

Editorial

The UK allergy paradox

It is a remarkable paradox that the United Kingdom has an unrivalled record in allergy research but one of the poorest clinical allergy services in the developed world. How can this bizarre state of affairs have arisen?

The world's very first allergy clinic was established at St Mary's Hospital in London shortly after the publication of the pollen immunotherapy trials by Noon (1) and subsequently Freeman (2) in 1911. The very first double blind placebo controlled clinical trial of immunotherapy was performed in the same allergy clinic, demonstrating efficacy unequivocally (3). In retrospect, it is interesting to note a comment made in the initial Freeman paper (4) reporting efficacy which stated that the observations may have been modified by a "tendency to detect improvement in adventitious fluctuations of health". Through the 1960s and 1970s, there were many notable developments originating from British allergy researchers. Professor Jack Pepys was perhaps the most notable. His work clarified the different mechanisms and patterns of allergic responses with a particular focus on extrinsic allergic alveolitis (5). Since then, allergy research has become a huge international enterprise but there are still many notable British allergy researchers of whom Profs Stephen Holgate, Barry Kay, Tak Lee are the most well known. Despite this, allergy as a monospeciality has only very recently gained recognition and a training program within the UK, and there are precious few comprehensive allergy services in the country. The situation is even worse for pediatric allergy. The number of comprehensive pediatric allergy clinics can be counted on one hand and the majority is currently supported by an academic enterprise rather than by the Health Service. This means that continuation of the clinical services is entirely dependent on a university's research agenda. If this changes, then there is the potential for the allergy services to disappear.

There are, of course, many system specialist clinicians who are excellent allergists. However, they usually just offer an allergy service for their

own specific system. Indeed, allergy services survive on the good offices of chest physicians, dermatologists, gastroenterologists etc, who have usually educated themselves in allergology. This leaves patients and their families desperately negotiating their way through a system which does not cater for their often multi-system problem. Thus, children with allergic problems may be simultaneously attending dermatology, respiratory and ENT clinics. This is hardly a cost-effective way of running a health system.

Much of the problem in the UK has arisen out of a general medical antipathy towards allergy as a discipline. In part, this is because the allergy clinics of the relatively recent past were only offering an allergy diagnosis and recommendations on avoidance or the administration of immunotherapy. Thus one could say that the discipline was based on a single treatment strategy in the absence of a good scientific grounding or indeed an adequate evidence base. Of course, this situation has changed dramatically in the last 30 years. The discipline is founded on excellent basic science and the evidence base is now good for a wide range of approaches to management. The pace of development in new therapeutic strategies is remarkably rapid. However, the prejudice lingers and it is only too easy for policy makers with limited budgets to overlook the need for change.

A number of us in the UK have been fighting for a change but achieving this is rather like trying to change the direction of a huge fuel tanker floating in treacle. The patient demand is enormous, waiting lists for children to be seen in allergy clinics are some of the longest for any problem and, in some parts of the UK, there are no services available whatsoever. This has resulted in many families seeking help from complementary medicine, often employing totally bogus or unsubstantiated methods of allergy diagnosis and treatment.

Thankfully, there is a growing feeling of optimism that the environment is changing. Pediatric allergy now has a recognised training program, allied closely with clinical immunology

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and infectious disease. There is a recognition of the need to create more training posts and there is hope that more resource will be found to support the development of comprehensive pediatric allergy services uniformly around the country. I am most grateful to many colleagues around the world who have in many different ways supported the efforts to improve the situation in the UK and I hope to be able to report in future that our allergy services have moved into the 21st century.

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References

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