

## **Editorial**

# **Allergy – still a Cinderella subject**

Despite the best efforts of specialist allergy societies in many countries around the world the discipline of allergy continues to struggle for its existence (1). For paediatric allergy the problems are even greater.

It is interesting to speculate on why there is so much difficulty in establishing a recognized identity and profile for specialization in allergy. Given the incredibly high prevalence of allergic disease which dwarfs that of any other chronic condition, one might have expected to see a very flourishing medical discipline. It is even more of a mystery that a discipline with a very firm scientific basis which has led to a dramatic increase in the range of therapeutic modalities, many of which are likely to prove very expensive that governments are not demanding an increase in allergy training and services.

The problem has arisen because as the scientific basis of medicine has become ever more sophisticated, there has been a progressively increasing focus on specialization. In most countries this has evolved system by system. Thus tertiary specialization has carved up the holistic approach to medicine into organs. Allergy being a discipline which covers many systems and considerable co-morbidity, requiring a holistic approach, has been left behind as the remit of the generalist. As the scientific basis of allergy has advanced the generalist has unfortunately not kept pace with new knowledge leaving sufferers without any recourse to expert advice.

Remarkably in different countries allergy services have had very different origins. Thus in the UK and a number of other European countries, allergy has predominantly evolved out of respiratory medicine. It is only recently that a distinct programme for training an allergist has been developed in collaboration with clinical immunology. Similarly paediatric allergy in the UK has developed in association with clinical immunology and infectious disease. In Germany, allergy has been developed primarily by dermatologists. In Malaysia ENT surgeons have taken the initiative to set up an allergy society and have now been joined by a variety of other system specialists. Thankfully in some countries allergy has been a mono-speciality and has sustained its profile primarily linked with a

large allergen immunotherapy programme. This is certainly the case in France and the USA.

Having had some experience of allergy services in a number of countries around the world I remain uncertain as to what is the best pattern of service. Should we train a cadre of mono-specialists in adult and paediatric allergy or should we encourage the development of allergy clinics which encompass the expertise of respirologists, dermatologists, otorhinolaryngologists, etc. (2). How allergy should work alongside clinical immunology also is uncertain. Clearly there is a need for a good immunology service to back up allergy clinics, however, clinical immunology covers a very much wider area including immunodeficiency, rheumatology and in some circumstances infectious disease.

One might predict given trends over the last 100 years that in the future the discipline of allergy will be progressively split and we will have experts exclusively focusing on food allergy, respiratory allergy, dermatological allergy, etc. However, this will be at the expense of the patient with concurrent allergic problems in several systems which are all too frequent. I am referred ever larger numbers of children who have already been seen by a range of specialists and prescribed treatment relevant to the individual system problem. The cumulative effect of the drugs and particularly topical steroids is having a significant adverse influence on growth and development. I believe the future lies in ensuring that the discipline of paediatric allergy retains its integrity as a holistic discipline working harmoniously alongside systems specialists and clinical immunologists (3).

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## **References**

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