

REVIEW ARTICLE

Life after LEAP: How to implement advice on introducing peanuts in early infancy

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Abstract: The increase in food allergies worldwide has led to mounting concern among healthcare providers, families, schools, and the food industry. Of particular interest is the growing prevalence of peanut allergy. The Learning Early About Peanut Allergy (LEAP) study confirms that the early introduction of peanut significantly decreases the risk of developing peanut allergy among high-risk children. However, a number of issues, such as a unified definition of high risk and whether or not to screen patients before peanut introduction, remain. This article will review the LEAP findings and the new peanut allergy prevention guidelines, and then briefly discuss recommendations on the introduction of other allergenic foods based on results from other food allergy prevention randomised controlled trials.

Key words: food allergy; guideline; infant feeding; peanut allergy; prevention.

Introduction

Peanut allergy affects 1–3% of children in westernised countries and is a growing problem. Evidence suggests that the US prevalence may have tripled over the past 10–15 years.¹ In Australia, over 10% of 12-month-old infants have a food allergy proven by oral food challenge (OFC) to one of three common

immunoglobulin E (IgE)-mediated allergens: peanut (3.0%), egg (8.9%) and sesame (0.7%).² As the prevalence of peanut allergy among infants and children continues to rise in some countries, so does uncertainty in the minds of parents and care givers about the introduction of peanuts in early infancy as a means of avoiding allergy later in life. Given the significant impact of food allergies on health and quality of life, a considerable amount of energy and time has been devoted to identifying approaches that may lower the risk of the development of these allergies.³

Although the recent Learning Early About Peanut Allergy (LEAP) study provides data from a randomised controlled trial (RCT), showing that early introduction of peanuts significantly decreases the risk of developing peanut allergy among high-risk children and modulates immune responses to peanuts,⁴ a number of issues remain to be resolved. These include, but are not limited to, a unified, consistent definition of high risk and the benefit gained by screening for possible allergy versus universal, early introduction of peanut into infants' diets. This review highlights international consensus efforts for guidance on the implementation of early peanut introduction and several of the controversies surrounding this since LEAP was published in March 2015.

Key Points

- 1 Food allergies, including peanut allergy, have become a major health concern in many countries around the world.
- 2 The Learning Early About Peanut Allergy study, the first randomised controlled trial to study the introduction or avoidance of dietary peanut in infants aged between 4 and 11 months, found that infants who consumed peanut between 4 and 11 months of age were significantly less likely to have developed peanut allergy by age 5 years than those infants who avoided peanut until age 5 years.
- 3 Clinical guidelines have been revised to reflect the Learning Early About Peanut Allergy study findings and address other issues, such as how to introduce peanut in high-risk infants.

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Evolution of Food Allergy Prevention

In 1954, the American Academy of Pediatrics (AAP) Committee on Nutrition was formed, and in 1958, they issued their first report that summarised the science of solid food feeding to infants. No specific age for solid food introduction was provided at that time, but it did state that there were no attributable benefits of introduction before age 3–4 months.⁵ Before the year 2000, the AAP Committee on Nutrition had no specific guidelines for what foods to avoid or include in infant diets with respect to prevention, but in 2000, it recommended that mothers eliminate

peanuts and tree nuts and consider eliminating eggs, cows milk, fish and perhaps other foods from their diets while breastfeeding. In addition, they recommended the delayed introduction of certain highly allergenic foods: dairy until age 1 year; eggs until age 2 years; and peanuts, nuts and fish until age 3 years.⁶

In 2008, the AAP Committee on Nutrition and Section on Allergy and Immunology revised these earlier recommendations, concluding that evidence did not support a role for maternal dietary restrictions during pregnancy or lactation. Furthermore, there was little evidence that delaying the timing of the introduction of complementary foods beyond 4–6 months of age prevents development of atopic disease.⁷ Guidance from the Australasian Society of Clinical Immunology and Allergy had also suggested there is little evidence that delaying the introduction of complementary foods beyond 6 months reduces the risk of allergy.⁸

From 2010 to 2014, emerging data from observational studies suggested that the delayed introduction of complementary foods may actually increase the risk of food allergies, and the early introduction of allergenic foods may prevent them.^{9–11}

Learning Early About Peanut Allergy

LEAP was the first large RCT of peanut introduction or avoidance, enrolling a total of 640 infants, aged ≥ 4 months to <11 months. The primary endpoint was the proportion of subjects with peanut allergy at 5 years of age.⁴

Study design

Subjects were assigned to different groups according to whether they had a pre-existing sensitivity to peanut extract, as determined by a skin prick test (SPT). The two groups comprised those with no measurable wheal post SPT (negative SPT) and those with wheal measuring 1–4 mm in diameter (considered a positive SPT in LEAP). Infants in each group were then randomised to a subgroup in which peanut would be consumed or to a subgroup in which it would be avoided for 5 years.

Those subjects assigned to consumption were challenged orally, with those having negative SPT results being given 2 g of peanut protein in a single dose and those with positive SPT results given incremental doses up to a total of 3.9 g of peanut protein. Those who reacted avoided peanuts but were included in the intention-to-treat analysis.⁴

Subjects in the consumption subgroup without a reaction to the baseline challenge consumed ≥ 6 g of peanut protein distributed over three or more meals per week until 5 years of age. An OFC was used to determine peanut allergy at 5 years of age.⁴

Results

At 5 years of age, 1.9% of the SPT-negative peanut consumption group (the primary prevention group, i.e. before onset of sensitisation) were allergic to peanut, compared with 13.7% of the SPT-negative avoidance group. The absolute difference in risk of 11.8% (95% confidence interval (CI): 3.4, 20.3; $P < 0.001$) translates to an 86.1% relative reduction (Fig. 1).⁴ Compared with the consumption group, the prevalence of peanut allergy was significantly higher in the avoidance group in the secondary prevention cohort (i.e. SPT-positive but not initially allergic) (Fig. 1).

LEAP-On

Results from the follow-up study, LEAP-On, demonstrated that among children introduced to peanuts in the first year of life and who continued to routinely consume them for 5 years, a 12-month period of peanut avoidance was not associated with an increase in the prevalence of peanut allergy.¹² In other words, transient desensitisation was not seen when peanut was removed from the diet for 1 year, but rather there was sustained unresponsiveness to peanut. The LEAP subjects will be continued to be followed over time to assess whether true long-term tolerance is seen.

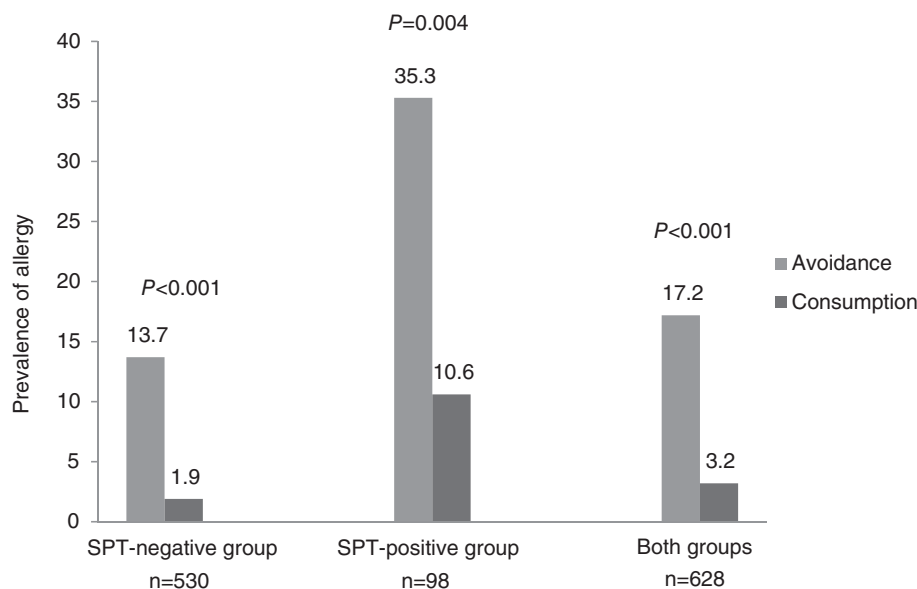


Fig. 1 The Learning Early About Peanut Allergy study: Primary outcome (intention-to-treat analysis).⁴

A Look at the Addendum Guidelines

In response to the LEAP findings, the US National Institute of Allergy and Infectious Diseases (NIAID), in co-operation with other stakeholders, convened an Expert Panel to develop an addendum to the 2010 Guidelines for the Diagnosis and Management of Food Allergy in the United States, specifically addressing the prevention of peanut allergy (henceforth referred to as the Addendum Guidelines).¹³

Definition of high risk

In the LEAP trial, high risk was defined by the presence of severe eczema and/or egg allergy. Three different criteria were used to assess eczema severity. The first was parents' description of the severity; the second was the frequency of use of topical creams and ointments containing corticosteroids or calcineurin inhibitors; and the third was the Scoring Atopic Dermatitis (SCORAD) System evaluation.

A more widely used definition of high risk is an infant who has a first-degree relative (≥ 1 parent or sibling) with an allergic condition, such as atopic dermatitis, food allergy, asthma or allergic rhinitis. However, even this definition of high risk is problematic, as it is all-inclusive and thus not weighted for type and number of allergic diseases. Thus, there is a non-uniformity in defining risk: family history versus severe eczema/egg allergy. A potential solution would be to implement early peanut introduction in both risk groups. A further problem lies with defining eczema severity. The SCORAD System evaluation is not practical in general practice and is time consuming. What is needed is an easy-to-use definition of severe eczema for clinicians and/or parents to assess eczema severity objectively.

The Addendum Guidelines continue to define high risk for peanut allergy as infants with severe eczema and/or egg allergy. Severe eczema is defined as persistent or frequently recurring eczema with typical morphology and distribution assessed as severe by a health-care provider and requiring frequent need for prescription-strength topical corticosteroids, calcineurin inhibitors or other anti-inflammatory agents despite appropriate use of emollients. Egg allergy is defined as a SPT wheal ≥ 3 mm with egg white extract in an infant with a history of allergic reaction to egg, or a patient who has failed an egg OFC.¹³

Introducing peanut

The Addendum Guidelines provide guidance for the introduction of peanut-containing foods according to three specific risk categories of infants, with three respective guideline recommendations according to this risk stratification¹³:

1 Guideline 1 (severe eczema and/or egg allergy): Age-appropriate peanut foods should be introduced as early as 4–6 months, (i) after introduction of other solid foods and (ii) prior to peanut introduction, after consulting with their health-care provider, consideration of evaluation with a peanut-specific serum IgE (PN-sIgE) test or SPT or both. Depending on the results of the PN-sIgE level and/or SPT and provider/care giver preference, peanut-containing foods could be introduced in the provider's office or at home.

2 Guideline 2 (mild to moderate eczema): Peanut-containing foods should be introduced around 6 months of age according to family preferences and cultural practices. Peanut-containing foods can be introduced at home without an in-office evaluation by a health-care provider, unless the infant's health-care provider or care giver prefers an evaluation and/or a supervised feeding.

3 Guideline 3 (no eczema or food allergy): Freely introduce peanut-containing foods together with other solid foods according to family preferences and cultural practices.

How to introduce peanut

Specific amounts, different types of peanut-containing foods that are safe for infants to eat and instructions on how to introduce at home or in-office via a supervised feeding or by graded OFC are provided in detail in Appendix D of the Addendum Guidelines. General recommendations for home peanut introduction include the following¹³:

- 1 Peanut should not be the first solid food introduced into an infant's diet.
- 2 Feed an infant only when he or she is healthy without a concomitant illness such as an upper respiratory infection.
- 3 Give the first peanut feeding at home rather than at day care or a restaurant.
- 4 Ensure that at least one adult care giver is able to focus all of his/her attention on the infant being fed peanut for the first time.
- 5 Ensure the care giver will have enough time, up to several hours, after ingestion to watch the infant for signs of an allergic reaction.
- 6 It is always safest to give an infant a small taste of a new food such as peanut and wait 10 minutes before giving a larger portion, rather than giving a full serving all at once.
- 7 Peanut butter directly from a spoon and whole peanuts should not be given to children less than 4 and 5 years of age, respectively, due to choking risk.

Dose and duration of peanut ingestion

The Addendum Guidelines recommend that infants who meet criteria for Guideline 1 should consume approximately 6–7 g of peanut protein per week divided over 3 or more feedings. However, there are uncertainties about the optimal amount and duration of peanut consumption once introduced. The LEAP trial only studied one time period of peanut ingestion (5 years), and only one minimum amount per week (6 g). It is, therefore, unknown whether consuming larger amounts for less time or smaller amounts for longer time would be as effective as the time and amount studied in LEAP. Infants with the lower-risk stratifications in Guidelines 2 and 3 should freely consume peanut-containing foods according to family and cultural practices, without specific amounts and frequencies provided,¹³ although in some cases specific amounts may be recommended. A simple recommendation for parents with infants of any risk is to have their infants eat peanut early in the diet (before age 1 year) and eat it often, as often as they like, rather than adding more potential stress about peanut introduction with exact ages and amounts.

It should be noted that identifying which infants should be considered for screening prior to peanut introduction, specific

cut-offs for SPTs and PN-sIgE levels if screened, when to consider home peanut introduction versus in-office challenge to peanut based on these tests, and the amounts and instructions for peanut introduction at home or in-office are provided in great detail in the Addendum Guidelines.¹³

Unanswered questions

One fundamental question that has been raised with respect to LEAP is whether or not to screen infants for possible peanut allergy without a history of prior peanut ingestion. The LEAP study did not investigate the necessity of screening high-risk infants, and previous food allergy guidelines recommend against screening for food allergy due to the inaccuracy of allergy testing without a clinical history of reaction. Logistically, it is not possible to perform SPT on every infant aged between 4 and 11 months and OFCs on the subset that test positive. Besides the difficulty in seeing all these patients within a narrow 5-month window before age 1 year, this may also have a serious impact on an allergist's ability to offer care to other patients. As an alternative to routine SPT, clinicians could instead discuss the low risk of anaphylaxis with home introduction of peanut and offer advice on safe, gradual introduction in the home setting,¹⁴ a practice that has been safely used for years in Israel and Australia and one that is outlined in the appendices of the Addendum Guidelines.

If skin testing is performed, however, and is positive (≥ 3 mm), there are no universal, clear cut-offs for wheal size in patients without a history of oral peanut ingestion. As a means to minimise overdiagnosis of food allergy by relying on SPTs and serum food-specific IgE levels alone in patients who have not ingested a food, 95% positive predictive values (PPV) have been determined, above which it is unlikely to pass an OFC to that food. HealthNuts, the only study that has skin tested and challenged a large number of infants close to the infant age group in LEAP, determined a 95% PPV for peanut of ≥ 8 mm.¹⁵ Using this PPV in the Addendum Guidelines seemed to be the most practical course of action until new evidence emerges. However, it should be noted that 95% PPVs have significant limitations, first and foremost being that these levels are only truly applicable to the group of subjects studied at that particular point in time, and, therefore, may not be reflective of other populations or more general allergy practices.

The addition of serum food-specific IgE testing to the Addendum Guidelines is also controversial, but one that was felt necessary by the consensus of members of the Expert Panel, primarily as a means for primary care providers and dermatologists to screen their high-risk patients if warranted because they do not perform skin testing. Based on the Addendum Guidelines, if the PN-sIgE is positive, that is >0.35 kU/L, then referral to a specialist for consultation and possible SPT is recommended. We know, though, that from LEAP, positive PN-sIgE levels did not correlate with positive OFC results, and numerous studies have proven the low PPV of a positive food-specific IgE level in the absence of a clinical allergic reaction with prior ingestion history. A further concern with PN-sIgE testing is that peanut may often not be the only allergen tested, as it is not uncommon for physicians outside of an academic centre to order a food allergen panel, which includes multiple major food allergens rather than just peanut and may lead to unnecessary food avoidance and the need to perform other OFCs to prove lack of clinical reactivity.

Taken at face value, however, the LEAP results clearly demonstrate that early introduction of peanut can dramatically reduce the risk of peanut allergy development. Thus, because we see infants without a family history or other risk factor for food allergies still develop them, should we recommend the introduction of peanut to all infants 11 months of age and younger, not just ones considered high risk based on the LEAP criteria? There is no simple answer to this question and, indeed, many other questions remain unanswered, as highlighted by a recent editorial accompanying the publication of the Addendum Guidelines.¹⁶ These include, but are not limited to, the following: should infants routinely consume 2 g of peanut protein three times a week for 5 years or can they consume smaller amounts intermittently for a shorter period of time? If regular consumption is stopped for a prolonged period of time, will tolerance persist? Can the LEAP findings be extrapolated to other potentially allergenic foods?

Recommendations for Other Foods

The Enquiring About Tolerance (EAT) trial enrolled infants from the general population, that is, not necessarily at high risk for food allergy, at 3 months of age, and randomised them to either early introduction of 6 major food allergens (milk, egg, peanut, sesame, fish and wheat) from 3 months to before 6 months of age or introduction of the six foods after age 6 months, along with breastfeeding. Although it was safe to introduce these major allergens, it was not very feasible at the frequency and dose required for the study. There were no differences in food allergy prevalence in the intention-to-treat analysis; however, the per-protocol analysis did show significantly lower prevalence of peanut and egg allergies with earlier introduction.¹⁷ It should be noted that the amount and quality of evidence supporting Guidelines 2 and 3 above is low, and was partially based on these EAT study results.

In addition to the EAT study, there have been five RCTs that have examined the timing of egg introduction. As seen in Table 1, the populations studied in the trials ranged from normal to intermediate to high risk, and the type and amount of egg consumed varied as well, from 350 mg daily to 2.5 g thrice weekly of raw, pasteurised egg.^{18–21} Only the Natsume *et al.* PETIT trial used heated egg, a practice more commonly used in the USA and other countries, and a 2-dose introduction regimen, along with atopic dermatitis management.²² Given that baked/cooked egg is less allergenic than raw egg, it was not surprising that there were more adverse events in the studies using the raw form^{18–20}; only one of these four studies (BEAT) showed a decrease in egg sensitisation with early egg introduction.²¹ However, using the cooked form of egg in the PETIT trial resulted in a significant reduction in egg allergy development, so much that the trial was stopped early at an interim analysis stage.²²

Finally, there was a recent meta-analysis on timing of allergenic food introduction published by Ierodiakonou *et al.* They determined that there was moderate-certainty evidence from the five egg RCTs (1915 participants) that early egg introduction at 4–6 months was associated with reduced egg allergy (risk ratio (RR): 0.56; 95% CI: 0.36–0.87; $I^2 = 36\%$; $P = 0.009$). From the two peanut RCTs trials (1550 participants), there was moderate-certainty evidence that early peanut introduction at 4–11 months was associated with reduced peanut allergy (RR: 0.29; 95% CI: 0.11–0.74; $I^2 = 66\%$; $P = 0.009$).²³

Table 1 Randomised controlled trials studying egg allergy in infants^{18–22}

Study	N	Population	Intervention	Primary outcome	Results
STAR	86	High-risk infants with moderate-to-severe eczema	0.9 g raw whole egg powder/day (0.4 g protein/day) from 4 to 8 months Cooked egg at 8 months	IgE-mediated egg allergy at 12 months based on positive SPT and egg OFC	Study terminated early: one third of patients reacted to egg at entry OFC At 12 months, 33% had egg allergy in egg group vs. 51% in control (NS)
STEP	820	Intermediate risk: • Atopic mums (allergic disease and positive environmental SPT) • Infants: no allergic disease	0.9 g raw whole egg powder/day (0.4 g protein/day) from 4 to 6.5 months Cooked egg at 8 months	IgE-mediated egg allergy at 12 months based on positive SPT and egg OFC	No significant differences in egg allergy between groups No anaphylactic reactions at initial egg introduction
BEAT	319	Intermediate risk: • Infants with first-degree relative with atopy • Infants: negative egg SPT	350 mg protein/day raw whole egg powder from 4 to 8 months Cooked egg at 8 months	Sensitisation by SPT at 12 months of age	Subjects in egg group vs. placebo had significantly less egg sensitisation (10.7% vs. 20.5%, $P = 0.03$) No harm with egg introduction
HEAP	406	Normal risk general population • Infants with IgE <0.35 kU/L at enrollment	Thrice weekly 2.5 g egg protein from 4 to 6 months until 12 months	Sensitisation based on egg IgE ≥ 0.35 kU/L at 12 months of age	No evidence of preventing egg sensitisation or allergy High rate of anaphylaxis at egg introduction at entry
PETIT	121	High-risk infants with atopic dermatitis	50 mg heated egg from 6 to 9 months daily 250 mg heated egg from 9 to 12 months daily Combined with aggressive treatment of eczema	IgE-mediated egg allergy at 12 months of age based on OFC	Prevalence of egg allergy 37.7% in placebo vs. 8.3% in egg group ($P = 0.0013$) No serious adverse events

BEAT, Beating Egg Allergy Trial; HEAP, Hens Egg Allergy Prevention; OFC, oral food challenge; PETIT, Prevention of Egg Allergy with Tiny Amount Intake; SPT, skin prick test; STAR, Solids Timing for Allergy Reduction; STEP, Starting Time for Egg Protein.

Taken as a whole, we can make some basic conclusions with respect to the other RCTs discussed here. With respect to egg, the early introduction of cooked egg is safer, especially when introduced in small amounts, such as in a baked form first, before proceeding to more concentrated forms such as hard-boiled or scrambled egg. The timing of egg introduction to prevent allergy may need to be sooner than 4 months in the most high-risk patients with severe eczema. With less known about the other major allergens, including milk, seafood, tree nuts and wheat, EAT did at least demonstrate that the introduction of multiple major allergenic foods in infancy appears safe and does not affect breastfeeding rates. Therefore, given the data to date, and similar to the change in recommendations made in 2008, there appears to be no benefit with respect to food allergy prevention in delaying the introduction of any major food allergen into an infant's diet.

Conclusions

Healthcare providers should recommend introduction of peanut-containing products into the diet of high-risk infants early in life, around 6 months but not before 4 months, where peanut allergy

is prevalent. Those infants with early-onset eczema that is difficult to manage with standard treatment and/or egg allergy in the first 4–6 months of life may benefit from evaluation by an allergist prior to peanut introduction. Given the impressive results from the LEAP study, it is likely that all infants may benefit from early peanut introduction for reducing the risk of allergy development.

Based on other RCT data and also previous observational data, there is likely no significant harm from introducing all major food allergens into an infant's diet prior to age 1 year, but whether early introduction of other allergenic foods like egg and milk will lead to similar benefits seen with peanut remains to be determined. However, it is clear that without active intervention by primary care providers and parents in implementing these guidelines, it is likely that such high-risk infants will remain at risk for delayed introduction of allergenic foods into their diet.

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Multiple Choice Questions

- Which of the following statements about the prevalence of food allergies is correct?
 - The prevalence of food allergy is decreasing worldwide.
 - Peanut allergy affects between 5% and 8% of children in the westernised world.
 - The prevalence of peanut allergy may have quadrupled over the past 10–15 years in the USA.
 - In Australia over 20% of 12-month-old infants have a food allergy proven by challenge.
 - In Australia the prevalence of peanut allergy is 3% among 12-month-old infants.
- Which of the following statements about the LEAP study is correct?
 - LEAP is the second large randomised controlled trial of peanut introduction or avoidance.
 - LEAP enrolled a total of 840 infants, aged ≥ 4 months to < 11 months.
 - The primary endpoint was the proportion of participants with peanut allergy at 2 years of age.
 - The two groups comprised those with wheal post SPT measuring 2–4 mm in diameter and those with wheal measuring 5–8 mm in diameter.
 - Patients in the consumption subgroups without a reaction to the baseline challenge consumed ≥ 6 g of peanut protein distributed over three or more meals per week.
- Which of the following statements is incorrect?
 - LEAP found that infants in whom dietary peanut was introduced between the ages of 4 and 11 months had significantly lower prevalence of peanut allergy at 5 years of age.
 - The NIAID addendum recommends introducing age-appropriate peanut-containing food in infants with severe eczema, egg allergy or both; those with mild-to-moderate eczema; and those without eczema as early as 4–6 months of age to reduce the risk of peanut allergy.
 - The NIAID addendum suggests that infants with wheals > 4 mm (a group excluded from LEAP) may benefit from early introduction of peanut if they tolerate peanut orally.
 - The latest Australasian Society of Clinical Immunology and Allergy guidelines published in 2016 suggest there is no good evidence that introducing dietary peanut in infant with severe eczema and/or egg allergy before 12 months of age can reduce the risk of peanut allergy.
- In Australia the prevalence of peanut allergy is 3% among 12-month-old infants. Correct: Egg allergy affects 8.9% and sesame allergy affects 0.7%.
- Which of the following statements about the LEAP study is correct?
 - LEAP is the second large randomised controlled trial of peanut introduction or avoidance. Incorrect: LEAP is the first large randomised control trial.
 - LEAP enrolled a total of 840 infants, aged ≥ 4 months to < 11 months. Incorrect: LEAP enrolled 640 patients.
 - The primary endpoint was the proportion of participants with peanut allergy at 2 years of age. Incorrect: the primary endpoint was the proportion of participants with peanut allergy at 5 years of age.
 - The two groups comprised those with wheal post SPT measuring 2–4 mm in diameter and those with wheal measuring 5–8 mm in diameter. Incorrect: The two groups comprised those with no measurable wheal post SPT and those with wheal measuring 2–4 mm.
 - Patients in the consumption subgroups without a reaction to the baseline challenge consumed ≥ 6 g of peanut protein distributed over three or more meals per week. Correct: This is the similar to the dose recommended by the NIAID addendum.
- Which of the following statements is incorrect?
 - LEAP found that infants in whom dietary peanut was introduced between the ages of 4 and 11 months had significantly lower prevalence of peanut allergy at 5 years of age. Correct: Interestingly, the secondary prevention group also experienced significant reduction in the prevalence of food allergy at age 5 years.
 - The NIAID addendum recommends introducing age-appropriate peanut-containing food in infants with severe eczema, egg allergy or both; those with mild-to-moderate eczema; and those without eczema as early as 4–6 months of age to reduce the risk of peanut allergy. Correct: This reflects the LEAP findings.
 - The NIAID addendum suggests that infants with wheals > 4 mm (a group excluded from LEAP) may benefit from early introduction of peanut if they tolerate peanut orally. Correct: The addendum recommends that infants with wheals > 4 mm may benefit.
 - The Guidelines addenda published in 2017 suggest there is no good evidence that introducing dietary peanut in infant with severe eczema and/or egg allergy before 12 months of age can reduce the risk of peanut allergy. Incorrect: The addenda suggest there is good evidence supporting dietary peanut in infants with severe eczema.

Answers.

- Which of the following statements about the prevalence of food allergies is correct?
 - The prevalence of food allergy is decreasing worldwide. Incorrect: The prevalence of food allergy is increasing.
 - Peanut allergy affects 5–8% of children in the westernised world. Incorrect: Peanut allergy affects 1–3% of children worldwide.
 - The prevalence of peanut allergy may have quadrupled over the past 10–15 years in the USA. Incorrect: The prevalence has tripled.
 - In Australia over 20% of 12-month-old infants have a food allergy proven by challenge. Incorrect: Just over 10% of 12-month-old infants have a food allergy proven by challenge.

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