

The nature of the fern allergens identified needs to be elucidated. IgE antibodies in our patient did not seem to be directed against cross-reacting carbohydrate determinants on glycoproteins that can be commonly found in pollens and foods and also in *Ficus benjamina* (fig) leaf extract (unpublished observations).

Diagnosis of fern allergy is simple: the most important step is to consider it. As no commercial extracts are available, testing should be performed with fresh fern leaves by the prick-to-prick method. Therapy is simple and consists of removal of all ferns, as there seems to be cross-reactivity between different fern species (2).

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Pediatric allergology in Austria

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• THE introduction of allergen-specific immunotherapy (SIT) has been an important advance in the management of allergies, because drug treatment is effective only while being administered, the symptoms reappearing as soon as the treatment is

stopped (1). For successful SIT, it is crucial to identify the patients most likely to benefit from it. Therefore, it is necessary to assess carefully

whether the severity of the disease justifies this kind of treatment, balancing the benefits, risks, and inconveniences of SIT (2, 3). Since 1993, three position papers on SIT have been published by the BSACI (4), the EAACI (2), and the WHO (5), respectively. These position papers are not thought to establish a standard for allergen SIT for individual countries. In the UK, strict criteria – SIT should be administered only in hospitals or specialized clinics – have been introduced regarding the pattern of adverse reactions (6). In Austria, as in many other European countries and the USA, no regulations for the administration of SIT exist, and any medical doctor, even those without special training, is allowed to perform SIT. Therefore, we decided to assess the knowledge of SIT and its efficacy and indications among the pediatricians of Vienna, Austria.

Of 140 registered pediatricians in Vienna, 93 were asked to answer a structured questionnaire by telephone. All interviews

were done by the same person. Out of 93 interviewed pediatricians, eight refused to answer the questionnaire, four stated that they were not familiar with SIT, and two did not complete the questionnaire. Table 1 shows an analysis of the answers to factual questions.

The most remarkable result of our survey is the finding that many pediatricians were not aware of the correct indications for and the risks of SIT. We were concerned that 65.6% of pediatricians who perform SIT in their office believe that SIT is indicated in severe asthma. There is a consensus in the literature that the greater the severity of asthma, the less the benefit to the patient of SIT and the higher the risk of severe side-effects (7). Both the EAACI and the WHO position papers recommend SIT in carefully selected mild asthmatics in order to break the vicious circle of inflammation and to improve quality of life (2, 5).

Furthermore, our survey shows that 46.9% of pediatricians who perform SIT in their office think that SIT is effective in polysensitized children. However, treatment of polysensitized patients with mixed allergens is rarely justified because of the lower likelihood of success and the potential for degradation of the mixed extract in storage (4). Many doctors were confused about the questions, “Can SIT prevent the onset of asthma?” and “Can SIT prevent the onset of new sensitization?”. However, there is evidence in the literature that SIT can prevent the onset of asthma as well as the onset of new sensitization. Mosbech & Østerballe reported a long-lasting therapeutic effect of SIT in a 6-year follow-up study of patients with grass-pollen rhinitis (8).

The establishment of SIT as a possible causal therapy for allergies offers important benefits if the therapy is used correctly. Unfortunately, most of the pediatricians’ offices lack the necessary resuscitative facilities, and, as shown by this

questionnaire survey, many pediatricians lack the knowledge needed to identify the patients who are most likely to benefit from SIT. Therefore, we suggest that regulations be enacted to reserve this kind of treatment to specialists with adequate knowledge of the effectiveness of SIT and its indications as well as the appropriate resuscitative facilities.

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Table 1. Pediatricians' answers to questionnaire

Questions	Answers (n=79) [n (%)]			Answers of those who perform SIT (n=32) [n (%)]		
	Yes	No	Don't know	Yes	No	Don't know
Do you think SIT is effective in grass-pollen allergy?	59 (74.7)	15 (19.0)	5 (6.3)	24 (75)	6 (18.7)	2 (6.3)
Do you think SIT is effective in house-dust-mite allergy?	31 (39.2)	38 (48.1)	10 (12.7)	15 (46.9)	14 (43.7)	3 (9.4)
Do you think SIT is effective in animal-dander allergy?	28 (35.5)	34 (43.0)	17 (21.5)	18 (56.3)	8 (25.0)	6 (18.7)
Do you think SIT is effective in mold allergy?	21 (26.6)	29 (36.7)	29 (36.7)	9 (28.1)	11 (34.4)	12 (37.5)
Do you think SIT is effective in food allergy?	19 (24.1)	46 (58.2)	14 (17.7)	11 (34.4)	17 (53.1)	4 (12.5)
Would you recommend SIT in allergic asthma?	58 (73.4)	20 (25.3)	1 (1.3)	27 (84.4)	5 (15.6)	–
If yes, would you recommend it in mild asthma?	14 (17.7)	41 (51.9)	3 (3.8)	12 (37.5)	15 (46.9)	–
If yes, would you recommend it in moderate asthma?	43 (54.4)	8 (10.1)	7 (8.9)	23 (71.9)	3 (9.4)	1 (3.1)
If yes, would you recommend it in severe asthma?	48 (60.7)	7 (8.9)	3 (3.8)	21 (65.6)	5 (15.6)	1 (3.1)
Would you perform SIT in patients who are sensitized to one allergen?	56 (70.9)	19 (24.0)	4 (5.1)	25 (78.1)	5 (15.6)	2 (6.3)
Would you perform SIT in patients who are sensitized to two allergens?	52 (65.8)	15 (19.0)	12 (15.2)	27 (84.4)	1 (3.1)	4 (12.5)
Would you perform SIT in polysensitized patients?	26 (32.9)	44 (55.7)	9 (11.4)	15 (46.9)	14 (43.7)	3 (9.4)
Can SIT prevent the onset of new sensitization?	14 (17.7)	48 (60.7)	17 (21.5)	6 (18.7)	19 (59.4)	7 (21.9)
Can SIT prevent the onset of asthma?	35 (44.3)	35 (44.3)	9 (11.4)	17 (53.1)	14 (43.7)	1 (3.1)
Do you recommend SIT in children?	59 (74.7)	18 (22.8)	2 (2.5)	28 (87.5)	4 (12.5)	–
Do you perform SIT in your office?	32 (40.5)	47 (59.5)	–	32 (100)	–	–