

Correspondence

Reply

To the Editor:

We thank Kelso¹ for submitting his thoughtful commentary regarding the “Consensus communication on early peanut introduction and the prevention of peanut allergy in high-risk infants.”² In his commentary, Kelso identifies several key questions that remain unanswered, both by the Learning Early About Peanut Allergy (LEAP) study³ and this interim consensus communication: (1) how do we best define “at risk” or “high risk”? (2) Is screening infants helpful, necessary, practical, cost-effective, or even harmful in the end because it may falsely exclude some infants who might benefit from early peanut introduction? (3) What are the real safety risks to infants of early peanut introduction without screening? and (4) If screening is to be performed, what should the skin test size cutoffs be that should preclude an infant from undergoing an observed food challenge?

The purpose of the consensus communication was not to answer all these questions, but rather to provide interim guidance on how to broadly interpret the LEAP data for physicians across the globe who may take care of infants potentially at risk for peanut allergy. Representatives from governing academic, medical societies, including Allergy, Pediatrics, and Dermatology, debated for several months on how to best answer this single question: what can we collectively do now, based on data from this one randomized controlled trial, to prevent peanut allergy? All these representatives (many of whom were asked to be on the National Institute of Allergy and Infectious Diseases Expert Panel) were aware of a forthcoming Expert Panel meeting sponsored by the National Institute of Allergy and Infectious Diseases, during which the questions raised by Kelso—and many others—were to be discussed. The

outcome of the Expert Panel’s deliberations will be an addendum to the 2010 National Institutes of Health Food Allergy Guidelines⁴ that focuses specifically on the prevention of peanut allergy, emphasizing whether or not to screen, risk stratification for screening, how best to screen, and then how to implement the results of any screening; this is scheduled for publication by the end of this year. With this forthcoming document, and more data from other randomized controlled trials of early allergenic food introduction coming in the next several years, we hope that some of the currently unanswerable questions will be resolved.

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Disclosure of potential conflict of interest: D. M. Fleischer serves on the National Peanut Board Food Allergy Council as an unpaid consultant. H. A. Sampson is an unpaid consultant on the DBV Scientific Advisory Board.

REFERENCES

1. Kelso JM. How to apply the LEAP study. *J Allergy Clin Immunol* 2016;137:XXX-XXX.
2. Fleischer DM, Sicherer S, Greenhawt M, Campbell D, Chan E, Muraro A, et al. Consensus communication on early peanut introduction and the prevention of peanut allergy in high-risk infants. *J Allergy Clin Immunol* 2015;136:258-61.
3. DuToit G, Roberts G, Sayre PH, Bahnson HT, Radulovic S, Santos AF, et al. Randomized trial of peanut consumption in infants at risk for peanut allergy. *N Engl J Med* 2015;372:803-13.
4. Boyce JA, Assa’ad A, Burks AW, Jones SM, Sampson HA, Wood RA, et al. Guidelines for the diagnosis and management of food allergy in the United States: summary of the NIAID-Sponsored Expert Panel report. *J Allergy Clin Immunol* 2010;126:S1-58.

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