagnosis such as allergic rhinitis to house dust mite is reached then the patient and parent are given a brief explanation by the doctor and are asked to watch an explanatory video plus being given leaflets which detail the necessary allergen avoidance measures. These are available not only for house dust mite, but also for grass pollen, moulds, for the oral allergy syndrome and for pets. A nurse is available to demonstrate treatment such as topical nasal sprays or inhalers. She may also be required to demonstrate the epi-pen where necessary for children who have had anaphylaxis or laryngeal-oedema.

Onward referral maybe necessary for primary ciliary dyskinesia or for sweat testing in the case of children who have nasal polyps.

Uncomplicated patients with a definitive diagnosis are seen only once. However they are given open appointments so that return is possible if the treatment is not working. They are also provided with a telephone number to ring if they have further questions after leaving the clinic, or are unsure if they need to return. This service is over used with some parents trying to use us instead of their GP, but we are attempting to ration it by restricting the times available to particular afternoons.

Children with major allergic problems such as anaphylaxis are kept under regular follow-up and their ability and that of their carers to use the epi-pen is monitored Severe food allergic children are referred to our excellent paediatric dietician at the Royal Free Hospital. Children with a possible diagnosis of asthma are usually seen again with a peak flow chart, but after that an asthma management plan is devised and they are referred back to primary care.



*Child undergoing tests to determine levels of nitric oxide (above) and peak flow (opposite page)*

Our paediatric rhinitis clinic has proved a very useful setting for undertaking research projects. With careful explanation many parents are willing to let their children take part in trials of therapy. We have recently completed a study started in the early 1990s looking at medical treatment of otitis media with effusion. This has demonstrated that topical flixonase nasal spray can reduce the need for grommet insertion by over 40% at 2 years, the Otovent device reduces the need for grommet insertion by 30%. Interestingly use of the two together is no better than placebo. I have speculated that this tells us quite a lot about the pathogenesis of the problem, suggesting that postnasal organisms are responsible for the chronic or recurrent ear infections.

We are about to embark on a trial of sublingual immunotherapy for house dust mite with and without active probiotics in the form of lactobacillus.

Dealing with children is always complicated by the fact that one not only needs to see and treat the patient but it is also necessary to establish a dialogue with the relevant carer. This is not always easy, but in a clinic dedicated to children, with multiple opinions available if necessary, it becomes simpler than in the middle of a crowded clinic where adults are also present.

Our clinic plus all the others at RNTNE and the Royal Free where children with ENT problems are seen is undergoing an audit – it is likely that we will identify areas where improvement is needed. The clinic is in a constant state of evolution. Responding to advances in knowledge and the exchange of knowledge between different professionals is what makes it fun.



**“Uncomplicated patients are given open appointments so that return is possible if the treatment is not working”**

# National Safety Audit of Alutard Immunotherapy

Professor Anthony Frew

Allergy and Respiratory Medicine, School of Medicine, University of Southampton

In December 2002 Professor Tony Frew wrote to a number of consultants involved in immunotherapy in the UK to clarify the current situation in regard to certification of use of Alutard immunotherapy products. As detailed in the accompanying letter the MCA has now issued DDX certificates for the use of Alutard products including house dust mite, cat, dog, horse, silver birch and mixed tree pollens, as part of a national safety audit. The use of the EAACI immunotherapy forms was recommended to capture the data that will be necessary for reporting, although it is recognised that other forms may also be suitable. The letter is being reproduced here to ensure that it reaches all those who may be wishing to use these products.

As you will recall, the MCA imposed restrictions on the use of Alutard vaccines in 2000/2001 because they were concerned that large numbers of patients were being treated on a named patient basis without systematic collection of safety data. In order to continue the treatment of patients who were already receiving immunotherapy with Alutard products, the MCA issued a series of national DDX certificates covering the continued use of Alutard products in patients who had already started their courses of immunotherapy. However, they would not permit us to put new patients onto treatment with Alutard vaccines outside the context of clinical trials. Many of us took part in the UK22 study of grass pollen immunotherapy and you will be aware of the open label safety audit that is taking place with grass pollen immunotherapy under the title of UK23. Both UK22 and UK23 are being conducted under a CTX certificate, which is an application by the manufacturer to conduct clinical trials on a product that does not have a product licence.

Earlier this year, several of us applied individually for exemptions under the DDX scheme to allow us to treat new patients with Alutard products other than grass pollen. Although the MCA did grant a number of these, they have subsequently decided that they would prefer to see all such use brought together into a single safety audit with data collected on a national basis and submitted to the MCA annually. Accordingly, they asked me to submit a DDX application to cover this safety audit and they invited me to coordinate the collection of safety data. I have filled in the necessary paperwork and I am pleased to report that the MCA have now sent through the DDX certificates which cover the use of Alutard products including house dust mite, cat, dog, horse, silver birch and mixed tree pollens.

My purpose in writing now is to inform you about this development and to invite you to participate in the national safety audit of these products. Please note that the basis of this study is different to UK22 and 23 in that we will be treating patients purely on the basis of clinical

need and there will be no active recruitment to the study. Each clinic has slightly different arrangements for recording safety information but it will be necessary to collect a minimum data set and submit this on an annual basis. Our preference is that clinics should use the EAACI immunotherapy treatment forms which contain all the necessary safety information and are not cumbersome in clinical use. We appreciate that this may represent a change in practice for certain clinics and there is no problem if you wish to collect more data than the EAACI form but you cannot collect less!

## Certificates likely to be rescinded

Please note that the individual DDX certificates issued to clinics earlier this year are likely to be rescinded\* as the MCA wishes to subsume these into the national safety audit. It follows that if you wish to continue using Alutard products and in particular, if you wish to start new patients on these products, you will need to take part in the national safety audit. If you wish to proceed with this, you will need to apply to ALK who have to send in an MLA163 form for each centre that is participating.

Since this is an audit rather than a clinical trial and is essentially the collection of safety information on patients who are undergoing routine clinical treatment for a standard indication, it is our view that the audit sits outside the Ethics Committee framework. We are seeking formal clarification of this and will let you know if there are any Ethics Committee implications. By the same token, there is no financial support to clinics for the work involved in this audit. Individual clinics may have specific arrangements with ALK to support their UK22 and UK23 patients but these are separate from the safety audit patient discussed above.

If you have any queries about this audit, please do not hesitate to contact me. I do hope that you will consider taking part in the audit and that this may provide a mechanism for securing supplies of Alutard products for those patients in whom you believe this is appropriately indicated.

\* Since this article was written the original DDXs have now been subsumed into the collective DDX.

# A chairborne adventure in DTC microscopy

H Morrow Brown

**H Morrow Brown says goodbye to his old BH2 microscope and marvels at the advances in technology**

Last year joining my microscope to my video camera enabled me to show not only what Charles Blackley saw happens on wetting fresh pollen in 1873 but also, by illuminating the specimen from the side, particles of pollution as well as the crystals of pleomorphic calcium sulphate I had described in 1980.

Being dissatisfied with the quality of the images from my old BH2 I decided this spring that (at the age of 85) I would get much more pleasure out of an Olympus BX51 microscope with differential interference contrast than a new car! This decision has proved correct, and all summer I have had great fun exploring the possibilities of this technological advance which enables the examination of living organisms without mounting or staining greatly magnified and visualised almost in 3D on a small LCD screen mounted on the microscope. All samples were captured in my spore traps in the garden using a plain slide with no adhesive, as pollution particles are dissolved or destroyed by using mountants, thus never seen.

Being such a wet summer, one of my first ploys was to examine centrifuged deposits from rain. As expected I found many trapped spores and pollens, but the surprise was the number of motile organisms of various shapes and sizes, some scooting very rapidly all over the place, reminding me that Van Leeuwenhoek, the inventor of the microscope, had first described them in 1773, when he wrote to the Royal Society of London "in all falling rain animalcules are to be found. For these animalcules can be carried over by the wind, along with bits of dust floating in the air".

I made movies with commentary of these 'animalcules', the first micro-organisms to be seen by man, thinking how thrilled the inventor would have been to see them on the latest equipment! A picture is worth a thousand words, especially if it is moving! 'Animalcules' can be seen in condensation water on the surface of spore trap slides exposed in wet weather, so they

must have been trapped by the raindrops on the way down. There seems to be little recent work on the organisms in rainwater, and I have only once heard of a skin reaction to rain.

When I had learned how to make the various adjustments properly and cast off my microscopic 'L Plates' I could observe spores and pollens in more detail than ever before, and make a video record. The almost 3D contrast caused difficulty in identification of spores, as I am used to looking at mounted stained specimens. It was very interesting to observe that there was great activity in the cytoplasm of some pollens and spores, but not in others. Dramatic variations in the numbers of didymella and sporobolomyces spores were related closely to wet periods in August.

Crystals of what I presume are calcium sulphate appeared intermittently during the winter and spring, and sometime in wet summer weather, but no correlation with weather conditions has become evident. Particles of pollution of all shapes and sizes are commonly observed, and illuminating the specimen obliquely with a concentrated beam from an optical fibre enables the colour of the particles to be seen if the light from below and from above is balanced. As well as the obvious sooty particles, there are also white and red particles of a large size range which do not relate to the weather and are just as common on Bank Holidays, even in north Wales near the sea, so that an industrial source seems unlikely. It is hoped that it will be possible to identify these particles and the crystals by electron dispersive X-ray micro-analysis, as was done twenty years ago for the crystals. The possible role of these inorganic pollution particles would seem worthy of further investigation to determine their origin and possible significance for health.

My new microscope has also proved useful for examination of sputum and nasal smears from patients, and has enabled remarkable movies of ciliary activity in living epithelial cells. It may be possible to demonstrate effects of allergen extracts on sensitised cells at a later date.

The biggest task before the Third European Symposium on Aerobiology next year, where plans have been made to show videos on the Burkhardt stand, will be to edit the videos so as to present a coherent account of this adventure and stimulate further investigations.

**"A picture is worth a thousand words, especially if it's moving!"**



*H Morrow Brown with his Olympus BX51*

# Allergy training for nurses and other healthcare professionals

Monica Fletcher

Chief Executive, National Respiratory Training Centre

The prevalence of allergic disease is increasing<sup>1</sup> and is estimated to affect around 20% of the population. The rise in the prevalence of allergic diseases, coupled with wider public awareness, means that there is increasing need for better trained health professionals across health communities to manage allergic conditions.

It is suggested that over 80% of allergy care is managed in primary care however worryingly very few GPs or practice nurses have had any formal theoretical training in allergy. With appropriate training and support, however, practice nurses working in collaboration with GPs could provide much of basic allergy management in primary care. Practice nurses have an impressive track record of revolutionising the systematic care of asthma and other respiratory conditions in primary care, so why not in allergy care? It would appear to be a logical development given that the many patients present with upper and/or lower airway symptoms.

So what preparation would nurses need to provide them with the knowledge, skills and expertise to make this transformation in order to take a major lead in improving the quality of life of many patients?

This would depend to some extent on their level of involvement, but would range from: basic level to advanced level training in allergy

The basic knowledge required for successful management should include:

- evidence-based treatment guidelines for asthma, rhinitis, eczema and anaphylaxis
- appropriate selection of non-sedating anti-histamines and other therapeutics
- compliance- and technique-dependent effects of nasal, dermatological and inhaled corticosteroids
- appropriate referral for an allergy opinion

For a comprehensive allergy service, which included diagnostic services, then more advanced training would be required.

The National Respiratory Training Centre (NRTC), Warwick currently runs training courses to equip nurses and other health

professionals with the skills to practise from basic to advanced levels. These range from one day essential skills training days, through to a comprehensive degree level module, which is accredited with the Open University and can be part of a BSC (Hons) in Respiratory Health. For further details on training and other practical resources as as the Simply Allergy Pocketbook, explore the website [www.nrtc.org.uk](http://www.nrtc.org.uk) or telephone Kim Esslemont. Module Administrator at the NRTC on 01926 493313 or email on [k.esslemont@nrtc.org.uk](mailto:k.esslemont@nrtc.org.uk)

The NRTC believes that the provision of excellent allergy services in primary care is possible, but only with appropriately trained health professionals with a key interest, with appropriate back up from local specialist allergy services when required, can this become a reality.

Reference

1. Sibbald, B., Rink, E., & D'Souza, M. Is the prevalence of atopy increasing? *Brit J Gen Pract* 1990; 40: 338-340.

## MSc courses in Allergy

Jill Warner

University of Southampton

The Faculty of Medicine, Health and Biological Sciences at The University of Southampton is offering a number of part-time interrelated postgraduate modules in Allergy.

The modular programme structure enables you to take study and attain a Postgraduate Certificate, a Postgraduate Diploma or full MSc in Allergy. There are 6 modules in allergy related topics:

- Mechanisms & Management of Allergic Disease (I) = 40 credits
- Mechanisms & Management of Allergic Disease (II) = 40 credits
- Skin Disease and Its Management Module = 20 credits

National Respiratory Training Centre,  
The Athenaeum,  
10 Church Street,  
Warwick, CV34 4AB  
Telephone: 01926 493313  
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[m.fletcher@nrtc.org.uk](mailto:m.fletcher@nrtc.org.uk)



# Allergy training for the physician

Dr Christopher Corrigan

## What is allergy?

Allergic diseases are those which are a consequence, in whole or part, of interaction of antigen (allergen) with inappropriately produced, specific IgE. Such diseases include asthma and rhinitis, eczema, food allergy, allergy to drugs such as anaesthetics and antibiotics, allergy to insect venoms, latex allergy and some forms of urticaria. When severe these reactions may result in anaphylactic shock. Consequently, allergy embraces a variety of medical and surgical specialities, including paediatrics and dietetics, and the training is unique and varied. Allergic diseases affect millions, and there is ample opportunity to provide tangible and effective help to sufferers, both through active intervention (drugs, immunotherapy) and allergen avoidance.

## What makes Allergy an attractive career choice?

Our knowledge of the pathophysiology of asthma, allergic rhinitis, eczema and other

allergic diseases is expanding rapidly, with continual promise for improved therapy and primary prevention. On the other hand, in some areas such as drug and food allergy, there is still much that we do not fully understand. Thus a career in Allergy provides continual challenge but a real chance of advancements in therapy, which is a very stimulating environment in which to work. Allergy is practised largely in an outpatient setting. This means that there is little "on call" work out of hours, and that part-time training and practice for those who wish it is eminently possible. Allergy is a very academic discipline, and some of the major allergy centres in the UK produce world-renowned research, both clinical and basic. Unlike some disciplines, research is encouraged in every way. Equally, there is no shortage of patients wishing private consultations.

## What challenges face those entering Allergy?

Unlike in the United (*Continued overleaf*)

**"A career in Allergy provides continual challenge"**

- Nasal Disease & Its Management Module = 20 credits
- An Introduction to Respiratory Disease Module = 20 credits
- Dissertation = 60 credits

And 2 in Research Methods in Health:

- Foundations 1 : Using resources and understanding research methods
- Foundations 2 : Carrying out research in practice

The programme has been designed to be applicable to a wide range of people who require a basic understanding of allergic disease and who come into frequent contact with potential allergy sufferers e.g. doctors, nurses, midwives, health visitors, and school nurses. It is also suitable for specialist registrars and scientists who require a basic training in order to carry out research in allergy.

The overall aims of our Allergy programme are:

- Provide opportunities for you to develop your knowledge and skills in relation to your practice by

advancing your understanding of underlying biological/behavioural and clinical mechanisms of allergic disease.

- Enable you to become competent in the use of key new advances in technology or in care programmes to include management of unpredictable and rapidly changing situations in acute allergy cases.
- Demonstrate a caring and informed approach to the diagnosis and management of allergic disease, especially in settings where the previous experiences of the patient could influence their compliance with treatment.
- Undertake critical evaluation of current research, propose new hypotheses and evaluate methodologies.
- Encourage you to scrutinise and debate issues related to research design, instrument selection and the evidence base for practice.
- Undertake research utilising sound

methodological principles, which are appropriate to professional and patients' needs.

- Integrate research evidence into all aspects of decision making to apply knowledge, analytical and critical thinking skills to develop sound judgements about data applicable to care of allergic patients.
- Enable you to justify personal and professional decisions through critical evaluation and synthesis of relevant theories, empirical evidence and experience to optimise best practice.

The University of Southampton is recognised as one of the leading research and teaching institutions in the United Kingdom, with particular emphasis on health. This programme builds upon this tradition of excellence and offers participants an exciting introduction to allergy research, diagnosis and management.

## Allergy training for the physician - continued

States and Europe, allergy has been accredited with the specialist status it deserves in the UK only relatively recently. Although an excellent JCHMT training programme now exists, and Deaneries recognise allergy as a speciality for the provision of NTN, both training and consultation posts in allergy in the UK are relatively few and far between, and are at present located principally in major teaching hospitals. Asthma and allergic rhinitis are by far the commonest diseases in the UK, and the commonest causes of loss of time from school or work.

Furthermore, the increase in prevalence of allergic diseases can be accurately described as an epidemic, with nearly 50% of the population affected to some degree. Despite all these facts, the government does not yet recognise allergy as a priority for the creation of new posts, as reflected in its manpower committee allocations. Similarly, local service purchasers are not yet fully aware of the services that this “new” speciality can provide. Taking on a career in allergy is therefore also a commitment, to some degree, to righting these wrongs.

### What does the future hold for the speciality?

It seems that the only way is up. The British Society for Allergy and Clinical Immunology, which is the professional body representing allergy practitioners and researchers in the UK, is even now taking bold steps to lobby governmental manpower bodies and local care purchasers for the establishment of a network of allergy centres across the country. It is envisaged that the numbers of training and consultant posts will expand country-wide to meet the large and growing demand. Concurrently, there are now thriving schemes for the training of Specialist Nurses in Allergy both in hospital and in primary care. Again, while challenging, these are also exciting times for those embarking on a career in Allergy.

### The training programme

The training programme is based around a central core of general allergy clinics. This

should provide experience of a wide range of problems within the realm of the Allergist, including food allergy, drug allergy and the management of anaphylaxis. The trainee will be taught how to manage an allergen immunotherapy clinic. Alongside this, there are attachments to dermatology (for training in eczema, urticaria and contact dermatitis), ENT (evaluation and management of the upper respiratory tract), respiratory medicine (asthma, infant food allergy and substitute formulas, infant rhinitis, eczema and asthma) and immunology (vasculitis, immunoglobulin deficiency). In addition, the trainee will spend time in a diagnostic laboratory, becoming acquainted with the indications, methods and limitations of relevant diagnostic tests such as RAST.

Training is reinforced by regular assessment by educational supervisors and yearly formal assessment by the JCHMT. Trainees are taught how to remain conversant with the literature and collect relevant key papers and diagnostic protocols. Training is supplemented by and MSc course where possible, and attendance at nationwide meetings of involved with SpR training such as the BSI Travellers’ Club and the annual meetings of specialist societies such as the British Society for Allergy and Clinical Immunology. At all times, trainees are encouraged to produce case reports and participate in clinical and scientific journal clubs, as well as audit. Since Allergy is a very academic speciality, clinical research is considered fundamental to training, performed either during dedicated time throughout the training course or as an additional MD or PhD project.

The training programme lasts for 5 years, which may be extended if the trainee takes time out to read for a higher research degree. Candidates with MRCP or a recognised equivalent qualification are eligible for training. It should be noted that training in allergy is now quite distinct from training in immunology. NTN numbers are allocated separately, and dual accreditation is not possible unless the trainee wishes to pursue separate training programmes in both specialities.

“It is envisaged that the numbers of training and consultant posts will expand country-wide to meet the large and growing demand”

# From ENT - to playing for England as a Junior International

## Phase 1

Our son never slept at night, appeared irritable, always seemed to have stomach aches and I was forever visiting the local surgery for antibiotics to clear up ear and chest infections. He started to walk early but his talking was behind other children and he always seemed to grab my face when I spoke to him; a familiar story to any parent with a child having glue ear, asthma and allergy problems. By three, the problems got worse. At playschool he started to become aggressive (frustration at not being understood, as we later realised). We were referred to ENT and before long he was admitted for the insertion of grommets, and removal of adenoids and tonsils. After the operation there was a definite improvement. He seemed happier, slept better and didn't seem so frustrated. He still appeared more tired than other children but we were not to find the reason for this until later.

To gain confidence, academically, I encouraged him to work on simple Maths (Maths was visual, it was clear if it was right or wrong – unlike English in which, particularly in the early stages of learning, it is imperative that the child hears correctly). It was a good move and I would encourage other parents to consider this. We also encouraged our son to play sport. I wanted him to 'mix in' with team spirit of football but he never wanted to do this, probably because his asthma was not controlled. His uncle introduced him to Badminton and from the onset it was clear he had a particular aptitude for keeping the shuttlecock going; when he ran out of breath, he would use his strategic mind to technically 'place' shots.

## Phase 2

Things went well until the grommets fell out, ear and chest infections returned along with the temper. The asthma got out of control and he ended up in hospital on oxygen and steroids. Another grommet was inserted and his asthma medicine changed and checked. Our son was now receiving help with his speech and vowel sounds. (By the way, an inspiring note: he is now in the top set in English/ Maths/Science and French at secondary school. His badminton has steadily progressed and he is starting to make his mark.)

## Phase 3

Our son was now seven, and progress was being made, but he still seemed tired and appeared 'dark

eyed.' One evening we had a meal consisting of wheat pasta, nut cutlet and salad. Within seconds of eating, our son started to go bright red, his stomach became distended, he was sick and then his mouth started to swell. Tests were later carried out with the diagnosis of severe peanut and wheat allergies. He now carries an Epi-Pen. The tests actually gave us answers to many questions, for example why his skin was so itchy, his stomach pains and tiredness. Looking back, I think this was possibly the turning point.

We now monitor his diet; finding things that are wheat free and 'palatable' to youngsters is not easy, (corn pasta with tomato sauce is not too bad!) He has to avoid all nut products – if anyone is developing sports energy bars without nuts /nut paste or too much wheat please contact us! I noticed that the asthma, glue ear and food allergies although symptomatic in isolation, seemed to have a knock on effect. By regulating the food our son was starting to believe things could now be controlled.

## Phase 4

In March 2002 a letter came from the Badminton Association of England asking our son to attend two assessment days for the World Class Start programme. The assessment days are tough. He made me promise I would not let them know about his various health problems. I kept my word and, after checking safety procedures, did not offer any more information than was asked for. He was one of twelve to pass the assessment. In December 2002 he progressed to observation level 1. In March 2003 he was invited to be part of the England Squad entering the Junior OLVE tournament in Belgium; six boys and six girls had been selected. He went off to Belgium and did well. Obviously medical questions had to be answered for travel abroad and food arrangements are not easy, but they are not impossible to accommodate. Also the older he gets the more responsibility he can take on himself. In sport there are no excuses or extenuating circumstances allowed and at the end of the day 'funders' want athletes accumulating medals and consistency of results.

Interestingly his badminton peers know nothing of his hearing problems and do not believe he has or has ever had asthma!

I hope that other children who have a similar medical background will take heart.

The beginning of this article, I am sure will be a familiar story to many parents with children afflicted with hearing/ asthma and allergy problems. I am hoping that the end of the article will reassure those parents and children that there is 'light' at the end of the tunnel and that children can surpass and achieve things that seemed impossible to you as parents whilst sitting in the hospital waiting room.

Anne Went



## Bridging the Gap

In January 2003 BSACI, working together with seven other organisations, published a guide to the commissioning and delivery of high quality integrated respiratory health care. The publication was designed principally to support the work of colleagues working in primary care. However, its recommendations, which were expressed in terms of a “reasonable patient entitlement”, and covered asthma, COPD and other long term respiratory disease, as well

as allergy, have implications across all sectors of health care.

The section on allergy summarised the burden of the disease and proposed a framework for an effective primary care allergy service. A checklist of key components of effective provision for patients with allergy was given; namely

- Convenient access, with adequate staffing to meet needs
- Education of primary health care professionals

in allergy management

- Patient education in allergy
- Secondary centres with facilities for specialist testing
- Tertiary support in regional centres.

Copies of *Bridging the Gap* were sent to all primary care trusts in the UK. It is available on the new BSACI website [bsaci.org](http://bsaci.org); or a copy can be obtained from the BSACI administrative office.

## Allergy is the neglected disease: Allergy UK Survey Reports

An Allergy UK survey of people with allergy was published under the title *Stolen Lives* to initiate Allergy Week. The report is a mixture of case studies and statistical information.

The survey found that

- Over half of respondents were prevented from taking a full part in leisure or work
- Two thirds said holiday and social arrangements

were influenced by their allergy

- Three quarters had never been asked by their doctor or nurse about the effects of allergy on everyday life
- One third had no agreed management plan for their allergy.

## Farewell to Sue Duff



We were very sad to say farewell to Sue Duff at the BSACI conference dinner in Harrogate last December.

Sue ran the BSACI Secretariat for 8 years, although she had looked after the Society earlier when she worked for Conference Associates. She became the face (or rather the voice) of BSACI to the membership and to the many enquirers.

She had wonderful qualities, which were evident to those on Council who worked closely with her. During my period as President she was wonderfully supportive. Although she worked from home and most of our communication was by phone or e-mail, I felt I knew her well. She was highly efficient, tremendously loyal and had great integrity – and combined this with being an extremely nice person. She devoted herself to the Society and did much more than she need have done.

She had an amazing memory and having been with the Society for so long, usually knew what had happened, and knew all the Society rules and procedures. She became part of the fabric of the Society, and it was a familiar sight to see Sue, working quietly in the background, at every BSACI Conference – ensuring things were running smoothly. It was good to see her husband Michael at many of the meetings – he too got involved.

For Sue it was more than a job – she really supported the officers and Council and believed in Allergy and all we were striving for. We will miss her and wish Sue and Michael a long and happy retirement.

Pam Ewan

Allergy UK emphasise in *Stolen Lives* the need for appropriate training for primary care doctors and nurses in the clinical management of the very large number of their patients with allergy.



Copies of the report are available from Allergy UK at 0208 303 8525, or via their website [www.allergyuk.org](http://www.allergyuk.org)