

Spreading the Word on Food Allergy Education: Lessons from Childhood Asthma

There has been a dramatic increase in the prevalence of immunoglobulin E mediated food allergy (FA) in the pediatric population in the past decade. Now FA is diagnosed in one in 20 children, and clinicians are counseling new parents to cope with this life-changing diagnosis daily.¹ Sicherer et al have presented in this issue of *The Journal* the first rigorously evaluated education program to enhance management skills of parents.²

Although recognition of FA has been present for decades, the volume of children newly diagnosed with FA has furthered the need to consider public health, population-focused efforts to ameliorate effects of the condition. Infrequently does a chronic disease have such an immediate impact beyond the affected child and family. However in FA, other members of the community attending schools, traveling in airplanes, and using public spaces can be affected.³ The study by Sicherer et al calls for educational efforts that are validated and disseminated widely.²

Achieving effective levels of self-management is key in FA. As noted by Bock et al, the main cause of morbidity and poor outcome in accidental FA exposure is delay of treatment with epinephrine.⁴ Multiple barriers exist including familiarity with the device, anxiety with the device's use, and misconceptions about when to use the device. Particular to pediatric populations, caregivers are often charged with administering medication in these life-threatening situations because the child is not often able to comprehend the severity of the situation and need for prompt action.

Despite the overwhelming numbers of those newly diagnosed as having FA, the dearth of pediatric allergy and immunology specialists comfortable with FA creates further barriers to caregivers receiving appropriate education and reaching a comfort level for managing anaphylaxis. Sicherer et al and the members of Consortium of Food Allergy Research have presented a summary that is valuable information for FA stakeholders. FA education has predominately been left to grass roots organizations, patient advocacy groups, and individual clinicians motivated to provide information and counseling. The Sicherer study provides evidence for positive outcomes associated with standardized, uniform education. The hope is that such educational efforts will also help to reduce parent, family members, and others' anxiety surrounding FA-induced anaphylaxis. The study also reinforces the importance of re-evaluation of techniques during the time of treatment.

The parallels between the development of FA education and childhood asthma education in the past 3 decades are remarkable, and asthma might serve as a model for FA. From Wilson-Pessano's study of self-management asthma education in 1985 to the recent National Heart, Lung, and Blood Institute's Expert Panel Asthma Guidelines and the National Asthma Control Initiative, the benefits of both self-management education and community-based education in improving aspects of asthma morbidity and healthcare use have been significant.⁵

Because many first time reactions occur unexpectedly in young children, a parent's first experience with an auto-injector may be in an emergency department with staff not focused on pediatric education efforts.⁶ Having easily accessible education in clinics, emergency departments, and hospitals could improve outcomes as it has in some asthma intervention programs.⁷

As noted by Sicherer et al, many caregivers are reluctant to respond appropriately to an allergic reaction because of anxiety about auto-injector use.² Furthermore, because many caretakers often misunderstand the complex variables that may trigger a severe allergic reaction, caregiver education seems paramount.⁸ Misconceptions of caregivers and community members only increase the anxiety and confusion surrounding FA. The conflicts attending FA and negative experiences for children can lead to their isolation and anxiety or even set the stage for bullying.⁹

Unlike many chronic diseases, FA also affects the surrounding community in important ways. Because children with FA face circumstances in which the offending food is present when they are away from primary caretakers, education must move beyond the family to others, including school teachers, childcare personnel, and extracurricular activity supervisors. These potential responders are as important as face-to-face contact with a physician at the time of a FA event. In asthma, with time, education has been evaluated and disseminated to all those in the circles of influence around the child. Communities have been organized to change policies and systems to provide better care and education. Similarly, efforts may be necessary in FA, led as much by the community as the advocate community.

Education efforts should be accessible to stakeholder groups regardless of socioeconomic, geographic, language, or cultural barriers. Perception of disease severity and the

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role food plays in community health must be addressed to enhance the capacity of stakeholders to assist a child in need. Having cost-effective education available in a range of settings could improve FA-related long-term outcomes and emergency service use.

Clinicians and public health researchers have the opportunity to observe the surge of a chronic disease and its increasing impact on individuals and community members. Because of the limited repertoire of acceptable medical treatments for FA children, dissemination of evidence-based FA education deserves serious attention as a means to improve the quality of life for children, families, and communities. ■

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