

Complexity and Diversity of Food Allergy Requires Individualized Care



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This issue of *The Journal of Allergy and Clinical Immunology: In Practice* includes articles covering key food allergy topics that are of high clinical relevance. Food allergy continues to affect a significant portion of the population, either directly or indirectly, impacting life on a daily basis. There have been tremendous research gains in recent years in developing therapies, and as we get closer to having more options for our patients, the importance of accurate diagnosis and addressing social determinants of health become even more important.

New developments in the treatment of food allergy are on the horizon, which will hopefully expand options for food-allergic patients. The clinical commentary by Dantzer and Kim¹ discusses some of the new treatments being investigated, which could provide alternatives to oral immunotherapy (OIT) as well as have the potential to treat multiple food allergies. Food-specific immunotherapies are being developed using alternate routes of delivery, such as sublingual immunotherapy and epicutaneous immunotherapy. These can address key barriers to OIT, including logistics of dosing visits, adverse reactions, and potential impacts of augmentation factors.¹ As examples, sublingual immunotherapy has fewer restrictions surrounding dosing and epicutaneous immunotherapy requires less frequent visits to the doctor's office as compared with OIT. Both these routes of food-specific immunotherapy entail lower-dose allergen exposure than OIT, likely accounting for differences in efficacy and safety. For patients with multiple allergies, Sindher et al² highlight the continued advances in the development of biologics that will transform management because these approaches are not specific to single foods, and may allow for the treatment of multiple allergic disorders with a single medication.

Because treatments for food allergies are generally intended to be continued long-term, the importance of accurate food allergy diagnoses cannot be overemphasized. One of the challenges to accurate diagnosis is illustrated in the Grand Rounds review by Giovannini et al,³ which discusses the clinical conundrum of nut allergy versus pollen food allergy syndrome. Although both diagnoses will demonstrate positive testing results, clinical history is critical to determining whether the primary sensitization is to the nut or pollen. Clarity of diagnosis is necessary for patients to understand their risk of severe reactions, an important element of decision making when considering initiation of treatment.

The review by Oriel et al⁴ discusses the nuances of sesame allergy diagnosis, including management decisions based on threshold considerations. Many patients with sesame allergy will be able to tolerate scattered sesame seeds and oil even though tahini (concentrated sesame) will trigger reactions, and half the patients with sesame allergy may tolerate one-third teaspoon or more of tahini before reacting.⁴ Threshold variations also exist for allergy to other foods, and this is likely to be an important factor for many families as they consider whether to pursue food allergy treatment, which aims to protect patients from severe reactions due to accidental ingestions. These decisions will vary across families, who must also consider time and effort associated with treatment administration, safety profile, and expense of treatment, and weigh these factors against the potential benefits of raising the threshold of reactivity with treatment. This decision will require detailed discussions with patients and their families on these subtleties, which is integral to informed decision making regarding starting treatment.

As new treatments are developed for food-allergic patients, equitable access to treatment remains a challenge. Health inequities in food allergy diagnosis are well documented, and it is imperative to reduce the existing inequities in a multi-pronged approach as outlined by the clinical commentary review by Dehbozorgi et al.⁵ Biologics have been approved for asthma and a number of other allergic disorders for many years now, but their access is not uniform. Lower use of biologics has been observed in patients with asthma who have public insurance (as compared with private insurance).⁶ Although multiple factors may be contributing to this disparity in patients with asthma, it will be important for clinicians to ensure that as new therapies for food allergy become available, we are not widening existing inequities. Given that food allergy treatment will be long-term and does not result in a cure, shared decision making that incorporates discussion of patient phenotype and treatment goals, as well as risks, benefits, and alternatives, will need to become an integral part of routine practice.⁷

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Regardless of which management approach is selected for patients with food allergy, nutritional adequacy continues to be an important factor to assess. As described by Venter et al,⁸ food allergy can impact growth, nutrition, and feeding, and therefore attention to these parameters is essential in routine food allergy management. This review provides an overview of the range of factors that may contribute to nutritional risk, which can vary by age, foods avoided, underlying allergic disorder, and food security, highlighting the importance of individualized care. Clinical markers of nutritional risk and interventions to address nutritional needs are also discussed to support clinicians in providing optimal food allergy care.

Our understanding of the diversity and complexity of food allergy continues to evolve, allowing us to improve the lives of patients and their families by providing personalized management plans. The articles provided in this issue illustrate the promise of new therapies as well as highlight the areas that require our continued attention.

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