Management of Peanut & Tree Nut Allergy in Children

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| **Key Points*** Clinical history and allergy tests are needed to make the diagnosis
* Children with eczema & egg allergy are at increased risk of peanut allergy
* Previous severe reaction is a risk factor for another severe reaction
* Most patients with mild reactions do not go on to have severe reactions
* Skin prick wheal > 8mm or specific IgE > 15kU/L have high positive diagnostic accuracy for true allergy rather than sensitisation
* This is Frimley site only as in different referral Networks
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| **Guidelines Lead(s):** | Dr Kate O’Farrell Consultant Paediatrician & Dr Maisara Soliman Consultant Paediatrician |
| **Contributors:** | Dr Kate O’Farrell |
| **Lead Director/ Chief of Service:** | Dr Jo Philpot |
| **Ratified at:** | Departmental Clinical Governance Meeting |
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| **Pharmaceutical dosing advice and formulary compliance checked by:** **Key words:** | Ruth Botting Senior Paediatric Pharmacist 9th May 2020 Member of the Clinical Governance Committee |
| This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it. |

**Version Control Sheet**

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| 1 | 5/5/2020 | Dr Kate O’Farrell |  |  |
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**Related Documents**

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| Document Type | **Document Name** |
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**Abbreviations**

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| SPT | Skin prick test |
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1. **Background**
* Primary nut allergy affects 2% of children in the UK
* Children with eczema & egg allergy are at higher risk of peanut allergy
* Usually presents within the first 5 years of life
* 20% of peanut allergy and 9% of tree nut allergy resolves usually by age 6 years
1. **Presentation**
* Primary nut allergy presents most commonly in the first five years of life, often after the first known ingestion, with typical rapid-onset IgE-mediated symptoms
* Pollen food syndrome is a distinct disorder, usually mild, with oral/pharyngeal symptoms, in the context of hay-fever or pollen sensitisation, which can be triggered by nuts
* Previous severe reaction is a risk factor for another severe reaction
* Most patients with mild reactions do not go on to have severe reactions
* Clinical history of asthma increases the risk of a severe reaction
1. **Diagnosis**
* Clinical history is the cornerstone of diagnosis for nut allergy
* Skin prick testing or serum IgE to support diagnosis
* If +ve SPT > 3mm or IgE > 0.35 in context of suggestive history give diagnosis of peanut allergy and advise avoidance
* SPT wheal does not correlate with clinical severity
* Children with 1 nut allergy are at risk of allergy to other nuts therefore if not already tolerating they should also be tested to the other nuts.
* Do not test to nuts that are tolerated in the diet
1. **Management**
* Nut avoidance advice
* Children can continue to eat nuts to which they are not allergic to at home but should avoid all nuts in restaurants due to risk of cross contamination
* Patients with a history of very severe past reactions, uncontrolled asthma or a very low threshold for reactivity should be advised to avoid PAL (precautionary allergen labelling) as well
* Provide a management plan for school / home / nursery – use BSACI allergy action plan, available at <https://www.bsaci.org/about/download-paediatric-allergy-action-plans>
* All patients should be prescribed an antihistamine for mild to moderate reactions. Chorphenamine < 2 years or Cetirizine > 2 years
* Those with previous severe reaction / asthma / reactions to trace amounts should be prescribed adrenaline – need to be trained in use of this
1. **Follow Up**

* 2 yearly until age 6, then 3 yearly
* Take history of reactions due to accidental exposure to nut and identification of new allergies
* On-going education on nut avoidance measures
* Periodic measurement of nut SPT +/- serum IgE to look for resolution
* Management of co-morbidities, especially asthma, rhinitis and eczema
1. **Who needs a food challenge**
* Positive history & negative tests - > 80% will have a negative test therefore if symptoms mild (no airway, respiratory or cardiovascular compromise) can consider home introduction in this group
* Potential tolerance – those with previous definite nut allergy who on review have negative or significantly reduced allergy tests
* Positive allergy tests in a child who has not previously eaten nuts
	+ In a child > 2 years with SPT < 8mm or serum IgE < 15kU/L who has never actually eaten nuts, a diagnosis cannot be made on allergy tests alone. About 50% of these children will show no symptoms on challenge and therefore a challenge prior to starting school is recommended
	+ In a baby < 1 year old with eczema and/or egg allergy and SPT<6mm to peanuts a challenge is recommended. If they pass the challenge continued regular peanut ingestion may prevent the development of peanut allergy (at least 3 times a week until 3 years old)