

Correspondence

Reply

To the Editor:

All case-controlled studies inevitably suffer from some degree of bias. The main purpose of our study¹ was to relate recall of peanut consumption to subsequent clinical phenotype. We had no option but to exclude families who did suspect peanut allergy because this would have skewed their recollection of previous peanut consumption, especially because public health advice to avoid peanut during pregnancy and lactation strongly suggests to parents that maternal consumption is causally linked to later allergy. Had we included children with known or suspected peanut allergy in the study, our findings could have been explained on the basis of parental exaggeration of peanut consumption in affected families. Had we found the opposite findings (decreased household peanut consumption in affected families), this could have been interpreted on the basis of parental denial because of feelings of guilt.

However, avoiding one form of bias inevitably leads to another form of bias, and doctors Keet and Wood² do rightly raise the question of whether by selecting such patients, we have a less representative sample of the population. Although the median age of children in our study was 26 months, 46.5% (206/443) of the children in the study were less than 2 years of age (and 25% were less than 14 months of age).

We repeated the analysis for the main outcomes using only the subgroup of children under 2 years of age and show no different results, suggesting little influence of age of child at enrollment on the results, as shown in Table I.

Indeed, the relationship between increasing household peanut and likelihood of peanut allergy is more pronounced in the younger children.

Recent data have further supported the possible protective effect of early exposure to peanut that our data suggest,³ but we agree that this does need to be further explored with prospective studies. This work is currently underway as part of the Learning Early About Peanut Allergies (LEAP) study (<http://www.leapstudy.co.uk>) being conducted at King's College London, funded by the Immune Tolerance Network.

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TABLE I. Relative risk of peanut allergy

Household peanut (g peanut protein)	Age less than 2 y		Age more than 2 y	
	Odds ratio of peanut allergy	95% CI	Odds ratio of peanut allergy	95% CI
0	1		1	
0.1-3.75	2.9	0.5-17.4	1.1	0.3-3.8
3.75-15	9.2	1.9-44.9	4.8	1.7-13.5
15+	40.9	8.3-200.3	15.7	5.5-44.5

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Disclosure of potential conflict of interest: G. Lack has provided consultation for the advisory board for Synovate, Novartis, and ALK-Abelló; has provided academic lectures for SHS Nutricia, Nestlé, and SHS International; has received research support from the Immune Tolerance Network, the National Peanut Board, the Food Standards Agency, the Medical Research Council, the Food Allergy and Anaphylaxis Network, and the Food Allergy Initiative; and has served as a scientific advisor for the Anaphylaxis Campaign and the National Peanut Board. A. T. Fox has served as a consultant for SHS Nutricia and has attended a conference for Nestlé. P. Sasieni has received research support from Cancer Research UK and Health Technology Assessment, and has provided expert witness testimony on a variety of patent issues, none related to allergy. G. du Toit has received research support from the National Peanut Board, USA, and the Immune Tolerance Network, National Institutes of Health. The other author has declared that he has no conflict of interest.

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