Australian Paediatric Society

APS ALLERGY MASTERCLASS WORKSHOP

EVENT PROGRAM

THE LANGHAM, MELBOURNE – 4TH MAY 2024

Welcome

Dear Colleagues,

The Australian Paediatric Society (APS) welcomes you to the 7th Annual APS Allergy Workshop!

Our 2020 workshop was held face to face just prior to Covid restrictions. We have been lobbied to resume our case-based workshop as a collegiate meeting with networking opportunities. Our new challenge is to add a hybrid virtual attendance format to increase accessibility for those restricted by on-call obligations, remoteness, cost, or family commitments.

The APS is an active participant in the National Allergy Council (NAC) initiatives to deliver quality allergy services in rural, regional, and suburban Australia. We collaborate with RACGP and ACRRM through the NAC to facilitate that aim and plan to learn from each other, share resources, and continue to build a "Rural and Regional Clinal Allergy Network." You will hear more about the "R2CAN" over the next year!

We acknowledge and appreciate the input of our speakers who have given up time and part of their weekend to increase the knowledge and perspectives on various aspects of allergy of those who work at the clinical coalface.

The workshop would not be possible without the support of our sponsors. We acknowledge and thank our Gold Sponsors Sanulac, Stallergenes-Greer, Ego Pharmaceuticals, CSL Sequirus and Nestle Health Sciences, and Silver Sponsors Viatris and Arrotex. Please visit the sponsor displays on site and read about their new products in this booklet.

We express our appreciation to Gary Smith, Armchair Medical, for assistance with the virtual and recording component of the program.

I thank my fellow participants on the organising Committee - David Bannister and Mike Nowotny. We invite you all to submit ideas, speakers (including yourselves) to continue to produce such a collegiate and successful workshop!!

Thank you all for again committing and contributing to the 7th Annual APS Allergy Masterclass workshop to produce the best possible outcomes for children with allergy!

Peter Goss

Chair APS Allergy

PROGRAM

4th May 2024

9.00am	Management of Nut allergy	Tim Brettig
10.00am	The Future of Food Allergy	Kirsten Perrett
10.50am	MORNING TEA	
11.10am	The Spectrum & Management of Cows Milk Allergy	Paxton Loke
12.00am	Principles of Successful Eczema Management	Rod Phillips
12.50pm	LUNCH	
13.30pm	Interesting Allergy Cases	Mike Nowotny
14.00pm	Urticaria and Angioedema- a Practical guide	Sam Mehr
14.50pm	AFTERNON TEA	
15.10pm	Atypical Food Reactions	Vicki McWilliam
16.00pm	Sublingual Immunotherapy is Underused	Peter Goss

Cases

PRESENTATION 1:

Management of Nut Allergy

Tim Brettig

CASE 1: CASHEW

9 month old girl, eczema from 2 weeks old. First exposure to cashew butter (1teasp) Within 5 minutes, facial swelling, rash, coughing, short of breath and wheezing, lethargic and floppy. Ambulance attendance, given Claratyne, taken to ED, improved.
SPT at one year of age. Histamine 3mm. Cow milk 0mm. Egg White 4mm. Peanut 0mm. Cashew 3mm. Pistachio 3.5 mm..
Review at 2 years SPT Histamine 5mm Egg White 0mm. Cashew 0mm, Pistachio 0mm

QUESTIONS

1. *Should the child be challenged with cashew or pistachio? If so, where?*
2. *Likelihood of growing out of tree nut allergy?*
3. *Is it worth repeating SPT or performing ssIgE to cashew/ Component testing?*
4. *How useful/reliable are blood tests.*

CASE 2: PEANUT SENSITISATION

16-year-old boy. Severe eczema. Asthma unstable. Flixotide 125ug/ day.Positive SPT to cow milk, egg, wheat at 6 months. Advised to avoid all nuts.
Cow milk goat milk exposures caused generalised hives, lip swelling and vomiting. Treated with antihistamine. Scrambled egg exposure caused hives and vomiting. Tolerating wheat but no nut exposures for 16 years.
SPT Histamine 5mm. Cow's milk 9mm, Egg white 11mm, Peanut 20mm (ssIgE 10KU/L)

QUESTIONS.

1. *How do you manage which nuts can be introduced into his diet?*
2. *What is the prevalence of peanut and tree nut allergy and is it increasing?*
3. *What are the commonest tree nut allergies and when do they usually present?*
4. *Should we specifically test closely related nuts (pistachio / cashew, pecan /walnut) or avoid both after a reaction to one?*
5. *Likelihood of tree nut allergy if allergic to peanut, sesame and egg?*

PRESENTATION 2:

The Future of Food Allergy

Kirsten Perrett

CASE 1: 12-year-old girl with history of peanut allergy. Reacted at 2 years of age with urticaria of face and angioedema of lips. No respiratory or CVS involvement.
Mild eczema. Infrequent episodic asthma.
Peanut SPT at 2 years = 15mm (ssIgE 15KU/L) and at 12 years = 18mm (ss IgE 21KU/L).
Tolerates all tree nuts and all other foods.

QUESTIONS:

1. *What is the likelihood of outgrowing her peanut allergy?*
2. *What do you see as viable interventions in the future - will desensitisation programs be the answer?*

CASE 2: A 7-month-old boy, on first exposure to quarter teaspoon of peanut butter, developed immediate hives, irritability, and vomiting. No respiratory or CVS involvement. History of mild, well controlled eczema from 3 months. SPT peanut 4mm. (ssIgE=0.9KU/L)
Has not been exposed to another nuts. Tolerates egg, wheat, dairy, fish, vegetables, and fruits.

QUESTIONS.

1. *Is it likely that this boy may be a candidate for an early desensitisation program?*
2. *How do you see such a process for such a patient evolving for regional children?*

Cases

PRESENTATION 3:

The Spectrum and Management of Cows Milk Allergy

Paxton Loke

CASE 1: 8-month-old breast fed boy was given 20ml of a cow milk formula supplement with immediate urticaria, lip swelling and vomiting without breathing difficulty, cough, or wheeze. Mild eczema from 4 months. Solids from 6 months. Tolerates all other foods including egg, peanuts, and tree nuts. SPT 8mm to cow's milk at 10 months (ssIgE 5KuU/L).

QUESTIONS:

1. *What is your suggested management?*
2. *When would you recommend to re-test /re-challenge?*
3. *What is the natural history of IgE mediated cow milk allergy and development of tolerance?*

CASE 2: 12-month-old breast fed girl. Irritable, crying, vomiting excessively from 2 months. Frequent (x8) loose stools with mucous and occasional specks of blood. Mild truncal eczema.At 3 months, on MCHN advice, dairy products removed from maternal diet with complete symptoms resolution. Tolerates all other foods.Mother challenged with cheese and yoghurt at 10 months with immediate return of GIT symptoms and eczema flare. SPT 0mm to cow's milk extract (ssIgE 0.05 KU/L). Bf planned for further 6 months.

QUESTIONS:

1. *What is the natural history of non-IgE Cow milk allergy?*
2. *When and how should re-introduction of dairy products be attempted?*
3. *What are alternative supplementary milk sources?*
4. *Does mother need dietary assessment?*

PRESENTATION 4:

Principles of Successful Eczema Management

Rod Phillips

CASE 1: 7-month-old boy with facial eczema from 3 months, extending over months to be generalised, with weeping crusty areas and inflamed cradle cap. Baby irritable but growing well. Eczema not responding to 1% hydrocortisone cream applied sparingly as per pharmacist instructions. Breast fed on limited solids. (vegetables and fruits). Otherwise growing well.

QUESTIONS.

1. *Your suggested management?*
2. *Any investigations likely to be helpful or useful?*
3. *What is the likely outcome for the eczema at this age?*

CASE 2. 7-year-old girl with chronic, mainly flexural eczema but also on her trunk and limbs. Improved with Advantan Fatty Ointment daily but never completely cleared with eczema flares once topical steroid is stopped. Otherwise growing well. No asthma /allergic rhinitis and no obvious symptoms with food.

QUESTIONS:

1. *How would you manage this girl?*
2. *What are the likely/possible triggers to consider?*
3. *Are any investigations likely to be helpful?*

CASE 3: 12-year-old boy with chronic, persistent, generalised eczema since 18months.

Several courses of antibiotics for superimposed infection which assist for 7-10 days. Responds poorly to various topical steroids but did briefly clear on two occasions when prescribed oral steroids.

QUESTIONS:

1. *How would you manage this child?*
2. *Would he be a candidate for Dupilimab treatment or another immunosuppressant?*
3. *How can the paediatrician assist the work up for Duplimab*

Cases

PRESENTATION 5:

Alleged Penicillin Allergy

Mike Nowotny

CASE 1: 6-year-old noted incidentally to have "Penicillin allergy" on medical record. Mother recalls at about 13 months age, high fever for 3 days and prescribed Amoxyl for "slight" ear infection. Rash appeared all over her body the following day. Not urticaria. Advised to stop amoxyl because probably allergic. Rash resolved over next 2 days.

QUESTIONS:

1. *Is amoxycillin allergy likely in this child?*
2. *When labelled "penicillin allergic" should all penicillins and cephalosporins be avoided?*
3. *Are blood tests or skin prick tests helpful?*
4. *What action should be taken?*
5. *If the child has immediate urticaria and lip swelling, would the management be different?*

CASE 2: FRESH PINEAPPLE REACTION

A 15 year old girl complains of mouth itch and tongue tingling every time she eats fresh pineapple though she has no problem eating Hawaiian pizza with pineapple. A similar mouth reaction occurs with melons. Has significant seasonal allergic rhinoconjunctivitis symptoms from August to January. Persistent asthma, worse in spring.

QUESTIONS:

1. *Is this dangerous and will it go away?*
2. *What tests may be helpful?*
3. *Will immunotherapy help this condition?*

PRESENTATION 6:

Urticaria and Angioedema - A Practical Guide

Sam Mehr

CASE 1: A previously well 10-year-old girl has a 9-month history of daily generalised urticaria. Spontaneously onset with no obvious trigger. Flares with heat, stress and intercurrent illness. Occasional swelling of lips and fingers.

Symptoms reduce but not cleared with standard recommended doses of antihistamine (Zyrtec) twice daily. Her skin is constantly itchy and annoying. Missed 8 days school related to swelling.

QUESTIONS:

1. *What is our understand of the cause of Chronic Spontaneous urticaria?*
2. *Are any investigations useful?*
3. *How would you manage her?*
4. *Is she a candidate for Xolair?*

CASE 2: A 12-year-old boy develops small itchy welts all over his body when he swims in the surf lasting about 30 minutes. On one occasion he felt very dizzy and almost fainted as he exited the surf. No symptoms when swimming in a heated pool. Similar symptoms on his face only when he visited the snowfields.

QUESTIONS:

1. *How do you manage this condition?*
2. *How long will it last?*
3. *Are any investigations useful?*

CASE 3: A 4-year-old boy woke on 2 occasions 4 weeks apart with unilateral (left) eye swelling. Lasted about 6 hours and responded to antihistamine. No urticaria, no family history of swelling. Perennial rhinitis symptoms overnight. Cat in the house but not in the bedroom.

QUESTIONS:

1. *What is the likely diagnosis and prognosis*
2. *Are any investigations useful?*

Cases

PRESENTATION 7:

Atypical Food Reactions

Vicki McWilliam

CASE 1: 7-year-old boy. For the past 6 years, eating anything red leads to rapid hiveswithout swelling or respiratory problems. Worsened over last12 months with several episodes of hives, swelling lips and abdominal pain.

Foods include red capsicum, strawberries, raspberries, red apples, tomatoes, cherries, tomato sauce, sweet chilli sauce, plus banana lollies, multi coloured snakes. Cetirizine 5mls helps

Family History: Mastocytosis / Mast cell activation syndrome / Hereditary alpha tryptasaemia. Tryptase 5.5 ug/l (<11.4)

CASE 2: 13 year old girl - Four months ago, ate previously tolerated Sanatarium cereal then began vomiting, itchy rash on trunk, arms and face. Developed swollen face, slight cough but no wheeze. Assisted by Claratyne 5ml.

Puffiness gone by next day, vomiting settled quickly but rash lasted for about a week.

3 months ago, consumed a bubble gum flavoured milkshake, Rapid onset vomiting and rash, settled with Claratyne.

2 months ago, drank raspberry lemonade and fish and chips then immediately developed generalised itchy rash. Given Claratyne. Several hours later, began vomiting, coughing, wheeze and had difficulty breathing. Given Claratyne and ambulance called. Obs stable and breathing better.

Now avoiding artificial colourings and flavourings (especially 120 and 160)

QUESTIONS:

1. *How common are colouring reactions?*
2. *What chemicals are implicated?*
3. *Is it a dose related effect?*
4. *What kind of reactions can occur?*
5. *Do children outgrow reactions or can they become worse?*

PRESENTATION 8:

Sublingual Immunotherapy is Underused

Peter Goss

CASE 1: 12-year-old boy with school problems – underperforming, poor concentration, lack energy, lost interest in sport -ADHD? Psych issues? During discussion, noted open mouth posture, nasal speech, nose congested, frequently rubbing nose and sniffing. Also, history of nocturnal cough, sneeze, multiple tissues. Tried antihistamines without success. Does not like nose sprays. No seasonal hay fever.

QUESTIONS:

1. *What further assessment should be undertaken?*
2. *What is first line therapy?*
3. *Is SLIT an option?*

CASE 2: 8-year-old girl, dreads spring because of severe hay fever - nasal itch, congestion sneezing. eye itch weeping swelling. Well at all other times, no asthma usually but wheezy in spring. Missed 14 days school last spring. Uses antihistamine most days in spring but does not want to "become immune" to it – swapped Zyrtec to Claratyne to Aerius

QUESTIONS:

1. *What investigations and management should be undertaken*
2. *Are there alternatives like SLIT and how should we go about considering those alternatives?*

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