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CLINICAL PRACTICE GUIDELINE

BSACI Guidance on Assessment of Individuals With Allergic and Immunological Conditions on Behalf of the United Kingdom Armed Forces

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ABSTRACT

This guideline, developed by the British Society for Allergy and Clinical Immunology (BSACI) Military Working Group, provides clinical guidance for assessing allergic and immunological conditions in UK Armed Forces serving personnel or recruits. The document outlines principles for individualised assessment rather than prescriptive rules, as assessment of these conditions is often nuanced and reliant on a best estimate of risks following individualised assessment. It discusses the unique challenges of military service—including unpredictable exposures, rigorous environments, and limited access to medical care—which necessitate stringent medical standards for recruitment and retention. The guideline addresses the allergic and immunological conditions most frequently encountered, such as food allergies, drug and vaccine hypersensitivities, venom allergies, allergic rhinitis, chronic spontaneous urticaria, idiopathic anaphylaxis, and immunodeficiencies. The role of allergists, immunologists, or other specialists with a role in assessment of these conditions is to provide detailed diagnostic evaluations and risk assessments to inform military occupational health decisions, without making direct judgements on fitness for service.

1 | Introduction

This clinical practice guideline has been produced by the Allergy in the Military working group of the British Society for Allergy and Clinical Immunology (BSACI). This group consists of expert adult and paediatric allergists and immunologists, and military occupational medicine consultants. The document is intended to provide guidance for clinicians assessing allergic and immunological

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Key Clinical Messages

- This document is intended to provide advice for clinicians assessing potential military recruits with allergic or immunological conditions
- Broad assessment principles are outlined. It is not intended to be a prescriptive guideline, reflecting the complex nature of the issues at stake and the need for individualised assessment
- Allergic disease is common and it has an impact on military recruitment and retention.
- Military service involves unpredictable physical and dietary exposures, and limited access to conventional medications. Subjects compromised by allergic conditions can put others at risk.
- Decisions on recruitment are made by military occupational health teams. Numerous factors need to be considered, including risk of incapacitation, need for medication, cofactors, and future prognosis, along with other medical conditions.
- The role of allergists and immunologists is to provide an accurate diagnosis and risk assessment, to inform the military occupational decision.
- Applicants can underplay their symptoms; decisions regarding challenge testing can therefore raise ethical dilemmas
- Food allergy is common, and anaphylaxis to foods is a barrier to entry. Some presentations such as mild pollen-food syndrome may be acceptable. Most cases, including patients with potentially resolved childhood food allergy, require detailed assessment including challenge testing where indicated.
- Anaphylaxis to key drugs used in military practice is a barrier to entry. Penicillin allergy itself, where not causing anaphylaxis, may not be a barrier to recruitment or retention.
- Venom anaphylaxis is generally considered a barrier to entry, even after successful immunotherapy.
- Allergic rhinitis is not a barrier to entry unless disabling.
- Assessment of asthma and dermatitis is complex, and best considered in conjunction with respiratory physicians and dermatologists respectively.
- Chronic spontaneous urticaria (CSU) requiring medication within 2 years is considered a temporary barrier to entry.

conditions in existing service personnel and potential recruits to the military, so they can provide the most effective clinical assessment to support the needs of the individual and contribute to a safe and helpful occupational health assessment by the armed forces.

The focus is on conditions primarily assessed by allergists, immunologists, or other specialists with expertise in assessment of these conditions (hereafter called the assessing specialist); brief comments on asthma and eczema are provided but as these often fall under the remit of respiratory medicine and dermatology they are not covered in detail. Not all conditions are covered to the same depth, as the assessment for some (such as food allergy) is often more nuanced than others (such as immunodeficiencies).

It is not intended to be a prescriptive guideline, as the issues involved are complex and each case requires a personalised approach. Anecdotally, assessing specialists are aware that the requirement to carry adrenaline autoinjectors constitutes a barrier to recruitment/retention, but often have little more knowledge of what the "red lines" are. The intention is therefore to help clinicians understand the unique and complex requirements of military service and to outline some broad principles of assessment. There is discussion of conditions frequently encountered in specialist practice, with comment on the specific considerations involved. It complements an updated medical policy from the UK Armed Forces [1]. The group also intends to publish a patient information leaflet in the future to support this work.

2 | Medical Considerations for Military Service

Military personnel must be medically fit to meet a variety of challenges both in daily employment and when they deploy on exercise or overseas operations. All service personnel carry out general service duties, as well as their specific trade duties such as drivers, medical officers, or musicians among others. There are many medical conditions which would have a negative impact on the individual's capacity to undertake the required service duties, and consequently a policy document, the Joint Service Publication 950 Medical Policy Leaflet 6–7-7; Joint Service Manual of Medical Fitness, (JSP 950 Lft 6–7-7) is available outlining the occupational medicine requirements. The document provides a framework for the medical assessment of functional capacity of potential recruits and serving personnel, and the outcome determines fitness for service [1]. In JSP 950 Lft 6–7-7 the impact of medical conditions is considered from the perspective of (a) recruitment and (b) in-service personnel.

Strict criteria apply to new applicants to the armed forces. The military may approach assessment of existing armed forces personnel who develop a new allergic condition whilst in service differently—the same broad principles apply, but sometimes more flexibility can be offered depending upon current and future service roles.

Box 1 describes the nature and conditions potentially experienced during military service, illustrating the requirement for significant flexibility in diet (in practice avoidance of foods is not possible), activities and exposures, and living in an austere environment without ready access to medical care. Assessment of potential allergic disease needs to accommodate these factors.

The medical standards described in JSP 950 Lft 6–7-7 apply to all UK Armed Forces (Royal Navy, Royal Marines, British Army, Royal Air Force; both the Regular and Reserve forces). Single services are permitted to set a higher standard in respect

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BOX 1 | Nature and conditions during military service in the UK armed forces.

Activities

- additional physical and mental demands for prolonged periods
- safety critical work such as weapon and machinery handling, therefore mitigating the risk of sudden incapacitation is important
- wearing standard uniform, including wool, leathers, synthetics, rubber/latex
- using relevant Personal Protective Equipment including, but not limited to: General Service Respirator (Chemical, Biological, Radiation, Nuclear [CBRN] environments), rubberised gauntlets (CBRN), Kevlar helmet, in/on-ear hearing protection, body armour
- exposure to environmental extremes such as temperature, dust, altitude, pressure, fumes, oils, vibration, noise

Locations

- worldwide – on land, in the air, at sea (including in submarines).
- remote locations which may make access to routine/emergency medical
- short notice tasking, which may interrupt treatment or review
- increased exposure to extreme environments: temperature, pollens, dust, fumes, etc.

Medical and logistic support

- austere environments and environmental extremes, hampering the ability to correctly store and resupply medication
- lack of cold storage for medication
- unpredictable or uncontrolled dietary provision with little or no access to alternative nutrition (operational ration packs are routinely available in standard, vegetarian, Halal, Sikh/Hindu and Kosher variants). Whilst there is a system for the labelling of allergens in dining facilities in the UK, this may not be the case in overseas locations where contracted catering, or the facilities of non-UK armed forces may be used.
- immunisation against worldwide diseases (offered but not mandated)

of specific employment types (e.g., aviation, diving). The UK Armed Forces are exempt from anti-discrimination legislation for the protected characteristic disability described in the Equality Act (2010).

3 | General Assessment of Military Personnel and Recruits

Box 2 provides the list of factors that a patient assessment can helpfully include in order to inform the military decision on employment risk. Providing this level of detail and discussion will usually require a thorough assessment of the patient by the assessing specialist, including skin prick, specific IgE, and/or challenge testing as appropriate. The military occupational medical team prefer a greater level of detail of assessment including as much information as possible, so they are fully informed when they make an operational decision regarding an individual's application or serving status. Clinical correspondence which contains at least the information in Box 3 is of particular use to the military occupational health team, although the greater the detail included the more helpful the letter is.

Avoidance of any statement that implies an outcome of military assessment, such as 'this person should be able to join the UK Armed Forces'.

There are some complexities in assessment which need to be considered when investigating military personnel who are often aware of the implications on their career of a positive diagnosis of an allergic disease.

BOX 2 | Factors to incorporate in a patient assessment to make inform employment risk.

Risk

- likelihood of incapacitation/death if untreated

Vulnerability

- integrity of dermal barrier
- severity of sensitivity

Treatment

- acute or prophylactic
- effects and side effects
- route of administration (oral, IM, IV)
- storage and supply (including fridge storage)
- effect of treatment gap due to loss of or separation from medication
- requirement for urgent pre-hospital care
- requirement for urgent evacuation to a medical facility
- requirement for urgent secondary care treatment (including type e.g. ED, ITU)
- requirement for routine secondary care review (including frequency)
- requirement for regular diagnostic testing (including bloods)

Co-factors

- diet (ingredient avoidance cannot be assured), including degree of sensitivity / effect of food processing such as grinding or cooking / cross-reactivity
- exercise (including after recent food intake)
- environmental temperature
- stress
- other

Prognosis

- likelihood of recurrence
- potential severity of recurrence

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BOX 3 | Minimum information to include in clinical letters.

- Symptoms – localised, systemic, severity, timing, complications, prognosis
- Testing undertaking and results (including any challenge tests)
- Diagnosis-including clear statement of whether or not the clinical presentation is anaphylaxis
- Allergen(s) identified
- Cross-reactivity and related exposures (if any)
- Allergen threshold required to elicit allergic reaction (if known), acknowledging the possibility of cofactors
- Treatment required (preventive, immediate, urgent) including clear statement of whether AAI required
- Implications of emergency or preventative treatment being unavailable
- Likelihood of treatment failure (e.g. refractory anaphylaxis)
- Frequency of assessing specialist follow up

Some individuals downplay the severity of their previous reactions or deny reactions entirely; or take antihistamines to try and minimise or prevent symptoms during a food challenge. While these are the very small minority the possibility of a misleading history being given needs to be considered (but not prejudged).

There are also ethical issues encountered during investigation. In ordinary practice a patient with an uncertain clinical history but strong sensitisation (e.g., peanut specific IgE > 15 kU/L and/or SPT > 8 mm) the assessing specialist may recommend avoidance on the basis that these results confer a high (> 90% and > 95% respectively) positive predictive value of reaction on exposure to peanut [2]. Food challenges pose an inherent risk of anaphylaxis, which may be severe, so the relative benefit of challenge from an occupational point of view (which may be different for serving military personnel than aspiring recruits, and be higher for occupational than lifestyle reasons) needs to be balanced against this risk. Adding to this evaluation is the presence of any other comorbidities or factors which may affect the military assessment and make a challenge irrelevant if they were precluded on another basis (such as severe asthma).

In practice there may be a lower threshold to undertake food challenges in view of the military implications [3], which may be appropriate, but the potential safety of this needs to be carefully evaluated by the clinician responsible for assessment. There is no absolute requirement to undertake challenge testing in order to advise on the level of risk for military recruitment and ongoing service if a considered clinical opinion can be formed on the basis of other assessments alone, and discussion with the military occupational medicine team may be helpful if the situation is complex.

The decision regarding recruitment and retention remains a solely military decision, and assessing specialists should avoid giving the individual any opinion or speculation about any decision the military may make.

4 | Assessment of Allergic and Immunological Diseases

Allergic diseases are a diverse group of conditions which present with immunologically-mediated symptoms in response to a variety of triggers. They include such conditions as asthma and eczema, rhinitis, urticaria and angioedema, anaphylaxis, and non-IgE-mediated conditions such as food protein-induced enterocolitis syndrome (FPIES) and eosinophilic oesophagitis (EoE). The prevalence of these is increasing rapidly worldwide, especially in children [4, 5].

Anaphylaxis is the most severe form of acute allergic reaction. Foods are the most common cause of anaphylaxis in children, with the greatest risk from food allergy being in teenagers and adults up to the age of 30; he causes of anaphylaxis in adults are more varied, with a greater proportion being due to medications and venom, the latter primarily from Hymenoptera insects [6]. IgE-mediated food allergy can also present with milder phenotypes.

Nut allergy, for example, can present in a number of different ways, ranging from the mild oral itch of pollen-food syndrome (PFS) to severe or fatal anaphylaxis [2]. Severe reactions tend to occur in children, whereas PFS generally starts in adulthood. Allergic reactions can vary in severity on different occasions within an individual, and predicting whether there is a risk of severe reaction is not always straightforward. Hospital-based challenges are not helpful at predicting the likelihood of accidental exposure in the community [7, 8], and there are a number of individual factors which can increase the severity of individual reactions, such as quantity of allergen ingested, nature of the allergen (e.g., roasted/cooked versus raw), asthma, vigorous exercise, risk-taking behaviour, alcohol ingestion, failure to carry adrenaline autoinjectors if prescribed, and delay in accessing emergency care [8].

In view of the high population prevalence of self-reported or confirmed allergic disease, especially in children, it is no surprise that many aspiring military recruits have a documented history of allergy or anaphylaxis in their primary healthcare record. In some circumstances the presence of allergic disease will adversely affect the individual's application and potentially result in rejection of their application. In personnel who are already serving, there may be consequences for employment, deployment and retention.

In this context, specialist medical assessment may be sought to clarify any relevant aspects that may have occupational implications. While assessments of allergic and immunological disease are routine practice for assessing specialists, there are aspects of military assessments with which assessing specialists may be less familiar. In 2018 the American Academy of Allergy, Asthma, and Immunology (AAAAI) Military Allergy and Immunology Assembly recognised that the United States (US) military requirements were not well understood by civilian and military health care providers and specialists, and as a

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result they hosted a panel discussion of the issues [3]. During the session there were discussions of military requirements, but also of 'real-life' cases. In the UK no such discussion or guide exists, and the purpose of this document is to outline the general military requirements and then apply them to IgE-mediated allergy as an illustration of the process.

Each case should be assessed on its own merits with a thorough clinical and investigative assessment, but there are some general principles which are helpful to understand when providing recommendations on different conditions. In the sections below we try to outline the general principles to be taken into account when assessing patients with suspected allergic or immunological disease.

5 | Food Allergy

IgE-mediated food allergy is one of the most common atopic disorders, affecting approximately 5% of children at up to 4 years of age, reducing to about 2.3% at 10 years, and increasing again to 4% at 18 years [9]. As the majority of individuals applying to join the military will be in adolescence or early adulthood any history of food reactions is likely to have occurred in childhood, so there is a need to determine whether the allergy has resolved.

A thorough clinical history is the cornerstone of an allergy diagnosis as it allows estimation of the pre-test probability for the individual patient and informs the selection and interpretation of the results of subsequent tests such as skin prick testing and specific IgE testing. The AAAAI Military Allergy and Immunology Assembly determined that sensitisation in an individual who can tolerate the food without symptoms meets the entry standard, so in the absence of a clinical history a food challenge may be required to demonstrate clinical tolerance of the food [3]. This may include individuals with pollen-food syndrome: whereas food challenges are rarely required in normal practice the small risk of anaphylaxis and the need to eliminate unnecessary dietary restrictions may necessitate observed challenge [10].

The BSACI has produced guidelines to a number of foods including peanuts and tree nuts, pollen food syndrome, egg, and milk, which help to provide a standardised basis for clinical assessment of these candidates, and where guidelines are not available in a particular case an analogous approach is usually taken [2, 10, 11, 12].

5.1 | General Principles in Assessment of Food Allergy

- In general a typical clinical history supported by the presence of sensitisation is sufficient to make a diagnosis of likely allergy and challenge is not required. The assessing specialist should not feel obliged to adjust this approach but they may choose to do so if there are other factors that influence the decision.
- A typical history of pollen food syndrome supported by appropriate sensitisation (including components in some cases) is usually sufficient to make a diagnosis of PFS. A detailed assessment, including the severity, risk of exposure, and an estimate of anaphylaxis or other complications will help the military make an appropriate operational decision, and oral food challenge may be considered.
- An atypical or uncertain clinical history requires investigation with appropriate skin prick and specific IgE testing, and if either is positive a hospital-based food challenge may be required to confirm tolerance. Occasionally individuals may downplan or underreport reactions, or claim tolerance despite sensitisation, but experience a systemic reaction with hospital-based challenge.
- Some units include co-factors in challenge test protocols; examples include exercise during or after the challenge doses, or administration of aspirin prior to the challenge. Our experience is that in some individuals this can provoke in mild systemic reactions that may have occupational implications in view of the demands of military service outlined above.
- A history or high risk of anaphylaxis, regardless of cause, has potential military retention implications and is usually a barrier to recruitment even if testing to all foods potentially implicated is negative and they have a successful hospital-based food challenge.

The clinical presentation of non-IgE-mediated or mixed IgE- and non-IgE-mediated food allergies is variable and marked by delayed gastrointestinal or cutaneous symptoms which remit with exclusion of the food and recur with reintroduction. Examples include FPIES, EoE, and atopic dermatitis. The majority of cases of FPIES occur in childhood and the majority resolve prior to adolescence; confirmation of tolerance can demonstrated via a graded challenge; the prognosis in adults is uncertain [13].

Individuals with eosinophilic oesophagitis may be accepted if symptom-free for a period of 1 year after completion of treatment [1]. Requirement for maintenance therapy is a preclusion even if symptom free for 1 year, due to the risk of recurrence of symptoms, including incapacitating food bolus, and serious long-term health risks of the underlying condition such as oesophageal stricturing.

Assessing specialists should follow normal pathways and guidelines; the military implications should not influence the management of the patient, although individual circumstances may be taken into account. A comprehensive description of the history, results, interpretation, and justification for the clinical recommendations is valuable to the military occupational health team regardless of whether a challenge was undertaken.

Generally, from the military perspective, a history of anaphylaxis to food who are advised to carry adrenaline autoinjector(s) precludes recruitment/retention. For mild to moderate food allergy, without anaphylaxis, applicants may be accepted if symptoms are not disabling, can be controlled with over the counter medication, and do not require deliberate avoidance of the allergen. Where these criteria do not apply, the default position is that the applicant is not fit for service, but in this situation a decision influenced by a clinical assessment with analysis of risk.

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6 | Drugs and Vaccines

The UK Armed Forces has a standard set of drugs it administers (either for prophylaxis or as part of patient care pathways). Allergy or contraindication to any of these may impact recruitment and retention. A history of immediate or delayed drug hypersensitivity is assessed and managed through a comprehensive history supported by skin or serological testing as appropriate. Following this an opinion can be given regarding the likely risk and consequence of reactions on re-exposure to the specific or related drugs.

Penicillin is an important antibiotic widely used in the military setting. In the US, studies have shown that penicillin delabelling in military recruits is safe and effective, however this not currently offered for all recruits. Penicillin allergy is not an automatic preclusion to recruitment or retention as the UK military has alternative antibiotics if required. However, quinolones are used in prevention and treatment of biological attacks and, while alternatives may be available, confirmed allergy would require individual military occupational health assessment.

There are also some drugs with which assessing specialists may be less familiar, and as they are only used in specific circumstances they are likely to be more relevant to existing service personnel rather than new recruits. Pyridostigmine is used in the military context to mitigate the impact of nerve agent exposure; allergy or contraindication to this drug is likely to prevent deployment in service and preclude recruitment. Similarly, the treatment following chemical attacks is primarily with pralidoxime, atropine, and avizafone/diazepam so confirmed allergy or contraindication to these would require military occupational health assessment regarding fitness for service/deployment.

A history of latex allergy with ongoing evidence of sensitisation would usually preclude recruitment and retention. Vaccine allergy may have occupational implications, although in many cases the vaccine may not be required again (e.g., in cases where the full course has been completed and no booster dose will be required). In some cases the required dose(s) could be administered as a graded dose challenge to exclude allergy, or in the rare cases of true vaccine anaphylaxis desensitisation protocols have been published that may allow administration [14].

Anaphylaxis to opiates (morphine in particular) or a clear history of hypersensitivity following single or multiple non-steroidal anti-inflammatory drugs (NSAIDs) may prevent recruitment or retention. Where the history is less certain investigation via oral challenge to the index drug using standard protocols may be required. Note that some common comorbid conditions (such as asthma) may have their own implications for military service and need to be considered when deciding whether or not to undertake a challenge, especially to NSAIDs.

7 | Venom Allergy

Insect venom reactions in the UK are most commonly due to bees and wasps, and minor local reactions to stings are normal and do not warrant any testing or specific treatment. The prevalence of large local reactions (LLR) is up to 26.4% of the general population; and systemic reactions (SR) occur in up to 7.5% of the general adult population and 3.4% in children [15]. In the absence of other risk factors, individuals with a history of LLR have a low risk of subsequent SR, so no further testing is needed and there should be no implications for military service.

Patients with a history of SR should be investigated according to guidelines and offered venom immunotherapy (VIT) if appropriate [16]. At present in the UK the only licensed VIT products are Alutard Bee and Wasp Venom, which can be initiated via weekly doses for 7-weeks, 15-weeks, or 25-weeks depending on risk and is then continued every 6–8 weeks for 3–5 years [17]. VIT is effective in preventing SR to wasp venom in 95%–100% of patients and bee venom in 80%, although the BSACI guideline recommends individuals continue to carry adrenaline autoinjectors (AAIs) if they have continuing risk of multiple stings, if they experience allergic reactions during VIT, or if they have a raised baseline mast cell tryptase or mastocytosis [16].

Cases where the sting reaction occurred elsewhere in the world are more difficult. Honey bee (*Apis mellifera*) and common wasp (*Vespula* spp.) products are routinely available in the UK, but most UK centres will not have access to products available elsewhere in the world for skin prick testing or immunotherapy for insects such as paper wasps (*Polistes* spp.), bumblebees (*Bombus* spp.), fire ants (*Solenopsis invicta*), or jumper ants (*Myrmecia pilosula*) [15]. For some insects there may be no suitable product at all.

In general, a history of venom anaphylaxis, even after completion of immunotherapy, would preclude recruitment as long-term efficacy is unpredictable. The outcome for serving personnel will be a military decision, taking into account a number of different operational factors.

8 | Allergic Rhinitis

Allergic rhinoconjunctivitis (hayfever) is common. For most it is a minor irritation but for some it can reduce quality of life significantly, including effects on sleep, vision, athletic performance, and cognition; in some cases, this may pose a barrier to recruitment or retention if severe. In general, if reliance on medication is absent or low, the deliberate avoidance of the allergen is not required, and the candidate has mild symptoms (manageable with over-the-counter treatments and able to miss doses without disabling effects), they may be accepted. There is a large degree of variability between patients so providing individualised advice is important for the military to make an informed decision.

Aeroallergen immunotherapy can reduce symptoms if severe, according to product licence and commissioning. Some products are available but not licensed or commissioned and there should be no pressure to treat with these products because of the military implications.

9 | Spontaneous Urticaria/Angioedema/Anaphylaxis

Chronic spontaneous urticaria (CSU) refers to patients with urticaria and/or angioedema occurring on most days for at least

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6 weeks. The condition can have a significant impact on quality of life in large part due to the pruritus and unpredictable nature of exacerbations [18].

CSU requiring regular medication is normally a barrier to recruitment. In contrast to many allergic or immunological disorders JSP 950 Lft 6-7-7 provides specific guidance with regard to CSU, specifying that candidates requiring treatment are considered unfit for service, but those whose CSU has 'fully resolved and free from treatment for 2 years' may be accepted [1]. Candidates with a history of physical urticaria (e.g., to heat, cold, physical exercise, or sunlight) are not fit for military service as those triggers are common and not easily avoided [1]. There can be significant uncertainty about how reproducible these triggers might be for the individual, and clearly the outcome for serving personnel will be a military decision taking into account a number of different factors.

Idiopathic anaphylaxis (IA) poses a greater difficulty due to the unpredictable nature of the episodes and lack of avoidable trigger. In these patients, particular attention needs to be paid to whether the diagnosis of anaphylaxis is correct, and if so whether there is an identifiable cause that can be avoided. AAIs are routinely prescribed and in most cases are not actively discontinued for some years due to prognostic uncertainty regarding frequency and severity of episodes, even after a prolonged period with no symptoms. Some authors suggest that there is a remission rate after a few years of 90% with frequent (at least two episodes in the previous 2 months or at least six episodes in the preceding year) and 65% with infrequent (not meeting the above criteria) IA but there have been advances in diagnostics since then and the clinical profile of individual cases is different [19].

An assessment of a military patient with IA will usually involve a comprehensive description of the case with a nuanced narrative opinion giving overall estimates of risk rather than a specific prognosis; it is then up to the military to make a risk-informed operational decision on recruitment or retention.

The assessment of acute spontaneous/idiopathic angioedema will require a blend of the approaches to CSU and IA depending on the frequency, location, severity and severity of urticaria and angioedema, and any comorbid symptoms or conditions.

10 | Asthma

Whilst asthma is considered as an allergic condition, in fact it is better considered as a chronic inflammatory disorder where allergen exposure is one of a number of potential triggers. Detailed assessment of asthma diagnosis is outside of the scope of this guidance and is covered in the respiratory section of JSP 950 Lft 6-7-7. In most cases, an assessment for suitability for a subject with asthma should be performed by a respiratory physician. For allergists and immunologists asthma may exist alongside other allergic comorbidities and may be a factor to include in the overall assessment of fitness.

The following features would generally preclude recruitment and retention:

- Current asthma-like symptoms (including exercise-induced)
- Diagnosed asthma who have experienced symptoms and/or have been prescribed any treatment for asthma in the preceding 1 year
- Occurrence of more than five acute episodes of asthma-like symptoms requiring primary healthcare intervention after the age of 3 years
- Requirement for specialist/secondary healthcare management of asthma

The assessing specialist may identify allergens, such as animal dander, that have the potential to act as triggers for asthma, and if exposure to these are possible during active service this should be mentioned as part of a risk assessment. This could be relevant for instance where asthma has not been active for over a year, but the exposure to the allergen has not occurred.

11 | Atopic and Contact Dermatitis

Like asthma, atopic and contact dermatitis are chronic inflammatory disorders for which allergen exposure is one potential trigger. Detailed assessment of dermatitis is outside the scope of this guidance and is covered under the dermatology section of the UK Armed Forces guidance. Assessment is usually undertaken by dermatologists, although it may co-exist with other allergic disorders and factor into the overall assessment.

Active dermatitis would normally preclude recruitment or retention. The requirements relating to those with a history of dermatitis is complex. However, the principles are that candidates would usually be considered unfit for recruitment or retention if their history is of:

- Dermatitis affecting the hands
- Requirement for secondary care outpatient or inpatient care
- Requirement for immunomodulatory or phototherapy
- Functional impairment such as difficulty with school/work, sleep disturbance, restriction in clothing or footwear due to dermatitis
- Irritant dermatitis on exposure to oils, greases or detergents.

12 | Immunodeficiencies

Candidates with other immune system conditions that make the candidate more vulnerable to developing infection are usually not acceptable for military service due to the risks of infection in the course of military service. However, a diagnosis of human immunodeficiency virus (HIV) in itself is no longer a barrier for recruitment and subsequent service, provided the condition is stable, and CD4 and viral load requirements are met.

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13 | Conclusion

Clinical assessment of potential military recruits is a complex process, for allergic and other medical conditions. Clinicians should follow usual standards of clinical assessment, history taking, review of relevant documentation, and investigation. Alongside this, particular attention should be paid to the special requirements of military service, especially factors such as challenging environments and exposures, inability to control or restrict diet, and lack of access to specialist care. Assessing specialists must balance the pressure to investigate that may result from the individual's aspirations with the risks of those investigations, and the military requirements described above. The assessment should provide a detailed clinical picture and review of investigations, which then supports a detailed assessment of current and future risk, rather than an opinion on whether an individual is suitable for service. Crucially, assessing specialists must understand that the final decision rests with the military as part of an operational occupational health assessment.

Author Contributions

A.F.W., H.S.J., and S.N. drafted the manuscript, K.W., A.P. and M.Y. provided military advice, all other authors reviewed and approved the manuscript.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

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