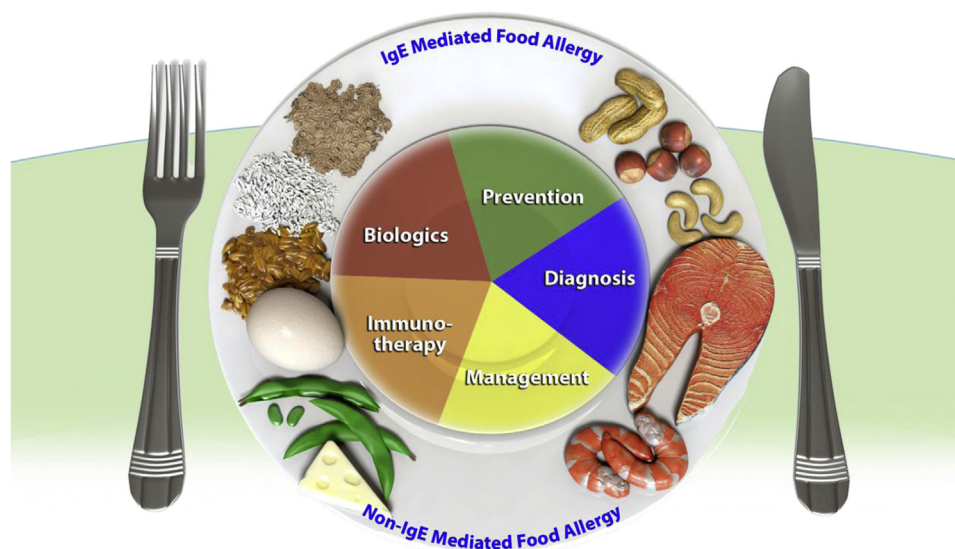




Editorial

Food-for-thought



This year's Food Allergy theme puts a hefty portion of food-for-thought on your plate! We bring you important updates on the clinically relevant sizzling hot topics in food allergy, spanning prevention, diagnosis, and management of IgE and non-IgE-mediated food allergic disorders. For the first time, we are showcasing a series of pro and con debates presenting opposing views and welcome your feedback whether you enjoy reading such exchanges of opinions among the experts.

Following the landmark Learning Early About Peanut (LEAP) and additional important studies regarding early introduction of egg into the infant's diet, the official guidelines for introduction of solids underwent a seismic shift. As discussed by Fisher, Lack, and duToit¹ considering evidence demonstrating a positive preventive effect, the wide consensus favors the early introduction of allergenic foods such as peanut and egg in the infants at risk for atopic disease from 4–6 months of age as well as in the general population without atopy risk factors within the first year of life. However, the logistics of early solid food introduction can be daunting and the caregivers need support from the pediatricians and the allergists not only with the initial

introduction but also with sustained inclusion of the foods in the diet as pointed out by Muraro and Arasi.²

Food allergy frequently presents as a diagnostic dilemma. The accuracy of diagnosis is critical, as misdiagnosis may put patients at risk of anaphylaxis or at risk of unnecessary dietary and life style restrictions. While oral food challenge (OFC) remains a diagnostic gold standard, its availability is limited; the procedure is labor-intensive, time-consuming and associated with a risk of anaphylaxis. Anagnostou points out that the component-resolved diagnostics introduced additional resolution to food allergy diagnosis.³ This is particularly relevant due to the ability to discern between sensitization to the cross-reactive allergens such as birch pollen PR 10 proteins (eg, Bet v 1) or profilins (eg, Bet v2) in the individuals with pollen allergy and suspected food allergy to plant foods such as peanut or tree nuts. However, Greenhawt emphasizes that the majority of the food allergic individuals are sensitized to multiple allergens from the same food, the results cannot be interpreted as simply positive (confirmed allergy) versus negative (refuted allergy).⁴ Thus similar to predicting the likelihood of clinical reactions based on the serum levels of the whole food-specific IgE, the diagnostic decision points need to be validated in various patients' populations before using them as surrogates for OFC, sums up the editorial by Lieberman.⁵

Asymptomatic or minimally symptomatic patients with EoE present a challenging therapeutic dilemma. Muir, Moore and Spergel highlight the need of careful balancing the risks of the disease progression.⁶ In contrast, Lieberman is concerned about the negative effects of therapy.⁷ In the accompanying editorial, Chehade enforces

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close monitoring and periodic reevaluations with endoscopies and biopsies in patients managed with a non-interventional approach.⁸

Rapidly developing field of food allergy therapies, in particular oral immunotherapy (OIT) engenders lively discussion, at times hosted on the pages of the Annals.^{9,10} Bird cites an ever-growing body of evidence that the majority of the treated patients can be desensitized to the doses that exceed the doses triggering accidental exposures.¹¹ Caubet and Braun raise the concerns about the risk of anaphylaxis and eosinophilic esophagitis (EoE).¹² Clearly, there is much to be learned about the selection of patients most likely to respond favorably, the optimal age of the initiation of OIT, the duration of maintenance phase, the frequency of maintenance dosing, the potential long-term consequence (eg, late-onset EoE) as outlined by Spergel in his editorial.¹³

To that end, Albuhairei and Rachid review the emerging biologic therapeutics for food allergy including their mechanism of action, potential applications and the status of clinical trials investigating these agents.¹⁴

The fascinating story of alpha-gal allergy in the mammalian meats continues to evolve and Levin et al review its epidemiology, clinical phenotypes in diverse patient populations and present future research towards understanding the mechanism of sensitization and the role of microbial adjuvants.¹⁵

McGowan et al tackle the enigma of food-specific IgG4 antibodies in IgE-mediated food allergy and EoE.¹⁶ If you are perplexed by the conundrum of the apparently conflicting roles of IgG4 in oral tolerance and in the active EoE, this is a must read. Two reviews highlight the challenges in non-IgE mediated food allergic disorders. Mehr and Brown-Whitehorn discuss the essentials of diagnosis and management for gastrointestinal food allergic disorders, including food protein-induced enterocolitis syndrome, enteropathy and allergic proctocolitis.¹⁷ Chehade, Meyer and Beauregard identify the types of feeding difficulties encountered in infants and young children with non-IgE-mediated gastrointestinal food allergies which put them at risk for suboptimal nutrition and pose a big burden on the caregiver primarily responsible for child's feeding. They also provide rational and practical approaches to managing feeding difficulties such as food chaining or division of responsibility.¹⁸

Enjoy the entire delicious 2019 food allergy menu or sample the individual articles and check out the Annals in the coming months for more cutting-edge clinical updates in food allergy!

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