



Pediatric food allergy clinic: a way to improve the quality of service

Zakaria Barsoum¹

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Paediatric food allergy is a common problem with a prevalence of 5% across the UK [1]. There are increasing demands of developing allergy services across the health care system in the UK. Establishing new allergy services among district hospitals, run by paediatricians with a special interest in allergy is recommended. Allergy clinics are multi-disciplinary in their design with emphasis on the role of dieticians and asthma nurses in the management of allergy. Clinicians should always think about tools to improve the quality of allergy clinics. We propose an allergy pro forma to be used in food allergy clinics to improve the quality of the service (Supplementary material 1).

The proposed pro forma should be thorough, concise, pertinent and succinctly focus on the important aspects of food allergy, such as age at presentation, type of food allergy, such as dairy, nut, egg and other food allergies. Allergy pro forma should include information about type of allergic reactions whether immediate, delayed or mixed and a brief description of clinical symptoms including anaphylaxis or breathing difficulties requiring the administration of adrenaline auto-injectors as well as family history of atopy and other co-morbidities associated with food allergy, such as asthma, allergic rhinitis eczema or gastro-oesophageal reflux (GOR).

Whether food allergy was confirmed prior to consultation, by elimination and re-introduction of allergen later, should be recorded. A brief description of clinical examination including child's weight and height should be visible on the pro forma. Previous investigations by skin prick testing or immunoglobulin E (IgE) and radioallergen sorbent (RAST) test should be dated and recorded. Adrenaline auto-injectors

whether required or not or already with the patient should be noted.

Action plans of management pathways should be briefly described. These may include performing a skin prick testing, IgE and RAST testing or both, prescribing adrenaline auto-injectors, advice to continue to avoid a specific allergen or to challenge with the allergen either at home if it is safe to do so or under medical supervision at hospital if required. Timing of food challenge should be clear either following consultation or four to six months later in liaison with dietician advice. Plans may entail advice to confirm allergy by encouraging parents to eliminate the possible allergen and to re-introduce it later after 4–6 weeks depending on their level of comfort and their willingness to do so without anxiety.

Further follow-up appointments or discharge from the clinic should be clearly stated. Allergy pro forma is key to clinicians to direct clinical care to be more focused on obtaining a proper allergy focused clinical history which is a quality statement in the management of allergy [2]. Additionally, they speed up the duration of consultation by focusing on aspects related to allergy, subsequently, saving time and efforts of clinicians. Allergy pro forma should be brief, thorough and informative and helpful, with much less paper to use, and easy to follow by general practitioners; therefore, allergy pro forma can improve the quality of clinical letters and shorten them by referring to copies of pro forma that will be dispatched to general practitioners. Allergy pro forma help facilitate further auditing and monitoring the service and make data collection easier and more accessible.

Reflecting on our practice in our unit, allergy service started in 2018 and was audited a year later using the pro forma. Reports from auditors were encouraging in terms of easy access and collection of data and the response from general practitioners was also satisfactory.

We would encourage each pediatric unit running allergy services to develop an appropriate allergy pro forma to facilitate and streamline the quality of service. We are enclosing our own pro forma used in our unit aiming it may be of help

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✉ Zakaria Barsoum
doctorzakaria@yahoo.com

¹ South West Acute Hospital-Paediatric Department, 124
Irvinestown Rd, Enniskillen BT74 6DN, Northern Ireland

to other clinicians as they start a new allergy service in their units or continue to find out ways of quality improvement of pediatric allergy services.

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflicts of interest.

References

1. Holloway E, Fox A, Fitzsimons R. Diagnosing and managing food allergy in children. *Practitioner*. 2011;255:19–22.
2. The National Institute for Health and Care Excellence (NICE) (2016) NICE report. March 2016. <https://www.nice.org.uk>. Accessed 24 Mar 2016

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Paediatric Food Allergy Clinic

Date:

Patient details:

- Age:
- Weight: Centile: Height: Centile:
- Type of allergy: Cow's Milk Protein Allergy (CMPA)
Nuts Others:
- Asthma Allergic Rhinitis Eczema Gastro-Oesophageal Reflux (GOR)
- Family history of food Allergy:
- Brief description of symptoms:
- Type of reaction:
Immediate reaction Delayed reaction Both
- Feeding:
- Clinical examination:
- Investigations: Skin Prick Test (SPT): Result:
IGE: RAST:
- Confirmed Food Allergy based on elimination and re-challenge.
- Adrenalin pen: Required Not Required Already with patient
- Clinical advice:
- Perform SPT Result:

- Perform IGE &RAST
- Avoid allergen.
- Adrenalin pen.
- Nutramigen or Elemental AA formula for 2-6 weeks, re-challenge and confirm allergy with follow up.
- Nutramigen or Elemental AA formula and challenge after 6 months with follow up.
- Challenge with allergen now with advice from Dietician on milk ladder approach.
- Challenge with allergen after 4- 6 months with advice from dietician.
- Challenge with allergen now under supervision of carers at home.
- Challenge with allergen under supervision in day ward.
- Add anti reflux medication or Carobel or both for GOR.
- No longer allergy and discharge from clinic.
- Review in one year in OPD.
- Review in 6 months in OPD.