Dear Colleagues in Allergology

It is with profound pleasure that I greet you as the new Chairman of the Allergy Society of South Africa. Thank you for voting me in to the Executive Committee and thank you to the new EXCOM for their vote of confidence in me as Chairman. I would like to pledge my term in office to tackling some of the issues I outline below.

We have just had a most successful ALLSA Congress at the Vineyard Hotel in Cape Town and all of you who were there will, I am sure, share my view that the programme and scientific content was phenomenal. Thank you to Sharon Kling for organising the meeting and making this one of ALLSA's flagship events. Thank you too, to our International guests (Prof Peter Schmid-Grendelmeier, Dr Carina Venter and Dr George du Toit) for making their time available to share new ideas in Allergy management and for being present throughout the Congress to lead discussion on many other topics.

I have to say that ALLSA and the annual ALLSA Congress has the most unbelievable feeling of being with family. It is the one Society and National Congress where meeting colleagues is like meeting with friends and family. I would also like to thank our outgoing Chairman, Ahmed Manjra, for the leadership of our Society and for continuing to maintain the Society in a healthy way, both scientifically and financially. The new EXCOM has a number of new faces and we have lost an old stalwart. Thank you Andrew Halkas for your very important leadership in our advocacy domain. Andrew has ensured that ALLSA has been an important role player in education, outreach and leadership.

ALLSA is privileged to have a number of excellent contacts within the Medical fraternity of South Africa. We enjoy a very special relationship particularly with the South African Thoracic Society and our Primary Immunodeficiency colleagues in both South Africa and beyond our borders. Next year’s congress will ensure that these relationships are explored in the form of joint scientific symposia. I look forward to seeing all of you there.

Finally I want to express my heartfelt congratulations to Professor Matt Haus who has been appointed as Extraordinary Professor at the University of Pretoria. Matt this is a most well deserved honor for a man who has given so selflessly to advancing the practice of, and research into, Allergology over many years.

These are my pledges to you as members of the Allergy Society for the coming triennium:

I undertake to contribute to improving the profile of 3 aspects of ALLSA

1. Communication
   - To improve communication platforms within and beyond ALLSA Membership:
   - Renewal of website and improvement of website information
   - Provision for electronic communication with members
   - Explore the creation of Facebook and twitter accounts for ALLSA communication

2. Education:
   - Greater postgraduate training workshops for individual doctors wishing to enrol for the Allergology Diploma
   - Greater use of Diploma alumni for ALLSA educational activities

3. Advocacy
   - Improved care of allergy patients in SA:
     - Commitment to World Allergy Week and resources to support outreach
     - Outreach into Africa
     - Greater involvement in World Allergy activities

I welcome your feedback and involvement in ALLSA.

Robin J Green
Anaphylaxis is a sudden and severe allergic reaction that may be life threatening. It must be treated as an emergency, and patients who have anaphylaxis or are at risk for anaphylaxis must know how to reduce their risk by preventing exposure to potential triggers, knowing how to recognise early signs and be prepared for emergency treatment at any time.

**Triggers:** Common triggers of anaphylaxis are:

**Foods:** Egg, milk, peanuts, nuts, fish, shellfish, sesame, soya and wheat are the most common foods that can cause anaphylaxis. However almost any food can cause anaphylaxis for a specific person.

**Insect stings:** Bee venom is the most common cause of anaphylaxis due to insect stings. Reactions to wasp venom are much less common in South Africa.

**Medications:** Any medications can cause an allergy. More common causes include antibiotics (predominantly the penicillin-like “beta lactam” antibiotics), pain killers and drugs used during anaesthetics.

**Other:** Latex allergy is less common. Some people have anaphylaxis only when 2 triggers are present, such as a specific food with exercise. Some people have anaphylaxis without any cause being identified.

**Symptoms of anaphylaxis:** Symptoms of anaphylaxis usually occur very quickly within 15 minutes to 1 hour of exposure to an allergen, sometimes even quicker! The rapid development and worsening of anaphylaxis makes it a very dangerous condition. Features of anaphylaxis may be isolated to a single part of the body or involve several organ systems at one time. It is important to realise that the features of anaphylaxis can range from mild skin changes and facial swelling to life-threatening breathing and heart involvement.

**Treatment for anaphylaxis:** Anaphylaxis can be prevented and treated. Identifying triggers and avoiding them is far better than treating an anaphylactic reaction! Anaphylaxis must be recognised early and treated quickly before it progresses. Call for an ambulance as soon as possible.

The only effective treatment for the serious effects of anaphylaxis is adrenaline. Adrenaline must be injected into a muscle as soon as anaphylaxis occurs. If someone has an emergency injection with them either help them inject it into the large muscle of their thigh, or give it to them yourself. Help avoid shock by lying the person down with their feet raised off the ground. Do not give any medication by mouth if the person is having difficulty breathing. Other treatments that can help after adrenaline has been given, include antihistamine and steroids.

Adrenaline given for anaphylaxis saves lives and rapidly reverses the dangerous effects of anaphylaxis. In some cases it may be necessary to maintain a clear airway for the patient, provided oxygen and to monitor the circulatory system and blood pressure very closely.

It is important to consult your doctor if you have ever experienced an anaphylactic episode. The correct diagnosis must be established and your doctor will complete an action plan, an application form for a Medic-Alert bracelet, provide the necessary education and prescribe an automatic adrenaline injector or adrenaline kit for emergency use.

**Key points**
- Anaphylaxis is the most severe form of sudden and life-threatening allergic reaction.
- Foods, insect venoms, antibiotics and some other medications are the main triggers for anaphylaxis.
- Adrenaline is the essential treatment for anaphylaxis.
- Adrenaline can only be given by injection.
- The Epipen® is a devise designed for emergency use by people at risk, which injects adrenaline automatically.
- Antihistamines do not reverse the dangerous complications of anaphylaxis and must only be used after adrenaline has been injected.
ALLSA NEWS: 2011 RESEARCH AWARDS

ALLSA is pleased to announce the recipients for the ALLSA Research Awards.

Six applications were received. After the reviewers’ scores were collated the committee recommended awards to four applicants, but one subsequently withdrew. We thank Aspen/GSK and CiplaMedpro for their continued generous support of allergy research in South Africa.

The awards are as follows:

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<thead>
<tr>
<th>APPLICANT</th>
<th>AWARD</th>
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<tr>
<td>NE NIEUWENHUIZEN</td>
<td>CIPLA R25 000</td>
<td>The role of IL-4 receptor alpha signalling on dendritic cells in allergic airway disease</td>
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<tr>
<td>M LEVIN</td>
<td>GSK R50 000</td>
<td>The impact of demographic, environmental, nutritional and infectious influences on the expression of allergy and atopy within the Drakenstein birth-cohort study</td>
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<tr>
<td>MS SUCHARD</td>
<td>AHN Pharma R25 000</td>
<td>Laboratory Monitoring of Regulatory T cells induced by bee venom desensitisation</td>
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INFORMATION ON RECIPIENTS AND STUDIES

Dr Natalie Nieuwenhuizen is currently a postdoctoral fellow in the Division of Immunology at the University of Cape Town, and studying the role of IL-4 receptor alpha in chronic asthma and airway remodelling. She obtained her PhD in Immunology in 2007. Among her many awards is that of runner-up for the Young Investigator Award at the 9th ERS Lung Science conference in 2011.

Dr Mike Levin is head of the allergy clinic at Red Cross War Memorial Children's Hospital and obtained his PhD in Linguistics in 2005. He is a past chairman of the National Asthma Education Programme and is currently an ALLSA EXCOM member. He is investigating the allergy and atopy link in a large birth cohort study in the Paarl area of the Western Cape Province.
Dr Melinda Suchard is a consultant clinical pathologist with the National Health Laboratory Service, with a joint appointment to the University of the Witwatersrand in the Department of Molecular Medicine and Haematology. Among others, she runs the new immune-haematology division of the flow cytometry unit.

Her research focuses on the regulatory aspects of the immune system, with her interests including the development of novel diagnostic tests for Tuberculosis and the development of methods for the detection of antigen specific T lymphocytes and the role of regulatory T cells in infectious disease and allergy. This research project focuses on the regulatory T cells induced by bee venom desensitisation.

Dr Melinda Suchard receiving her award from Dr Ahmed Manjra

CONGRATULATIONS!

It is with great pride that I announce that Sharon Kling has been promoted to Associate Professor in the Department of Paediatrics and Child Health at the University of Stellenbosch. Sharon has been a real key role player in the Allergy Society over many years, serving as Chairman and Secretary.

She has been instrumental in developing allergy services at Tygerberg Hospital. Sharon was the Convenor of the last ALLSA Congress in Cape Town which was such a resounding success. Over the years Sharon has been an Examiner and Convenor of the Diploma in Allergology many times.

She has published and lectured widely in the field of Allergology and has been a member of local and International Guideline Committees.

Congratulations on this most deserved appointment Professor Kling!

AUGUST 2012 FIRST EDITION
The inter-relationship between atopic dermatitis and food allergy is complex. Many patients and/or their carers believe that atopic dermatitis is caused by something in their diet however it is rarely diet alone that triggers atopic dermatitis. In some patients with food allergy and atopic dermatitis, dietary modification may help atopic dermatitis, but all patients with eczema will need a good skin-care routine irrespective of whether they have food allergies or not. Investigations for food allergy should not be routine in all cases of atopic dermatitis. Concomitant or causative food allergy should be considered in those patients with a convincing history of food allergy and those with moderate to severe eczema that does not respond to topical treatment.

Sensitisation to foods (presence of raised ImmunoCAP or positive skin prick tests (SPT)) is common in atopic dermatitis, but is not synonymous with clinically relevant food allergy. About 60% of patients with atopic dermatitis are sensitised to food allergens3,4,5,6,7 which is much greater than the overall prevalence of food sensitisation in the general population of around 16%. In 2009, South African infants with atopic dermatitis were shown to have frequent sensitisation to foods, most commonly egg white (47.1%), cow’s milk (28.4%) and peanuts (26.8%). In 2011, infants attending a tertiary dermatology clinic for atopic dermatitis were shown to have even higher sensitisation rates (66% to at least one food), most commonly to egg (52%), peanut (39%) and cow’s milk (25%).

Approximately 30-40% of children with atopic dermatitis have co-existing food allergy3,6,12-18 but this is much less common in adults. In a substantial number of patients the reaction is an immediate hypersensitivity reaction. These immediate non-eczematous reactions that coexist with atopic dermatitis usually have cutaneous features4 (pruritus, rashes, urticaria), with or without gastrointestinal reactions (vomiting, diarrhoea) and respiratory symptoms or anaphylaxis and occur within 2 hours of food ingestion. Such reactions make up 50% of cases.

South African data in infants attending a tertiary dermatology clinic for atopic dermatitis show 41% of patients have a concomitant immediate type food allergy.11 Data on delayed reactions in the South African setting is lacking. International literature shows isolated eczematous reactions are rarer, occurring in 10% of reactions and are usually delayed > 6 hours after food ingestion.1,13,14 A combination of non- and eczematous reactions occurs in 40% of cases.1,13,14

The same food allergens that cause reactions in the general population are responsible for the majority of reactions in children with atopic dermatitis. Egg, milk, peanut, wheat and soy are causative foods for 90% of reactions in children with AD.13,14 Hen’s egg is the most frequent causative food; allergy occurs in about two thirds of children with atopic dermatitis who have food allergy. Foods which cross react with pollen are less commonly associated with food allergy in children with AD,15 but may play a role in adolescents and adults. Rarely food additives and biogenic amines may be responsible for non-allergic food hypersensitivity i.e. food intolerances.

There is no specific diet for the treatment of atopic dermatitis. Elimination diets are not a routine treatment and are potentially harmful.26 Patients should not be routinely placed on exclusion diets. Food allergy should only be considered in specific cases, and elimination diets reserved for those children who have been proven to be allergic and tailored to the individual after appropriate investigations have been performed to assess possible food triggers. They must be done under the supervision of a dietician and should always be combined with atopic skin care.

Food allergy is more common in those with a very early onset of atopic dermatitis, where atopic dermatitis is more severe12 and where GIT symptoms are prominent. Evaluation for food allergy should be considered when:
- there is a history of an immediate non eczematous reaction to a food;
- there is a convincing history of food induced flares of atopic dermatitis;
- in cases of moderate to severe AD in an infant or child which is resistant to atopic skin care;
- in cases of severe AD in teenagers or adults which is resistant to atopic skin care.

An accurate diary of what the patient eats and of the condition of the skin (both atopic dermatitis and acute reactions) can be useful.

References available on request