Check for updates

BROUGH H.A. (Orcid ID : 0000-0001-8373-1367)
DR. BRUCE JOSHUA LANSER (Orcid ID : 0000-0002-3422-8658)
DR. CARINA VENTER (Orcid ID : 0000-0002-7473-5355)
PROF. GIDEON LACK (Orcid ID : 0000-0001-7350-4021)
DR. KARI C NADEAU (Orcid ID : 0000-0002-2146-2955)

Article type : Review

Early intervention and prevention of allergic diseases

Manuscript Acceptance Date: 09-Jul-2021

Brough H.A. MBBS PhD[1,2,3], Lanser B. J. MD MPH[4], Sindher S. B. MD [5,6,7], Teng J. M. C. MD PhD[8], Leung D. Y.M. MD PhD[4], Venter C PhD[9], Chan S.M.MBBS MD[1,2,3], Santos A. F. MD PhD[1,2,10, 3], Bahnson H. MPH[12], Guttman-Yassky E. MD PhD[13,14], Gupta R.S. MD MPH[15,16], Lack G MB BCh FRCPCH FMedSci [1,2,3], Ciaccio C. MD MSc[17], Sampath V [5], Nadeau K. C. MD PhD [5,6,7], Nagler C.R. PhD[18].

[1]Department Women and Children's Health (Pediatric Allergy), School of Life Course Sciences, Faculty of Life Sciences and Medicine, King's College London, London, United Kingdom

[2] Peter Gorer Department of Immunobiology, School of Immunology and Microbial Sciences, King's College London, London, United Kingdom

[3] Children's Allergy Service, Evelina Children's Hospital, Guy's and St. Thomas's NHS Foundation Trust, Westminster Bridge Rd, London, United Kingdom

[4] Division of Pediatric Allergy-Immunology, Dept of Pediatrics, National Jewish Health, Denver, CO, 80206 USA

[5] Sean N. Parker Center for Allergy and Asthma Research at Stanford University, Stanford University, Stanford, CA 94305, USA

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/ALL.15006

This article is protected by copyright. All rights reserved

Accepted Article

[6] Division of Pulmonary and Critical Care Medicine, Department of Medicine, Stanford University, Stanford, CA 94305, USA

[7] Division of Allergy, Immunology and Rheumatology, Department of Medicine, Stanford University, Stanford, CA 94305, USA

[8] Department of Dermatology, Lucile Packard Children's Hospital at the Stanford University School of Medicine, Palo Alto, California, USA.

[9] Section of Allergy & Immunology, School of Medicine, University of Colorado Denver, Children's Hospital Colorado, Anschutz Medical Campus, 13123 East 16th Avenue, Aurora, CO 80045, USA.

[10]Asthma UK Centre in Allergic Mechanisms of Asthma, London, United Kingdom

[12] Benaroya Research Institute and Immune Tolerance Network, Seattle, WA, 98101 USA

[13] Department of Dermatology and the Immunology Institute, Icahn School of Medicine at Mount Sinai, 5 E. 98th Street, New York, NY, 10029, USA.

[14] Laboratory for Investigative Dermatology, The Rockefeller University, New York, NY, USA.

[15] Center for Food Allergy and Asthma Research, Northwestern University Feinberg School of Medicine, Chicago, Illinois, 60611, USA.

[16] Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago, Illinois, 60611, USA.

[17] Department of Pediatrics and Medicine, University of Chicago, Chicago, Illinois 60637, USA.

[18] Department of Pathology and Pritzker School of Molecular Engineering, University of Chicago, Chicago, Chicago, Illinois 60637, USA

Corresponding author:

Dr. Helen A. Brough PhD FRCPCH[1]

Children's Allergy Service

2nd Floor, Stairwell B, South Wing

Evelina London Children's Hospital

St Thomas' Hospital, Westminster Bridge Road

London SE1 7EH

Email: helen.brough@kcl.ac.uk

Accepted Article

This article is protected by copyright. All rights reserved

Word count: *6075*

Abbreviations:

American Academy of Pediatrics: AAP
Atopic dermatitis: AD
Dendritic cells: DCs
European Academy of Allergy and Clinical Immunology: EAACI
Food allergy: FA
Filaggrin: FLG
Gut associated lymphoid tissue: GALT
Interleukin: IL
Lamina propria: LP
Mesenteric lymph node: MLN
Randomized controlled trial: RCT
Regulatory T cells: Tregs
Retinal dehydrogenase: RALDH
S100A: S100 calcium-binding protein A
Short chain fatty acids: SCFAs
Specific IgE: sIgE
Staphylococcus aureus: S. aureus
TSLP: Thymic Stromal Lymphopoietin
Transepidermal water loss: TEWL
Type 3 innate lymphoid cells: ILC3

Acknowledgements

We would like to acknowledge Ande Hesser for help with creating figure 6 for this review and Christopher Warren for creating Figure 1-3. We would like to thank Anna Globinska, graphics editor at Allergy for support with creating the figures for this review. We thank the Levin Foundation, the

This article is protected by copyright. All rights reserved

Reinhard Foundation, the Sean N. Parker Center for Allergies and Asthma Research at Stanford University, and the NIH (grants R01AI140134 and U19AI070535) for their generous support.

Statement of contribution

Dr. Brough coordinated the group, amalgamated sections, reviewer responses and references. Dr. Chan and Dr. Ruchi wrote the introduction and arranged Figures therein. Dr. Brough, Dr. Sindher, Dr. Teng, Dr. Leung and Dr. Guttman-Yassky wrote the cutaneous and environmental exposure section and created figures for this section. Dr. Venter, Dr Santos, Dr. Lack and Dr. Nagler wrote the dietary factors section and Dr Nagler created the figure for this section. Dr Lanser, Dr. Bahnson, Dr. Sampath and Dr. Nadeau wrote the conclusion section, and box of future research perspectives. Dr. Bahnson created the causal diagram. Dr. Lanser created the Tables. Dr. Ciaccio wrote the abstract. Dr. Brough, Dr. Lanser and Dr. Nagler proof-read the final document, figures and checked references. All authors reviewed the manuscript.

Conflicts of Interest:

Dr. Brough reports receiving research grants from the National Institutes of Health (NIH) (U01 # AI147462), Aimmune and DBV Technologies and speaker fees from DBV Technologies and Sanofi outside of the submitted work. Dr. Lanser reports grants and personal fees from Aimmune Therapeutics, grants and personal fees from DBV Technologies, grants and personal fees from Genentech, personal fees from Allergenis, personal fees from Hycor, personal fees from GSK, grants from US NIH/NIAID-sponsored Consortium on Food Allergy Research, grants from Regeneron, outside the submitted work. Dr. Sayantani Sindher reports grants from NIH, grants from Regeneron, grants and other from DBV Technologies, grants from AIMMUNE, grants from Novartis, grants from CoFAR, grants and personal fees from FARE, other from Astra Zeneca, outside the submitted work. Dr Chan report grant funding from National Institutes of Health (NIH) (U01 # AI147462) and Aimmune for the ARC005 study. Dr. Santos reports grants and personal fees from Medical Research Council (G0902018, MR/M008517/1 and MR/T032081/1); grants from Food Allergy Research and

This article is protected by copyright. All rights reserved

Education (FARE), Asthma UK and the NIHR through the Biomedical Research Centre (BRC) award to Guy's and St Thomas' NHS Foundation Trust, during the conduct of the study; grants from Immune Tolerance Network/National Institute of Allergy and Infectious Diseases (NIAID, NIH); personal fees from Thermo Scientific, Nutricia, Infomed, Novartis, Allergy Therapeutics, Buhlmann, as well as research support from Buhlmann and Thermo Fisher Scientific through a collaboration agreement with King's College London. Henry Bahnson reports personal fees from King's College, London, UK, during the conduct of the study; personal fees from DBV technologies, outside the submitted work. Guttman-Yassky reports research funds (grants paid to the institution) from: Abbvie, Almirall, Amgen, AnaptysBio, Asana Biosciences, AstraZeneca, Boerhinger-Ingelhiem, Cara Therapeutics, Eli Lilly, Galderma, Glenmark/Ichnos Sciences, Innovaderm, Janssen, KAO, Kiniksa, Kyowa Kirin, Leo Pharma, Novan, Pfizer, Ralexar, Regeneron Pharmaceuticals, UCB Consultancy fee from: Abbvie, Almirall, Amgen, Arena, Asana Biosciences, AstraZeneca, Boerhinger-Ingelhiem, Bristol-Meyers Squibb, Cara Therapeutics, Connect Pharma, Eli Lilly, EMD Serono, Evidera, Galderma, Ichnos Sciences, Incyte, Janssen Biotech, Kyowa Kirin, Leo Pharma, Pandion Therapeutics, Pfizer, RAPT Therapeutics, Regeneron Pharmaceuticals, Inc., Sanofi, SATO Pharmaceutical, Siolta Therapeutics, Target PharmaSolutions, UCB, Ventyx Biosciences. Dr. Gupta reports receiving research support from the National Institutes of Health (NIH) (R21 ID # AI135705, R01 ID # AI130348, U01 ID # AI138907), Food Allergy Research Education (FARE), Rho Inc, Melchiorre Family Foundation, Sunshine Charitable Foundation, Walder Foundation, UnitedHealth Group, Thermo Fisher Scientific, Genentech, and the National Confectioners Association (NCA); serves as a medical consultant/advisor for Aimmune Therapeutics, Before Brands, AllerGenis LLC, Kaléo Inc, Novartis, Genentech, DBV Technologies, and Food Allergy Research and Education (FARE); is employed by Ann & Robert H. Lurie Children's Hospital of Chicago; and is professor of pediatrics and medicine at Northwestern University Feinberg School of Medicine. Dr. Lack reports grants from National Institute of Allergy and Infectious Diseases (NIAID, NIH), other from Food Allergy & Research Education (FARE), other from MRC & Asthma UK Centre, other from UK Dept of Health through NIHR, other from National Peanut Board (NPB), grants from UK Food Standards Agency (FSA), other from The Davis Foundation, during the conduct of the study; personal fees and other from DBV Technologies, other from Mighty Mission Me , personal fees from Novartis , personal fees from Sanofi-Genyzme, personal fees from Regeneron, personal fees from ALK-Abello, personal fees and other from Lurie Children's Hospital, outside the submitted work. Dr. Ciaccio reports personal fees from Novartis, personal fees from ALK, other from Clostrabio,

This article is protected by copyright. All rights reserved

other from Siolta, personal fees from Aimmune, personal fees from DBV, personal fees from Astra-Zeneca, personal fees from Sanofi Genzyme, outside the submitted work. Dr. Nadeau reports grants from National Institute of Allergy and Infectious Diseases (NIAID), National Heart, Lung, and Blood Institute (NHLBI), National Institute of Environmental Health Sciences (NIEHS), and Food Allergy Research & Education (FARE); Director of World Allergy Organization (WAO) , Advisor at Cour Pharma, co-founder of Before Brands, Alladapt, Latitude, and IgGenix; and National Scientific Committee member at Immune Tolerance Network (ITN), and National Institutes of Health (NIH) clinical research centers, outside the submitted work; In addition, Dr. Nadeau has the following patents: Special Oral Formula for Decreasing Food Allergy Risk and Treatment for Food Allergy, Granulocyte-based methods for detecting and monitoring immune system disorders, Methods and Assays for Detecting and Quantifying Pure Subpopulations of White Blood Cells in Immune System Disorders, and Microfluidic Device and Diagnostic Methods for Allergy Testing Based on Detection of Basophil Activation. Dr. Nagler reports grants from National Institutes of Health (NIAID) and is the President and co-founder of ClostraBio, Inc. Dr. Teng and Dr. Sampath report no conflicts of interest.

Accepted Article

This article is protected by copyright. All rights reserved

Abstract:

Food Allergy (FA) is now one of the most common chronic diseases of childhood often lasting throughout life and leading to significant worldwide healthcare burden. The precise mechanisms responsible for the development of this inflammatory condition are largely unknown; however, a multifactorial aetiology involving both environmental and genetic contributions is well accepted. A precise understanding of the pathogenesis of FA is an essential first step to developing comprehensive prevention strategies that could mitigate this epidemic. As it is frequently preceded by atopic dermatitis and can be prevented by early antigen introduction, the development of FA is likely facilitated by the improper initial presentation of antigen to the developing immune system. Primary oral exposure of antigens allowing for presentation via a well-developed mucosal immune system, rather than through a disrupted skin epidermal barrier, is essential to prevent FA. In this review, we present the data supporting the necessity of 1) an intact epidermal barrier to prevent epicutaneous antigen presentation, 2) the presence of specific commensal bacteria to maintain an intact mucosal immune system and 3) maternal/infant diet diversity, including vitamins and minerals, and appropriately timed allergenic food introduction to prevent FA.

Key words: Prevention, barrier, food allergy, atopic dermatitis, immune tolerance

Accepted Article

This article is protected by copyright. All rights reserved

Introduction:

Atopic conditions, including atopic dermatitis (AD), food and environmental allergies and asthma, have become an important public health concern world-wide. [1] This review will focus primarily on early interventions to prevent food allergy (FA). [2-4] Recent studies reinforce the strong connection between early severe AD and the development of FA. Pediatric FA has become an epidemic in many countries, with increasing rates in the past few decades, although substantial variations from 1% to 10% exist by country. To date, some of the highest rates have been observed in high-income countries such as the United Kingdom, United States, and Australia, where population-based surveys and analyses of healthcare utilization data suggest the burden of disease has substantially increased. [5-9] While there is consensus that prevalence has increased in many parts of the world, the magnitude is difficult to ascertain due to numerous factors, including a lack of systematic population-based surveillance efforts incorporating repeated, validated prevalence assessments, and high-quality estimates lacking from many countries. Figure 1 visualizes the most recently available population-based estimates of pediatric FA prevalence.[10-12]

It is also difficult to estimate FA prevalence globally or compare rates by country because of the limited international coordination of disease surveillance efforts, leading to heterogeneity in study design, FA case definitions, and study populations. [10,13] Even in studies with similar populations, direct comparisons of prevalence rates are challenging as there are variations in social, cultural, and economic factors. Despite the literature gaps, extensive research into paediatric FA epidemiology provides insight into possible FA aetiology and promising disease prevention avenues. For example, an epidemiologic finding of disparate rates of infant peanut allergy among genetically similar populations in the UK and Israel led to insights regarding the protective role of early life exposure to major food allergens.[14] These insights have now been tested in randomized controlled trials (RCTs) and translated into clinical practice guidelines that advocate the early introduction of allergenic solids for primary prevention. [15-17]

The multifactorial aetiology of FA is well-recognised, with environmental and genetic factors contributing to FA development. However, strategies to manage FA remain limited in most cases to strict allergen avoidance and managing allergic reactions, including teaching patients/caregivers to administer epinephrine during suspected anaphylaxis, which can adversely impact patient/caregiver quality of life. [18] Food allergen immunotherapy appears to offer transient protection but is allergen-

This article is protected by copyright. All rights reserved

specific, time-intensive, and side effects limit tolerability.[19] Even when gold standard treatments exist, prevention remains the ultimate goal since it can circumvent early morbidity from disease and ameliorate treatment burden.

AD often heralds the atopic march and frequently precedes the development of FA, allergic asthma and allergic rhinitis. Whether AD is the primary insult, or the earliest manifestation of other underlying factors is not yet fully established. However, AD is a significant risk factor for FA and may play a key role in FA prevention. Numerous studies suggest a causal role of cutaneous sensitization in FA's development where both the skin barrier and immunology are thought to be key players.[20]

The true global prevalence for AD is also unclear, with previous studies indicating paediatric AD prevalence varying by country. [21] Between 1999 and2004 the International Study of Asthma and Allergies in Childhood incorporated a standardized school-based sampling methodology and symptom questionnaire to estimate current AD prevalence among 6-7-year-olds in 60 countries and estimates for 13-14-year-olds in 96 countries. Subsequent studies have independently verified this increase in prevalence of AD across several countries. These landmark findings are visualized in Figures 2 and 3. However, they are nearly 20 years old, and no comparable effort to systematically assess longitudinal changes in the global prevalence of AD has since been undertaken.

Early life nutrition is another staple of FA prevention. It has been studied to varying degrees, including the impact of oral tolerance induction, breast and formula feeding, Vitamin D, dietary diversity, and the role of pre-, pro-and syn-biotics. The interaction of the skin and diet come together in the interplay between oral tolerance induction and epicutaneous allergen exposure. This forms the basis of the dual-allergen exposure hypothesis, which proposes that epicutaneous food allergen exposure in early life is associated with the development of FA, whilst early life oral exposure is protective. [22-24]

Finally, microbial factors may impact FA prevention with the mode of delivery at birth, pet exposure and bacterial (*S. aureus*) colonisation. The roles of viruses and fungi are still unknown. This review will explore AD, the infant diet, microbial factors, and the complex interplay of all factors in FA development, focusing primarily on early intervention to prevent FA. We conclude our review with a discussion of future and ongoing research including key topics that must be addressed.

This article is protected by copyright. All rights reserved

Cutaneous factors and environmental exposures in the development of FA

Early AD is implicated in the subsequent development of allergic diseases, including FA, asthma, allergic rhinitis and is termed the "atopic march".[2-4] In the "outside-in" hypothesis, skin barrier defect allows penetration of allergens and microbes leading to atopic sensitization whereas, in the "inside-out" paradigm, a polarized immune response leads to a defective skin barrier (Figure 4).[25] A summary of changes identified in AD compared to healthy skin in the microbiota, skin barrier, and inflammatory cytokines are outlined in **Table 1**.

Table 1: A summary of changes identified in atopic dermatitis compared to healthy skin in the microbiota, skin barrier, and inflammatory cytokines

Element or Characteristic	**Direction and Relative Magnitude of the Difference in AD v Healthy Skin**	**Key Points**	**Reference**
Skin Microbiome			
Microbial diversity	↓↓		26
S aureus colonization (including MRSA)	↑↑↑	Correlates with severity of AD	27,28
*S aureus v*irulence factors	↑↑	Superantigens, biofilms, alpha-toxin, protein A, and exogenous proteases	29,30
Commensal bacteria	↓	*Streptococcus,* coagulase negative *Staphylococcus, Corynebacterium* and *Cutibacterium spp.*	27,31
Malassezia spp.	↑	Seen in seborrheic dermatitis in infants and in adults with IgE to *Malassezia.*	32
Skin Barrier			

This article is protected by copyright. All rights reserved

Filaggrin gene expression and breakdown products including natural moisturizing factor	↓↓	Complex genetic and environmental interactions play a major role in the pathogenesis of AD and risk for FA in AD.	[33,34]
Skin pH	↑	A loss of acidity leads to enhanced adhesion, altered lipid structure, and susceptibility to *S. aureus*	[35]
Transepidermal water loss (TEWL)	↑	Causing skin dehydration, can be used as a noninvasive skin assessment	[36,37]
Tight junction expression and function	↓	Impaired barrier function and enhanced allergen exposure	[38,39]
Organization of the lipid bilayer and fatty acid chain length	↓	The lipid bilayer is disorganized with altered ceramides with short-chain fatty acids which have anti-microbial and anti-inflammatory properties	[40]
Inflammatory Cytokines			
IL-4, -13, and other Th2 cytokines	↑↑↑	Allows for *S. aureus* colonization, central role in AD shown by the successful treatment with blockade by dupilumab	[41,42]
Thymic Stromal Lymphopoietin (TSLP)	↑	A pro-inflammatory, IL-7-like cytokine	[43]
IL-31	↑	The key component of the itch-scratch cycle and primary driver of pruritis in AD	[44]

This article is protected by copyright. All rights reserved

IL-33 & ILC2s	↑	IL-33 increases with skin trauma (scratching), which leads to increased intestinal ILC2s, which may be an important link between AD and FA	[45]

Experimental models and clinical observations in humans support the concept of epicutaneous food allergen sensitization.[20,46] The epidermis plays a key role in maintaining the skin barrier against allergens, irritants and microbes potentially penetrating the skin and eliciting the host immune response. These events are facilitated by skin barrier dysfunction in AD, promoting the penetration of food allergens from topical application or the environment. Lack et al.[23] first reported that peanut allergy was associated with the topical application of skin creams containing peanut protein. Subsequently, Fox et al.[24] reported increased FA in households that ate peanuts. In addition, Brough et al.[47] found a dose-dependent increase in peanut sensitization and allergy in infants exposed to higher peanut protein levels in household dust, particularly in patients with skin barrier impairment, as assessed by either filaggrin (FLG) null mutations, leading to low FLG expression in the skin, or children with AD[48] or egg allergy.[49] These observations supported a role for the "outside-in" process of food sensitization where exposure to environmental peanut in an individual with skin barrier dysfunction leads to enhanced FA.

The "inside-out" process implicates the immune response in making the skin barrier more susceptible to skin epithelial dysfunction, development of AD, and allergen entry. The current understanding of 'AD's pathogenesis is centered on the robust activation of Type 2 (IL-4, IL-13, IL-31) and Type 22 (IL-22) cytokine axes in both skin and serum.[25,50-54] Model systems showed that type 2 cytokine activation inhibits keratinocyte terminal differentiation products (i.e., filaggrin, loricrin), tight junctions (i.e., claudins), and lipid products.[55-58] Recent findings show that Th2 cytokines decrease antimicrobial peptides, causing AD skin to be more prone to colonization of infectious organisms, such as *S. aureus*. Thus, IL-4 and IL-13 play a hallmark role in the Th2 immune response in AD, contributing to both immune activation and skin barrier dysfunction. IL-31, another Th2 cytokine, has been shown to interact synergistically with IL-4, driving pruritus and contributing to the inflammatory

This article is protected by copyright. All rights reserved

and barrier defects of AD.[59-64] The Th22 axis also plays a role in suppressing the epidermal barrier and the lichenification and increase of S100 calcium-binding protein A (S100As) in chronic AD lesions.[65,66] Additional proinflammatory axes, including Th17, are preferentially upregulated in certain AD populations, such as Asians and children, revealing the heterogeneous nature of AD across its subtypes.[67-71] Recently, minimally invasive studies of the skin using tape strips, performed in infants, children and adults with moderate-to-severe AD, show robust upregulation of type 2 and 22 T-cell immune cytokines in both lesional and non-lesional AD skin.[72-74] The upregulation of immune markers in involved and uninvolved skin showed high correlations with disease severity scores and the functional barrier measure trans-epidermal-water-loss (TEWL).[75-77]

Allergic disease development is associated with a Th2 cell-mediated inflammatory response[78,79] described above. Allergic disease is preceded by the formation of specific IgE (sIgE) antibodies against environmental and food allergens, also known as the sensitization phase. In epicutaneous sensitization, specific resident dendritic cell (DC) subsets residing in the skin[80] sample antigens and present to naïve $CD4^+$ T cells in draining lymph nodes This promotes differentiation into allergen-specific $CD4^+$ T cells favouring B cell isotype class switching to sIgE cells further driving the production of IgE memory B cells[81]. Through the maturation and production of plasma cells, large amounts of sIgE antibodies are produced. The sensitization phase drives the production of a large memory pool of allergen-specific B cells and Th2 cells.

The sensitization phase is followed by the effector phase, which is triggered by subsequent exposure to previously sensitized allergens. This causes cross-linking of sIgE bound to receptor FcεRI on sensitized mast cells and basophils. Activation of these cells leads to the release of inflammatory mediators triggering an allergic reaction[82]. The immune mechanisms linking the skin and gut have their origins in skin injury-induced release of IL-33 from keratinocytes, leading to intestinal mast cell hyperplasia and food-induced anaphylaxis in mice.[83] IL-33 blocking antibodies have also been shown to prevent peanut allergy induced anaphylaxis.[84]

Interestingly, skin sampling in patients with peanut allergy but not AD reveals low filaggrin levels but increased long-chained lipid species, which may protect the skin from dryness and AD.[85] Other risk factors have been associated with peanut allergy, including filaggrin mutations, severe infantile AD, environmental irritant exposures such as detergents and *S. aureus* colonization on the skin.[86-88]

This article is protected by copyright. All rights reserved

Skin dysbiosis, often observed among individuals with AD, is often characterized by reduced microbial diversity and the presence of one or few dominant microbes. The loss of commensal microbes is likely due to several factors including host genetics, local immune response, environmental factors such as pH, temperature, humidity, hygiene practice and exposure to antibiotics. It is estimated that 30% to 100% of individuals with AD are colonized by S. *aureus*, a dominant pathogen implicated in this disease (Figure 5a). [89] *S. aureus* affects the development of both innate and adaptive immune responses. It can lead to uncontrolled inflammation by inducing lymphocyte and macrophage activation. The increased presence of *S. aureus* in the dermis directly correlates with a Th2 response evident by increased expression of IL-4, IL-13, IL-31 and TSLP (Thymic Stromal Lymphopoietin).[30] These Th2 cytokines in turn suppress the production of antimicrobial peptides (AMPs) by the skin that inhibits *S. aureus* proliferation.[31] Therefore, it is not surprising that colonization by *S. aureus* is associated with increased AD severity and treatment thereof has been shown to decrease disease severity.[90,91]

Malassezia spp., previously known as Pityrosporum, is a genus of lipophilic yeast. Its role in AD's pathogenesis was initially speculated when some AD patients responded to topical and systemic antifungal therapies.[92-96] A large population study showed more than 40% of children with seborrheic dermatitis during early childhood will develop AD later on, suggesting early sensitization of seborrheic skin may result in the onset of AD.[97] Most of the Malassezia species lack fatty acid synthases genes, therefore relying on exogenous fatty acid sources that are abundant at certain cutaneous sites such as the head, neck and skin folds (Figure 5b).[98] Although the pathogenesis of *Malassezia spp* in AD is not entirely clear, yeast is known to trigger a multitude of immune responses. It is estimated that 80% of adults with AD have detectable *Malassezia* IgE antibodies.[99-101] *Malassezia spp.* in the epidermis and dermis, can be recognized by keratinocytes and Langerhans cells as well as dermal DCs. These antigen presenting cells in turn activate downstream immunologic cascades that lead to the release of proinflammatory cytokines such as TNF-alpha, IL6, IL-8, IL-10, and IL-12p70. Induced expression of TLR2 and TLR4 on human keratinocytes and DCs upon exposure to *Malassezia spp.* have been observed, suggesting direct activation of innate immune response.[102,103] In addition, the NLRP3 inflammasome in skin DCs can also be activated by *Malassezia spp* with subsequent release of Th2 cytokines (e.g., IL-1beta, IL-4, 5, 13,) likely directly contributing to AD pathogenesis.[104,105]

This article is protected by copyright. All rights reserved

There is growing interest in understanding the specific roles of different bacteria in skin well-being. Many cosmetic products using a variety of formulations and diverse bacterial strains have been developed and filed for patents. However, there is a significant lack of scientific evidence to support the claims from these products. [106] Clinical manipulation of the skin microbiome as therapy for a variety of skin diseases is actively being explored. Several clinical trials have been conducted using targeted microbiome transplant via topical probiotic cream in the treatment of AD.[107] These proof of concept studies have enrolled very limited numbers of subjects, and there is insufficient evidence currently reported. Nonetheless, there have been no safety concerns reported. Larger scale, randomized, controlled trials are underway.

Lamellar bilayer structural integrity is highly organized in normal skin, seen under electron microscopy, but very abnormal in those with AD and peanut allergy. The epidermis in AD with peanut allergy is associated with high TEWL, high type 2 immune activation, *S. aureus* colonization, reduced filaggrin breakdown products, and a reduced proportion of long-chained lipid products. These observations suggest that a defective skin barrier in patients with AD and peanut allergy may predispose affected individuals to epicutaneous allergen sensitization. The availability of minimally invasive skin tape sampling techniques may play an important role in identifying infants with early epidermal barrier dysfunction who may benefit from timely initiation of novel therapies for skin barrier dysfunction, non-lesional immune activation, and microbial dysbiosis. Using this technique epidermal profiling of lipids, proteins, and transcriptome identifies differences in the epidermis between patients with peanut allergy and AD versus AD alone.[85,108]

Barrier protection is the cornerstone of AD management. Skin hydration and prevention of TEWL are keys in maintaining skin barrier homeostasis. Animal studies also suggest that changes in hydration and corneocyte adhesion within stratum corneum affect the development and maturation of the epidermis.[109] Although there has been considerable controversy about whether early application of skin emollients can prevent AD and FA,[20] these studies have often not targeted high-risk infants with pre-existing skin barrier dysfunction. Moreover, the ingredients of emollients have not been optimized for infant skin barrier repair. The use of topical steroids to prevent AD flares and control subclinical inflammation is being evaluated as a potential strategy to prevent FA in AD.[20] Other novel pathogenesis-based topical and systemic therapies targeting inflammation of the skin have also been investigated for their roles in preventing FA.[110]

This article is protected by copyright. All rights reserved

Petrolatum, a non-physiologic mineral lipid, is often considered a gold standard ointment-based emollient that can prevent TEWL effectively for 4-6 hours. Therefore, to maintain optimal skin hydration, ointment-based emollients should be applied 3 to 4 times daily to provide complete protection. However, ointment-based emollients can also exacerbate AD; therefore, alternatives must be considered. Lipids including ceramide, fatty acids and cholesterol are mixed in appropriate ratio within stratum corneum to maintain its integrity.[111,112] Atopic skin is known to be deficient in lipids especially ceramide and hygroscopic amino acids that are the result of filaggrin breakdown products.[113,114] Newer generations of emollients containing these lipids have been developed in recent years.[115,116] A recent study demonstrated a trilipid cream was more effective than a paraffin-based emollient in reducing TEWL and sIgE levels.[20,117] However, efficacy in AD or FA prevention is yet to be proven in a randomized clinical trial.[118] While treating AD patients with a barrier-based approach, a liver X receptor agonist upregulated terminal differentiation and lipid products in the skin of patients with AD, consistent with its mechanism of action;[119] however, it was not associated with clinical benefit or suppression of immune products (Th17/Th22/IL6). This suggests that although barrier-based approaches may be valuable for disease prevention, the immune abnormalities perpetuate the AD disease phenotypes and should be targeted to resolve active AD.

The discovery of cytokine dysregulation in non-lesional skin from AD patients suggest the role of systemic therapy especially for individuals with severe disease. The increased understanding of AD's immune pathogenesis led to the development of immune-based treatments targeting Th2 cytokines.[120-125] Downregulation of immune markers in the skin of patients treated with such agents highly correlated with reductions in disease severity scores, demonstrating clinical improvement.[53,126-131] Furthermore, the Th2-targeting anti-IL-4R mAb dupilumab was shown to induce significant changes in the microbiome of skin lesions, again supporting the key role of the Th2 cytokines in inducing the disease pathogenesis.[132]

This article is protected by copyright. All rights reserved

Dietary factors

The obvious dietary factor relevant to the establishment of oral tolerance (and susceptibility to FA) is **food allergens**. Oral tolerance is the active maintenance of both mucosal and systemic non-responsiveness to ingested food allergens.[133] The induction of tolerance to dietary antigen is a multistep process;[134] **dietary vitamin A** plays a critical role in its regulation. $CD103^+$ dendritic cells (DC) in the gut associated lymphoid tissue (GALT) express elevated levels of retinal dehydrogenase (RALDH) enzymes which enhance their ability to metabolize dietary vitamin A. Antigen-loaded $CD103^+$ DC migrate to the mesenteric lymph node (MLN) from the intestinal lamina propria (LP). Retinoic acid (RA) produced by these DC and by stromal cells in the MLN induce the expression of the gut homing receptors CCR9 and $\alpha4\beta7$ favoring TGF-b dependent conversion of $Foxp3^+$ regulatory T cells (Tregs). [135-137] Committed Tregs then home back to LP, expanding under the influence of IL-10 produced by $CX3CR1^{hi}$ macrophages. Some Tregs exit the mucosa via the lymph or bloodstream to promote systemic tolerance. [134] Elegant studies in germ-free mice on an antigen-free diet showed that, in the small intestine, $Foxp3^+$ Tregs are induced by exposure to dietary antigen.[138] In the large intestine, however, $Foxp3^+$ Tregs are induced by a subset of the mucosa-associated bacteria which comprise the intestinal microbiota. [139]

The increasing prevalence of FA parallels increases in other non-communicable diseases and can be explained, in part, by alterations in the composition and function of the commensal microbiome. 21st century lifestyle practices including increased antibiotic use, low fiber/high fat diets, reduced exposure to infectious diseases, Caesarean birth and formula feeding have collectively depleted populations of bacteria beneficial to health.[140-142] In addition to dietary antigen induced $Foxp3^+$ Tregs, a bacteria-induced barrier protective response is required to prevent allergic sensitization to food. [143,144] Clostridia-induced IL-22 production by type 3 innate lymphoid cells (ILC3) is necessary and sufficient to reduce intestinal epithelial permeability to dietary allergen.[143] IL-22 protects the intestinal epithelial barrier by regulating epithelial proliferation and the production of mucus and anti-microbial peptides.[144] The mechanisms by which intestinal bacteria, particularly those in the Clostridia class, regulate mucosal immunity and allergic disease are increasingly understood. Prominent among these is their ability to ferment short chain fatty acids (SCFAs) from dietary fiber. SCFAs have potent immunomodulatory effects correlated with host health [145] including induction of colonic Tregs [146] and improvement of allergy symptoms in a mouse model.[147] Butyrate, in particular, is an important energy

This article is protected by copyright. All rights reserved

source for colonic epithelial cells. [148] Butyrate drives oxygen consumption by colonocytes through b-oxidation, which maintains a locally hypoxic niche for butyrate-producing obligate anaerobes.[149] Early dysbiosis characterized by an impaired capacity to produce butyrate may be a common feature of allergic diseases.[150] **Tryptophan metabolites**, from both dietary and bacterial sources, also play a central role in regulating tolerance in the gut. Catabolism of tryptophan to indole derivatives produces ligands which bind to the aryl hydrocarbon receptor on innate lymphoid cells (ILC3) and stimulate the production of IL-22 to regulate epithelial barrier permeability. [151] Finally commensal bacteria can metabolize **bile acids** to produce bioactive mediators which regulate T cell differentiation in the intestinal lamina propria (Figure 6). [152]

The data suggest that compositional and proportional differences in the gut microbiome are linked to the generation of diverse favorable neurotransmitters and neuromodulators, which are associated with the degree of AD symptoms. They can also affect skin barrier dysfunction and immune system dysregulation, which are the key pathophysiologies in the development of AD. The gut microbiome can modulate the gut-skin axis through direct and indirect pathways. Tryptophan produced by the gut microbiome causes an itching sensation in the skin,[153] whereas Lactobacillus and Bifidobacterium species can produce γ-aminobutyric acid (GABA), which inhibits skin itch.[154] Escherichia and Enterococcus species can produce serotonin, which is involved in skin pigmentation. Moreover, cortisol, usually released under stress conditions, can change gut epithelium permeability and barrier function by altering the composition of the gut microbiome.[155] This also alters the levels of circulating neuroendocrine molecules, such as tryptamine, trimethylamine, and serotonin, and thereby modifies the skin barrier and skin inflammation.[156]

The dual allergen-exposure hypothesis is supported by evidence from mouse models that food allergen exposure was necessary for the development of tolerance, as well as observational studies in humans linking allergen avoidance in the first few years of life with the development of FA. Specifically, a cross-sectional study showed that early in life peanut consumption in Israel was associated with a lower prevalence of peanut allergy than a population with a similar ancestry in the UK, where peanut was typically avoided in the first few years of life.[157] Whereas avoidance of food allergens in an infant's diet was standard advice in many countries, advice has changed, and oral tolerance induction is being used as a strategy to prevent peanut and other FA by introducing food allergens early into the diet of young infants.[17] The LEAP study showed that early introduction could

This article is protected by copyright. All rights reserved

reduce the rate of peanut allergy by 86% in non-sensitised children and the LEAP-On study confirmed that this protection against peanut allergy remained one year after complete subsequent avoidance of dietary peanut from 5 to 6 years of age.[158] The impact of early peanut introduction in LEAP was peanut specific and did not protect against other FA.[159] The EAT study (a lower risk, exclusively breastfed population) showed similar results for peanut in a per protocol analysis.[160] It also showed that consuming cooked egg in infancy was associated with a reduction in egg allergy. Since, subsequent studies and a meta-analysis have confirmed the efficacy of this approach,[157,161-163] and a recent Japanese study has shown that early introduction of cow's milk in early infancy protects against the development of milk allergy.[164] Introducing multiple foods early and continuing to eat them regularly proved challenging for most families in the EAT study. The study identified several factors associated with reduced adherence to this strategy: increasing maternal age, feeding difficulties in the neonate, and non-Caucasian ethnicity. This could help identify families who might benefit from further support to encourage early weaning. [165-167]

Many other dietary factors have been studied for their association with FA and/or AD. Observational studies have been summarized in a number of systematic reviews focusing on the maternal and infant diet [168,169] or the maternal diet during pregnancy alone. [168,170] Collectively over a hundred papers from observational studies have been identified reporting dietary patterns, diet diversity, fruit and vegetable intake, fat and fatty acid intake, vitamin and mineral intake, and a wide range of other dietary exposures, including alcohol, tea or coffee intake. Summarizing these studies using meta-analysis is limited as study exposures and outcome definitions are highly heterogeneous. A comprehensive review by the UK Food Standards Agency focusing on maternal and infant dietary intake concluded that there is no consistent evidence for associations between dietary exposures and allergy outcomes based on observational studies.[168] Other systematic reviews have, however, attempted to summarize findings from these studies.

Breastfeeding

A recent systematic review from EAACI[171] indicated that breast feeding may not reduce the risk of FA or cow's milk allergy. This echoes the recommendations of both the American Academy of Pediatrics (AAP) [172], the AAAAI/ACAAI/CSACI 2020[173] consensus statement and the EAACI FA prevention guidelines, indicating that no conclusions can be made about the role of breastfeeding in preventing or delaying the development of any food allergies.[174] In terms of AD the AAP guidance concluded

This article is protected by copyright. All rights reserved

that exclusive breastfeeding for 3 to 4 months decreases the development of eczema in the first 2 years of life.[172] The systematic review by Garcia-Larsen et al.[175] indicated that breast feeding of any duration does not seem to have a protective effect on FA but that there is some weak evidence that breast feeding may prevent the development of AD in the infant. Breast feeding is, however, recommended for all mothers due to the numerous benefits for both mother and infant.[176]

Dietary patterns and food groups

Dietary patterns, such as the Mediterranean diet, have not been associated with reduced AD or FA in offspring. During pregnancy, [169] no studies report on maternal dietary patterns in lactation and AD or FA outcomes in the infant. However, two systematic reviews tentatively conclude that fruit, vegetable, and yogurt intake in pregnancy may prevent offspring AD and that margarine and vegetable oil may increase the risk of AD.[168,170] Studies of the associations between intake of particular foods and infant FA are lacking.[170] Diet patterns in infancy have not been associated with infant AD. One study indicates that a diet pattern of predominantly home-cooked food may prevent FA. [177]

Diet diversity

Diet diversity is the number of different foods, food groups or food allergens eaten over time, such as the first year of life. Recently there has been considerable interest in the effect of infant diet diversity in preventing allergic diseases. A task force report from the European Academy of Allergy and Clinical Immunology (EAACI)[178] suggested that increased diet diversity in infancy may reduce the risk of developing allergic diseases such as asthma, AD, allergic rhinitis or FA in later childhood. Two observational studies, have shown increased diet diversity in the first year of life to be associated with reduced FA by six[177] and ten[179] years. Using data from Europe and the UK, these observational studies suggest that early oral intake of a variety of foods and food allergens, once the infant is developmentally ready, may reduce the incidence of FA in the first 10 years of life. Studies focusing on diet diversity in infancy and AD in childhood are however less clear. The LISA study found that increased diet diversity within the first 6 months of life (but not 4 months of life) reduced the risk of doctor diagnosed AD up to 2 years of age as well as early skin or allergic symptoms.[180,181] Three studies found both an increased risk[182,183] and a preventative effect[184-186] of increased diet diversity on AD outcomes in childhood. Of interest, an increase in microbial diversity was found at week 52 of peanut OIT;[187] the authors postulated this could be as a result of the immunomodulatory effect on the

This article is protected by copyright. All rights reserved

host immune system in successful desensitisation or as a direct cause from peanut flour on the gut microbiota.

Vitamins and minerals

Vitamin D insufficiency and deficiency have been associated with IgE sensitization[188] and FA in some studies[189] but not others.[190] There is little evidence from interventional studies of vitamin D supplementation for primary allergy prevention[191-194] as reviewed by Yepes-Nunez, et al.[195] The lack of clear evidence from observational studies about the role of vitamin D in FA risk is in part related to the multiple factors influencing vitamin D levels that need to be accounted for when designing studies. These factors include sun exposure, country and latitude of residence, migratory status, skin colour, ethnicity, age, diet, vitamin D supplementation (timing, formulation and dose), genetic polymorphisms affecting metabolism, epigenetic changes contributing to vitamin D levels, vitamin D binding protein, interaction with disease-associated genetic polymorphisms (e.g., ORMDL3), definition of vitamin D insufficiency/deficiency, and time-points to assess levels (longitudinal versus cross-sectional)[196].

One systematic review indicated that intake of beta-carotene, vitamin E, zinc, calcium, magnesium, and copper during pregnancy might be protective of offspring AD[170]. This review also summarized a small number of papers indicating that copper and vitamin C intake during pregnancy may reduce the risk of offspring FA. In contrast, vitamin D intake was associated with an increased risk of offspring FA. The amount of vitamins and minerals taken in these studies did not align with healthy eating guidance, and the results should be interpreted with caution.[170]

Antioxidants

Oxidative stress has recently been explored in the development of AD and FA. Oxidative stress results from an imbalance in reactive oxygen species (ROS) and antioxidant defence, which may lead to release of pro-inflammatory cytokines, alter enzymatic function and thereby impaired skin barrier function.[197] In OVA-sensitised mice, oral supplementation of capsaicin reduced oxidative stress and IL-33 but did not reduce IgE production. [198] Intake of nuts has also been shown to reduce oxidative stress inflammation.[199] There are currently no guidance regarding the use of anti-oxidant supplementation in FA prevention.[171,174,175,200]

This article is protected by copyright. All rights reserved

Fatty acid consumption

The role of omega 3 fatty acids in the prevention of FA and AD needs further clarification. Omega-3 fatty acids clearly have immunoregulatory effects, with a particular role in tolerogenic immune responses; however, studies show contradicting results, most likely due to timing of intervention, lack of standardized formats (food or supplement, source of supplement), standardized doses, and lack of measuring serum fatty acid levels at study entry.[201,202] As an example of this confusion, the EAACI guidelines[174] state that no recommendation can be made for or against the prevention of food allergies. The BSACI guidelines[203] suggest that omega-3 fatty acids may help reduce the risk of AD in early life and the ASCIA guidelines[204] recommend 3 portions of fatty fish per week in infants.

Role of fiber, pre- and probiotics in allergy prevention

Gut microbiota structure and function is an important consideration in the development of FA and AD. The composition and metabolic activity of the gut microbiota has significant effects on mucosal immune responses, which make the gut an interesting target for immune modulation. Microbial metabolites, particularly butyrate, may protect against the development of allergic disorders via their effect on T-regulatory cells.[205,206] Diet plays an important role in shaping the gut microbial metacommunity.

Fiber, pre-, pro and synbiotics and the gut microbiome

Diet diversity[201,207] and increased fiber intake[208,209] increase gut microbiome diversity and butyrate production. Prebiotics provided as dietary fibre or human milk oligosaccharides, probiotics and synbiotics have been shown to affect gut microbiome structure and function.

Fiber, pre-, pro and synbiotics and atopic dermatitis and food allergy outcomes

The role of fiber intake, pre-, pro and synbiotics in the prevention of AD and food allergies are currently unclear. The authors are unaware of any clinical trials assessing the role of fiber intake on the prevention of food allergies or AD. A recent meta-analysis of 14 prevention studies showed a pooled relative risk reduction in AD in those treated with probiotics versus placebo; however, on subgroup analyses it was only mixed strains of probiotics that had a significant effect. Probiotics

This article is protected by copyright. All rights reserved

administered solely to infants did not prevent the development of AD, but effects were significant when probiotics were administered to both pregnant mothers and their infants or solely to pregnant mothers. The authors cautioned about interpretating the significance of results due to heterogeneity among the studies and lack of standardized measurements.[210]

The World Allergy Organization (WAO) recommends probiotics during pregnancy, lactation and/or infancy for the prevention of AD but acknowledges the low level evidence that this recommendation is based on.[211] The WAO guideline panel also acknowledged that the available evidence on prebiotic supplementation to reduce the development of AD and FA is currently uncertain. The guidelines did however recommend that prebiotics could be added to the diet of non-exclusively breastfed infants, both at high and at low risk for developing allergy. This is a conditional recommendation with very low certainty of evidence.[212]

The most recent FA prevention guidelines did however not make any recommendations for the use of pre, pro or synbiotics on the prevention of AD or FA. The European Academy of Allergy and Clinical Immunology (EAACI) FA prevention guidelines concluded that no recommendation can be made for or against the use of prebiotics, probiotics or synbiotics in pregnancy, when breastfeeding or in infancy.[174] The joint FA prevention consensus statement from the American Academy of Asthma, Allergy and Immunology(AAAAI), American College of Allergy and Clinical Immunology (ACAAI) and the Canadian Society of Allergy and Clinical Immunology (CSACI) concluded that no recommendation can be made regarding the use of pre and probiotics in allergy prevention.[173] This echoes a similar statement from the Australian Society of Clinical Immunology and Allergy (ASCIA).[213] The guidelines were supported by a systematic review indicating that probiotic supplementation throughout pregnancy, lactation and/or infancy may prevent AD but the evidence for FA prevention is lacking. Garcia-Larsen et al.[175] indicated that maternal supplementation, with *Lactobacillus rhamnoses* may reduce risk of AD and sensitization to milk but not clinical FA outcomes. This systematic review did not find an overall preventative effect of prebiotics or allergy prevention. Despite wide-spread interest, synbiotics have not been studied in allergy prevention.

Results from RCTs have been summarized in several guideline papers and systematic reviews, with or without meta-analysis, to guide families. Results from these meta-analyses largely support current

This article is protected by copyright. All rights reserved

recommendations from the American Academy of Pediatrics (AAP),[172] EAACI,[17] and the consensus statement from the 3 North American allergy societies.[16]

Conclusions

The 2000 AAP policy [214] recommended avoidance of allergenic foods for breastfeeding mothers and delayed introducing allergenic foods to infants to prevent FA was based on expert opinion informed by a limited number of low quality studies.[215] These guidelines influenced infant feeding practices for almost 20 years,[216] while FA continued to increase, rather than decrease. These guidelines were reversed in 2008, but not replaced with comprehensive guidelines, only limited recommendations.[215] With publication of data from higher-quality studies, recent guidelines offer a comprehensive approach to maternal/infant diet.[16,17,172,217] The foundation for these studies and ongoing efforts to study the prevention of atopy was laid throughout the 1900s by pioneers in the field (Table 2).

It is critical to not only have consistent diagnostic criteria for the conditions being studied, but also to have comparable outcomes that are patient-relevant when possible. This will allow for valid and complete comparisons across studies in diverse populations, including high and general risk populations, regionally and globally. Reliable estimates of the global burden of atopic disease and improved epidemiologic data for these conditions is crucial to gain support for and acceptance of prevention guidelines.

Interventions to prevent AD and FA targeted at the first few months of life are not early enough for some babies. There are likely factors already in place within the first few weeks of life, or earlier, particularly in at-risk infants who may start the march towards atopy and a Th2 milieu in the womb. The proposed increased risk for FA with more than daily application of moisturizer in the EAT study cohort highlights the need for earlier assessments and interventions among diverse and representative populations employing consistent disease definitions using easily applied and clinically relevant assessments.[218] This finding further cautions against drawing potentially premature conclusions when important confounders cannot be adequately accounted for. These most recent findings add to the conflicting evidence about the potential to prevent AD to reduce the risk of FA.[219] Further, this supports the need for intervention trials designed from the outset to study FA using a broadly accepted definition as the primary outcome, beginning in the first weeks of life, with intentionally developed treatment groups and carefully planned assessments in hopes of Stopping

This article is protected by copyright. All rights reserved

669 Eczema and ALlergy (SEAL, NCT03742414). The SEAL Study will also attempt to answer ongoing
670 research questions identified in this review, summarized in Box 1.
671
672 It is unlikely that there is a single way to stop the atopic march once underway or a master switch
673 that could render all the external factors discussed in this review ineffective at inducing a Th2
674 response. It remains important to investigate these potential targets for prevention (Figure 7) and
675 continue to search for others. Given the remarkably conflicting results within and between studies on
676 the microbiome and a wide variety of dietary factors, it seems that well-informed guidelines in these
677 areas are farther off in the future, and may require extensive public health campaigns to slowly
678 change behaviors if successful approaches can be identified.
679
680 It is of course still necessary to provide recommendations before definitive evidence that is
681 applicable to diverse populations is available. In the interim, recent updates from North America[16]
682 and the UK[17] are more unified with those from Australasia.[217] There will certainly be disagreement
683 with some aspect of any guideline, but these do represent a responsible approach toward prevention
684 of atopic conditions, based on the presently limited evidence base. Well-designed trials must continu
685 in the face of unprecedented challenges faced today by study subjects, clinical researchers, and
686 scientists so that the field can move closer to an understanding of the complex mechanisms driving
687 allergic sensitization early in life. Effective strategies for the prevention of atopic conditions,
688 particularly AD and FA will almost certainly be the result.

Accepted Article

This article is protected by copyright. All rights reserved

Accepted Article

Table 2A*: Major Milestones Laying the Foundation for Prevention Studies*

Topic	**Year (reference)**	**Study or Publication Title**	**Author(s)**	**Key Findings and Contributions to Allergy**	**Notable Limitations**	**Study Population**	**Study Type**	**Level of Evidence[220]**
Ancient Maternal Dietary Avoidance	2735-2598 BC[221]	*Interdictions Concerning Foods*	Chinese emperors Shen Nong and Huang Di	Advised pregnant women to avoid shrimp, chicken, meat, and other agents incriminated in skin lesions	Ancient Chinese History, lacking detailed methods	Ancient Chinese	The first known official guideline recommending food avoidance to prevent disease, via Emperor's decree	n/a
Defining a Disease and a Medical Specialty	1906[222]	*Allergy*	von Pirquet C	*"For this general concept of a changed reactivity I propose the*	Opinion	n/a	Clinical observations	n/a

This article is protected by copyright. All rights reserved

Accepted Article

				term Allergy. 'Allos' implies deviation from the original state, from the behaviour of the normal individual, as it is used in the words Allorhythmia, Alloptropism."				
Oral Tolerance Induction	1908[223]	*A case of egg poisoning*	Schofield AT	First modern oral desensitization for food allergy		London clinic patient	Case Report	Level 5
Diagnosing Food Allergy and Inducing Oral Tolerance	1912[224]	*A case of allergy to common foods*	Schloss OM	The early development of food extracts for scratch testing; identification of ovomucoid as	Single case	New York clinic patient	Case report	Level 5

This article is protected by copyright. All rights reserved

Accepted Article

				the major egg allergen and its use for oral desensitization				
The Concept of Immunoglobulin E	1921[225]	The Prausnitz-Küstner Test	Prausnitz O & Küstner H	Demonstrated passive sensitization of the skin in health subjects by transferring serum from a sensitized individual using the PK test		Prausnitz (tolerated fish) & Küstner (allergic to fish)	Mechanistic	Level 5
Diagnosing Food Allergy	1950[226]	*Allergy for corn and its derivatives: experiments with a masked ingestion test for its*	Loveless MH	Amid widely varying reports of the incidence of corn allergy, recognized that positive tests and patient histories often		Survey of American Academy of Allergy members, case series from US	Case series and cohort	Level 4

This article is protected by copyright. All rights reserved

		diagnosis		do not match a "blindfold test," and appealed for standardized FA testing		allergy clinics		
The Discovery of IgE	1966-8[227,228]	*Immunoglobulin E, a new class of human immunoglobulin*	K & T Ishizaka; Johansson SGO & Bennich H	The search for reagin concludes with the nearly simultaneous identification of IgE, the critical component of an immediate hypersensitivity reaction	The IgE receptor, discovered a few years later, confirmed the effector functions of IgE	Myeloma cell lines	Mechanistic	Level 4

Accepted Article

This article is protected by copyright. All rights reserved

Accepted Article

Diagnosing Food Allergy	1976[229] 1988[230]	*Objective clinical and laboratory studies of immediate hypersensitivity reactions to foods in asthmatic children; Double-blind, placebo-controlled food challenge (DBPCFC) as an office procedure*	May CD, Bock SA, et al.	The gold-standard of diagnosis, the double-blind, placebo-controlled oral food challenge was described and became more accessible to the practicing allergist; defined a SPT <3mm as negative		US asthma center	Cohort	Level 4
Mechanisms of	1996[231]	The dual exposure	Lack G & Golding J	"Avoidance measures would	Opinion, observed		n/a	Level 5

This article is protected by copyright. All rights reserved

Accepted Article

Sensitization		hypothesis		serve only to reduce exposure to peanuts to low levels, and this could paradoxically increase allergic sensitisation to peanuts: low dose exposure to allergens favors production of IgE and as little as 1 μg of inhaled allergen a year may be sufficient to induce allergic sensitization vias the	less peanut allergy in some cultures outside Britain that also frequently consumed peanut			

This article is protected by copyright. All rights reserved

Accepted Article

				airways."				
Diagnosing Food Allergy	1997[232] & 2001[233]	Food-specific IgE values predict OFC outcomes	Sampson HA & Ho DG; Sampson HA	Proposes and validates predictive values or cut-offs, guiding the decision to perform an OFC	Highly atopic population, at high risk for FA	US tertiary care, academic allergy clinic	Cohort	Level 4

At the time of publication of most of these milestones, the existence of food allergy was questioned by many in the medical community, including most allergists. Despite how remarkable and significant these achievements were for the field of allergy and immunology, it was not until the end of the 20th century that food allergy as a field began to overcome the reputation of being scientifically weak. Over the past three or four decades, due to increasing prevalence, improved epidemiologic studies and increased awareness of food allergy given the risk for severe reactions including fatal anaphylaxis, the study of food allergy is contributing to the understanding of the mechanisms of sensitization and the origins of atopy.[234,235] In 1982, Dr. May reflected on the history of food allergy and commented:

The probability of encountering these obstacles in the future through repetition of the errors of the past would be lessened by curbing certain tendencies that interfere with learning from the lessons of the past, for example: (1) lack of historical perspective, (2) incompetence in weighing evidence, and (3) the faulty habit of adoption of opinion by feeling rather than reasoning from facts.[236]

This article is protected by copyright. All rights reserved

Accepted Article

Table 2B*: Major Milestones in Studying the Prevention of Atopy*

Area of Focus	Year (Reference)	Study Name or Publication Title	Author	Key findings or recommendations	Notable Limitations	Population Studied	Type of Study	Level of Evidence[220]
Cutaneous Sensitization	1994[237]	Increased airways responsiveness in mice depends on local challenge with antigen	Saloga J, et al.	First evidence to support that sensitization could occur through skin	Murine skin differs from human skin	Murine model	Mechanistic	Level 5
Cutaneous Sensitization	2003[238]	Avon Longitudinal Study of Parents and Children (ALSPAC)	Lack G, et al.	Peanut allergy associated with topical use of peanut oil infants, but not with maternal consumption		UK, general population	Population-based, longitudinal birth cohort	Level 2
The Role of Filaggrin in AD	2006[113]	*Common loss-of-function variants of the*	Palmer CNA, et al.	AD was more common in homozygous or	Only 2 mutations had been	9 Irish families with ichthyosis	Multiple cohorts	Level 2

This article is protected by copyright. All rights reserved

Accepted Article

		epidermal barrier protein filaggrin are a major predisposing factor for atopic dermatitis		compound heterozygous for FLG null alleles, and nearly absent in those without	identified and analyzed, both common in those of European ancestry, but rare in other ethnicities	vulgaris and/or AD; 2 cohorts of Scottish children with and without asthma; Danish children from the COPSAC study		
The Role of Filaggrin in FA	2011[86]	*Loss-of-function variants in the filaggrin gene are a significant risk factor for peanut allergy*	Brown SJ, et al.	FLG loss-of-function mutations significantly increase the risk of peanut allergy, suggesting a role for epithelial barrier	Different definitions of AD and criteria for diagnosing peanut allergy were used in the different populations; difficult to	English, Dutch, and Irish subjects with peanut allergy and controls; replicated in a white, Canadian	Case-control study	Level 3

This article is protected by copyright. All rights reserved

Accepted Article

				dysfunction	distinguish the role of AD from FLG status, and other variables affecting the development of peanut allergy; the effect varied in different populations despite all being predominantly white and of European ancestry	case-control population		
Skin Barrier Dysfunction and	2014[47]	*Peanut allergy: Effect of environmental*	Brough HA, et al.	Exposure to peanut protein in household dust	Peanut allergy not challenge-	UK, high risk infants (family	Observation al study within	Level 3

This article is protected by copyright. All rights reserved

Transcutaneous Sensitization in FA		*peanut exposure in children with filaggrin loss-of-function mutations*		demonstrated a dose-response relationship with measures of peanut sensitization and allergy at 8 and 11y in children with FLG mutations, when controlling for other factors; no effect of exposure was seen in children with WT-FLG	proven in all subjects; overall small number of subjects with peanut allergy, FLG gene status, and exposure history; excluded non-Caucasians as the 6 FLG mutations studied were only defined in Caucasians	history of atopy)	randomized controlled study	
Topical Intervention for AD	2014[239]	Application of moisturizer to neonates prevents development of	Horimoku K, et al.	Daily application of an emulsion-based moisturizer starting at	Control group could use petroleum jelly if desired, which may be	Japan, high risk	RCT	Level 2

Accepted Article

This article is protected by copyright. All rights reserved

Accepted Article

		atopic dermatitis		1week of life prevented AD in 1/3 of infants at 8m	beneficial for SB, limiting the impact of the intervention			
Oral Tolerance Induction	2015[240] & 2016[241]	LEAP & LEAP-On	du Toit, et al.	Early introduction and regular consumption of peanut in infants at high risk for FA prevents peanut allergy, and likely induces durable, and long-lasting tolerance	Excluded infants with peanut SPT>4mm at entry	UK, high risk cohort	Randomized, open-label, controlled trial	Level 2
Preventative Emollient Therapy for AD and FA	2018[242]	A randomised trial of a barrier lipid replacement strategy for the	Lowe AJ, et al.	Twice daily application of emollient rich in ceramides to infants in the	Food sensitization only assessed at 1y, not later in	Australia, high risk infants (parental history of	Pilot randomized, parallel, single-blind, controlled	Level 3

This article is protected by copyright. All rights reserved

Accepted Article

		prevention of atopic dermatitis and allergic sensitisation: The PEBBLES Pilot Study		first 3weeks of life through 6m demonstrated a trend towards less AD and food sensitization at 12month; infants who had emollient applier BID for at least 5/7 day per week did have a significant reduction in food sensitization	life and not challenge-proven; Small (n=80), pilot study.	atopy)	trial	
Assessing Skin Barrier Dysfunction	2019[243]	The nonlesional skin surface distinguishes atopic dermatitis with	Leung DYM, et al.	Using a non-invasive, well-tolerated skin tape stripping method, identifies unique	Results require validation in larger, diverse populations with	62 US children classified as AD+FA+, AD+FA- or controls	Blinded, prospective mechanistic study	Level 3

This article is protected by copyright. All rights reserved

Accepted Article

		food allergy as a unique endotype		immature skin barrier characteristics in the stratum corneum that distinguish between children with AD and FA (AD+FA+) from those with AD but without FA (AD+FA-)	challenge-proven allergy to a variety of foods, not just peanut			
Proactive Early AD Treatment and the Prevention of FA	2019[244]	Prevention of Allergy via Cutaneous Intervention (PACI) pilot	Miyaji Y, et al.	Earlier aggressive treatment of AD shortened its duration in infants, and resulted in fewer food allergies at 2 years of life	Smaller, retrospective pilot study; cohorts had significant differences in baseline characteristics	Japan	Retrospective cohort	Level 4

This article is protected by copyright. All rights reserved

Accepted Article

Preventative Emollient Therapy for AD and FA	2020[245]	Barrier Enhancement for Eczema Prevention (BEEP)	Chalmers JR, et al.	No evidence for prevention of AD at 2y with daily emollient use, but possible slight increase in infection risk, and nonsignificant increase in FA (largely to egg) in the intervention group	Choice of emollient; limited FA assessment; median time to initiation of skin care at 11 days of life	UK, high risk	Pragmatic, parallel group RCT	Level 2
Oral Tolerance Induction	2020[246]	Preventing food allergy in infancy and childhood	de Silva D, et al.	Early introduction of cooked egg (not raw or pasteurized egg) likely helps prevent egg allergy; avoiding	Many are small studies with low certainty of evidence, findings need to be validated in	n/a	Systematic review with meta-analysis	Level 2

This article is protected by copyright. All rights reserved

Accepted Article

				supplementation with cow's milk-based formula in the first week of life may slightly reduce milk allergy; nearly every other dietary intervention reviewed has little to no effect	large, heterogeneous populations			
Preventative Emollient Therapy for AD and FA	2020[247]	Preventing Atopic Dermatitis and ALLergies in Children (PreventADALL)	Skjerven HO, et al.	Found no decrease in AD or FA at 12m with skin emollient use, early complementary feeding or both	Skin intervention started at 2 weeks of life using a bath oil and cream; early food introduction began with peanut butter	Scandinavian standard risk birth cohort	Prospective interventional, cluster-randomized controlled trial	Level 2

This article is protected by copyright. All rights reserved

Accepted Article

					at 3m; overall poor adherence in the intervention groups; low statistical power to assess FA (results for FA at 3y forthcoming)			
Link between Emollient use and Food Allergy	2021[218]	Association of frequent moisturizer use in early infancy with the development of food allergy	Perkin M, et al.	Observed an increased risk of food allergy with the application of moisturizer more frequent than once daily	All but 1 case of FA developed in children with at least 1 atopic parent; AD only assessed at 3m enrolment visit; the	UK, exclusively breastfed standard risk cohort enrolled in the EAT study and randomized to standard	Retrospective analysis of questionnaire data	Level 3/4

This article is protected by copyright. All rights reserved

Accepted Article

					cohort frequently used oils for baby massage, which may prevent formation of an intact skin barrier; unable to control for some potential confounding factors	vs early introduction of 6 foods with poor protocol adherence		

This article is protected by copyright. All rights reserved

Accepted Article

Box 1: Topics for future research

- Definitions of disease that are easy to apply, widely accepted and clinically relevant
- Accurate estimates of the global epidemiologic burden of atopy
- Incorporate patient-relevant outcomes for food allergy and AD into trial designs
- Earlier timing of interventions to address skin barrier dysfunction (SBD)
- Randomized trials focusing on maternal and early life nutrition with robust measurements of food, macro and micronutrient intake and clearly defined study outcomes
- Current efforts should be broadened to more fully understand the mechanisms underlying initiation, maintenance, loss, and redevelopment of tolerance
- Fully characterize the molecular mechanisms underlying the phenotypes of SBD that place some, but not all patients with AD at a significantly increased risk for atopy, particularly food allergy
- Distinguish other SBD phenotypes, as seen in seborrheic dermatitis and psoriasis from those in AD identifying potential targets to maintain tolerance later in life
- Identify targeted treatment approaches to heal the SBD associated specifically predisposing to atopy
- Ongoing evaluation of environmental exposures including irritants, pollution, pollen, bacteria, viruses and fungi
- Begin to better understand the complex interaction of the commensal microbiome of the gut and skin with potentially pathogenic bacteria and fungi
- Focus the study of environmental and microbial factors on identifying modifiable risks for manageable public health interventions benefiting the majority of the global population

This article is protected by copyright. All rights reserved

Accepted Article

References

1. Loh W, Tang M. The Epidemiology of Food Allergy in the Global Context. *Int J Environ Res Public Health.* 2018;15.
2. Lowe A, Leung D, Tang M, Su J, Allen K. The skin as a target for prevention of the atopic march. *Ann Allergy Asthma Immunol.* 2018;120(2):145-151.
3. Dharmage S, Lowe A, Matheson M, Burgess J, Allen K, Abramson M. Atopic dermatitis and the atopic march revisited. *Allergy.* 2014;69(1):17-27.
4. Davidson WF, Leung DY, Beck LA, et al. Report from the National Institute of Allergy and Infectious Diseases workshop on “Atopic dermatitis and the atopic march: Mechanisms and interventions”. *J Allergy Clin Immunol.* 2019;143(3):894-913.
5. Perkin M, Logan K, Tseng A, Raji B, Ayis S, Peacock J. Randomized Trial of Introduction of Allergenic Foods in Breast-Fed Infants. *N Engl J Med.* 2016;374(18):1733-1743.
6. Gupta R, Warren C, Smith B. The Public Health Impact of Parent- Reported Childhood Food Allergies in the United States. *Pediatrics.* 2018;142(6).
7. Osborne NJ, Koplin JJ, Martin PE, et al. Prevalence of challenge-proven IgE-mediated food allergy using population-based sampling and predetermined challenge criteria in infants. *J Allergy Clin Immunol.* 2011;127(3):668- 676.
8. Peters R, Koplin J, Gurrin L. The prevalence of food allergy and other allergic diseases in early childhood in a population-based study: HealthNuts age 4- year follow-up. *J Allergy Clin Immunol.* 2017;140(1):145- 153.
9. Tang M, Mullins R. Food allergy: is prevalence increasing? *Intern Med J.* 2017;47(3):256-261.
10. Warren C, Jiang J, Gupta R. Epidemiology and Burden of Food Allergy. *Curr Allergy Asthma Rep.* 2020;20(2).
11. Lyons SA, Clausen M, Knulst AC, et al. Prevalence of Food Sensitization and Food Allergy in Children Across Europe. *J Allergy Clin Immunol Pract.* 2020;8(8):2736-2746 e2739.
12. Venter C, Pereira B, Voigt K, et al. Prevalence and cumulative incidence of food hypersensitivity in the first 3 years of life. *Allergy.* 2008;63(3):354-359.
13. Prescott S, Pawankar R, Allen K. A global survey of changing patterns of food allergy burden in children. *World Allergy Organ J.* 2013;6(1).
14. Du Toit G, Katz Y, Sasieni P. Early consumption of peanuts in infancy is associated with a low prevalence of peanut allergy. *J Allergy Clin Immunol.* 2008;122(5):984-991.

This article is protected by copyright. All rights reserved

Accepted Article

15. Togias A, Cooper SF, Acebal ML, et al. Addendum guidelines for the prevention of peanut allergy in the United States: Report of the National Institute of Allergy and Infectious Diseases-sponsored expert panel. *J Allergy Clin Immunol.* 2017;139(1):29-44.
16. Fleischer DM, Chan ES, Venter C, et al. A Consensus Approach to the Primary Prevention of Food Allergy Through Nutrition: Guidance from the American Academy of Allergy, Asthma, and Immunology; American College of Allergy, Asthma, and Immunology; and the Canadian Society for Allergy and Clinical Immunology. *J Allergy Clin Immunol Pract.* 2021;9(1):22-43 e24.
17. Halken S, Muraro A, de Silva D, et al. EAACI guideline: Preventing the development of food allergy in infants and young children (2020 update). *Pediatr Allergy Immunol.* 2021.
18. Warren C, Otto A, Walkner M, Gupta R. Quality of Life Among Food Allergic Patients and Their Caregivers. *Curr Allergy Asthma Rep.* 2016;16(5).
19. Macdougall JD, Burks AW, Kim EH. Current Insights into Immunotherapy Approaches for Food Allergy. *ImmunoTargets Ther.* 2021;10:1.
20. Brough H, Nadeau K, Sindher S. Epicutaneous sensitization in the development of food allergy: What is the evidence and how can this be prevented? *Allergy.* 2020;75(9):2185-2205.
21. Odhiambo J, Williams H, Clayton T, Robertson C, Asher M. Global variations in prevalence of eczema symptoms in children from ISAAC Phase Three. *J Allergy Clin Immunol.* 2009;124(6):1251-1258.
22. Strid J, Hourihane J, Kimber I, Callard R, Strobel S. Epicutaneous exposure to peanut protein prevents oral tolerance and enhances allergic sensitization. *Clin Exp Allergy.* 2005;35(6):757-766.
23. Lack G, Fox D, Northstone K, Golding J. Factors Associated with the Development of Peanut Allergy in Childhood. *N Engl J Med.* 2003;348(11):977-985.
24. Fox A, Sasieni P, du Toit G, Syed H, Lack G. Household peanut consumption as a risk factor for the development of peanut allergy. *J Allergy Clin Immunol.* 2009;123(2):417-423.
25. Leung DY, Guttman-Yassky E. Deciphering the complexities of atopic dermatitis: Shifting paradigms in treatment approaches. *J Allergy Clin Immunol.* 2014;134(4):769-779.
26. Kong HH, Oh J, Deming C, et al. Temporal shifts in the skin microbiome associated with disease flares and treatment in children with atopic dermatitis. *Genome Res.* 2012;22(5):850-859.

This article is protected by copyright. All rights reserved

Accepted Article

27. Tauber M, Balica S, Hsu CY, et al. Staphylococcus aureus density on lesional and nonlesional skin is strongly associated with disease severity in atopic dermatitis. *J Allergy Clin Immunol.* 2016;137(4):1272-1274 e1273.
28. Totte JE, van der Feltz WT, Hennekam M, van Belkum A, van Zuuren EJ, Pasmans SG. Prevalence and odds of Staphylococcus aureus carriage in atopic dermatitis: a systematic review and meta-analysis. *Br J Dermatol.* 2016;175(4):687-695.
29. Shi B, Leung DYM, Taylor PA, Li H. Methicillin-Resistant Staphylococcus aureus Colonization Is Associated with Decreased Skin Commensal Bacteria in Atopic Dermatitis. *J Invest Dermatol.* 2018;138(7):1668-1671.
30. Blicharz L, Rudnicka L, Samochocki Z. Staphylococcus aureus: an underestimated factor in the pathogenesis of atopic dermatitis? *Postepy Dermatol Alergol.* 2019;36(1):11-17.
31. Nguyen HLT, Trujillo-Paez JV, Umehara Y, et al. Role of Antimicrobial Peptides in Skin Barrier Repair in Individuals with Atopic Dermatitis. *Int J Mol Sci.* 2020;21(20).
32. Prohic A, Jovovic Sadikovic T, Krupalija-Fazlic M, Kuskunovic-Vlahovljak S. Malassezia species in healthy skin and in dermatological conditions. *Int J Dermatol.* 2016;55(5):494-504.
33. Irvine AD, McLean WH, Leung DY. Filaggrin mutations associated with skin and allergic diseases. *N Engl J Med.* 2011;365(14):1315-1327.
34. McAleer MA, Irvine AD. The multifunctional role of filaggrin in allergic skin disease. *J Allergy Clin Immunol.* 2013;131(2):280-291.
35. Vavrova K, Henkes D, Struver K, et al. Filaggrin deficiency leads to impaired lipid profile and altered acidification pathways in a 3D skin construct. *J Invest Dermatol.* 2014;134(3):746-753.
36. Goleva E, Calatroni A, LeBeau P, et al. Skin tape proteomics identifies pathways associated with transepidermal water loss and allergen polysensitization in atopic dermatitis. *J Allergy Clin Immunol.* 2020;146(6):1367-1378.
37. Flohr C, England K, Radulovic S, et al. Filaggrin loss-of-function mutations are associated with early-onset eczema, eczema severity and transepidermal water loss at 3 months of age. *Br J Dermatol.* 2010;163(6):1333-1336.
38. De Benedetto A, Rafaels NM, McGirt LY, et al. Tight junction defects in patients with atopic dermatitis. *J Allergy Clin Immunol.* 2011;127(3):773-786 e771-777.
39. Gruber R, Bornchen C, Rose K, et al. Diverse regulation of claudin-1 and claudin-4 in atopic dermatitis. *Am J Pathol.* 2015;185(10):2777-2789.

This article is protected by copyright. All rights reserved

Accepted Article

40. Cole C, Kroboth K, Schurch NJ, et al. Filaggrin-stratified transcriptomic analysis of pediatric skin identifies mechanistic pathways in patients with atopic dermatitis. *J Allergy Clin Immunol.* 2014;134(1):82-91.
41. Beck LA, Thaci D, Hamilton JD, et al. Dupilumab treatment in adults with moderate-to-severe atopic dermatitis. *N Engl J Med.* 2014;371(2):130-139.
42. Suarez-Farinas M, Dhingra N, Gittler J, et al. Intrinsic atopic dermatitis shows similar TH2 and higher TH17 immune activation compared with extrinsic atopic dermatitis. *J Allergy Clin Immunol.* 2013;132(2):361-370.
43. Fornasa G, Tsilingiri K, Caprioli F, et al. Dichotomy of short and long thymic stromal lymphopoietin isoforms in inflammatory disorders of the bowel and skin. *J Allergy Clin Immunol.* 2015;136(2):413-422.
44. Meng J, Moriyama M, Feld M, et al. New mechanism underlying IL-31-induced atopic dermatitis. *J Allergy Clin Immunol.* 2018;141(5):1677-1689 e1678.
45. Leyva-Castillo JM, Galand C, Kam C, et al. Mechanical Skin Injury Promotes Food Anaphylaxis by Driving Intestinal Mast Cell Expansion. *Immunity.* 2019;50(5):1262-1275 e1264.
46. Leung DY, Berdyshev E, Goleva E. Cutaneous barrier dysfunction in allergic diseases. *J Allergy Clin Immunol.* 2020;145(6):1485-1497.
47. Brough HA, Simpson A, Makinson K, et al. Peanut allergy: effect of environmental peanut exposure in children with filaggrin loss-of-function mutations. *J Allergy Clin Immunol.* 2014;134(4):867-875 e861.
48. Brough H, Liu A, Sicherer S. Atopic dermatitis increases the effect of exposure to peanut antigen in dust on peanut sensitization and likely peanut allergy. *J Allergy Clin Immunol.* 2015;135(1):164-170.
49. Brough H, Kull I, Richards K, Hallner E, Soderhall C, Douiri A. Environmental peanut exposure increases the risk of peanut sensitization in high-risk children. *Clin Exp Allergy.* 2018;48(5):586-593.
50. Guttman-Yassky E, Krueger J, Lebwohl M. Systemic immune mechanisms in atopic dermatitis and psoriasis with implications for treatment. *Exp Dermatol.* 2018;27(4):409-417.
51. Ewald D, Malajian D, Krueger J. Meta-analysis derived atopic dermatitis (MADAD) transcriptome defines a robust AD signature highlighting the involvement of atherosclerosis and lipid metabolism pathways. *BMC Med Genomics.* 2015;8(1).

This article is protected by copyright. All rights reserved

52. Suárez-Fariñas M, Ungar B, Correa da Rosa J, Ewald D, Rozenblit M, Gonzalez J. RNA sequencing atopic dermatitis transcriptome profiling provides insights into novel disease mechanisms with potential therapeutic implications. *J Allergy Clin Immunol.* 2015;135(5):1218-1227.
53. Renert-Yuval Y, Thyssen JP, Bissonnette R, et al. Biomarkers in atopic dermatitis-a review on behalf of the international eczema council. *J Allergy Clin Immunol.* 2021.
54. Brunner P, Guttman-Yassky E, Leung D. The immunology of atopic dermatitis and its reversibility with broad-spectrum and targeted therapies. *J Allergy Clin Immunol.* 2017;139(4s):S65-s76.
55. Czarnowicki T, Krueger J, Guttman-Yassky E. Skin Barrier and Immune Dysregulation in Atopic Dermatitis: An Evolving Story with Important Clinical Implications. *J Allergy Clin Immunol.* 2014;2(4):371-379.
56. Guttman-Yassky E, Suárez-Fariñas M, Chiricozzi A. Broad defects in epidermal cornification in atopic dermatitis identified through genomic analysis. *J Allergy Clin Immunol.* 2009;6(124):1235-1244.
57. Berdyshev E, Goleva E, Bronova I, et al. Lipid abnormalities in atopic skin are driven by type 2 cytokines. *JCI insight.* 2018;3(4).
58. Danso M, Van Drongelen V, Mulder A. TNF-α and Th2 cytokines induce atopic dermatitis-like features on epidermal differentiation proteins and stratum corneum lipids in human skin equivalents. *J Investigative Derma.* 2014;7(134):1941-1950.
59. Wang F, Kim B. A Paradigm of Neuroimmune Crosstalk. *Immunity.* 2020;52(5):753-766.
60. Stott B, Lavender P, Lehmann S, Pennino D, Durham S, Schmidt-Weber C. Human IL-31 is induced by IL-4 and promotes TH2-driven inflammation. *J Allergy Clin Immunol.* 2013;2(132):446-454.
61. Saleem M, Oussedik E, D'Amber V, Feldman S. Interleukin-31 pathway and its role in atopic dermatitis: a systematic review. *J Dermatolog Treat.* 2017;28(7):591-599.
62. Oetjen LK, Mack MR, Feng J, et al. Sensory Neurons Co-opt Classical Immune Signaling Pathways to Mediate Chronic. *Cell.* 2017;1(171):217-228.
63. Raap U, Weibmantel S, Gehring M, Eisenberg A, Kapp A. Fölster-Holst R. IL-31 significantly correlates with disease activity and Th2 cytokine levels in children with atopic dermatitis. *Pediatr Allergy Immunol.* 2012;3(23):285-288.

Accepted Article

This article is protected by copyright. All rights reserved

64. Neis M, Peters B, Dreuw A. Enhanced expression levels of IL-31 correlate with IL-4 and IL-13 in atopic and allergic contact dermatitis. *J Allergy Clin Immunol.* 2006;4(118):930-937.
65. Nograles K, Zaba L, Guttman-Yassky E. Th17 cytokines interleukin (IL)-17 and IL-22 modulate distinct inflammatory and keratinocyte-response pathways. *Br J Dermatol.* 2008;159(5):1092-1102.
66. Sa S, Valdez P, Wu J. The effects of IL-20 subfamily cytokines on reconstituted human epidermis suggest potential roles in cutaneous innate defense and pathogenic adaptive immunity in psoriasis. *J Immunol.* 2007;178(4):2229-2240.
67. Suárez-Fariñas M, Dhingra N, Gittler J, Shemer A, Cardinale I, de Guzman Strong C. Intrinsic atopic dermatitis shows similar TH2 and higher TH17 immune activation compared with extrinsic atopic dermatitis. *J Allergy Clin Immunol.* 2013;132(2):361-370.
68. Nomura T, Wu J, Kabashima K, Guttman-Yassky E. Endophenotypic Variations of Atopic Dermatitis by Age, Race, and Ethnicity. *J Allergy Clin Immunol.* 2020;8(6):1840-1852.
69. Noda S, Suárez-Fariñas M, Ungar B. The Asian atopic dermatitis phenotype combines features of atopic dermatitis and psoriasis with increased TH17 polarization. *J Allergy Clin Immunol.* 2015;136(5):1254-1264.
70. Chan T, Sanyal R, Pavel A. Atopic dermatitis in Chinese patients shows T(H)2/T(H)17 skewing with psoriasiform features. *J Allergy Clin Immunol.* 2018;142(3):1013-1017.
71. Wen H, Czarnowicki T, Noda S. Serum from Asian patients with atopic dermatitis is characterized by T(H)2/T(H)22 activation, which is highly correlated with nonlesional skin measures. *J Allergy Clin Immunol.* 2018;142(1):324-328.
72. He H, Bissonnette R, Wu J. Tape strips detect distinct immune and barrier profiles in atopic dermatitis and psoriasis. *J Allergy Clin Immunol.* 2020.
73. Pavel A, Renert-Yuval Y, Wu J. Tape-strips from early-onset pediatric atopic dermatitis highlight disease abnormalities in non-lesional skin. *Allergy.* 2020.
74. Guttman-Yassky E, Diaz A, Pavel A. Use of Tape Strips to Detect Immune and Barrier Abnormalities in the Skin of Children With Early-Onset Atopic Dermatitis. *JAMA Dermatol.* 2019.
75. Esaki H, Brunner P, Renert-Yuval Y. Early-onset pediatric atopic dermatitis is TH2 but also TH17 polarized in skin. *J Allergy Clin Immunol.* 2016;138(6):1639-1651.

Accepted Article

This article is protected by copyright. All rights reserved

76. Brunner P, Israel A, Zhang N, Leonard A, Wen H-C, Huynh T. Early- onset pediatric atopic dermatitis is characterized by TH2/TH17/TH22-centered inflammation and lipid alterations. *J Allergy Clin Immunol.* 2018;141(6):2094-2106.
77. Brunner P, He H, AB, Pavel The blood proteomic signature of early-onset pediatric atopic dermatitis shows systemic inflammation and is distinct from adult long-standing disease. *J Am Acad Dermatol.* 2019;81(2):510-519.
78. Chinthrajah R, Hernandez J, Boyd S, Galli S, Nadeau K. Molecular and cellular mechanisms of food allergy and food tolerance. *J Allergy Clin Immunol.* 2016;137(4):984-997.
79. Werfel T, Allam J, Biedermann T, Eyerich K, Gilles S, Guttman-Yassky E. Cellular and molecular immunologic mechanisms in patients with atopic dermatitis. *J Allergy Clin Immunol.* 2016;138(2):336-349.
80. Humeniuk P, Dubiela P, Hoffmann-Sommergruber K. Dendritic cells and their role in allergy: uptake, proteolytic processing and presentation of allergens. *Int J Mol Sci.* 2017;18(7):1491.
81. Satitsuksanoa P, Daanje M, Akdis M, Boyd SD, van de Veen W. Biology and dynamics of B cells in the context of IgE-mediated food allergy. *Allergy.* 2020.
82. Palomares O, Akdis M, Martin-Fontecha M, Akdis C. Mechanisms of immune regulation in allergic diseases: the role of regulatory T and B cells. *Immunol Rev.* 2017;278(1):219-236.
83. Leyva-Castillo J-M, Galand C, Kam C, et al. Mechanical skin injury promotes food anaphylaxis by driving intestinal mast cell expansion. *Immunity.* 2019;50(5):1262-1275. e1264.
84. Chinthrajah S, Cao S, Liu C, et al. Phase 2a randomized, placebo-controlled study of anti-IL-33 in peanut allergy. *JCI Insight.* 2019;4(22).
85. Leung DY, Calatroni A, Zaramela LS, et al. The nonlesional skin surface distinguishes atopic dermatitis with food allergy as a unique endotype. *Sci Transl Med.* 2019;11(480).
86. Brown SJ, Asai Y, Cordell HJ, et al. Loss-of-function variants in the filaggrin gene are a significant risk factor for peanut allergy. *J Allergy Clin Immunol.* 2011;127(3):661-667.
87. Keet C, Pistiner M, Plesa M, et al. Age and eczema severity, but not family history, are major risk factors for peanut allergy in infancy. *J Allergy Clin Immunol.* 2021;147(3):984-991. e985.
88. Martin P, Eckert J, Koplin J. Which infants with eczema are at risk of food allergy? Results from a population-based cohort. *Clin Exp Allergy.* 2015:255-264.
89. Park HY, Kim CR, Huh IS, et al. Staphylococcus aureus Colonization in Acute and Chronic Skin Lesions of Patients with Atopic Dermatitis. *Ann Dermatol.* 2013;25(4):410-416.

Accepted Article

This article is protected by copyright. All rights reserved

Accepted Article

90. Huang JT, Abrams M, Tlougan B, Rademaker A, Paller AS. Treatment of Staphylococcus aureus colonization in atopic dermatitis decreases disease severity. *Pediatrics.* 2009;123(5):e808-814.
91. Simpson EL, Villarreal M, Jepson B, et al. Patients with Atopic Dermatitis Colonized with Staphylococcus aureus Have a Distinct Phenotype and Endotype. *J Invest Dermatol.* 2018;138(10):2224-2233.
92. Broberg A, Faergemann J. Topical antimycotic treatment of atopic dermatitis in the head/neck area. A double-blind randomised study. *Acta Derm Venereol.* 1995;75(1):46-49.
93. Bäck O, Bartosik J. Systemic ketoconazole for yeast allergic patients with atopic dermatitis. *J Eur Acad Dermatol Venereol.* 2001;15(1):34-38.
94. Lintu P, Savolainen J, Kortekangas-Savolainen O, Kalimo K. Systemic ketoconazole is an effective treatment of atopic dermatitis with IgE-mediated hypersensitivity to yeasts and Asthma Proceedings. *Allergy.* 2001;56:512-517.
95. Kanda N, Enomoto U, Watanabe S. Anti-mycotics suppress interleukin-4 and interleukin-5 production in anti-CD3 plus anti-CD28-stimulated T cells from patients with atopic dermatitis. *J Invest Dermatol* 2001;117:1635-1646.
96. Kaffenberger BH, Mathis J, Zirwas MJ. A retrospective descriptive study of oral azole antifungal agents in patients with patch test-negative head and neck predominant atopic dermatitis. *J Am Acad Dermatol.* 2014;71:480-483.
97. Halkjaer LB, Loland L, Buchvald FF, et al. Development of atopic dermatitis during the first 3 years of life: the Copenhagen prospective study on asthma in childhood cohort study in high-risk children. *Arch Dermatol.* 2006;142(5):561-566.
98. Jagielski T, Rup E, Ziolkowska A, Roeske K, Macura AB, Bielecki J. Distribution of Malassezia species on the skin of patients with atopic dermatitis, psoriasis, and healthy volunteers assessed by conventional and molecular identification methods. *BMC Dermatol.* 2014;14:3.
99. Kato H, Sugita T, Ishibashi Y, Nishikawa A. Detection and quantification of specific IgE antibodies against eight Malassezia species in sera of patients with atopic dermatitis by using an enzyme-linked immunosorbent assay. *Microbiol Immunol.* 2006;50(11):851-856.
100. Watanabe S, Kano R, Sato H, Nakamura Y, Hasegawa A. The effects of Malassezia yeasts on cytokine production by human keratinocytes. *J Invest Dermatol.* 2001;116(5):769-773.

This article is protected by copyright. All rights reserved

101. Devos SA, van der Valk PG. The relevance of skin prick tests for Pityrosporum ovale in patients with head and neck dermatitis. *Allergy.* 2000;55(11):1056-1058.
102. Brasch J, Morig A, Neumann B, Proksch E. Expression of antimicrobial peptides and toll-like receptors is increased in tinea and pityriasis versicolor. *Mycoses.* 2014;57(3):147-152.
103. Baroni A, Orlando M, Donnarumma G, et al. Toll-like receptor 2 (TLR2) mediates intracellular signalling in human keratinocytes in response to Malassezia furfur. *Arch Dermatol Res.* 2006;297(7):280-288.
104. Ishibashi Y, Sugita T, Nishikawa A. Cytokine secretion profile of human keratinocytes exposed to Malassezia yeasts. *FEMS Immunol Med Microbiol.* 2006;48(3):400-409.
105. Kroger S, Neuber K, Gruseck E, Ring J, Abeck D. Pityrosporum ovale extracts increase interleukin-4, interleukin-10 and IgE synthesis in patients with atopic eczema. *Acta Derm Venereol.* 1995;75(5):357-360.
106. Boxberger M, Cenizo V, Cassir N, La Scola B. Challenges in exploring and manipulating the human skin microbiome. *Microbiome.* 2021;9(1):125.
107. Ambrożej D, Kunkiel K, Dumycz K, Feleszko W. The use of probiotics and bacteria-derived preparations in topical treatment of atopic dermatitis-A systematic review. *J Allergy Clin Immunol Pract.* 2021;9(1):570-575.e572.
108. Goleva E, Calatroni A, LeBeau P, et al. Skin tape proteomics identifies pathways associated with transepidermal water loss and allergen polysensitization in atopic dermatitis. *J Allergy Clin Immunol.* 2020;146(6):1367-1378.
109. Imayama S, Ueda S, Isoda M. Histologic changes in the skin of hairless mice following peeling with salicylic acid. *Arch Dermatol.* 2000;136(11):1390-1395.
110. Wu J, Guttman-Yassky E. Efficacy of biologics in atopic dermatitis. *Expert Opin Biol Ther.* 2020;20(5):525-538.
111. Feingold KR, Elias PM. Role of lipids in the formation and maintenance of the cutaneous permeability barrier. *Biochim Biophys Acta.* 2014;1841(3):280-294.
112. Van Smeden J, Bouwstra JA. Stratum Corneum Lipids: Their Role for the Skin Barrier Function in Healthy Subjects and Atopic Dermatitis Patients. *Curr Probl Dermatol.* 2016;49:8-26.
113. Palmer CN, Irvine AD, Terron-Kwiatkowski A, et al. Common loss-of-function variants of the epidermal barrier protein filaggrin are a major predisposing factor for atopic dermatitis. *Nat Genet.* 2006;38(4):441-446.

Accepted Article

This article is protected by copyright. All rights reserved

114. Sandilands A, Sutherland C, Irvine AD, McLean WI. Filaggrin in the frontline: role in skin barrier function and disease. *J Cell Sci.* 2009 122(9):1285–1294.
115. Van Zuuren E, Fedorowicz Z, Arents B. Emollients and moisturizers for eczema: abridged Cochrane systematic review including GRADE assessments. *Br J Dermatol.* 2017;177(5):1256-1271.
116. van Zuuren EJ, Fedorowicz Z, Christensen R, Lavrijsen A, Arents BWM. Emollients and moisturisers for eczema. *Cochrane Database Syst Rev.* 2017;2(2):Cd012119.
117. Sindher S, Alkotob SS, Shojinaga MN, et al. Increases in plasma IgG4/IgE with trilipid vs paraffin/petrolatum-based emollients for dry skin/eczema. *Pediatr Allergy Immunol.* 2020;31(6):699-703.
118. Miller DW, Koch SB, Yentzer BA, et al. An over-the-counter moisturizer is as clinically effective as, and more cost-effective than, prescription barrier creams in the treatment of children with mild-to-moderate atopic dermatitis: a randomized, controlled trial. *J Drugs Dermatol.* 2011;10(5):531-537.
119. Czarnowicki T, Dohlman AB, Malik K, et al. Effect of short-term liver X receptor activation on epidermal barrier features in mild to moderate atopic dermatitis: A randomized controlled trial. *Ann Allergy Asthma Immunol.* 2018;120(6):631-640 e611.
120. Renert-Yuval Y, Guttman-Yassky E. New treatments for atopic dermatitis targeting beyond IL-4/IL-13 cytokines. *Ann Allergy Asthma Immunol.* 2020;124(1):28-35.
121. Li R, Hadi S, Guttman-Yassky E. Current and emerging biologic and small molecule therapies for atopic dermatitis. *Expert Opin Biol Ther.* 2019;19(4):367-380.
122. Diaz A, Guttman-Yassky E. Topical agents for the treatment of atopic dermatitis. *Expert Rev Clin Immunol.* 2019;15(4):369-382.
123. He H, Guttman-Yassky E. JAK Inhibitors for Atopic Dermatitis: An Update. *Am J Clin Dermatol.* 2019;20(2):181-192.
124. Simpson E, Imafuku S, Poulin Y. A Phase 2 Randomized Trial of Apremilast in Patients with Atopic Dermatitis. *J Investigative Derma.* 2019;139(5):1063-1072.
125. Wollenberg A, Howell MD, Guttman-Yassky E, et al. Treatment of atopic dermatitis with tralokinumab, an anti–IL-13 mAb. *J Allergy Clin Immunol.* 2019;143(1):135-141.
126. Olesen C, Pavel A, Wu J. Tape-strips provide a minimally-invasive approach to track therapeutic response to topical corticosteroids in atopic dermatitis patients. *J Allergy Clin Immunol.* 2020.

Accepted Article

This article is protected by copyright. All rights reserved

127. Bissonnette R, Pavel A, Diaz A. Crisaborole and atopic dermatitis skin biomarkers: An intrapatient randomized trial. *J Allergy Clin Immunol.* 2019;144(5):1274-1289.
128. Pavel A, Song T, Kim H-J, Del Duca E, Krueger J, Dubin C. Oral Janus kinase/SYK inhibition (ASN002) suppresses inflammation and improves epidermal barrier markers in patients with atopic dermatitis. *J Allergy Clin Immunol.* 2019;144(4):1011-1024.
129. Guttman-Yassky E, Pavel A, Zhou L. GBR 830, an anti-OX40, improves skin gene signatures and clinical scores in patients with atopic dermatitis. *J Allergy Clin Immunol.* 2019;144(2):482-493.
130. Hamilton J, Suárez-Fariñas M, Dhingra N. Dupilumab improves the molecular signature in skin of patients with moderate-to-severe atopic dermatitis. *J Allergy Clin Immunol.* 2014;134(6):1293-1300.
131. Bissonnette R, Maari C, Forman S, et al. The oral Janus kinase/spleen tyrosine kinase inhibitor ASN002 demonstrates efficacy and improves associated systemic inflammation in patients with moderate-to-severe atopic dermatitis: results from a randomized double-blind placebo-controlled study. *Br J Dermatol.* 2019;181(4):733-742.
132. Callewaert C, Nakatsuji T, Knight R. IL-4Rα Blockade by Dupilumab Decreases Staphylococcus aureus Colonization and Increases Microbial Diversity in Atopic Dermatitis. *J Invest Dermatol.* 2020;140(1):191-202.
133. Pabst O, Mowat AM. Oral tolerance to food protein. *Mucosal Immunol.* 2012;5(3):232-239.
134. Hadis U, Wahl B, Schulz O, et al. Intestinal tolerance requires gut homing and expansion of FoxP3+ regulatory T cells in the lamina propria. *Immunity.* 2011;34(2):237-246.
135. Benson MJ, Pino-Lagos K, Rosemblatt M, Noelle R. All-trans retinoic acid mediates enhanced T reg cell growth, differentiation, and gut homing in the face of high levels of co-stimulation. *J Exp Med.* 2007:1765-1774.
136. Coombes JL, Siddiqui KR, Arancibia-Carcamo CV, et al. A functionally specialized population of mucosal CD103+ DCs induces Foxp3+ regulatory T cells via a TGF-beta and retinoic acid-dependent mechanism. *J Exp Med.* 2007;204(8):1757-1764.
137. Sun CM, Hall JA, Blank RB, et al. Small intestine lamina propria dendritic cells promote de novo generation of Foxp3 T reg cells via retinoic acid. *J Exp Med.* 2007;204(8):1775-1785.
138. Kim KS, Hong SW, Han D, et al. Dietary antigens limit mucosal immunity by inducing regulatory T cells in the small intestine. *Science.* 2016;351(6275):858-863.

Accepted Article

This article is protected by copyright. All rights reserved

139. Atarashi K, Tanoue T, Shima T, et al. Induction of colonic regulatory T cells by indigenous Clostridium species. *Science.* 2011;331(6015):337-341.
140. Iweala OI, Nagler CR. The Microbiome and Food Allergy. *Annu Rev Immunol.* 2019;37:377-403.
141. Feehley T, Plunkett CH, Bao R, et al. Healthy infants harbor intestinal bacteria that protect against food allergy. *Nat Med.* 2019;25(3):448-453.
142. Bao R, Hesser LA, He Z, Zhou X, Nadeau KC, Nagler CR. Fecal microbiome and metabolome differ in healthy and food-allergic twins. *J Clin Invest.* 2021;131(2).
143. Stefka AT, Feehley T, Tripathi P, et al. Commensal bacteria protect against food allergen sensitization. *Proc Natl Acad Sci U S A.* 2014;111(36):13145-13150.
144. Wesemann DR, Nagler CR. The Microbiome, Timing, and Barrier Function in the Context of Allergic Disease. *Immunity.* 2016;44(4):728-738.
145. Tan JK, McKenzie C, Marino E, Macia L, Mackay CR. Metabolite-Sensing G Protein-Coupled Receptors-Facilitators of Diet-Related Immune Regulation. *Annu Rev Immunol.* 2017;35:371-402.
146. Furusawa Y, Obata Y, Fukuda S, et al. Commensal microbe-derived butyrate induces differentiation of colonic regulatory T cells. *Nature.* 2013;504(7480):446-450.
147. Tan J, McKenzie C, Vuillermin PJ, et al. Dietary Fiber and Bacterial SCFA Enhance Oral Tolerance and Protect against Food Allergy through Diverse Cellular Pathways. *Cell Rep.* 2016;15(12):2809-2824.
148. Donohoe DR, Garge N, Zhang N, et al. The microbiome and butyrate regulate energy metabolism and autophagy in the mammalian colon. *Cell Metab.* 2011;13(5):517-526.
149. Byndloss MX, Olsan EE, Rivera-Chavez F, et al. Microbiota-activated PPAR-gamma signaling inhibits dysbiotic Enterobacteriaceae expansion. *Science.* 2017;357(6351):570-575.
150. Macia L, Mackay CR. Dysfunctional microbiota with reduced capacity to produce butyrate as a basis for allergic diseases. *J Allergy Clin Immunol.* 2019;144(6):1513-1515.
151. Zelante T, Iannitti RG, Cunha C, et al. Tryptophan catabolites from microbiota engage aryl hydrocarbon receptor and balance mucosal reactivity via interleukin-22. *Immunity.* 2013;39(2):372-385.
152. Hang S, Paik D, Yao L, et al. Bile acid metabolites control TH17 and Treg cell differentiation. *Nature.* 2019;576(7785):143-148.

Accepted Article

This article is protected by copyright. All rights reserved

153. Jin UH, Lee SO, Sridharan G, et al. Microbiome-derived tryptophan metabolites and their aryl hydrocarbon receptor-dependent agonist and antagonist activities. *Mol Pharmacol.* 2014;85(5):777-788.
154. Akiyama T, Iodi Carstens M, Carstens E. Transmitters and pathways mediating inhibition of spinal itch-signaling neurons by scratching and other counterstimuli. *PLoS One.* 2011;6(7):e22665.
155. Cryan JF, Dinan TG. Mind-altering microorganisms: the impact of the gut microbiota on brain and behaviour. *Nat Rev Neurosci.* 2012;13(10):701-712.
156. Yokoyama S, Hiramoto K, Koyama M, Ooi K. Impairment of skin barrier function via cholinergic signal transduction in a dextran sulphate sodium-induced colitis mouse model. *Exp Dermatol.* 2015;24(10):779-784.
157. Garcia-Larsen V, Lerodiakonou D, Jarrold K. Diet during pregnancy and infancy and risk of allergic or autoimmune disease: A systematic review and meta-analysis. *PLoS Med.* 2018;15(2).
158. Du Toit G, Roberts G, Sayre PH, et al. Randomized trial of peanut consumption in infants at risk for peanut allergy. *N Engl J Med.* 2015;372(9):803-813.
159. du Toit G, Sayre PH, Roberts G, et al. Allergen specificity of early peanut consumption and effect on development of allergic disease in the Learning Early About Peanut Allergy study cohort. *J Allergy Clin Immunol.* 2018;141(4):1343-1353.
160. Perkin MR, Logan K, Tseng A, et al. Randomized Trial of Introduction of Allergenic Foods in Breast-Fed Infants. *N Engl J Med.* 2016;374(18):1733-1743.
161. de Silva D, Halken S, Singh C, et al. Preventing food allergy in infancy and childhood: systematic review of randomised controlled trials. *Pediatr Allergy Immunol.* 2020;31(7):813-826.
162. Obbagy JE, English LK, Wong YP, et al. Complementary feeding and food allergy, atopic dermatitis/eczema, asthma, and allergic rhinitis: a systematic review. *Am J Clin Nutr.* 2019;109(Suppl_7):890s-934s.
163. Burgess JA, Dharmage SC, Allen K, et al. Age at introduction to complementary solid food and food allergy and sensitization: A systematic review and meta-analysis. *Clin Exp Allergy.* 2019;49(6):754-769.

Accepted Article

This article is protected by copyright. All rights reserved

Accepted Article

164. Urashima M, Mezawa H, Okuyama M, et al. Primary Prevention of Cow's Milk Sensitization and Food Allergy by Avoiding Supplementation With Cow's Milk Formula at Birth: A Randomized Clinical Trial. *JAMA Pediatr.* 2019;173(12):1137-1145.
165. Fisher HR, Du Toit G, Bahnson HT, Lack G. The challenges of preventing food allergy: Lessons learned from LEAP and EAT. *Ann Allergy Asthma Immunol.* 2018;121(3):313-319.
166. Perkin MR, Logan K, Marrs T, et al. Enquiring About Tolerance (EAT) study: Feasibility of an early allergenic food introduction regimen. *J Allergy Clin Immunol.* 2016;137(5):1477-1486.e1478.
167. Koplin JJ, Peters RL, Dharmage SC, et al. Understanding the feasibility and implications of implementing early peanut introduction for prevention of peanut allergy. *J Allergy Clin Immunol.* 2016;138(4):1131-1141.e1132.
168. Venter C, Agostoni C, Arshad SH, et al. Dietary factors during pregnancy and atopic outcomes in childhood: a systematic review from the European Academy of Allergy and Clinical Immunology. *Pediatr Allergy Immunol.* 2020;31(8):889-912.
169. Netting M, Middleton P, Makrides M. Does maternal diet during pregnancy and lactation affect outcomes in offspring? A systematic review of food-based approaches. *Nutrition.* 2014;30:1225-1241.
170. Grimshaw K, Maskell J, Oliver E. Diet and food allergy development during infancy: birth cohort study findings using prospective food diary data. *J Allergy Clin Immunol.* 2014;133(2):511-519.
171. de Silva D, Halken S, Singh C, et al. Preventing food allergy in infancy and childhood: systematic review of randomised controlled trials. *Pediatr Allergy Immunol.* 2020.
172. Greer FR, Sicherer SH, Burks AW, Committee On N, Section On A, Immunology. The Effects of Early Nutritional Interventions on the Development of Atopic Disease in Infants and Children: The Role of Maternal Dietary Restriction, Breastfeeding, Hydrolyzed Formulas, and Timing of Introduction of Allergenic Complementary Foods. *Pediatrics.* 2019;143(4).
173. Fleischer DM, Chan ES, Venter C, et al. A Consensus Approach to the Primary Prevention of Food Allergy Through Nutrition: Guidance from the American Academy of Allergy, Asthma, and Immunology; American College of Allergy, Asthma, and Immunology; and the Canadian Society for Allergy and Clinical Immunology. *J Allergy Clin Immunol Pract.* 2020.
174. Halken S, Muraro A, de Silva D, et al. EAACI guideline: preventing the development of food allergy in infants and young children (2020 update). *Pediatr Allergy Immunol.* 2021.

This article is protected by copyright. All rights reserved

Accepted Article

175. Garcia-Larsen V, Ierodiakonou D, Jarrold K, et al. Diet during pregnancy and infancy and risk of allergic or autoimmune disease: A systematic review and meta-analysis. *PLoS Med.* 2018;15(2):e1002507.
176. James DC, Dobson B. Position of the American Dietetic Association: Promoting and supporting breastfeeding. *J Am Diet Assoc.* 2005;105(5):810-818.
177. Venter C, Greenhawt M, Meyer R, et al. EAACI position paper on diet diversity in pregnancy, infancy and childhood: Novel concepts and implications for studies in allergy and asthma. *Allergy.* 2020;3(75):497-523.
178. Roduit C, Frei R, Depner M. Increased food diversity in the first year of life is inversely associated with allergic diseases. *J Allergy Clin Immunol.* 2014;133(4):1056-1064.
179. Sausenthaler S, Heinrich J, Koletzko S. Early diet and the risk of allergy: what can we learn from the prospective birth cohort studies GINIplus and LISAplus? *Am J Clin Nutr.* 2011;94(6):2012-2017.
180. Zutavern A, Brockow, Schaaf B. Timing of solid food introduction in relation to eczema, asthma, allergic rhinitis, and food and inhalant sensitization at the age of 6 years: results from the prospective birth cohort study LISA. *Pediatrics.* 2008;121(1):44-52.
181. Zutavern A, Brockow I, Schaaf B. Timing of solid food introduction in relation to atopic dermatitis and atopic sensitization: results from a prospective birth cohort study. *Pediatrics.* 2006;117(2):401-411.
182. Fergusson D, Horwood L, Shannon F. Risk factors in childhood eczema. . *J Epidemiol Community Health.* 1982;36(2):118-122.
183. Nwaru B, Takkinen H, M, Kaila Food diversity in infancy and the risk of childhood asthma and allergies. *J Allergy Clin Immunol.* 2014;133(4):1084-1091.
184. Roduit C, Frei R, G, Loss Development of atopic dermatitis according to age of onset and association with early-life exposures. *J Allergy Clin Immunol.* 2012;130(1):130-136.
185. Turati F, Bertuccio P, Galeone C. Early weaning is beneficial to prevent atopic dermatitis occurrence in young children. *Allergy.* 2016;71(6):878-888.
186. Sharief S, Jariwala S, Kumar J, Muntner P, Melamed M. Vitamin D levels and food and environmental allergies in the United States: results from the National Health and Nutrition Examination Survey 2005-2006. *J Allergy Clin Immunol.* 2011;127(5):1195- 1202.
187. He Z, Vadali VG, Szabady RL, et al. Increased diversity of gut microbiota during active oral immunotherapy in peanut-allergic adults. *Allergy.* 2021;76(3):927-930.

This article is protected by copyright. All rights reserved

188. Allen KJ, Koplin J, Ponsonby A. Vitamin D insufficiency is associated with challenge-proven food allergy in infants. *J Allergy Clin Immunol.* 2013;131(4):1109- 1116.
189. Hennessy Á, Hourihane JOB, Malvisi L, et al. Antenatal vitamin D exposure and childhood eczema, food allergy, asthma and allergic rhinitis at 2 and 5 years of age in the atopic disease-specific Cork BASELINE Birth Cohort Study. *Allergy.* 2018;73(11):2182-2191.
190. Thorisdottir B, Gunnarsdottir I, Vidarsdottir A, Sigurdardottir S, Birgisdottir B, Thorsdottir I. Infant Feeding, Vitamin D and IgE Sensitization to Food Allergens at 6 Years in a Longitudinal Icelandic Cohort. *Nutrients.* 2019;11(7).
191. Hollams E, Teo S, Kusel M. Vitamin D over the first decade and susceptibility to childhood allergy and asthma. *J Allergy Clin Immunol.* 2017;139(2):472-481.
192. Litonjua AA, Carey VJ, Laranjo N. Effect of Prenatal Supplementation With Vitamin D on Asthma or Recurrent Wheezing in Offspring by Age 3 Years: The VDAART Randomized Clinical Trial. *JAMA Dermatol.* 2016;315(4):362-370.
193. Rosendahl J, Pelkonen A, Helve O. High-Dose Vitamin D Supplementation Does Not Prevent Allergic Sensitization of Infants. *J Pediatr.* 2019:139-145.
194. Yepes-Nunez J, Brozek J, Fiocchi A. Vitamin D supplementation in primary allergy prevention: Systematic review of randomized and non-randomized studies. *Allergy.* 2018;73(1):37-49.
195. Hawrylowicz C, Santos A. Vitamin D: can the sun stop the atopic epidemic? *Curr Opin Allergy Clin Immunol.* 2020;20(2):181-187.
196. Greer F, Sicherer SH, Burks A. Committee On N, Section On A, Immunology. The Effects of Early Nutritional Interventions on the Development of Atopic Disease in Infants and Children: The Role of Maternal Dietary Restriction, Breastfeeding, Hydrolyzed Formulas, and Timing of Introduction of Allergenic Complementary Foods. *Pediatrics.* 2019;143(4).
197. Ichiishi E, Li XK, Iorio EL. Oxidative Stress and Diseases: Clinical Trials and Approaches. *Oxid Med Cell Longev.* 2016;2016:3458276.
198. Antunes MM, Coelho BSL, Vichi TM, et al. Oral supplementation with capsaicin reduces oxidative stress and IL-33 on a food allergy murine model. *World Allergy Organ J.* 2019;12(7):100045.
199. Ros E. Health benefits of nut consumption. *Nutrients.* 2010;2(7):652-682.
200. Venter C, Agostoni, C,. Arshad, S.H., Ben-Abdallah, M., Du Toit, G., Flesicher, D.M., Greenhawt, M., Glueck, D., Groetch, M., Maslin, K., Maiorella, A., Meyer, R., Muraro, A.,

Accepted Article

This article is protected by copyright. All rights reserved

Accepted Article

Netting, M., Nwaru, B.N., Palmer, D.J., Palumbo, M.. Roberts. G., Roduit, C., Smith, P.K., Untersmayr, E., Vanderlinden, L., O'Mahony, L. Dietary factors during pregnancy and atopic outcomes in childhood: a systematic review from the European Academy of Allergy and Clinical Immunology. *Pediatr Allergy Immunol.* 2020;In press.

201. Venter C, Greenhawt M, Meyer RW, et al. EAACI position paper on diet diversity in pregnancy, infancy and childhood: Novel concepts and implications for studies in allergy and asthma. *Allergy.* 2020;75(3):497-523.
202. Venter C, Meyer RW, Nwaru BI, et al. EAACI position paper: Influence of dietary fatty acids on asthma, food allergy, and atopic dermatitis. *Allergy.* 2019;74(8):1429-1444.
203. Turner PJ, Feeney M, Meyer R, Perkin MR, Fox AT. Implementing primary prevention of food allergy in infants: New BSACI guidance published. *Clin Exp Allergy.* 2018;48(8):912-915.
204. Allergy ASoCIa. Australasian Society of Clinical Immunology and Allergy guidelines for infant feeding and allergy prevention. . https://www.allergy.org.au/patients/allergy-prevention/ascia-guidelines-for-infant-feeding-and-allergy-prevention Published 2016. Accessed.
205. Roduit C, Frei R, Ferstl R, et al. High levels of butyrate and propionate in early life are associated with protection against atopy. *Allergy.* 2019;74(4):799-809.
206. Thio CL, Chi PY, Lai AC, Chang YJ. Regulation of type 2 innate lymphoid cell-dependent airway hyperreactivity by butyrate. *J Allergy Clin Immunol.* 2018;142(6):1867-1883 e1812.
207. Claesson MJ, Jeffery IB, Conde S, et al. Gut microbiota composition correlates with diet and health in the elderly. *Nature.* 2012;488(7410):178-184.
208. Laursen MF, Andersen LB, Michaelsen KF, et al. Infant Gut Microbiota Development Is Driven by Transition to Family Foods Independent of Maternal Obesity. *mSphere.* 2016;1(1).
209. Bach Knudsen KE, Lærke HN, Hedemann MS, et al. Impact of Diet-Modulated Butyrate Production on Intestinal Barrier Function and Inflammation. *Nutrients.* 2018;10(10):1499.
210. Jiang W, Ni B, Liu Z, et al. The Role of Probiotics in the Prevention and Treatment of Atopic Dermatitis in Children: An Updated Systematic Review and Meta-Analysis of Randomized Controlled Trials. *Paediatr Drugs.* 2020;22(5):535-549.
211. Cuello-Garcia CA, Brozek JL, Fiocchi A, et al. Probiotics for the prevention of allergy: A systematic review and meta-analysis of randomized controlled trials. *J Allergy Clin Immunol.* 2015;136(4):952-961.

This article is protected by copyright. All rights reserved

212. Cuello-Garcia C, Fiocchi A, Pawankar R, et al. Prebiotics for the prevention of allergies: A systematic review and meta-analysis of randomized controlled trials. *Clinical & Experimental Allergy.* 2017;47(11):1468-1477.
213. Netting MJ, Campbell DE, Koplin JJ, et al. An Australian Consensus on Infant Feeding Guidelines to Prevent Food Allergy: Outcomes From the Australian Infant Feeding Summit. *J Allergy Clin Immunol Pract.* 2017.
214. American Academy of Pediatrics. Committee on Nutrition. Hypoallergenic infant formulas. *Pediatrics.* 2000;106(2 Pt 1):346-349.
215. Greer FR, Sicherer SH, Burks AW, American Academy of Pediatrics Committee on N, American Academy of Pediatrics Section on A, Immunology. Effects of early nutritional interventions on the development of atopic disease in infants and children: the role of maternal dietary restriction, breastfeeding, timing of introduction of complementary foods, and hydrolyzed formulas. *Pediatrics.* 2008;121(1):183-191.
216. Gupta RS, Bilaver LA, Johnson JL, et al. Assessment of Pediatrician Awareness and Implementation of the Addendum Guidelines for the Prevention of Peanut Allergy in the United States. *JAMA Netw Open.* 2020;3(7):e2010511.
217. Joshi PA, Smith J, Vale S, Campbell DE. The Australasian Society of Clinical Immunology and Allergy infant feeding for allergy prevention guidelines. *Med J Aust.* 2019;210(2):89-93.
218. Perkin MR, Logan K, Marrs T, et al. Association of frequent moisturizer use in early infancy with the development of food allergy. *J Allergy Clin Immunol.* 2021;147(3):967-976 e961.
219. Kelleher MM, Cro S, Cornelius V, et al. Skin care interventions in infants for preventing eczema and food allergy. *Cochrane Database of Systematic Reviews.* 2021(2).
220. Group OCfE-BMLoEW. The Oxford 2011 Levels of Evidence. In:2011.
221. Cohen SG. Food allergens: landmarks along a historic trail. *J Allergy Clin Immunol.* 2008;121(6):1521-1524, 1524 e1521.
222. Kay AB. 100 years of 'Allergy': can von Pirquet's word be rescued? *Clin Exp Allergy.* 2006;36(5):555-559.
223. Schofield A. A case of egg poisoning. *The Lancet.* 1908;171(4410):716.
224. Schloss OM. A case of allergy to common foods. *American Journal of Diseases of Children.* 1912;3(6):341-362.
225. Prausnitz C, Küstner H. Studien über die Überempfindlichkeit. *Zentralbl Bakteriol.* 1921;86:160-169.

Accepted Article

This article is protected by copyright. All rights reserved

226. Loveless MH. Allergy for corn and its derivatives: experiments with a masked ingestion test for its diagnosis. *J Allergy.* 1950;21(6):500-509.
227. Platts-Mills TAE. The continuing effect of the discovery of IgE by Kimishige Ishizaka. *J Allergy Clin Immunol.* 2018;142(3):788-789.
228. Immunoglobulin E, a new class of human immunoglobulin. *Bull World Health Organ.* 1968;38(1):151-152.
229. Bock SA, Lee WY, Remigio L, Holst A, May CD. Appraisal of skin tests with food extracts for diagnosis of food hypersensitivity. *Clin Allergy.* 1978;8(6):559-564.
230. Bock SA, Sampson HA, Atkins FM, et al. Double-blind, placebo-controlled food challenge (DBPCFC) as an office procedure: a manual. *J Allergy Clin Immunol.* 1988;82(6):986-997.
231. Lack G, Golding J. Peanut and nut allergy. Reduced exposure might increase allergic sensitisation. *BMJ.* 1996;313(7052):300.
232. Sampson HA, Ho DG. Relationship between food-specific IgE concentrations and the risk of positive food challenges in children and adolescents. *J Allergy Clin Immunol.* 1997;100(4):444-451.
233. Sampson HA. Utility of food-specific IgE concentrations in predicting symptomatic food allergy. *J Allergy Clin Immunol.* 2001;107(5):891-896.
234. Sampson HA. Food allergy: Past, present and future. *Allergol Int.* 2016;65(4):363-369.
235. Smith M. Another person's poison. *Lancet.* 2014;384(9959):2019-2020.
236. May CD. Food allergy: lessons from the past. *J Allergy Clin Immunol.* 1982;69(3):255-259.
237. Saloga J, Renz H, Larsen GL, Gelfand EW. Increased airways responsiveness in mice depends on local challenge with antigen. *Am J Respir Crit Care Med.* 1994;149(1):65-70.
238. Lack G, Fox D, Northstone K, Golding J, Avon Longitudinal Study of P, Children Study T. Factors associated with the development of peanut allergy in childhood. *N Engl J Med.* 2003;348(11):977-985.
239. Horimukai K, Morita K, Narita M, et al. Application of moisturizer to neonates prevents development of atopic dermatitis. *J Allergy Clin Immunol.* 2014;134(4):824-830 e826.
240. Du Toit G, Roberts G, Sayre PH, et al. Randomized trial of peanut consumption in infants at risk for peanut allergy. *N Engl J Med.* 2015;372(9):803-813.
241. Du Toit G, Sayre PH, Roberts G, et al. Effect of Avoidance on Peanut Allergy after Early Peanut Consumption. *N Engl J Med.* 2016;374(15):1435-1443.

Accepted Article

This article is protected by copyright. All rights reserved

Accepted Article

242. Lowe AJ, Su JC, Allen KJ, et al. A randomized trial of a barrier lipid replacement strategy for the prevention of atopic dermatitis and allergic sensitization: the PEBBLES pilot study. *Br J Dermatol.* 2018;178(1):e19-e21.
243. Leung DYM, Calatroni A, Zaramela LS, et al. The nonlesional skin surface distinguishes atopic dermatitis with food allergy as a unique endotype. *Sci Transl Med.* 2019;11(480).
244. Miyaji Y, Yang L, Yamamoto-Hanada K, Narita M, Saito H, Ohya Y. Earlier aggressive treatment to shorten the duration of eczema in infants resulted in fewer food allergies at 2 years of age. *J Allergy Clin Immunol Pract.* 2020;8(5):1721-1724 e1726.
245. Chalmers JR, Haines RH, Bradshaw LE, et al. Daily emollient during infancy for prevention of eczema: the BEEP randomised controlled trial. *Lancet.* 2020;395(10228):962-972.
246. de Silva D, Halken S, Singh C, et al. Preventing food allergy in infancy and childhood: Systematic review of randomised controlled trials. *Pediatr Allergy Immunol.* 2020;31(7):813-826.
247. Skjerven HO, Rehbinder EM, Vettukattil R, et al. Skin emollient and early complementary feeding to prevent infant atopic dermatitis (PreventADALL): a factorial, multicentre, cluster-randomised trial. *Lancet.* 2020;395(10228):951-961.

This article is protected by copyright. All rights reserved

Legends:

Figure 1. Prevalence of Paediatric FA Around the World adapted from Warren C, Jiang J, Gupta R.Epidemiology and Burden of Food Allergy. *Curr Allergy Asthma Rep.* 2020;20(2), Lyons SA, Clausen M, Knulst AC, et al. Prevalence of Food Sensitization and Food Allergy in Children Across Europe. *J Allergy Clin Immunol Pract.* 2020;8(8):2736-2746 e2739 and Venter C, Pereira B, Voigt K, et al. Prevalence and cumulative incidence of food hypersensitivity in the first 3 years of life. *Allergy.* 2008;63(3):354-359.

Figure 2: Prevalence of Current Eczema Symptoms (ISAAC Phase III: Ages 6-7 adapted from Odhiambo J, Williams H, Clayton T, Robertson C, Asher M. Global variations in prevalence of eczema symptoms in children from ISAAC Phase Three. *J Allergy Clin Immunol.* 2009;124(6):1251-1258

Figure 3: Prevalence of Current Eczema Symptoms (ISAAC Phase III: Ages 13-14) adapted from from Odhiambo J, Williams H, Clayton T, Robertson C, Asher M. Global variations in prevalence of eczema symptoms in children from ISAAC Phase Three. *J Allergy Clin Immunol.* 2009;124(6):1251-1258

Figure 4: In the “outside-in” hypothesis, skin barrier defect allows penetration of allergens and microbes leading to atopic sensitization whereas, in the “inside-out” paradigm, a polarized immune response leads to a defective skin barrier. Adapted with permission from the Journal of Allergy and Clinical Immunology from Leung DY, Guttman-Yassky E. Deciphering the complexities of atopic dermatitis: Shifting paradigms in treatment approaches. *J Allergy Clin Immunol.* 2014;134(4):769-779.

Figure 5: Skin dysbiosis, especially colonization of *Staphylococcus aureus* and *Malassezia spp.,* is often seen among young children with atopic dermatitis. (a) *S. aureus* colonization on a six-month child; (b). heavy colonization of *Malassezia spp.,* also known as Pityrosporum, on the scalp of an infant.

This article is protected by copyright. All rights reserved

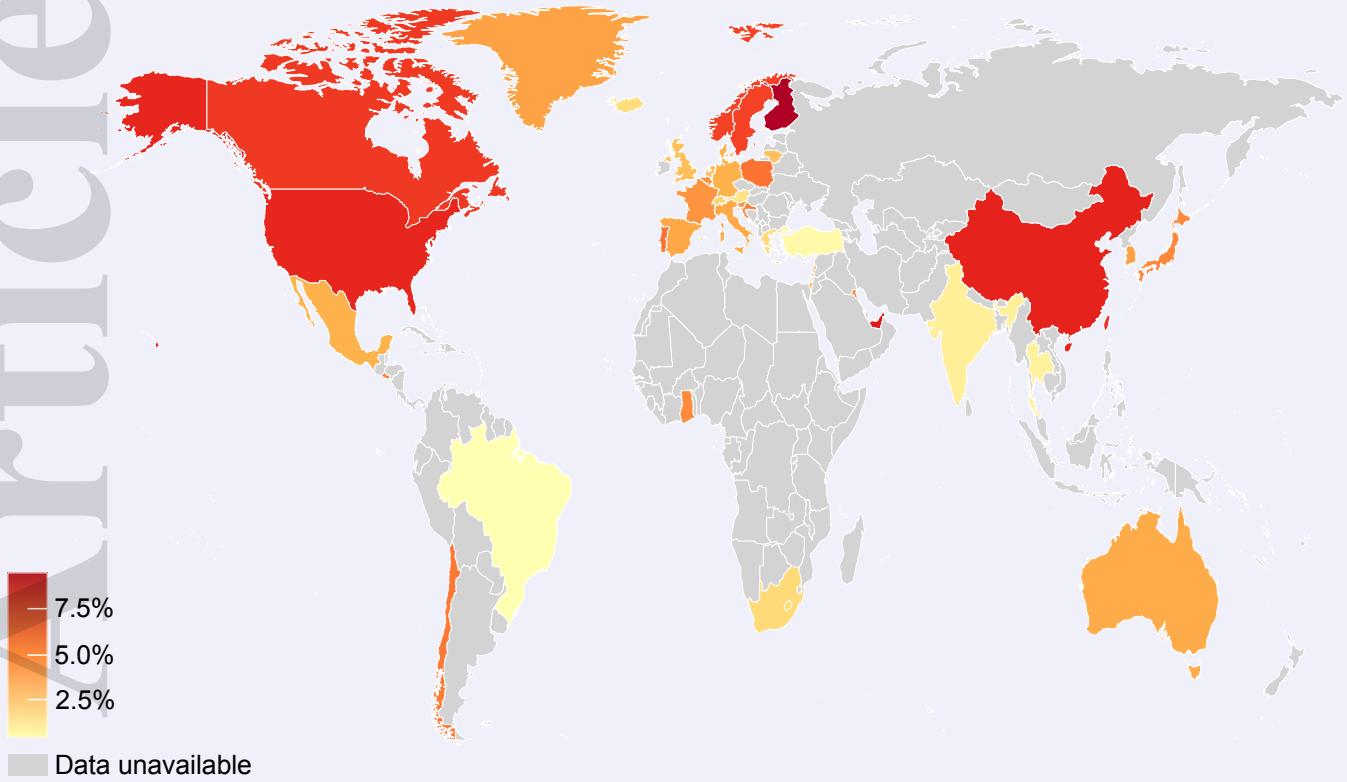
Figure 6: Dietary compounds and their conversion by commensal bacteria influence oral tolerance. Several dietary components and digestive products contribute heavily to the function of the gut immune system. Gut-resident $CD103^+$ dendritic cells (DCs) directly convert dietary vitamin A to retinoic acid (RA) for further downstream immune signaling. Conversely, tryptophan, liver-derived bile acids, and fiber must first be metabolized by commensal bacteria such as Clostridia. These bacteria degrade tryptophan into several compounds that can bind to the aryl-hydrocarbon receptor (Ahr) of ILC3s, playing a role in IL-22 production. Secondary bile acids and short chain fatty acids (SCFAs), including butyrate, signal directly to epithelial cells as well as local immune cell populations residing in the lamina propria. Collectively, these compounds enhance epithelial barrier integrity by stimulating Paneth cells to produce anti-microbial peptides, goblet cells to produce mucus, and epithelial cells to produce tight junction and adherens proteins. In addition, they induce populations of tolerogenic lymphocytes such as peripherally induced regulatory T cells (iTregs) and IgA-producing plasma cells. Together, these functions are essential for the maintenance of oral tolerance.

Figure 7: Diagram of possible causal associations between genetics, skin exposures, diet leading to eczema and/or food allergy. The interplay between genetics, diet, and skin/microbiome exposure are connected by arrows showing the direction of causality hypothesized to ultimately influence food allergy. The relevant causal factors of the dual allergen exposure hypothesis are outlined by the blue rectangle. This hypothesis postulates that allergen exposure through the skin leads to the development of food allergy. The degree of a broken skin barrier involved with eczema is thought to interact with allergen exposure to increase the probability of allergy development with increasing barrier disfunction. While early introduction of food and diet diversity has been proven to prevent food allergy (dark green), other factors such as breastfeeding, commensal bacteria metabolizing bile acids, tryptophan from dietary/commensal bacterial sources, dietary fiber, vitamins, pre-pro- and syn-biotics have weaker evidence base for this (light green). Reducing eczema severity has yet to be consistently shown as a preventative causal mechanism. Nevertheless, eczema severity exists as one of the strongest predictors of food allergy, and therapies to heal a broken skin barrier remain as a leading mechanism to mediate the prevention of food allergy.

Accepted Article

This article is protected by copyright. All rights reserved

Prevalence of paediatric food allergy



North America

Canada	7.1%	Soller 2012	(0-17 yr)
Mexico	3.5%	Ontiveros 2016	(5-13 yr)
USA	7.6%	Gupta 2018	(0-17 yr)

Central America & South America

Brazil	0.6%	Goncalves 2016	(4-59 mo)
Chile	5.5%	Hoyos-Bachiloglu 2014	(5-15 yr)
El Salvador	5.3%	Cabrera-Chavez 2018	(4-12 yr)

Middle East

Israel	3.6%	Graif 2012	(13-14 yr)
Kuwait	5.4%	Ali 2017	(17-30 yr)
Lebanon	4.1%	Irani 2015	(0-17 yr)
Turkey	0.8%	Orhan 2009	(6-9 yr)
UAE	8.0%	Al Hammadi 2010	(6-9 yr)

Asia & Oceana

Australia	3.8%	Peters 2017	(4 yr)
China	7.7%	Hu 2010	(0-2 yr)
Hong Kong	4.8%	Ho 2012	(0-14 yr)
Japan	5.1%	Ebisawa 2017	(0-17 yr)
Singapore	5.4%	Lee 2014	(11-30 mo)
South Korea	4.1%	Kim 2017	(6-16 yr)
Taiwan	7.4%	Wu 2012	(0-18 yr)
Thailand	1.1%	Lao-Araya 2011	(3-7 yr)

Europe

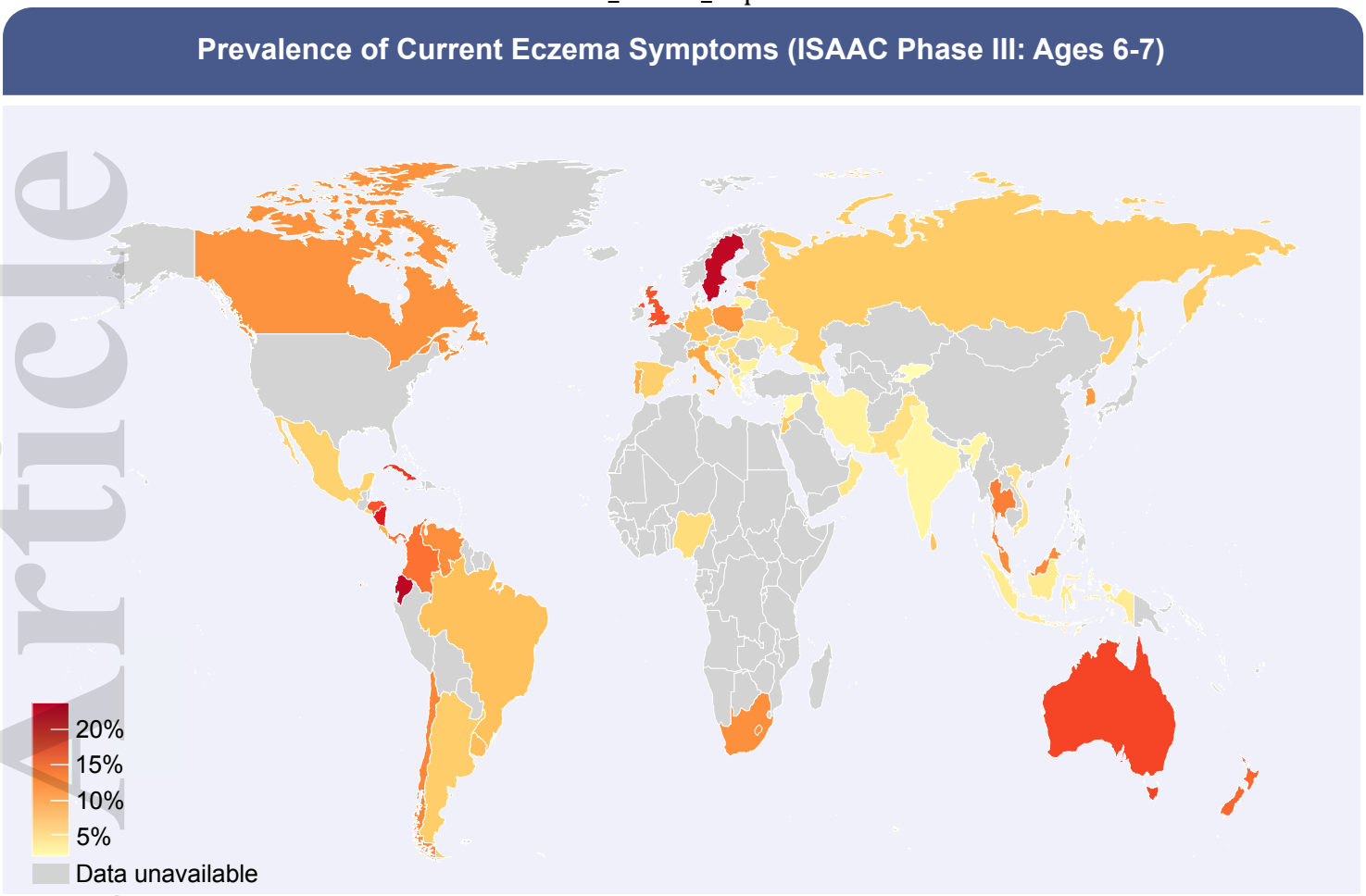
Austria	1.7%	Steinke 2007	(0-17 yr)
Belgium	4.9%	Steinke 2007	(0-17 yr)
Croatia	5.4%	Pavlović 2015	(6 yr)
Denmark	3.6%	Steinke 2009	(0-6 yr)
Finland	9.3%	Pyrhonen 2009	(1-4 yr)
France	4.7%	Rance 2005	(2-14 yr)
Germany	3.5%	Roehr 2004	(0-17 yr)
Greece	2.0%	Lyons 2020	(7-10 yr)
Greenland	4.1%	Krause 2002	(5-18 yr)
Iceland	1.9%	Lyons 2020	(7-10 yr)
Italy	3.9%	Steinke 2007	(0-17 yr)
Lithuania	3.0%	Lyons 2020	(7-10 yr)
Malta	2.5%	Abdilla 2016	(5-6 yr)
Netherlands	3.0%	Lyons 2020	(7-10 yr)
Norway	6.8%	Kvenshagen 2008	(2 yr)
Poland	5.6%	Lyons 2010	(7-10 yr)
Portugal	5.7%	Gaspar-Marques 2014	(0-6 yr)
Slovenia	4.6%	Steinke 2007	(0-17 yr)
Spain	3.9%	Lyons 2020	(7-10 yr)
Sweden	6.8%	Protudger 2016	(16 yr)
Switzerland	2.3%	Lyons 2020	(7-10 yr)
UK	3.0%	Venter 2008	(3 yr)

Africa

Ghana	5.0%	Obeng 2011	(5-16 yr)
South Africa	1.8%	Botha 2019	(1-3 yr)

(range of ages comprising study sample)

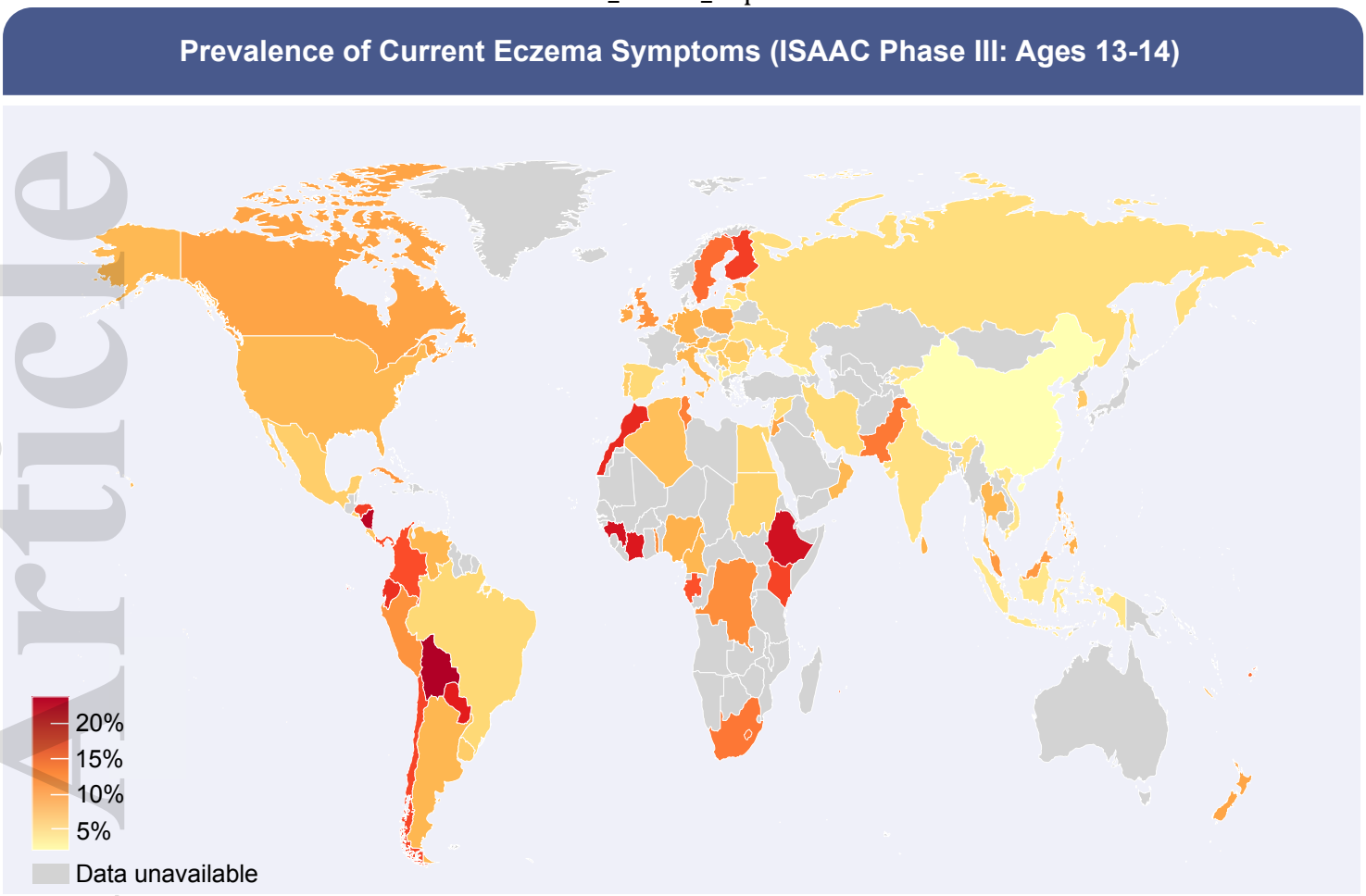
This article is protected by copyright. All rights reserved



Accepted Article

This article is protected by copyright. All rights reserved

Figure 2_Brough et al.

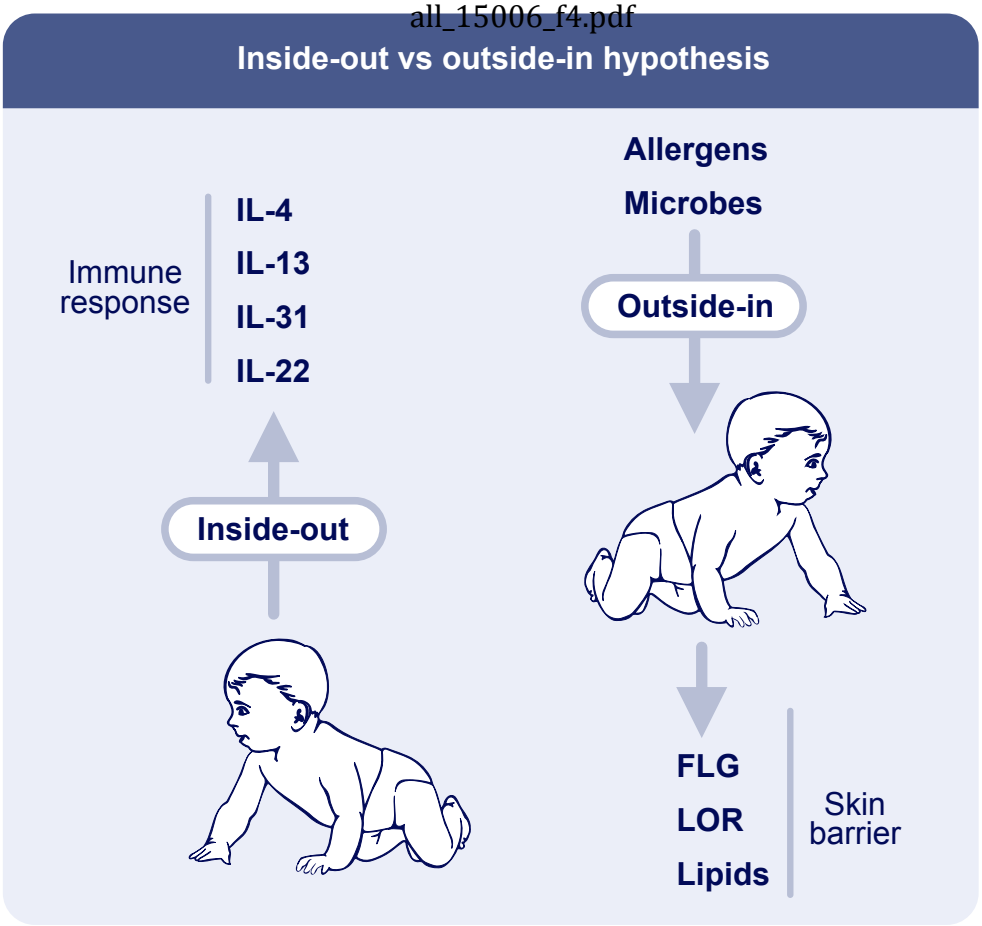


Accepted Article

This article is protected by copyright. All rights reserved

Accepted Article

all_15006_f4.pdf



This article is protected by copyright. All rights reserved

Figure 1_Brough et al.

Accepted Article



all_15006_f5a.png

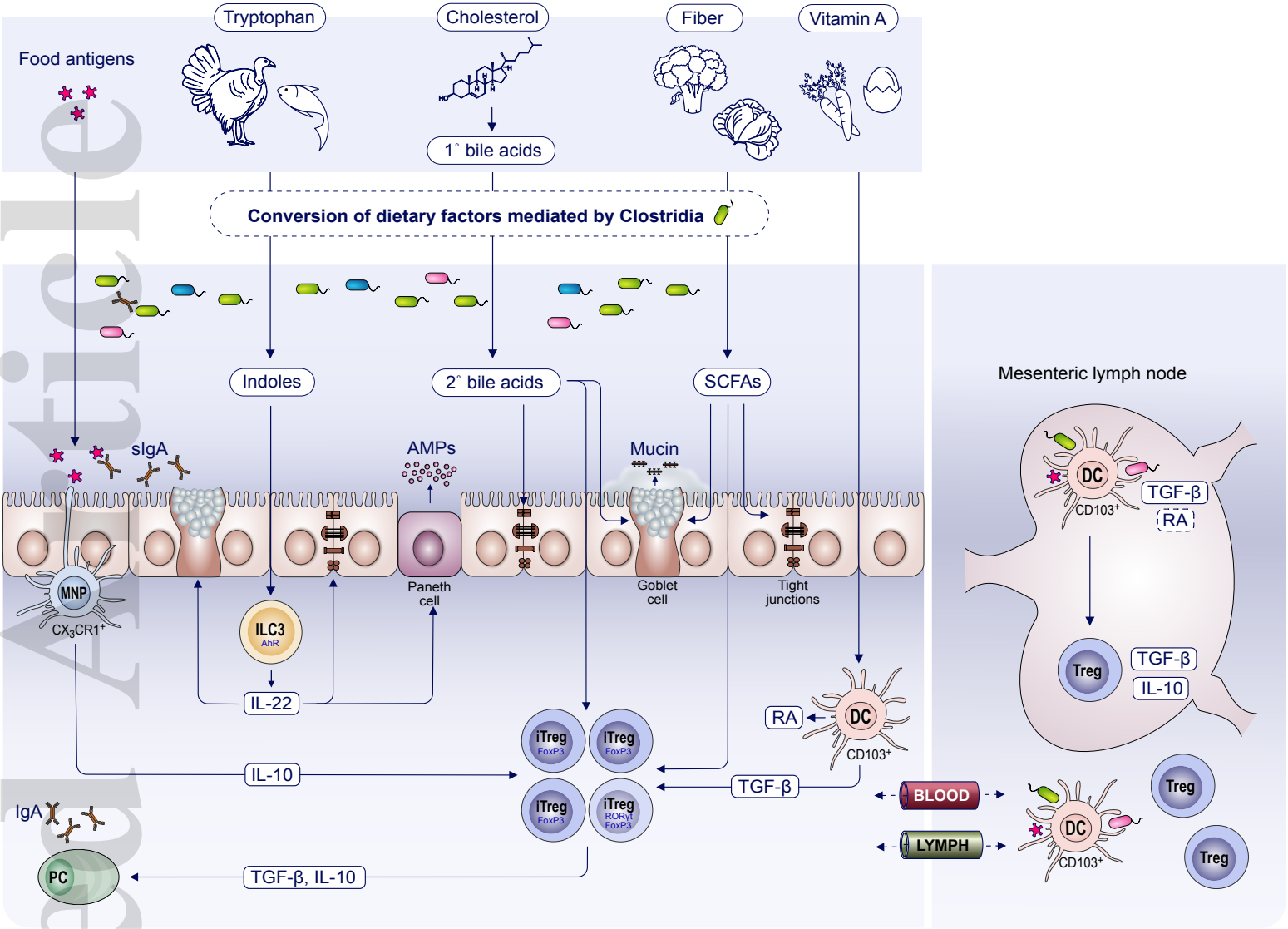
This article is protected by copyright. All rights reserved

Accepted Article



all_15006_f5b.png

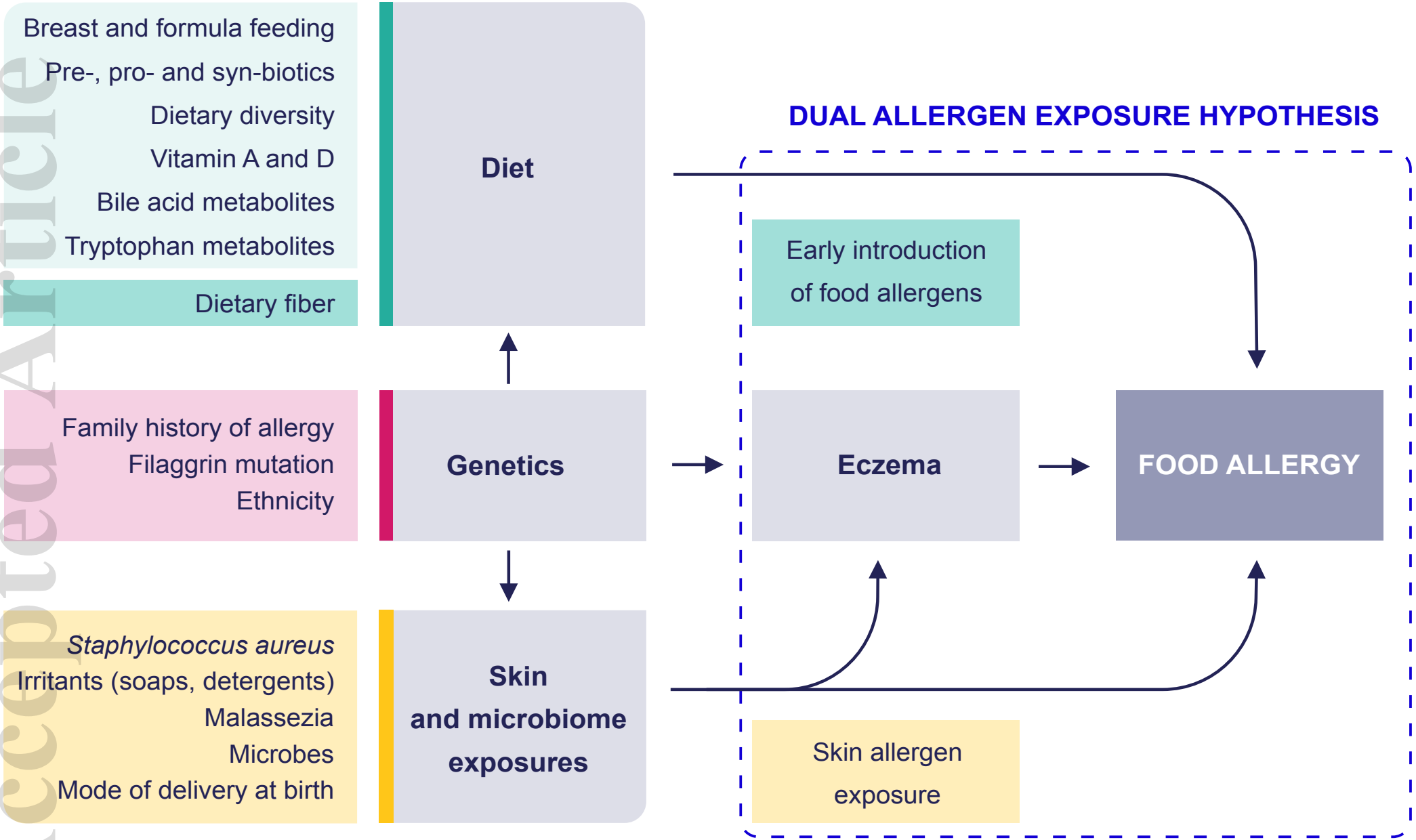
This article is protected by copyright. All rights reserved



Accepted Article

This article is protected by copyright. All rights reserved

Figure 1_Brough et al.



Accepted Article

This article is protected by copyright. All rights reserved