

Clinical & Experimental Allergy

Improving quality in allergy care

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The United Kingdom National Institute of Health and Care Excellence (NICE) quality standards on food allergy [1] and anaphylaxis [2] were published at the end of March 2016. These quality standards focus on high-priority areas for service improvement and are designed to support the measurement of improvements in clinical services in primary and community care. It is great to see that the profile of allergy in the UK is now sufficiently high to warrant two NICE quality standards. They seek to optimize the experience of patients by improving the diagnosis and assessment of food allergy and anaphylaxis. The food allergy quality standard highlights an allergy-focused history, allergen sensitization testing, a trial of elimination for suspected non-IgE-mediated allergy and a secondary or tertiary care review for suspected IgE-mediated food allergy. The anaphylaxis quality standard highlights the importance of a secondary or tertiary review for anyone with suspected anaphylaxis; training for patients prescribed an adrenaline autoinjector and consideration of immunotherapy for patients experiencing a systemic

reaction to bee or wasp venom. Reassuringly that these are very well aligned with the recent European food allergy and anaphylaxis guidelines [3, 4]. There is an expectation that local healthcare commissioners and providers should aim to achieve these quality standards, but they will though need a comprehensive programme to effectively implement them. The mention of venom anaphylaxis also coincides with the publication of the BSACI survey on venom immunotherapy [5]. In general, the current BSACI guidelines [6] are being followed in clinics although some areas are highlighted where improvement is required.



Mamidipudi Thirumala Krishna

With an allergy service focused on care delivered in relatively few clinical centres, we need to consider innovative ways to improve the access to care for our patients who may live at some distance from these centres. One approach

is telemedicine. In these issues of the Journal, Drs Krishna *et al.* [7] ask the question: Is there a role for telemedicine in adult allergy services? In the absence of evidence from allergy, they appraise the evidence from studies using this approach in other specialties. They conclude that telemedicine may have a role but that we need some well-designed clinical studies to assess its effectiveness and cost-effectiveness.

In clinic, we always hope that our advice is going to be followed. How often do we assess whether this actually happens once a patient leaves our consultation room? Drs Norman *et al.* [8] have assessed whether providing written dietary advice increases the amount of non-allergic nuts that children with existing nut allergies eat. They used a randomized, double-blinded approach with 75 children either supplied with the intervention recipe booklet plus monthly text reminders or the usual standard verbal dietary advice to eat non-

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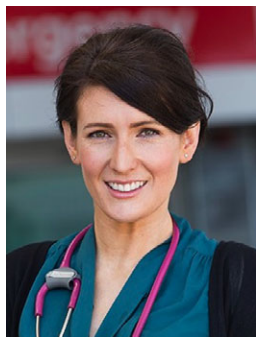
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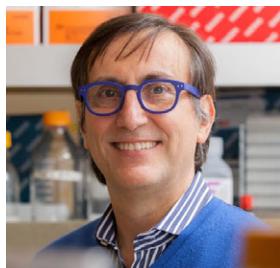
Caption to cover illustration: Roflumilast inhibited lung inflammation and T-helper (Th)-2 cytokines in a murine model of chronic asthma. (b) Both the Roflumilast groups exhibited a less peribronchial inflammatory cell infiltration. (c) Roflumilast groups showed a significant decrease in Th2 cytokines. [see figure 1 in S.W. Kim *et al.* (pp. 754–763)].

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Mellisa Norman

allergic nuts. Six months later, they found that there was no difference in the amount of non-allergic nuts eaten in each group. If eating non-allergic nuts is a useful strategy, we need to find better behavioural interventions to encourage our patients to consume these. They present data suggesting that a negative food challenge to the non-allergic nuts was a positive predictors for successful introduction into the diet while concern by the child about having a reaction was a negative predictor. This suggests that a supervised introduction to the non-allergic nuts within a clinic setting might be the best approach.



Alessandro Sette

With so many people now affected by hay fever, we perhaps have to think in terms of why some people do not develop an IgE response to grass pollen. In this issue, Drs Hinz *et al.* [9] examine the changes in timothy grass-specific T-cell responses in peripheral blood mononuclear cells (PBMC) in and out of the pollen season. PBMC collected from allergic individuals during the pollen season produced more IL-5 and IL-10 than PBMC collected out of season. For non-allergic

individuals, while less IL-5 was produced, there was considerable IFN γ production. However, these non-allergic individuals demonstrated decreased responsiveness during the pollen season. The authors suggest that non-allergic individuals actively modulate downwards their responses to grass pollen during the pollen season. Might this explain why they have not developed hay fever?



Six months before the 2016 BSACI Meeting might seem rather early to mention the annual meeting. Like all good events, these meetings need considerable planning. This year the meeting is under the guidance of Helen Brough and Tom Marrs. The meeting

will launch with a President's Plenary session revealing the outcome of Professor Durham's subcutaneous versus sublingual immunotherapy trial. The major focus of the BSACI annual meeting will be translating research into practice at the front line with sessions dedicated to anaesthetic allergy and occupational allergy affecting the skin. After last year's rather heated pro-con debate about whether peanut oral immunotherapy is ready for the clinic, the 2106 meeting will feature debates on the use of probiotics and 'nut bans' in schools. I look forward to meeting all my colleagues at the 2016 BSACI meeting.

References

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- 9 Hinz D, Seumois G, Gholami AM *et al.* Lack of allergy to timothy grass pollen is not a passive phenomenon but associated with allergen-specific modulation of immune reactivity. *Clin Exp Allergy* 2016; **46**:705–19.