Allergy Today

Allergy UK's publication for healthcare professionals

Winter 2021/2022

AllergyUK

Allergy News - Report on the National Allergy Crisis
Articles on Atopic Dermatitis and the Psychosocial and physical impacts of peanut allergy

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AllergyUK

Allergy UK is the operational name of the British Allergy Foundation. We are the leading charity for people living with allergic disease, providing support and advice about all kinds of allergic conditions. We act as the 'voice' of the millions of people who live with allergies, representing the concerns and healthcare needs of those affected by this multi-organ disease.

Our strategy for the next five years is centred on a new Mission:
"For everyone in the UK to take allergy seriously"

With our Vision that:
"No-one should die from allergy"

The allergic community is at the heart of everything that we do and our work is focused on improving the lives of people who live with allergic disease.

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Foreword

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Welcome to this edition of Allergy Today.

This is the third edition of Allergy Today which has been published in the time of Covid-19 and I am writing this Foreword as the path of the pandemic becomes even more uncertain with the arrival of the Omicron variant. In response, the government is speeding up and extending the vaccination programme by offering all adults in England a booster jab and halving the gap between second doses and boosters in a bid to avoid a further significant wave of infection.

For many people with allergic conditions vaccination is a matter of much concern and they struggle to find the information they need about the types of vaccines available to them. Understandably this means that they are reluctant to have a vaccination and fearful of the possible consequences, thereby missing out on the opportunity to protect themselves from serious infection. Their first port of call is, of course, their GP and over the months it has become clear that GPs also need support in providing accurate information about vaccinations to those living with allergic conditions. Just recently the BSACI has published the guidance and help that GPs will find valuable in advising their patients, and the patient charities continue to work with the BSACI to respond to the information needs of both those living with allergy and their GPs at a time when vaccination is so important.

The broader need for better care for people living with allergic disease was spelled out very clearly in October in the new report form the All Party Parliamentary Group for Allergy and the National Allergy Strategy Group, entitled Meeting the challenges of the National Allergy Crisis. Despite a series of reports over the years highlighting the need for a national allergy strategy, little has changed and allergy remains an under resourced service within the NHS, despite the fact that around 21 million people in the UK are living with allergy, with more than five million of these severe enough to require specialist care. The presentation of this report to the Minister of State for Care and Mental Health, Gillian Keegan, by a young allergy sufferer marks the beginning of increased lobbying and representation to our health services to take action and recognise the true burden that allergy can place on individuals and their families.

This edition of Allergy Today includes an article on the psychosocial and physical impact of peanut allergy, highlighting very clearly the significant burden that a food allergy has on an individual and their family and its impact on quality of life and mental health. I hope you will find this and all the articles in this new edition of Allergy Today interesting and thought provoking.

Welcome

The value of our Helpline and our wide range of resources and information has never been more evident than it has been over the last couple of years. Covid-19 has taken its toll on everyone and for people living with allergy it has presented challenges around isolation, delayed or cancelled appointments and limited access to their GP. As the leading patient charity for this health condition, we have consistently been a voice at the end of the phone and a provider of support and guidance, particularly around issues such as comparative symptoms and vaccinations. Anxiety is the common thread between people with all kinds of allergy and our Helpline team, supported by our Clinical team, have answered hundreds of calls, responding with information and support when these callers need it most.

Inevitably, the pandemic has prompted a change in the way that we disseminate our resources – our highly respected Masterclasses are now presented as webinars and new resources, such as videos and podcasts, have replaced some of our printed materials. Our Masterclass programme for 2021 has now been completed with seven events during the year and our programme for 2022 will be published soon. This autumn also saw the launch of our new website, already attracting over 80,0000 visitors every month and hundreds of downloads of Factsheets and other materials. We have made all our resources as easily accessible as possible so that Factsheets, for example, can be easily found on topic pages and the user journey is simplified.

Allergy Today remains a key priority for us for the provision of up to date and relevant information on all kinds of allergy for health professionals, all written by experts in their fields. Atopic dermatitis, the psychosocial impacts of peanut allergy and information on the new food labelling legislation all feature in this edition, which we hope you will find interesting and informative.

Carla Jones, CEO

Amena Warner, Head of Clinical Services

Allergy News

National Allergy Crisis Report

In October the All Party Parliamentary Group, in conjunction with the National Allergy Strategy Group (NASG), launched a new report entitled "Meeting the Challenges of the National Allergy Crisis". The report calls for an influential lead for allergy to be appointed who will implement a new strategy to help the millions of people across the UK whose lives have been affected by allergic disease.

Over the last two decades a series of reports have reviewed the prevalence of allergic disease and the consequent patient and service provision need and this new report again highlights the continuing shortfalls in the provision of NHS services for people with allergic disease.

Four key recommendations for action are highlighted:

- The requirement for a National Plan for Allergy
- The expansion of specialist care, with training programmes to ensure that specialists of the future are appropriately trained
- The need for GPs and other healthcare professionals to be more informed about allergic disease (8% of GP consultations are for allergy)
- The requirement for local commissioners to ensure access to paediatric and adult allergy consultants and pathways to care.

Representatives from Allergy UK and Anaphylaxis Campaign, together with families and friends whose lives have been impacted by allergy gathered at the Department of Health headquarters for the presentation of the report to Gillian Keegan, Minister for Care and Mental Health. Nine-year-old Arlo Gillard-Moss, an Allergy UK Child Hero, presented the report to the Minister "on behalf of all of those whose lives have been impacted by allergic disease".

(The National Allergy Strategy Group is an alliance of the British Society for Allergy and Clinical Immunology and patient charities Allergy UK and the Anaphylaxis Campaign)

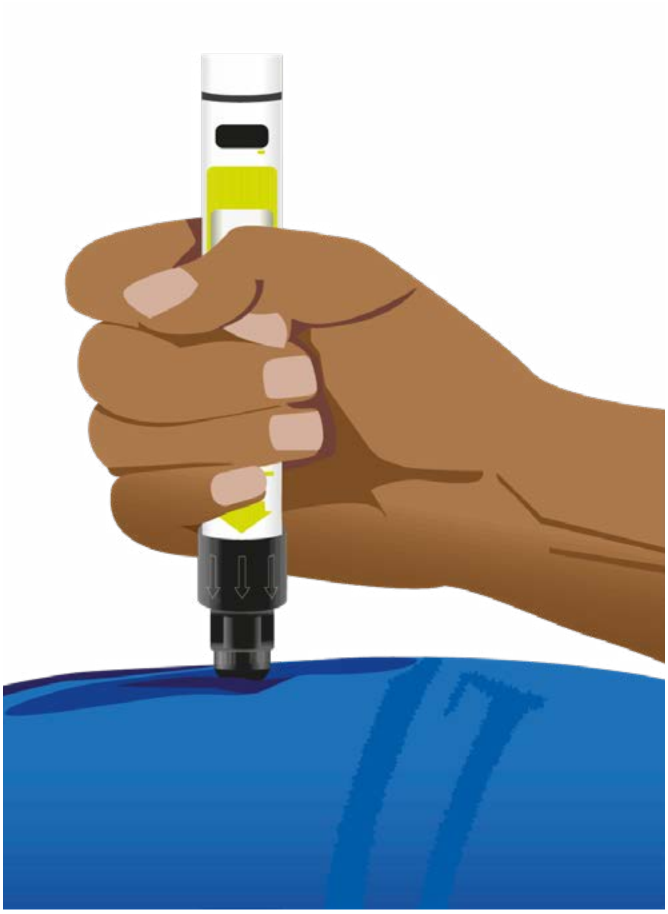
CHM report on the use of AAIs

In November the Commission on Human Medicines published its report on the use of adrenaline autoinjectors, outlining recommendations for the safe and effective use of AAIs to help save lives. The report included guidelines on the use of an AAI in an emergency and the recommendation that people who could have an allergic reaction should carry two adrenaline auto injectors at all times. It also highlighted the importance of being familiar with how to use an AAI, particularly as each of the brands is used differently. The Medicines and Healthcare Products Regulatory Agency (MHRA) is taking forward these recommendations, some of which are already in place.

The report also progressed the discussion on making adrenaline autoinjectors available in public places, noting that a public consultation will be needed before a decision could be made, along with legislative change. Allergy UK's CEO Carla Jones was a member of the

Expert Working Group which produced this report which comes as a result of the most thorough and rigorous scientific review of the use of AAIs.

Commenting on the launch of the report she said: "It was a privilege to be a member of the Expert Working Group which produced this important report for our allergic community. Its recommendations are absolutely fundamental in improving the understanding and use of AAIs – the first line of treatment for someone experiencing anaphylaxis, a condition which can be unpredictable and fatal.



Not Just Skin Deep...

This is the title of a new report from Allergy UK, produced in partnership with Sanofi, which reveals the distress, both physical and psychological, experienced by those living with atopic dermatitis (moderate-to severe eczema).

The report, based on a survey of both patients and healthcare professionals, highlights variations in waiting times across the country, negative mental health impacts and disruption to work and daily life. It presents actionable healthcare solutions to address the issues faced by patients living with this skin condition and improve lives. A key recommendation in the report is for NICE to prioritise the development of standardised adolescent and adult guidelines for eczema patients.

While many of the issues raised in the report existed before the Covid-19 pandemic almost half of the patients surveyed (46%) said that Covid-19 had made it even more difficult to access services and treatments. This new report comes four years after 'Seeing Red -Getting Under the Skin of Adult Eczema', and it reiterates many of the issues identified in 2017.
Allergy UK CEO Carla Jones commented: "The impact that moderate to severe eczema can have on a person's life is laid out in this new report in stark terms. As the leading patient charity for people with all kinds of allergic conditions we are committed to working for the changes that people with eczema need to help improve their lives." Read the report here: https://www.allergyuk.org/news/not-just-skin-deep-getting-under-the-skin-of-eczema/

To download past editions of **Allergy Today** please visit our website **www.allergyuk.org**

ATOPIC DERMATITIS

By Lokapriva Ananthan

Lokapriya Ananthan is a dermatology registrar at St Woolos Hospital, Newport.

She completed her undergraduate medical degree at Sri Ramachandra Medical College and Research Institute, Chennai, India. Following which she pursued an MSc in Clinical Dermatology from Cardiff University in the UK. In addition Lokapriva also attained a full MRCP degree and is now a Member of the Royal College of Physicians, London. Her aim is to attain a national training number in Dermatology over the next year and become a consultant in Dermatology within the next four to five years. Her interests include fitness, fashion, art and travelling to explore the world.

Atopic Dermatitis is a highly pruritic, chronic inflammatory skin disease frequently seen in patients with a history of allergy. This particular skin disease affects up to 20% of children worldwide & can persist into adulthood[1]. More than 50% of patients develop asthma & other atopic disorders[1] . Prevalence of atopic dermatitis varies. Areas of high prevalence include countries like Nigeria, United Kingdom and New Zealand followed by Latin America. Higher socioeconomic status, higher level of education in a family, smaller size of family and urban environment are a few risk factors associated with increased prevalence. Allergic reactions play an important role in a few patients. In many others factors such as disturbance of skin function, infection and stress are more relevant. Recently, it has been postulated that filaggrin deficiency is crucial in the disease initiation.

PATHOGENESIS OF ATOPIC DERMATITIS (AD). OUTSIDE-IN : INSIDE-OUT THEORY

Etiological Factors:

1) **Environmental factors** play an essential role in AD. Infection caused by Staphylococcus aureus, use of soap, dry weather, house dust mite, stress etc. exacerbate symptoms of AD[13].

2) **Microbiological influence** - House dust mites and staphylococcus aureus produces exogenous protease .It induces Thymic Stromal Lymphopoeitin (TSLP) from keratinocytes, which drives the CD4+ to favour T-Helper 2 (TH2) inflammatory response in addition to breaching the skin barrier. TH2 activity includes secreting cytokines involving IL4, IL5 and IL3 feeding the atopic features of the inflammatory skin disease. These proteases also activate protease activated receptor-2 contributing to allergic condition such as AD and asthma. Furthermore, inflammatory mediators such as IL4, IL17, IL22, IL25 and IL31 can compromise filagrin synthesis and cell-to- cell adhesion, destroying the skin barrier.

3) **Alteration of pH** - Overuse of detergents, soaps, or even water can disrupt the physiological acidic skin condition. This interferes with the equilibrium, as alkaline pH would lift the inhibition of the protease, which thereby leads to the breaking down of corneodesmosomes creating gaps between the skin barrier. Furthermore, alkaline pH also promotes the release of proinflammatory cytokines such as IL1 alpha and IL1 beta, which will drive the inflammation of the skin. Normal physiological process can lead to initiation of dermatitis in those who is genetically predisposed. This is typically seen in patients with facial eczema with alteration of pH by mildly basic saline, breast milk and food material. Aqueous cream used in early days of AD containing sodium lauryl sulfate can also worsen AD by reducing filaggrin level.

4) **Effects of the weather**[13]- Specific patterns of weather such as temperature, humid environment with elevated UV index and reduced use of central heating have a positive impact on AD. Cross sectional studies have shown a greater risk of AD in infants born in autumn and winter when compared to those born during summer and spring months[2]. Studies have shown that UVB can reduce filaggrin production in stratum granulosum. Patient often notice improvement after sunny holiday or narrowband-UVB therapy suggesting there is a balance between the immunosuppressive effect and also negative effect on filaggrin production. A longitudinal study from New Zealand suggested that even though low vitamin D levels in cord blood contributed to increased risk of respiratory infections and wheezing in childhood, children whose mothers had high serum levels during pregnancy were exposed to increased risk of pneumonia, bronchiolitis, eczema and asthma[3]. Severity of AD was assessed using SCORAD index using specific PC software and eczema was scored in each patient as mild, moderate and severe[4].

5) **Genetic Factors** - Mutations in gene encoding filaggrin – 50% heterozygous for a filaggrin mutation, mutations in genes encoding protease and protease inhibitors and defective cell mediated immunity play a vital role in AD. A number of twin studies showed wide ranges of concordance rates of between 0.23 and 0.86 for monozygotic twins and 0.15 and 0.5 for dizygotictwins[5-8].

Fig 1 – Infantile Atopic dermatitis on the face[9].

Fig 2 – Infantile Atopic dermatitis on the trunk[9].

Clinical features of Atopic Dermatitis

Acute Dermatitis is erythematous (red), exudative (weeping/crusted) and may have blisters (vesicles/bullae). Overtime the dermatitis becomes chronic and the skin becomes less red but thickened and scaly. Fissures can occur.

Infantile Atopic dermatitis

At or 3 months after birth, atopic dermatitis may present as infantile seborrhoeic dermatitis involving the scalp, armpit and groin creases. The skin often feels dry and rough. As the condition progresses, the face and flexures become involved. The dermatitis is not necessarily confined to these sites and can be more extensive. The nappy area is usually spared due to moisture retention of nappies, however irritant contact napkin dermatitis can still develop.

Toddler and school age atopic dermatitis

As children grow and develop, the clinical presentation of dermatitis changes. The extensor aspects of the elbows and wrists, knees and ankles are affected with activities like crawling for instance. The distribution becomes flexural with walking, particularly involving the antecubital and popliteal fossae. Dribbling and food can cause dermatitis around the mouth and chin. Scratching and chronic rubbing can cause the skin to become lichenified and around the eyes can lead to eye damage. Various other manifestations of atopic dermatitis seen in the school-age children and adolescents include – discoid eczema, lip lacker's dermatitis, pityriasis alba, pompholyx and pityriasis amiantacea9.

Fig 3 – Pruritic Atopic Dermatitis[9].

Fig 4 – Eyelid Atopic Dermatitis[9].

Adult Atopic dermatitis

This may present in a variety of forms. It may continue in the flexural pattern or become diffuse. Madarosis, nodular prurigo and lichenification may follow chronic rubbing. Discoid and papular patterns can develop. Some patients can present with hand atopic dermatitis secondary to occupational and domestic duties. In some adults, involvement of the nipples and areolae can lead to severe disease[9].

Fig 5 - Acute flexural atopic dermatitis[9].

Fig 6 - Lichenified flexural atopic dermatitis[9]

Complications of Atopic dermatitis -

a) Bacterial skin infections caused by staphylococcus or streptococcus is very common due to inherently abnormal skin barrier.
b) Viral skin infections such as molluscum contagiosum, eczema herpeticum, eczema coxsackium is common particularly in infants and young children.
c) Fungal infections can also occur secondary to atopic dermatitis.
d) Psychological effects of atopic dermatitis
e) Contact dermatitis, Occupational skin disease
f) Erythroderma

Diagnosis –

Atopic dermatitis/Eczema is usually diagnosed clinically. Patch testing may be required particularly if the dermatitis becomes resistant to treatment.

Treatment Pathway –

A) **Identify and Eliminate/Avoid Exacerbating factors** – Avoid soaps/detergents, avoid clothes containing coarse wool or synthetic fibres, avoid extremes in temperature[9].

B) **Keep skin hydrated** - hydrate with warm soaking baths for at least 10 minutes followed by application of moisturiser/emollient. Emollients are the cornerstone of eczema therapy and patients should be advised to use them generously[9].

C) **Treat pruritus and flare ups**[13] –
   1) Low-potency topical corticosteroids may be used for maintenance therapy if eczema is not controlled by emollients alone[9].
   2) Antihistamines may provide relief for some patients, particularly for those with concomitant urticarial or allergic rhinitis, or when taken at night when pruritus is usually worse[9].

3) Immunomodulatory agents like topical tacrolimus or pimecrolimus may be used of the face, eye lids and skin folds, for eczema unresponsive to low-potency topical corticosteroids[9].

D) **Treat exacerbations/Flare ups**[13]–

1) Intermediate and high-potency topical corticosteroids like Clobetasone butyrate (Eumovate)/Betamethasone dipropionate (betnovate) can be used for short periods of time to treat exacerbations[9].
2) Ultra high potency topical corticosteroids like clobetasol propionate (Dermovate) should only be used for very short periods (1-2 weeks) on non-facial and non-skinfold areas[9,13].

E) Treat secondary bacterial/viral/fungal skin infections early.

F) **Treatment of mild eczema**[14] -

1) **In infants, toddlers and young children, mild potency steroids** – 1% hydrocortisone is commonly used on face and flexures. For body, moderate potency steroids like eumovate is used.
2) **In adults, moderate potency steroids** – Eumovate is used especially for eczema on the face and flexures. For mild eczema on the body, moderate or potent steroids such as eumovate or Betnovate (Betamethasone valerate 0.1%) ointment are used once daily for 2-3 weeks and then weaned down gradually.

G) **Treatment of moderate eczema**[14] –

1) In infants, toddlers and young children, moderate topical steroids such as eumovate is applied once daily on active areas of the face, flexures and body for 2 weeks and then weaned down gradually. Alternatively, protopic ointment (0.03%) can be used if resistant to topical steroids.
2) In Adults, Moderate topical steroids such as eumovate is applied once daily on active areas of the face and flexures for 2 weeks and then weaned down gradually. Potent steroids such as Betnovate or Elocon (mometasone) is used on the body during flare ups. Alternatively, protopic ointment (0.1%) can be used if resistant to topical steroids.

H) **Treatment of severe eczema/Refractory Eczema**[9,12]–

1) **Wet dressings** – Application of wet dressings along with topical corticosteroids helps with skin barrier recovery, as it increases the efficacy of the corticosteroid and protects the skin from persistent scratching.
2) **Phototherapy** – Most commonly used phototherapy modality is narrow-band UVB. Photochemotherapy with PUVA should be avoided in patients with severe widespread eczema[12].
3) **Systemic agents** – Methotrexate, ciclosporin, mycophenolate mofetil, azathioprine, interferon-gamma, systemic corticosteroids and biologic therapies have shown to provide benefit for patients with severe refractory eczema[12]. Topical treatments are prescribed to be used concurrently with these systemic agents.
4) Hospitalization is essential for hemodynamically unstable erythrodermic patients secondary to severe eczema. Patient education and compliance with therapy are intensified.

Follow-up therapy –

Most of the patients with atopic dermatitis will require a long-term follow up plan which includes9

a) Education of the patient and family members about the chronic nature of eczema, exacerbating factors, and appropriate therapy to achieve effective control of their children.
b) Patient and caregivers educated about how to monitor their condition and when to seek medical help.
c) Review of therapy at follow-up appointments to provide the most appropriate treatment according to the severity of the disease.
d) Introduction to patient support organisations that provide up-to-date information about eczema.

Effects of Atopic dermatitis on the adult patient/ children and families -

Atopic dermatitis, like various other skin disorders has a tremendous psychosocial and mental impact on patients and their families. It affects their quality of life and daily living. It has been proven through multiple studies that patients with atopic dermatitis do have significantly high levels of anxiety and problems in dealing with anger and hostility. It has known to affect their self esteem and in turn contribute to social isolation. Many patients, especially female patients were found to develop depressive symptoms due to on-going symptoms particularly pruritus and recurrent flare ups despite appropriate treatment. Repeated hospital admissions of patients with refractory atopic dermatitis/atopic dermatitis with superadded infections have also shown a great impact on their quality of life. In few studies, it was shown that school-aged children with moderate and severe atopic dermatitis are at high risk of developing psychological difficulties, which may implications for their academic and social development[10,12]. This has also led to unemployment in certain group of patients particularly those with hand atopic dermatitis which in turn has led to financial constraints and therefore contributing to poor quality of living in these households. Sleep deprivation secondary to pruritus and soreness leads to tiredness, mood changes and impaired psychosocial functioning of the child and family, particularly at school and work[11,12].

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The psychosocial and physical impact of peanut allergy

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Dr Rebecca Knibb is an Associate Professor in Health Psychology and a practitioner Health Psychologist with 25 years of experience of conducting research into the psychological impact of allergies, publishing over 100 peer-reviewed papers and conference proceedings in this field.

Her research interests include the health-related quality of life and mental well-being of children, adolescents and parents who are managing long term conditions, particularly allergic conditions and asthma. She is involved in the development of strategies to help families cope through CBT based behaviour change methods and is particularly interested in how children cope with the transition to adolescence and with leaving home. She sits on a number of European Association for Allergy and Clinical Immunology Task Force groups, including a Task Force to investigate the impact of allergy on adolescents.

She is also the Chair of the Psychology Working Group for the British Society for Allergy and Clinical Immunology. Currently she is looking at psychological predictors of effective allergy management and psychological service needs of patients and families across the UK, Europe and North America.

Having food allergy presents a significant burden to the individual and their family. This burden has been the focus of much research over the last 20 years, which has consistently demonstrated the impact food allergy can have on quality of life and mental health. This may be particularly so for peanut allergy, where the ever-present risk of a potentially life-threatening reaction is cause for much fear and worry. Despite advances in immunotherapy, there is still no cure for food allergy and so those with peanut allergy have to be constantly vigilant for the presence of peanut in their environment and the food they eat.

Physical impact of peanut allergy

Peanut allergy is a global issue and studies suggest prevalence rates are increasing. In the US between 1997 and 2014 there was a five-fold increase in rates of peanut allergy in children under the age of 18 years (Sicherer & Sampson, 2018). By 2018 there were approximately 1.4 million children with peanut allergy in the US, with 76,000 new cases each year (Sicherer & Sampson, 2018). The UK has similar prevalence rates, with around 2% of children allergic to peanut, (Stiefel et al., 2017), three times the prevalence rate seen in the 1990s (Venter et al., 2010). For most children, a diagnosis of peanut allergy is with them for life, with only 20% of children growing out of the condition (Skolnick et al., 2001).

Children with peanut allergy have a higher likelihood of having a more severe reaction than children with other types of food allergies.

Gupta et al. (2018) reported on a cross-sectional survey of nearly 40,000 children under the age of 18 years in the US, which showed that nearly 60% of children with peanut allergy had reactions reported as severe.

This compared with just over 40% for reactions involving all other foods. There has also been a huge increase in emergency department visits due to peanut related anaphylaxis. Between 2005 and 2014 an increase of 195% was seen for peanut in the US (Motosue et al., 2018).

In the UK from 1992 to 2012, hospital admissions from all cause anaphylaxis increased by 615%

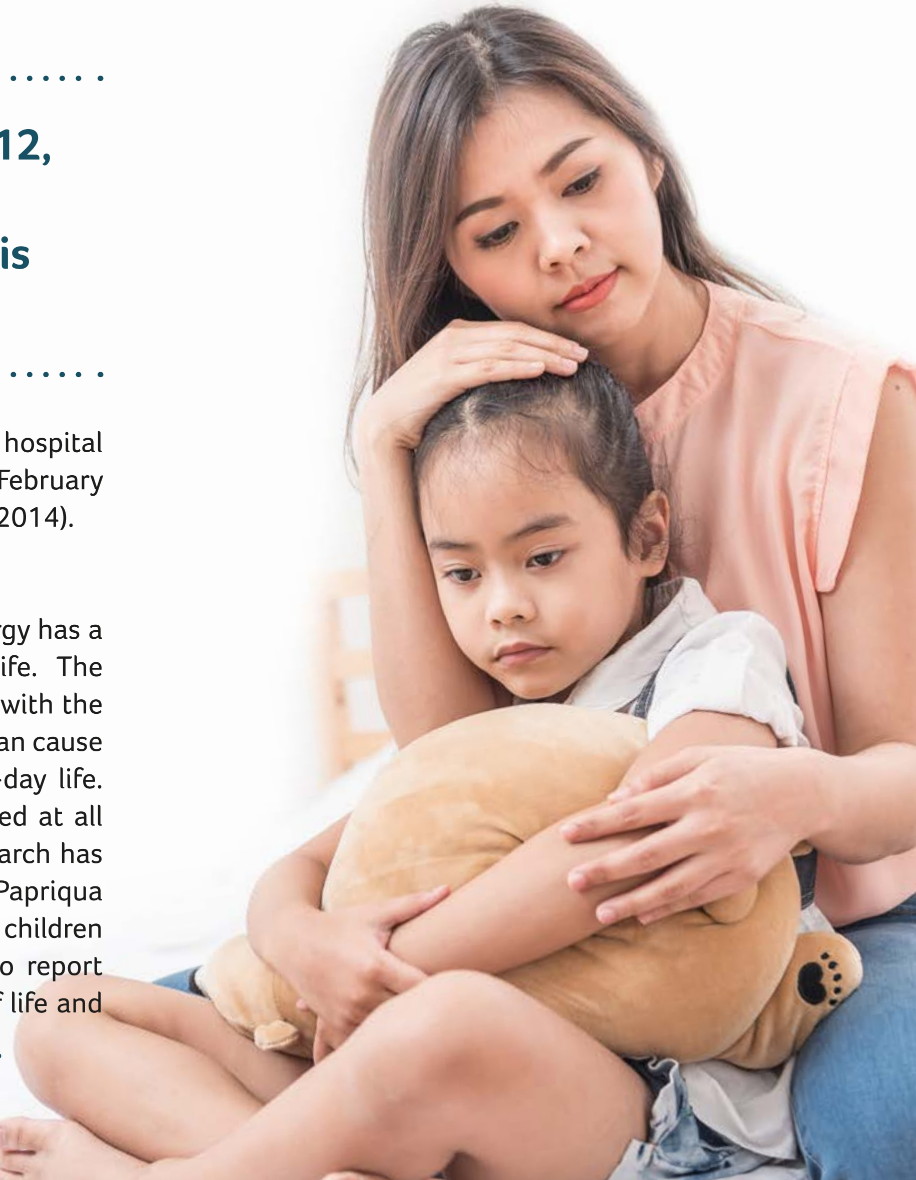
(Turner et al., 2014) and nearly one in five hospital admissions for an allergy from March 2013 to February 2014 were for anaphylactic reactions (HSCIC, 2014).

Psycho-social impact of peanut allergy

It is not surprising therefore that peanut allergy has a big impact on mental health and quality of life. The everyday burden of remaining vigilant, along with the unpredictable nature of an allergic reaction, can cause anxiety, worry and fear, and affects day-to-day life. The focus of much of the research has looked at all types of food allergies, but some recent research has looked specifically at peanut allergy. In the Papriqua study (Acaster et al., 2020), caregivers of children with peanut allergy in the UK were asked to report on the impact of peanut allergy on quality of life and productivity. Caregivers reported that having a child with peanut allergy had a significant impact not only on quality of life, but their careers and ability to work. Interestingly this was the same for both male and female cargivers, which perhaps demonstrates a shift in the responsibilities of caregivers in the family home.

When asked about quality of life and mental health, parents who reported that their child had a severe peanut allergy, compared to mild or moderate, reported a greater impact on social activities and more worry about their child having a reaction. Caregivers also reported significantly greater anxiety than would be expected in a normal UK population. This was also seen for quality of life, with poorer quality of life than a normal UK population reported, especially by parents who rated their child's peanut allergy as severe (Acaster et al., 2020).

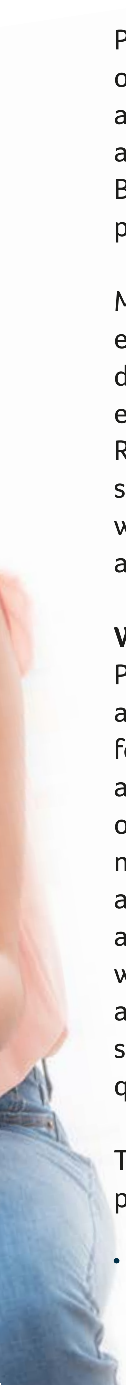
A similar pattern is seen across Europe. The APPEAL-1 study (DunnGalvin et al., 2020) surveyed nearly 2000 participants from eight European countries about the impact of peanut allergy on their life.



The majority of adults with peanut allergy and parents of children with peanut allergy (84-93%) said that peanut allergy had an impact on their lifestyle, 40% rated themselves as very frustrated or very stressed, 65% felt socially isolated and 43% reported they or their child had been bullied.

Participants were also asked to rate how they thought others viewed peanut allergy. Many agreed that friends and family had a good understanding of the condition and were not oblivious of the dangers of peanut allergy. But the reverse was true for their ratings of 'other people'.

Many of these issues have been highlighted in an excellent review paper by Lieberman et al (2021), which draws together the literature on the healthcare, socio-economic and psychological burden of peanut allergy. Reading food labels, dietary restrictions, eating out, school and bullying, travel, quality of life and emotions were the key areas highlighted by the paper as a being a burden for those with peanut allergy.



What can be done to help?
Psychological therapy for those with peanut allergy, and indeed food allergy more generally, may be helpful for those struggling to cope. However, research in this area is very limited so far. A recent systematic review of the effectiveness of interventions to improve self-management in adolescents and young adults with allergic conditions, found no interventions for food allergy for this age group (Knibb et al., 2020). There were interventions for young people with asthma, and those based on psychological therapies or peer-support showed promise for their ability to improve quality of life and adherence to treatment.

There is more evidence for the effectiveness of psychological support for parents of children with food allergy (Sugunasingha et al., 2020), with interventions based on providing education, offering peer or professional support, or having a psychological basis. Two UK-based studies have been published on interventions using Cognitive Behavioural Therapy (CBT). One showed that a 12-week course of face-to-face CBT for mothers of children with food allergy, run by a health psychologist in a non-clinical setting, can reduce anxiety, stress and depression and improve quality of life (Knibb et al., 2016). In a clinical setting, Boyle et al (2017) provided mothers of children with food allergy with one CBT-based risk communication session in allergy clinic by clinicians with training in CBT. After 6 weeks, mothers who had moderate to high anxiety in clinic showed significantly reduced levels of anxiety.

Unfortunately, provision of psychological support across the UK is still sparse, hampered by the lack of dedicated funding for psychologists to work within allergy clinics. Where it is being offered, uptake is high and appears to be very effective for both patients and parents (Knibb et al., 2019). The lack of psychological services is an issue not restricted to the UK. In our current study, Global Access to Psychological Services for food allergy (the GAPS study), we aimed to assess availability and uptake of psychological services across the United Kingdom, mainland Europe, North and South America and Australia. Nearly 3000 adults with food allergy and parents of children with food allergy from more than 20 countries have taken part in our first survey about access to and uptake of psychological services.

Nearly 70% of adults and 80% of parents reported they had experienced psychological distress related to their or their child's food allergy.

However, less than 20% of adults and parents had been assessed for food allergy-related psychological distress during their or their child's food allergy appointment; and only 21.2% of adults and 12.9% of parents had seen a mental health professional for treatment for food allergy related distress. Just under 10% of adults and parents had been diagnosed with a mental health disorder that was related to their or their child's food allergy. The biggest barriers to seeing a mental health professional were cost/lack of insurance coverage, failure to provide a referral, finding childcare and lack of a practitioner in the area (Knibb et al., 2021).

Conclusions

It is clear that peanut allergy has a big impact on life and psychological support could help patients and families. Further research in this area is needed to help us understand the best interventions to help people manage the burden of peanut allergy. Such evidence will help support the call for funding to enable wider access to psychological services for those in need.

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New legislation on prepacked food for direct sale

Lydia Collins-Hussey
Paediatric Allergy Dietitian

Lydia graduated from the University of Plymouth with BSc(Hons) Dietetics in 2013 and started her dietetic career at Cumbria Partnership NHS Foundation Trust and moved quickly into a paediatrics where her passion for food allergy started. For the last four years she has worked at Oviva UK Ltd in the CMPA programme where she went on to win the Barry Kay Award in Allied Health from the British Society for Allergy and Clinical Immunology(BSACI) in 2019 for her work in NHS Grampian. More recently, she has transitioned into a part-time partnerships and research role. Lydia joined AllergyUK in May 2021 as a Dietetic Advisor. Outside of work, Lydia is secretary for the BDA Food Allergy Specialist Group (FASG), and she has recently completed her MSc in Advanced Practice in Paediatric Dietetics.

It is estimated that 2 million people in the UK have a food allergy and less than 10 fatalities each year happen from food induced anaphylaxis (Conrado et al.,2021). Whilst fatalities are rare and have decreased over the last few decades, hospital admissions due to food induced anaphylaxis have increased threefold (Conrado et al.,2021). One study where EU labelling laws are followed, showed accidental reactions are mainly found from prepacked foods and meals outside the home (Blom et al.,2018) highlighting the need for accurate allergy information to be available for those living with food allergy.

As of the 1st of October 2021 the legislation on prepacked food for direct sale (PPDS) changed across the UK. The legislation has also been referred to as Natasha's Law, as Natasha Ednan-Laperouse is the teenager who had a severe allergic reaction and sadly died in 2016 after consuming an undeclared ingredient (sesame) in a prepacked baguette from a well-known food chain. At the time of Natasha's' death there was no legal requirement to have allergen labelling on food prepacked for direct sale. Instead, allergen information was relayed to the consumer either verbally or written down (such as an allergen folder).

However, in 2019, the regulations changed to include allergen labelling on PPDS. Since then, food businesses have had two years to adapt to the new legislation, which was enforced on the 1st of October. This means if food businesses do not comply with the legislation they risk fines or, in severe cases, prosecution. PPDS is referred to in the following amendments:

- The Food Information (Amendment) (England) Regulations 2019
  https://www.legislation.gov.uk/uksi/2019/1218/made/data.pdf
- The Food Information (Wales) (Amendment) (No. 2) Regulations 2020
  https://www.legislation.gov.uk/wsi/2020/295/pdfs/wsi_20200295_mi.pdf
- The Food Information (Amendment No. 2) Regulations (Northern Ireland) 2020
  https://www.legislation.gov.uk/nisr/2020/80/pdfs/nisr_20200080_en.pdf
- The Food Information (Scotland) Amendment Regulations 2021
  https://www.legislation.gov.uk/ssi/2021/70/contents/made

The Food Standards Agency and Food Standards Scotland have both brought out thorough guidance to support consumers and business with this change.

Why do we need this legislation?

Changing the legislation on PPDS allows those living with allergies to make an informed choice when purchasing food products on a premise that has food prepacked for direct sale. The undeclared presence of an allergen is of serious concern to those with food allergy, even small traces of an allergen can lead to a severe allergic reaction. The food allergic consumer relies on food manufacturers and businesses selling food and drinks to provide accurate information. The new legislation aims to increase transparency of PPDS by having allergen information clearly visible on the product label.

It is important to note, that challenges do still remain in food allergen labelling especially in relation to precautionary allergen labelling (PAL). PAL is used by manufacturers to show the possible presence of allergens due to cross contamination. For example, 'may contains'. Currently, these statements are voluntary which for consumers can be confusing and unhelpful when assessing the risks of potential allergens. The new PPDS legislation is one step closer to the consumer being better informed about the ingredients within a product that has been prepared on the premises for direct sale, however further work is needed in other areas of food labelling.

What is PPDS?

The Food Standard Agency (FSA) refer to PPDS as 'food which is packaged at the same place it is offered or sold to consumers and is in packaging before it is ordered or selected. It can include food that consumers select themselves (e.g. from a display unit), as well as products kept behind a counter and some food sold at mobile or temporary outlets'. It is different to prepacked foods and non-prepacked foods as stated in the table below:

Table 1: Type of packing/labelling

Type of packaging/labelling	Definition
Non prepacked food (also referred to as loose foods)	Food that is not in packaging before being ordered by the consumer and does not require a label with a product name, ingredients or allergen information.
Allergen information must still be available either verbally or written down (e.g. allergen folder)	
Prepacked food	Food packed by one business and supplied to another. It must state product name, ingredients and allergen information.

The PPDS changes affect a variety of business regardless of their size and include schools, cafes, restaurants, butchers, bakers, street food vendors and burger vans. The FSA has brought out a PPDS toolkit including a food decision tool to help business ensure products are labelled correctly, this can be accessed on their website.

What must be on a PPDS food label?

The label must show:

- The name of the food,
- A full list of ingredients, and
- List the 14 main allergens required to be declared by law

In December 2014 European food labelling law came into effect to ensure the 14 most common allergens across Europe are clearly identified on a prepacked product (e.g. in bold, capitals or highlighted). From the 1st of October 2021 the 14 main allergens must also be listed on PPDS and listed in Table 2.

Table 2: List of 14 main allergens

Celery
Cereals containing gluten (wheat, barley and rye)
Crustaceans (such as prawns, crabs and lobsters)
Eggs
Fish
Lupin
Milk
Molluscs (such as mussels and oysters)
Mustard
Peanuts
Sesame
Soybeans
Sulphur dioxide and sulphites
Tree nuts (such as almonds, hazelnuts, walnuts, brazil nuts, cashews, pecans, pistachios and macadamia nuts).

Examples of whether PPDS labelling is required

The new legislation may appear confusing for business and consumers. However, the following provides examples for further clarity on PPDS.

Table 3: Examples where PPDS is required

Example	PPDS Labelling Required	Comment
Fast food before it is ordered such as a packaged burger	Y	
Sandwich packed at a sandwich bar before consumer selects or order them	Y	
Food packed by one business and supplied to another business	X	This is a prepacked food and already must have full labelling requirements
Ordering a takeaway over the phone	X	This does not come under PPDS and is referred to as 'distance selling'. Allergen information should still be available to the consumer before purchasing the product either in writing or orally
Food packaged on site and sold by the same business on a market stall/vehicle	Y	
Cheese prepacked at the deli counter ready for sale	Y	
A takeaway coffee from a café	X	This is made to order and considered a 'non-prepacked food'
A breakfast pot bought from a school canteen	Y	
A cake served on an open cardboard tray	X	This is considered 'non prepacked food'

Conclusion

The change in legislation is a positive step forward for those living with food allergies; it allows them to make safer and confident choices when purchasing food prepacked on a premise for direct sale. Many establishments have already made the change since the announcement in 2019. The new legislation will hopefully have a big impact, as well as raise the awareness of food allergy. As a key stakeholder on this issue, AllergyUK is pleased to see this change come into law across the UK.

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What's New

The last year has seen the development of a range of new resources from Allergy UK on allergic conditions, including eczema and asthma.

All are available on our new website which has been designed to be as user friendly as possible, allowing access to all our resources quickly and easily.

Spotlight on new Resources from Allergy UK

Atopic eczema

Atopic dermatitis or atopic eczema is a very common skin condition that affects people of all ages with approx. 1 in 5 children and 1 in 10 adults affected in the UK. Eczema is an inflammatory condition of the skin characterised by dry skin, intense itching, erythema (redness of the skin) and lichenification (thickening of the skin), and can have a significant impact on physical, psychological and social well-being and dramatically impair quality of life. We have created a number or resources to support and inform people with eczema and their families.

For families with children

- **Factsheet – eczema in children**
  www.allergyuk.org/resources/eczema-in-children-factsheet
- **Video – caring for a baby's sensitive skin**
  www.allergyuk.org/resources/caring-for-a-babys-sensitive-or-eczema-skin
- **Coming shortly** – A series of videos aimed to support families and adults in caring for atopic eczema.

For young people and adults with eczema

- **Infographic – eczema more than an itch**
  www.allergyuk.org/resources/eczema-infographic-for-young-people
- **Factsheet - Triggers, allergens and irritants** www.allergyuk.org/resources/atopic-dermatitis-eczema-triggers-allergens-and-irritants
- **Factsheet - How to cope with eczema** – including how to manage eczema in the workplace
  www.allergyuk.org/resources/eczema-atopic-dermatitis-factsheet
- **Living with eczema**
  www.allergyuk.org/resources/living-with-eczema-podcast
- **Treatment options for moderate to severe eczema** – including information on biologic therapies www.allergyuk.org/resources/new-treatments-for-moderate-to-severe-atopic-eczema-biologic-therapies

AllergyUK

Advances in the treatment of severe atopic dermatitis

Information for healthcare professionals

www.allergyuk.org

Helpline 01322 619898

We have created some resources to support healthcare professionals in the management of patients and their families with eczema

- **Leaflet** – to briefly discuss treatment options for moderate to severe eczema including biologic therapy
- **Webinars for healthcare professionals** – with a focus on skin allergy and CSU
- We are currently in the process of developing a series of podcasts for healthcare professionals , entitled Allergy Insights

Episode 1 – Skincare for babies with eczema

Episode 2 – living with eczema – its impact and management

Episode 3 - Biological Therapies and New Advances in Atopic Dermatitis

Asthma

Asthma affects over 5.4 million people in the UK with 1 child in 11 affected. Asthma is a common chronic lung condition that requires ongoing management and is associated with high morbidity and reduced quality of life for individuals and families affected by asthma. In asthmatics the airways are sensitive and become inflamed and narrow on exposure to certain triggers, leading to difficulty in breathing. Asthma commonly starts in childhood but it is possible to develop asthma at any age, with environment and genetics playing a role in who develops asthma.

Factsheets

- **Asthma** www.allergyuk.org/resources/asthma-factsheet
- **Childhood asthma and wheeze**
  www.allergyuk.org/resources/childhood-asthma-wheeze-factsheet

Allergic rhinitis

Allergic rhinitis affects up to 40% of children and 30% of adults in the UK accounting for approx. 16.7 m GP visits per year. Allergic rhinitis can be perennial or seasonal depending on the trigger allergens and if very unlucky an individual can be sensitised to multiple trigger and experience symptoms all year round. Allergic rhinitis is known to have a significant affect an individual's quality of life including school or work performance. Allergic rhinitis is a known risk factor for developing asthma.

Factsheets

- **Allergic rhinitis and hay fever**
  www.allergyuk.org/resources/allergic-rhinitis-and-hay-fever-fact-sheet
- **Pollens and moulds in the garden**
  www.allergyuk.org/resources/pollens-and-moulds-in-the-garden-factsheet

Leaflet

- **Allergic rhinitis, hayfever and asthma**
  https://www.allergyuk.org/resources/allergic-rhinitis-and-hay-fever-fact-sheet/

Pollen food syndrome

Commonly referred to as oral allergy syndrome, is a hypersensitivity reaction to fruits, vegetables and nuts (often referred to as plant based foods) usually causing mild irritant symptoms such as itching of the mouth, lips and throat when eaten in their raw form.

With pollen food syndrome the immune system recognises the food protein that you eat as an allergen and creates an allergic responses. www.allergyuk.org/resources/oral-allergy-syndrome-pollen-food-syndrome-factsheet

Lipid transfer protein allergy

A more severe form or plant based food allergy is lipid transfer protein (LTP) allergy.

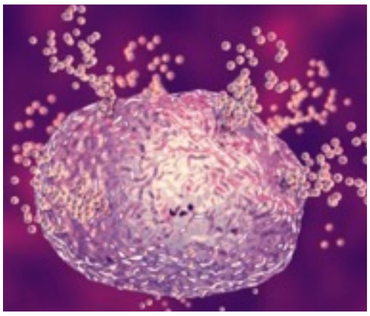
- **LTPs** www.allergyuk.org/resources/lipid-transfer-protein-allergy

Food allergy

Almost 1 in 12 young children and 1-2% of adults in the UK suffer from food allergy and up to 10% of adults and children in the UK have a food sensitivity. Food allergies can be divided into two main types, referred to as IgE mediated (immediate) and non-IgE mediated (delayed) allergy. Food allergy can have a huge impact on an individual and family's psychological, social and general wellbeing, with anxiety and stress being major factors.

At Allergy UK we have been working hard to create a number of resources to support individuals and their families with food allergies these include

- **Food allergy leaflet** www.allergyuk.org/resources/food-allergy-leaflet
- **Factsheet FPIES** www.allergyuk.org/resources/fpies-food-protein-induced-enterocolitis-syndrome
- **Series of food allergy Factsheets , including Cow's milk, egg, peanuts, soya** www.allergyuk.org/types-of-allergies/food-allergy



Anaphylaxis

Anaphylaxis is a life threatening severe allergic reaction. It is a medical emergency and requires immediate treatment. A severe allergic reaction can cause breathing difficulties, circulatory shutdown and anaphylaxis. Recognition of symptoms and prompt treatment with adrenaline is essential. The symptoms of anaphylaxis usually occur within minutes of exposure to a trigger substance (allergen).

- **Anaphylaxis the 4's Leaflet** https://www.allergyuk.org/resources/anaphylaxis-the-four-as/
- **Anaphylaxis and severe allergic reactions Factsheet** www.allergyuk.org/resources/anaphylaxis-and-severe-allergic-reaction-factsheet
- **Adrenaline auto-injectors Factsheet** www.allergyuk.org/resources/adrenaline-auto-injectors-factsheet

Chronic spontaneous urticaria

Chronic spontaneous urticaria (CSU) is a common and distressing skin condition that causes red, raised, itchy and sometimes painful hives or wheals on the skin with no known obvious trigger. To be considered chronic the wheals (urticaria) must be present daily for at least six weeks and is referred to as 'spontaneous' when symptoms are not triggered by a known cause. CSU affects approx 0.5-1% of the population in the UK, with women more than twice as likely than men to be diagnosed with CSU. CSU is an unpredictable and debilitating condition which can affect daily life in many ways including sleep deprivation, anxiety and social isolation.

- **CSU leaflet** www.allergyuk.org/resources/chronic-spontaneous-urticaria-csu-does-it-rule-your-life
- **Urticarial and angioedema Factsheet** www.allergyuk.org/resources/urticaria-and-angioedema-factsheet
- **In production** - a video to help support people with CSU

Resources created specifically for healthcare professionals

Educational session - Webinar Masterclass – Allergy UK provide free online webinar masterclasses, delivered by leading experts in the field of allergy on a range of allergy related topics.
https://www.allergyuk.org/hcp-resources/masterclasses/

Allergy Today is a publication written by healthcare professionals for healthcare professionals. Published by Allergy UK, it aims to educate and update healthcare professionals on the latest information surrounding allergic disease, to ensure patients living with allergy are getting the best possible care and support. The publication is made available on our website, at healthcare professional events and emailed to our healthcare professional database. Previous editions can be viewed here:
https://www.allergyuk.org/health-professionals/allergy-today#hcp_validation

...That is the mission around which all our work is focused. It encompasses every aspect of life from diagnosis and treatment to care at school, travelling with an allergy and eating out.

Allergy UK Website

Visit the Allergy UK new look website where you can access all of the above and many more valuable resources. **https://www.allergyuk.org/**

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Our Mission is for everyone in the UK to take allergy seriously.

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