Food Allergy – scoping workshop. 17th December 2009

Notes/key points from the meeting

1. Introductions
   MB discussed the pathways that the RCPCH are producing.

2. CT gave her presentation on the background of NICE and the processes used.
   Q – would this GL move from being a SCG to a standard one. A – No, but the opportunity to request an additional GL via topic selection.
   Q – Is it mandatory to implement the GL. A – No, but trusts are monitored on whether they do or don't, and if not have to report it as an exception.

3. BM gave her presentation on PPIP.

4. AS gave a presentation
   MB reminded the group that the GL is set in community setting but not hospitals
   How did we get the age groups? Consulted with Prof Warner.

Question 1: Population

Each group spent 5 minutes discussion the question 'Is the appropriate population covered by the draft Scope?' and then presented back to the wider group.

- Not always related to food.

- Division of age groups: suggestion were:
  0 – 12m, 1 year – 4 yrs, 4 years – 18 yrs
  0-6m, 6-12m, 12-24m, 2y-5y, 5-10y, 10-18yrs
  C 0-6m, 6-12m, 12-24m, 2y-5y, 5-10y, 10-14, 14-18yrs
  0-6m, 6-12m, 12m – 5 years, 5 – 10 years, 10 – 18 years

- First degree relative's not first generation relatives. Ist degree relatives – may not be clear enough and needs clarification

- A – key conditions missing from symptoms - anaphylaxis. Dont need eczema & atopic dermatitis – just could have atopic eczema.

- Lactose intolerance and cow's milk allergy. Need advice on ruling out lactose intolerance.

- Chronic erticaria & anaphylaxis

- B – well controlled – should it be less controlled?

- ? add exclude celiac disease.

- Groups in a – symptomatic, b – non- symptomatic
- Eczema – usually well controlled – look at again.
- Food intolerance – can it be picked up at a different stage?
- Glue ear is linked with food allergy and should be something GP consider
- Should be children and young people.
- Maybe should just be atopic disease.

Question 2: Health care setting

Each group spent 5 minutes discussion the question 'Are the healthcare settings proposed appropriate?' and then presented back to the wider group.

- Home environment – should be extended home environment.
- Child centres and sure start, baby and community health clinics, dietetic clinics.
- Need more clarification on a. In B should include after school clubs. Community paediatricians.
- Home environment/institution. Child centres and sure start, baby and community health clinics, dietetic clinics. Ordering of school in age order starting with nurseries. Word dietetic really important.

Question 3: Diagnostic strategies

Each group spent 5 minutes discussion the question 'Have the main diagnostic strategies and tools been covered?' and then presented back to the wider group.

- Is it worth including the patient diaries – or move them to B or C.
- Take out the double blind placebo – could this be done in primary care. Would the skin test be done in primary care.
- Non IGE.
- F – include the IGG.
- Why adults are mention in things not covered. Give an example of food intolerance.
- Diet diaries are some value in including them – are useful in excluding diagnosis as opposed to diagnosing. Conventional test should be clarified that these are call RASS test. Not double blind placebo tests. Patch test has very little role, but is a move to marketing direct to patients.

- F should be called alternative. IGG would be most valuable. Other techniques.
- Thorough clinical history – must be allergy focussed.
- MB – can recommend NOT using a test.
- Take out food challenge and blind test. Should skin prick test be done in primary care? C & E go together. Need to establish the process to secondary care. Important that all children with food allergy are seen in secondary care. E v important and the stage at which that referral are made.
- Felt F was quite important.
- Can we move b to a, as the clinical history taking is the most important thing. History is paramount. Need to emphasise allergy focussed history. Food diaries are not useful or reliable.
- C. Take out: double blind challenges and a topic patch testing. Order change.
- (1st add) Food eliminations. Can't ignore 1st line management
- Don't know why D is there. Can get rid of it.
- Problem with elimination diets is that we think there are already lots of children on elimination diets that shouldn't be on them.
- Can't do your diagnosis without the elimination diet. Need dietetic support when going down the food allergy diagnosis route. Could liaise with community dietician. Doesn't mean referral to a dietician every time.

Question 4: Key Outcomes:

Each group spent 5 minutes discussion the question 'Have all the important outcomes, appropriate for this guideline, been covered in the current draft Scope?' and then presented back to the wider group.

- A – wording issues. Non IGE should replace the food ..., History taking and examination be prioritised. Non IGE mediated instead of cell mediated.
- Appropriate referral.
- Follow the appropriate care pathway.
- E adverse events at the top.
- F – add for child and family (health related)
- Utility isn't quite clear.

- Prevention isn't mentioned anywhere and should be. Mentioned history and physical examination and should have a list of things to ask. Looking at the training – running an allergy clinic in primary care – people must be appropriately trained.

- Colic wasn't mentioned anywhere.

- Usefulness of diff test. Interpretation of skin prick tests in very young and usefulness. Should we mention elimination diets again.

- C – going to be done in Primary care after having skin prick test in secondary care? Interpretation of RATH tests. Should be someone who has had training to do this test. Would include dietetic advice. Can be a delay in getting access to this.

- Resource – would it include the costs of skin prick tests and the setting up of it – is it viable to set this up in primary care. Would GP's be inundated with people asking for the test

- Agreed with A

- B diagnostic strategies and managements

- C when to refer to secondary care – should be diff for IGE and cell mediated.

- Resource use/prescription use/frequent GP visits

- 20% of under 5's will present with eczema but only need to consider the ones with moderate to severe eczema – need to clarify moderate to severe.
- Can't write them off though as mild is something??

GDG Constituency

1 Paeds spec interest in allergy/&gastro/&derm/&paediatrician
2 Dietician
3 HV/
4 GP
5 Community Pharmacist
6 Patient/carer member
7 ?Community paediatrician or see/add 1

Important that we get the right GP.

At least one paediatrician to come from secondary care

Practice Nurse?