

Allergy & Anaphylaxis Australia

SPRING/SUMMER 2014

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Allergy & Anaphylaxis Australia

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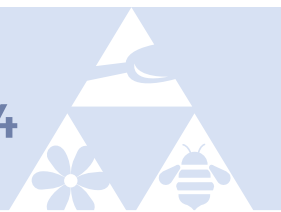
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YOUR TRUSTED CHARITY FOR ALLERGY SUPPORT



President's Report

Hello to all our members and friends,

I am writing this note whilst on a plane returning from the International Food Allergy and Anaphylaxis Alliance meeting in Washington DC. This year, representatives from almost twenty countries met to discuss food allergy management and anaphylaxis. The Alliance welcomed new members from Brazil, Mexico, Qatar and South Africa. We had two intense days of presentations and discussion thanks to educational grants from Mylan who produces the EpiPen® in the US and the Peanut Council of America who have been funding the initiative since the year 2000.

Allergy & Anaphylaxis Australia is a founding member of the international Alliance. When I attended the first meeting in 2000 and heard of progress in the US, Canada and the UK I was despondent as we had little support in Australia. At that time, South Australia had school guidelines thanks to the work of Dr Michael Gold but no other state recognised allergy and anaphylaxis as a condition warranting special attention despite our attempts to communicate with them. EpiPens were the only autoinjector available in Australia and we had to pay \$100+ for each device and most times, if devices had a shelf life of 6 months when you bought them, you were very fortunate.

There were no emergency response plans (Action Plans). As a nurse, I remember writing one myself and taking it to my GP to see if it was appropriate. Many people complained about managing on their own for years because health professionals did not understand food allergy in the way they understand it now. When we were finally referred to an allergist we felt heard and understood although overwhelmed. In the mid 1990's we managed to get in to see an allergist within less than 3 months. Food allergy was still rare but we were being contacted by more and more people and hearing stories we just do not hear any more. That is not to say we are managing allergic disease as well as we could be, it means access to care and community understanding is much better than it was.

I remember many children being refused childcare placements and even school enrolment because of fear of how to manage and what to do in an emergency. We had no guidelines and no training for school or childcare and we had parents or GP's and even allergists in some instances, going to a staff meetings to educate teachers. Parents reported staying at school with their child for the first month of kinder, allowing staff to adjust to care of a child at risk of anaphylaxis. There was one case where a child was diagnosed after being accepted at a preschool; he had been there for many months. Once diagnosed and prescribed an

EpiPen he was refused attendance. The mother presented her case explaining it was discrimination and police were called to remove her and her child from the premises. A teachers union at that time discouraged teachers from getting too involved in allergy management and teachers were advised not to administer an EpiPen. That was then; management of allergy and anaphylaxis and awareness in the community is now very different.

Food allergen labelling was not legislated until 2002. At that time, if you had a reaction to a food you just accepted you were unlucky. There was no wealth of information you could access such as websites like A&AA and even ASCIA. The only connection there was to people at risk of anaphylaxis was through our small organisation that was rapidly growing. We felt we had to learn how to live life with the risk of anaphylaxis almost alone. The medical research into so many aspects of allergic disease in the last 15 year period has helped us and continues to help us live life to the full. We now know the myths and continue to do our best to expel them.

In March 2002, 13-year-old Hamidur Rahman died as a result of peanut anaphylaxis on a school camp in NSW. His tragic loss of life was the catalyst for change at so many levels. Overnight, A&AA embarked on a campaign that helped progress allergy management in Australia. Until this point, it felt as though the efforts and very real concerns of ASCIA and A&AA were heard and put aside. A New South Wales Anaphylaxis Working Party was formed by NSW Department of Health (as it was called then). The Western Australian Health Department took the release of the Findings and Recommendations that transpired from the inquest of Hamidur Rahman and a lengthy report written by WA key stakeholder groups and developed a strategy to manage allergic disease in WA.

We, as individuals with allergic disease or parents/carers of children with allergic disease need to remember Hamidur Rahman and his lovely but grieving family. We need to honour them for their strength and courage in assisting us with allergy management today.

We remember Hamidur and his family with compassion as we recall the many gaps in care that lead to his sad loss. We think of the staff and students at the school Hamidur attended as well as their plan was to go away and have a great time on school camp and what happened left them traumatised and at a loss as well.

I still become despondent in 2014 BUT I need to remind myself of how much better life with allergic disease is now. Sure, there are still so many unanswered questions, there



President's Report (cont.)

are still people that 'don't get it' however, life with a food or insect allergy is a full life almost all of the time. With care, it really is a manageable condition. Sure, we do have to do some things a little differently, there are people that frustrate us no end and organisations such as restaurants or airlines that could listen more closely BUT most of the time, we have support and the tools to minimise risk and have a fun life!

It is wonderful to know that management of and research into allergic disease in Australia is on par with the UK, US, Canada and other world leaders. In some aspects, we have lead the way and that is wonderful to see. Our food regulations were first to be launched (both for packaged food and food service), we are the only country with nationwide Action Plan for Anaphylaxis (emergency response plan) which is the ASCIA plan (this allows lay people to more easily follow an emergency procedure) and we were the first to have adrenaline autoinjectors for general use in first aid kits (not prescribed for a specific person) and instruction on administering them to someone not previously diagnosed if they show signs of anaphylaxis. There are countries that still do not have adrenaline autoinjectors in their region and others that still have to pay \$100 or more for a device. I can almost hear some saying, "Yes, well that is great but last week my son....."

When we get frustrated with care, how long it takes to progress a change in procedure, another hiccup at school, wait staff that serve your order with grated cheese even though you have just told them you have cow's milk

allergy – take a step back, a deep breath and know we only understand allergy as well as we do, because we live the life. There is lots of support and information out there, we are the ones needing to manage our allergic disease and we cannot have unreasonable expectations of others because they will just write us off as too hard to deal with. Yes, managing allergic disease is unrelenting but we have a choice – we can make it harder for ourselves by expecting too much from others. I know this was a hard lesson for me in the mid 1990's when my son started school but I see it as a lesson for all of us.

I guess what I am saying is focus on the good, embrace it and encourage even more good.

Please note we have merged our Spring and Summer editions of Newsfacts because of our hectic schedule. We hope you find this bumper edition informative. Best wishes for Christmas and 2015! Take care,

Maria
Maria Said, President A&AA ■



Eighteen countries were represented at the International Food Allergy & Anaphylaxis Alliance meeting 2014. Thank you to the sponsors Mylan and American Peanut Council



Conferences

The 25th annual ASCIA conference was held at the Melbourne Convention Centre September 10-12, and A&AA once again attended.

This meeting of the peak professional body of allergy specialists and immunologists from Australasia will saw 37 speakers from the region.

International speakers were Professor Abul Abbas, Dr Linda Cox, Professor Joseph Dalmau, Professor Raif Geha, Professor Ruby Pawanker and Professor Harald Renz.

By attending the conference, A&AA is able to hear the latest research and developments in the allergy and immunology field and, with up-to-date scientifically validated information we are able to better advocate for you.

We also attended the Centre for Food & Allergy Research Symposium on the 9th September, which focused specifically on research being carried out in Australia.

The first theme looked at emerging evidence for the prevention of paediatric food allergy, with Professor Susan Prescott presenting on early regular egg exposure in infants and whether this induces tolerance.

Professor Mimi Tang talked about the co-administration of probiotic and peanut oral immunotherapy for treatment in peanut allergy.

Merryn Netting presented the question: does maternal diet during pregnancy and lactation affect allergy outcomes in offspring?

Professor Shyamali Dharmage looked at systematic reviews on the prevention of food allergy.

There was a three-minute publication session, where presenters talked about their published research.

These included:

- Rachel Peters: Let them eat cake;
- Associate Professor Debbie Palmer: Early regular egg exposure in infants with eczema: an RCT;
- Dr Sam Mehr: Safety and clinical predictors of reacting to extensively heated cow's milk challenge in cow's milk allergic children;
- Dr Melanie Wong: Loss of allergenic proteins during boiling explains tolerance to boiled peanut in peanut allergy;
- Sandip Kamath: Effect of heat processing on antibody reactivity to allergen variants and fragments of black tiger prawn: A comprehensive allergenomic approach;
- Dr Dean Tey: Population response to change in infant feeding guidelines for allergy prevention;
- Dr Jennifer Koplin: Increased risk of peanut allergy in infants of Asian-born parents compared to those of Australian-born parents. ■



ATTENTION

**NATIONAL OFFICE CLOSURE
over the holiday period:**

Allergy & Anaphylaxis Australia's national office will be closed from Thursday 18th December 2014 until Thursday 15th January 2015.

Orders received by COB Wednesday 17th December will be processed however resource orders received after that date will not be processed until after mid-January. We will not be responding to email and phone queries during this time. We look forward to our small team starting 2015 refreshed after a much needed break! Merry Christmas to all and hope 2015 is a happy, healthy year for us all. Maria



The development of a National Allergy Strategy

In February 2014, ASCIA submitted a report for allergic diseases to be recognised as a National Health Priority. ASCIA representatives met with a number of Health Ministers and Chief Medical Officers. ASCIA and Allergy & Anaphylaxis Australia (A&AA) also had the opportunity to meet with a number of Federal Members of parliament, through a morning tea organised by A&AA as part of Food Allergy Week. The response by the members of parliament was very positive, but it became clear from their feedback that pursuing national listing of allergic diseases as a National Health Priority Area (NHPA) was not going to improve the management of allergic diseases.

However, ASCIA and A&AA advocating for national listing of allergic diseases as a NHPA raised awareness of allergic diseases as a public health issue amongst politicians, both state and federal. It was clear that action was required by all levels of government and the community.

With this in mind ASCIA and A&AA working in partnership, believe a National Allergy Strategy (NAS) was required to provide effective and co-ordinated action.

To engage stakeholder organisations early, ASCIA and A&AA held an Allergy Summit in Sydney in August 2014. The aim of the Allergy Summit was to provide representatives from stakeholder organisations with the opportunity

to raise issues relating to the management of allergic diseases across all sectors and to participate in a way forward, discussing how to approach the development of a NAS.

A NAS Steering Committee has been formed and comprises of ASCIA and A&AA membership.

Five NAS Working Groups have been identified, each with ASCIA and A&AA co-chairs addressing the following key areas:

- Education and Training
- Care (Access to care and standards of care)
- Research
- Food Service/Food Industry
- Data

The membership of the Working Groups is yet to be finalised, but all Allergy Summit participants have been invited to nominate for membership of the Working Groups. The aim is to have input from all stakeholder organisations.

ASCIA has committed project officer support to the development of the NAS. ASCIA and A &AA will seek further funding to support this initiative.

The aim is to have a completed draft NAS by the end of February 2015 to be circulated broadly to stakeholders for review. If funding permits, an implementation meeting will be held in Sydney in mid 2015 to launch the finalised NAS. ■



Support organisations that had representatives attend the National Allergy Summit included AusEE www.ausee.org, TAMS (The Australasian Mastocytosis Society) www.mastocytosis.com.au and of course, Allergy & Anaphylaxis Australia www.allergyfacts.org.au



Nominations open for two awards

Allergy & Anaphylaxis Australia has 2 annual awards

- **The Dr John Ruhno Award** for an individual/s who has made a significant contribution to raising awareness of anaphylaxis
- **The Be a MATE Award** is given to a school or other establishment anywhere in Australia that has Made Allergy Treatment Easier for people living with the risk of anaphylaxis.

Nominations open in October with the winners for 2014 being announced in the following year.

Please send your nominations for 2014 in to coordinator@allergyfacts.org.au

2013 AWARD RECIPIENTS

We were very excited to receive some wonderful nominations for both our 2013 awards.

Be a MATE Award

The 2013 Be a MATE Award has been given to Blackwood Community Child Care Centre in South Australia.

Mark Thyer and Kathy Mrotek were proud to nominate Blackwood Community Child Care Centre (BCCCC) for the Be a MATE Award. Their son has multiple food allergies and has attended the centre since he was 9 months old. The BCCCC management and staff demonstrated a tremendous dedication and commitment to ensure their child care centre is a safe and secure place for children with allergies, such as their son, Joshua. They implemented a wide range of strategies, which met and/or significantly exceeded their expectations for allergy management. Specific examples of BCCCC changes included the following:

- Reorganisation of the layout and day-to-day operations of the baby room so that all food was stored and consumed behind a gated area. This was essential to allow infants to continue to drink cow's milk, while minimising the risk of exposure to Joshua.
- Providing training for relevant staff in recognising anaphylaxis and asthma and how to respond, exposure and risk management strategies, understanding the ASCIA Action Plan and administering both an EpiPen® and Anapen®.
- Raising awareness of food allergy and sharing strategies to reduce risk with all parents.
- Preparing a clearly defined list of staff roles in response to an anaphylaxis emergency (i.e. who administers the EpiPen, who calls the ambulance, who contacts the parents and who meets the ambulance etc.

- Maintaining a high level of communication with parents of children at risk of anaphylaxis.

However, it did not stop there. At the age of 2 years, Joshua was due to move into their "toddler room" – which presented a new set of challenges. Again, the parents were consulted and risks were identified.

Many hours of staff thoughts and personal time has gone into ensuring a safe and supportive environment for Joshua. Congratulations to Blackwood Community Child Care Centre! We hope your plaque has been placed somewhere it will be noticed.

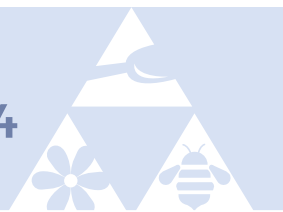
The winning entry of the **Dr John Ruhno Award 2013** was nominated by Francis and Sharon Polach who wrote to us saying their local pharmacists at **Hughes Capital Chemist in Canberra**, have made a significant contribution to raising awareness of anaphylaxis.

The Polach's shared that pharmacists Peter Holder and Harry Katsaros had both been incredibly helpful over the past couple of years since their daughter was diagnosed with severe allergy. Harry assisted with not only prescription and EpiPen® advice but also helped educate the family on changes including revised resources to help with everyday management of severe allergy. Harry demonstrated use of the EpiPen, reminded mum and dad to check expiry dates, asked about school management and suggested the parents alert the school to changes in education guidelines. As the pharmacist knew of discrepancies between ASCIA prescription guidelines and the product information, he checked to make sure the GP had prescribed the right dose adrenaline autoinjector for the child as she had reached 20kg. The family nominated Hughes Capital Chemist because they do much more than dispense medication.

Allergy & Anaphylaxis Australia would like to congratulate Harry Katsaros and Peter Holder of Capital Chemist Hughes in Canberra for providing such wonderful community care. We hope others will see the plaque we have awarded you and ask about allergy care!

If you would like to share information on allergy with your pharmacist please direct them to our website www.allergyfacts.org.au as well as the free anaphylaxis e-training for pharmacists <http://www.allergy.org.au/about-ascia/about-ascia-e-training>

General Practitioners (GPs), our primary carers, need to keep abreast of information on many health conditions. They may not be aware of the most current information and training courses available. Please share information on resources available on the ASCIA website with your GP, pharmacist and any other health professional involved in your care. ■



Hypoallergenic peanut

It was a media frenzy earlier this year when an 'allergy-free' peanut hit international headlines – although the reality was slightly different.

Rather than creating a hypoallergenic peanut, a US university has reduced two key proteins by up to 98 per cent.

There are over 11 proteins in peanuts that can cause an allergic reaction in some people however this was missed in the news reports.

The news is that North Carolina Agricultural and Technical State University has signed an exclusive licensing agreement a Toronto-based firm, Xemerge, to patent the actual process to reduce the allergens.

The process treats roasted peanuts, removed from the shell and skin, with food-grade enzymes commonly used in food processing. The peanuts are soaked in the enzyme solution and reduce two key allergens – Ara h 1 to undetectable levels and Ara h 2 by up to 98 per cent.

The treated peanuts, which are not genetically modified, look and taste like roasted peanuts.

Human clinical trials were carried out at the University of North Carolina using skin-prick tests.

The lead researcher Dr Jianmei Yu, a food and nutrition researcher at the university, is continuing to refine the process by testing the effectiveness of additional food-grade enzymes.

Although the method has been heralded as being one step closer to a hypoallergenic peanut, experts remain cautious – as is the case with much research into food allergy.

President of the American Peanut Council Patrick Archer said the recent publicity to create a hypoallergenic peanut is interesting experimental research that merits further review.

"To our knowledge the type of 'allergy-free' peanut research that recent publicity alludes to has focused on only two of several peanut proteins, still leaving some populations vulnerable and potentially creating confusion among consumers," he said.

Mr Archer said the American peanut industry supported credible, peer-reviewed research that focused on finding the root cause of food allergies.

"In fact, US peanut farmers have spent more than \$10 million, to date, on peanut allergy research and education.

"The industry also supports and implements strategies to mitigate allergic reactions until a cure is found."



Maria Said, president of Allergy & Anaphylaxis Australia added that such a product in the market place would cause confusion and could potentially lead to an increase in severe allergic reactions. "How is an allergic consumer meant to distinguish between peanuts without the two proteins and others with all the proteins? And even then the Ara h 2 protein is not completely removed from the altered peanut anyway," she said.

Maria stated that most consumers have no idea whether they are allergic to Ara h 1, Ara h 2 or any of the other proteins in the peanut. "How do we explain to children that they can eat a food with peanut in it one meal, but not the next?" she said.

Dr Brynn Wainstein, an Australian Paediatric Allergist and Immunologist, Sydney Children's Hospital and The Children's Clinic commented saying, "While any new developments that may make the lives of people living with food allergies easier are exciting, this latest development should be regarded with caution. This process reportedly, and incompletely, removes only 2 of the several allergens in peanuts responsible for allergic reactions. Ultimately there is a risk that the presence of a 'hypoallergenic' peanut produces confusion for peanut allergic consumers who might not know which product they are about to eat and for young children who are then expected to be able to tell the difference between 'safe' peanuts and unsafe ones. Hopefully there may be scope for using a product such as this into research about why peanut allergies occur or in developing treatments but consumers will need to remain very cautious." ■



Walk for kids with Allergies

2014

Don't forget to register



23rd NOVEMBER 9AM

STARTING: BRIGHTON BATHING BOXES

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POINT ORMOND ELWOOD

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PHONE A&AA:

02 9482 5988

All other enquiries contact Sia:

0401 458 381

The registration fee is NOT tax deductible, however all other donations are.

To donate, go to our donation page at www.allergyfacts.org.au and add walkathon in the comment section.

EVERY STEP MAKES A DIFFERENCE

SPRING/SUMMER 2014



freedom
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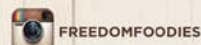
NEW FUN KIDS CEREAL

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- ✓ Source of fibre
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- ✓ Fun playful shapes
- ✓ No artificial colours or flavours
- ✓ Gluten[^], wheat and nut* free
- ✓ Pop some in a bag for a convenient lunch box snack

NEW FAMILY FAVOURITE

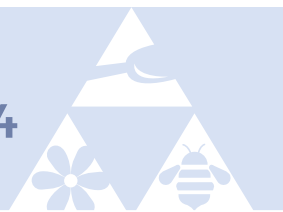
- ✓ Whole grain goodness
- ✓ Delicious and nutritious
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- ✓ Source of fibre
- ✓ No artificial colours or flavours
- ✓ Gluten[^], wheat and nut* free

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*Product manufactured in a factory which does not use and tests for the presence of peanuts, almonds, hazelnuts and walnut.



Caregivers' allergy perceptions not always accurate



A recent US study has found that just over two-thirds of caregivers accurately perceive the severity of their child's reaction.

More than 15 per cent over-perceived their child's reaction severity and 19 per cent under-perceived the reaction severity.

Caregivers had significant concerns regarding their ability to help in the event of a reaction, and also that others wouldn't understand the seriousness of their child's food allergy.

The study published in the July issue of *Annals of Allergy, Asthma and Immunology* examined 305 caregivers of children allergic to milk, egg, peanut or tree nut - the four most common food allergies.

The caregivers were asked about details of the children's most severe food reaction, as well as information about the caregiver's quality of life. Researchers found caregivers who understood their child's reaction to offending foods had a higher quality of life. If they knew exactly what foods could give their child an allergic reaction, they were less likely to be anxious and stressed.

The authors were surprised to learn that milk and egg allergies were the most worrisome for caregivers.

"It's assumed peanut and tree allergies are the most severe, and therefore it may be presumed they would cause the most strain for caregivers" said lead study author and allergy specialist Dr Laura Howe.

"But because eggs and milk are everywhere and used to prepare so many dishes, caregivers with children allergic to those two ingredients feel more worried and anxious."

President of the American College of Allergy, Asthma and Immunology Dr Michael Foggs said it was important for those who care for food-allergic children to work with an allergy specialist to determine exactly what foods their child

is allergic to and how to respond in an emergency situation.

"Parents need to have a clear plan of action in case their child eats a food they shouldn't. Children with a history of severe allergic reactions, and their caregivers, need to know how to administer epinephrine. Having plans in place can ease a parent's worries."

Travelling with allergies

ONCE upon a time it seemed almost impossible to be able to travel if you were at risk of anaphylaxis, but with careful preparation it can be done. Members have retold many a success story where, with the help of cards translated into the local language along with research of the destination, they have had a wonderful experience.

We have a couple of tips on organising the flight and searching for travel insurance.

Whether you are travelling by air domestically or internationally, you need to contact the airline directly to find out its policy on allergies and its rules for carrying medication on board. Most will have this on their website, but sometimes this takes a bit of navigation. It is important that you get this information directly from the airline or its website rather than through a travel agent. Most airlines will require you to fill in a special medical form, or have a letter outlining your allergy and what medication you are carrying and this must be signed by your doctor.

Notify your airline directly (not through a travel agent) of your specific allergies and requests at the time of booking your flights — and take note of who you talk to and when. That way, it is easier for both you and the airline to keep track of your requests, and you can follow up again shortly before your flight to check these have been met. You want to avoid any nasty surprises on the actual day of travel.

Then there is the travel insurance. Check you have adequate cover. Most insurance companies will cover for allergies, including food allergy or anaphylaxis, as long as it is well managed and you have not been hospitalised in the past six months. Most insurers look at a combination of factors: destination, duration of travel and the medical condition itself and may put a larger excess on the policy.

That being said, you will still need to call the insurance companies to find out their policy, and then read the fine print. Does this include replacement medication, will the policy pay for hospitalisation, does it pay directly to the hospital? And what is the excess? ■



Where does responsibility lie with sports clubs?



A common question asked of Allergy & Anaphylaxis Australia is, "What should sports clubs pack in their first aid kits?" Often a common concern is what to do when a child, not previously diagnosed with an allergy, has what looks like a severe allergic reaction, at the club.

We received the below query from a sporting association recently:

I am currently working with a sporting association that is reviewing its rules and guidelines regarding the required contents of first aid kits required for each team to access on match days.

I raised concerns last year as to their requirement for teams to have plasters and latex gloves in first aid kits, given the potential risk of latex allergies in children. I had a child in one of my teams who was at risk of anaphylaxis to seafood.

While parents and coaches at our club are aware of his allergy, there may be instances where coaches and other parents of competing clubs would not have knowledge of his allergy.

This made me think of the potential risks associated with not knowing histories/medical conditions of opposition players/supporters who may require first aid that is unrelated to their allergy or who may not be able to verbalise the allergy to first aiders, eg they are unconscious, have facial injuries, etc.

I was hoping you could provide me with some information and guidance.

Allergy & Anaphylaxis Australia replies:

It is great to hear you are thinking of allergies in your safety plan. The answer to the question opens up a host of additional questions.

In an ideal world, it would be great if each individual club looked at how they approach any registered member who has an allergy.

It would be great for sports clubs to start having in place some sort of process that identifies children/members at the time of enrolment who may be at risk of a life-

threatening allergy no matter what the trigger, which could be from insects such as bee, wasp, Jack Jumper ant, food, latex or other.

Schools have been managing severe allergies for some time now and most state education departments have generated guidelines for managing students at risk of anaphylaxis. They have developed a range of documents and some information would be pertinent and helpful to sporting clubs. These guidelines are freely available and we recommend you access them and use them to assist you with development of easy to understand, manageable guidelines for your sporting club.

For example; when a school student enrolls and the parent identifies their child as being at risk of anaphylaxis or having an allergy, this sets off a chain reaction of strategies/protocols the school then follows (see box with websites).

It is best practise for clubs to record information about children at risk of anaphylaxis (or those with asthma, diabetes, epilepsy etc) however the parents/carers of these children need to speak directly to the team coach/trainer about supervision at the weekly training and match days. The volunteer coaches, and managers should not be expected to care for these children without the support from their parents. Whilst a 13 or 14 year old with food allergy may be left at football training for an hour with their medical kit (and with supervising coach who is aware of condition, who has knowledge of signs and symptoms and is willing to act in an emergency) and told to only drink water supplied, one cannot expect a 7 year old to 'look after themselves'. Some coaches are very willing to have a parent explain signs and symptoms and emergency treatment but others may not be willing to take on that responsibility. Most coaches and trainers are volunteers and parents or carers need to be responsible for their child's health and wellbeing allowing the coach/trainer to do their job.



Where does responsibility lie with sports clubs?

Latex allergy is not common and it is even less common in the child population. Those who are at greatest risk of developing latex allergy are health care workers, those who work in the latex manufacturing industry and children who undergo multiple surgical procedures. See www.allergy.org.au/health-professionals/papers/management-of-latex-allergic-patients/about-guidelines#h

Some information about non latex products

• www.allergy.org.au/patients/product-allergy/latex-allergy

That said, it is reasonable to consider use of vinyl gloves in first aid kits and parents of any child with latex allergy should have band aids and first aid equipment for scrapes, sprains and grazes as part of their medical kit alongside their adrenaline autoinjector and ASCIA Action Plan. Parents of children with latex allergy are often well aware of what latex containing products they need to remove from their child's environment and they include items such as balloons, adhesive dressings, bandages containing elastic and latex gloves.

Some information about non-latex products can be found here: • www.allergy.org.au/patients/product-allergy/latex-allergy • www.allergy.org.au/health-professionals/papers/management-of-latex-allergic-patients/latex-allergy-advice

USEFUL WEBSITES

Here are some websites that have numerous freely accessible documents you can use as templates/examples for developing some procedures for your sporting association.

Have a look at the **NSW Anaphylaxis Mandated Procedures for anaphylaxis** • www.schools.nsw.edu.au/studentsupport/studenthealth/conditions/anaphylaxis/guidelines/index.php

Action Steps for parents • www.schools.nsw.edu.au/media/downloads/schoolsweb/studentsupport/studenthealth/conditions/anaphylaxis/guidelines/anaphylaxis-procedures.pdf

Action Steps for Principals • www.schools.nsw.edu.au/media/downloads/schoolsweb/studentsupport/studenthealth/conditions/anaphylaxis/guidelines/anaphylaxis-procedures.pdf

Western Australia Health Anaphylaxis

• www.health.wa.gov.au/anaphylaxis/home/

Victoria Anaphylaxis • www.education.vic.gov.au/school/principals/health/pages/anaphylaxischools.aspx ■

Chef Card

A&AA has re-introduced a revised version of the Chef Card we had many years ago. Once you have verbally disclosed your allergy to food service staff and discussed the most appropriate menu items, give staff a printed card naming the foods you are allergic to so they have the allergens in writing. The Chef card is only to be handed on once you have had the conversation with staff. It is one of many tools you can use to assist with management of food allergy when eating out. To print out several of the Chef Cards for your wallet go to <http://www.allergyfacts.org.au/living-with-the-risk/the-basics/out-and-about>

To the Chef:
I have **severe food allergies**. To avoid a life-threatening allergic reaction, I must avoid all foods that contain:

Please do your best to provide me with food that does not contain any of these ingredients.

Allergy & Anaphylaxis Australia
Your trusted charity for allergy support

The food preparation area, utensils and equipment used to prepare my meal, must be cleaned in/with warm soapy water prior to preparing my meal.
Thank you for providing me with appropriate food and therefore being **ALLERGY AWARE**

For more information about food allergy, contact **Allergy & Anaphylaxis Australia on 1300 728 000**
A&AA 2014

www.allergyfacts.org.au



How to manage your allergy as a teen or young adult



When our children become teens, we parents have a different role to play and hopefully we have put in the ground work from day one, where we have slowly taught your child age-appropriate responsibility

It has been suggested that if you allow teenager to practice making decisions over a wide range of areas in their life, they are more likely to do well.

One psychologist has described it as being the elastic band approach: if your child has been given age-appropriate responsibility, they may push that elastic band and the boundary will stretch a little.

However, if you take on all the responsibility and don't allow your child or teen any control, they will not be as well-prepared and will more likely rebel and pull that elastic band until it snaps. This could lead to dangerous consequences.

You want your teen or young adult to be empowered enough to say when it is not okay for them to eat and not feel pressured by friends or colleagues. You also want your teen or young adult to understand that accidents are never planned and they must carry their adrenaline autoinjector and ASCIA Action Plan for Anaphylaxis.

So, what is some advice for our teens and adults?

A Facebook post on this subject resulted in some great advice from people who are successfully managing their severe allergies.

Here is a taste of some of the comments from young people.

Bessie writes: I didn't have an anaphylaxis until I turned 33. I am more cautious now with what I eat, take more time preparing food and outings and carry my EpiPen everywhere!

Michelle says: Ask questions. If the answers aren't suitable, then go without.

Mel suggests: Never leave home without your rescue and make sure that includes a USB with contact information for doctors and specialists, and any other medical history information. This can be used by medical staff to easily access all of your information.

Word up a friend you are with or carry a small laminated card in your EpiPen pouch with your ID details, whether you have had an ICU admission as a result of anaphylaxis. This really helps ambos when you can't speak for yourself.

When going to weddings or other big events, get the number of the caterers and speak directly to them about the seriousness of your allergies.

Always carry a small pack of food if you are going out so that you have a safe snack no matter where you are. The risk of hand-to-bowl cross contamination puts most shared bowls of food into the danger zone. I have some wonderful friends who will keep unsafe foods off the menu to avoid the risk of cross contamination.

Lana writes: I'm 30 and have an allergy to seafood. Read ingredients of everything and ask loads of questions.

My hubby had a fish oil capsule and I kissed him on the lips; 20 minutes later I was at the local hospital – you can never be too careful!

Cassie says: Think of cross contamination, don't be afraid to quiz staff about contents, and if you find somewhere that is really good be sure to share!

Su writes: I'm 42 and have had allergies and anaphylaxis since childhood. I always carry an EpiPen, read ingredients, ask questions and carry emergency snacks.

Mikayla writes: I'm 19 and I have had multiple allergies and been at risk of anaphylaxis since birth, so I have learnt these few things over the years.

Don't be embarrassed, make sure your friends know what you can and can't have, and never let anyone pressure you into something you are not comfortable with.

Charlotte advises: I'm 21 and all I can say is, be careful, but don't let it run your life!

Allison writes: I make sure the people sitting near me at work know where my EpiPen is and how to use it. Plus I stuck instructions onto the first aid kit

Caroline says: I hated being a teen with allergies, especially when I was going out for a meal with my friends and had to talk to the wait staff at length about my allergies. Allergies



How to manage your allergy as a teen or young adult

weren't as socially recognised as they are now - 12+ years later - and I used to get glares from people at other tables. As a typical teenager, I found the whole experience embarrassing but my only alternative was to eat before I came (and then be the one at the table watching everyone else eat) or stay at home and miss out on regular teenager things.

I've done all of these and each is not pleasant for someone who just wants to fit in, which you unfortunately can't. I eventually got over the embarrassment when at about 17 years of age I realised that it would be far more embarrassing to have anaphylaxis in the middle of a restaurant than have a quiet word with the waitress shortly before my friends ordered their food. I'd have to say a big thanks to my mum Rosemary and my sister Rebecca for coaching me through what to say when we went out as a family so I knew what to do when I was on my own.

Esmeralda writes: I am nearly 30 and was only diagnosed with food allergy a few years ago. I have been in and out of hospital so many times that I know nearly everyone who works in the hospital in the town I live in!

I find it hard as an adult and used to find it difficult to question staff in restaurants/cafés etc but now I know better - after being hospitalised every few months - and know it's not worth the risk.

I have a medic alert tattoo on my wrist.

I too carry food with me at all times so no matter where I am; I always have something to eat. I used to eat before going out but hated watching everyone else eat.

I've only had two occasions where I was in a situation where I had nothing to eat; once on a long haul-flight from Perth to New York and the other time was in a cafe in Carlisle where I was told they could not fry me an egg and put it on a plate without it touching anything else. Both times I contacted the organisations in writing. I was upset and so disappointed but I knew the risk wasn't worth it.

I always carry my EpiPen, medic alert card and all my other medications. I also make sure the person I am with knows where my EpiPen is and how to administer it if need be.

I feel as an adult it is so much harder because there are fewer people to talk to as most places focus on kids with anaphylaxis. There are very few people I have met who have not had severe allergies since childhood.

Ann-Marie writes: My son is 16 years old and he always asks lots of questions about the food before it's ordered and asks if the food can be prepared on its own using clean

utensils. I am so proud of the way he handles his allergies. Also make sure your friends are aware of your allergies and when meeting new people make them aware too.

Ruth writes: I'm 24 and my biggest tip is to always carry safe snacks with you. I often go to parties where my friends have said that they have bought foods that are safe for me to eat, only to find that they haven't read the ingredients label in depth. By carrying snacks I'm never tempted to take an unnecessary risk!

Kara says: I wear an allergy alert band as well as telling everyone who I am around where my EpiPen is and how to use it!

Duja writes: At the moment I just try to be aware of everything around me. I have the action plan on my wall at work and the people I work with have been told where my EpiPen is. I also went over how to administer it with them.

Note: *Some minor changes have been made to comments by A&AA for educational purposes.*

Teens and bracelets

Vicki writes and asks how she can get her 14-year-old son to wear a medical identification bracelet. He has the bracelet on a sports band but won't wear it.

Allergy & Anaphylaxis Australia answers: This is not an uncommon query. When making decisions on what medical ID jewellery to buy we encourage parents to involve children/teens. They are more likely to wear something they have chosen themselves. That said, you probably did do this and he still won't wear it!

It is important to note that a medical ID tag alone is not going to be your best safeguard for prevention of a life threatening emergency. Maybe focus on him making sure his friends know of his allergy, that he always has his medication with him and that he always reads food labels and ask about food content.

We, as parents, need to learn to pick our battles.

If he does these other things to help keep safe, maybe he is doing okay. A medical ID bracelet is not going to be as helpful to him as the above.

It can be a challenge to make sure you have all safety strategies in place but focus should be on having several strategies and not just one or two.

You could also consider speaking with your GP discreetly



How to manage your allergy as a teen or young adult

and asking them to ask your son about strategies he has in place to help stay safe, ask him to show him how he would administer the EpiPen in an emergency and then maybe talk about medical ID.

Boarding school & Medication

Carolyn writes that her 15-year-old son is heading off to boarding school next year.

How do ensure they always have their EpiPen with them, she asks. Do they carry it in a bag, in a pocket? At the moment, Carolyn says she carries her son's medication.

A&AA answers: At age 15-years, your son needs to be responsible for carrying his adrenaline autoinjector everywhere, whether you are with him or not. He can choose to carry it (along with his ASCIA Action Plan) in a backpack, bum bag or in his pocket.

His friends and teachers need to know where it is kept and if it is in his backpack, the backpack needs to be close by i.e. in the classroom and not with 30 others on a verandah or in his school locker. It needs to be easily accessible at all times.

It is really important you put this management strategy into place now before he goes to boarding school so it is one less change when he leaves the safety net of home management.

If he currently travels to and from school on his own, he should be travelling with his EpiPen and his ASCIA Action Plan for Anaphylaxis, which guides him/his friends/fellow travellers through an emergency including administration of his adrenaline autoinjector.

A&AA worked on the development of a specific Boarding School Fact Sheet with the Department of Health in Western Australia a few years ago. To see this Fact Sheet, go to: <http://www.health.wa.gov.au/anaphylaxis/docs/schools/11289%20SK9%20Boarding%20schools.pdf> ■

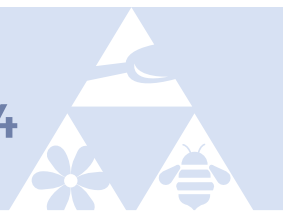


**wishing all our members and friends
a great festive season!**

**hope you and your family have a wonderful christmas
and that 2015 is a happy, healthy fun-filled year for all of us.**

best wishes.

maria. gee. debby. vicki. susan and jo from national office



Treating Anaphylaxis

One of our members recently wrote she thought she was good at reading the signs of anaphylaxis, as her six-year-old daughter is at risk. That is, until it happened to her.

She shares her experience:

"I took Keflex for about the 30th time in my life and had an anaphylactic reaction to it.

I started with itching in my hands. I thought I was allergic to the dog and tried washing my hands, which were bright red and swollen - then it spread everywhere.

I took Zyrtec and then ran to the bathroom to jump in the shower. God only knows how I thought that would help.

When I saw my reflection - swollen face, throat sucking right in like during an asthma attack - I realised what was happening!

When I tried calling for my husband I could barely speak. Luckily we live two minutes from the hospital and my husband was there to take me.

It was very scary. The emergency team were amazing, but I truly thought I was going to die. The doctors didn't recognise me the next day when I was back to normal!

My reason for sharing this story is just to remind everyone that if in doubt, use the EpiPen! The signs could possibly be passed off as something else, like blaming the dog, so monitor your loved ones closely."

Allergy & Anaphylaxis Australia responds:

We all question ourselves when we, our child or someone we are caring for suddenly starts showing signs of an allergic reaction. Are we imagining the redness? Is his lip really swollen? Is that a cluster of mosquito bites or are they hives? Is her breathing laboured or am I just imagining it? Should I give adrenaline or should I wait and see what happens? If I give the EpiPen or the Anapen, then I have to call an ambulance and go to hospital...and they keep you for at least four hours! Do I really have time for that?

STOP!

Take out your **ASCIA Action Plan for Anaphylaxis**, which should be stored with your adrenaline autoinjector, and **READ IT.**

This is your guide to use if someone prescribed an adrenaline autoinjector is having an allergic reaction. Follow steps closely depending on the signs and symptoms you have in front of you and be aware that:

- Most people will have skin symptoms before going into anaphylaxis, but they may be subtle or hidden under clothing;
- Some people – about 20 per cent - do not have skin symptoms and can suddenly have breathing difficulty or just collapse;

- If someone with asthma who is at high risk of anaphylaxis suddenly develops severe breathing difficulty **GIVE ADRENALINE BEFORE GIVING ASTHMA PUFFER;**
- If someone is having difficulty swallowing their saliva and/or the saliva suddenly becomes thick and sticky **GIVE ADRENALINE AUTOINJECTOR** and follow steps on ASCIA Action Plan for Anaphylaxis.

We can never remove the risk of reactions completely, but we can reduce risk and act appropriately when reactions happen.

Another member wrote about her experience:

"Yesterday, I had to call an ambulance for my 17-year-old daughter. I saw her walk past me three minutes before she called for help, and she had been perfectly fine and smiling then.

When I got to her, she was only able to take very short shallow breaths - when asked to take a slow deep breath she would then have a coughing fit and her face would go red.

It wasn't until after I administered the EpiPen that her eyes started to darken - a clear sign in Jess of an allergic reaction - to a very dark mulberry colour and her lips were turning blue while swelling and her face went grey and clammy.

She couldn't talk or swallow as her throat was closing over. The ambulance took us to our local hospital where we stayed for the next five hours. The care of the ambos, doctors and nurses was fantastic.

We are so lucky in Australia to have a health care system at all. I am very grateful for that."

UPDATE TO NSW EARLY EDUCATION GUIDELINES

The New South Wales Early Childhood Education and Care Directorate of Department of Education and Communities just released new Anaphylaxis Guidelines for Early Childhood Education and Care services.

These guidelines have been developed to assist:

1. In the management of the health care needs of children in the service who have been identified by a medical practitioner as being at risk of anaphylaxis;
2. In the day-to-day management of the service to reduce the likelihood of exposure to relevant allergens;
3. In the development of your service policy and procedures for managing children's medical conditions.

The electronic version of the document is available at: www.det.nsw.edu.au/media/downloads/what-we-offer/regulation-and-accreditation/early-childhood-education-care/anaphylaxis_guide.pdf. ■



Anaphylaxis Event Record

Suspected anaphylaxis event record form (to be completed by doctor or patient)

If your reactions have an allergic cause, then you are usually looking for one trigger that is common to all reactions experienced.

Fill out a separate event record form for every episode you have experienced. You may need more than one copy of this form to document food or medicines taken on the day of the reaction.

Bring your completed form/s to your appointment. You may also consider sending a copy to your allergy specialist, who might suggest bringing suspected food or medicine with you to your appointment, including packaging to help identify ingredients.

In the meantime, you may wish to read some information on allergy and anaphylaxis:

www.allergy.org.au/patients/ascia-education-resources

Patient name: _____

Phone number: _____

Date and time of reaction: _____

GP: _____

Specialist: _____

Suspected trigger/s (specify if known):

Food _____ Insect stings (e.g. bee) _____

Drug _____ Tick bites _____

Date of last menstrual period (females only) _____

Signs/symptoms:

Hives Tightness in throat Persistent dizziness

Tingling mouth Difficult/noisy breathing Collapse

Swelling of lips Difficulty talking/hoarse voice Pale and floppy

Swelling of tongue Wheeze Vomiting

Swelling in throat Persistent cough Abdominal pain

Location of reaction:

Home School Childcare

Work Dining out Other _____

Activity immediately before reaction:

Eating Gardening

Exercise Other _____



Anaphylaxis Event Record

Suspected anaphylaxis event record form (to be completed by doctor or patient)

Please list all you consumed in the hours prior to the reaction and the approximate time.

If the reaction occurred at night, go back to supper and dinner the night before.

If you do not recall what you ate that day, write down the types of foods that you might have eaten.

- All food ingredients, not just the obvious ones, even if you eat the food regularly. _____
- Foods that made you itchy in the mouth or throat _____
- Prescribed medications _____
- Non-prescription drugs _____
- Herbal medicines _____
- Did you have asthma symptoms? _____

How soon after exposure did symptoms begin? _____

Has patient had previous allergic reactions?

- Yes How severe? _____ Suspected allergen? _____
- No

Patient received treatment:

- Location of reaction
- At GP/medical centre
- In hospital By ambulance? Yes No

Medication given:

- Adrenaline autoinjector Antihistamine Steroids
- Adrenaline ampoule Bronchodilator Other: _____
- Patient has adrenaline autoinjector, but it was not used

Additional information: _____



Spring into Skin

We have sprung into spring, with flowers blooming, bees buzzing and ... skin itching!

It is a timely to have an update on what skin conditions there are, what possible triggers and what you can be on the lookout for.

The Australasian Society of Clinical Immunology and Allergy has this information on one skin condition - contact dermatitis.

Allergic contact dermatitis is a common skin condition that results in an itchy and weeping rash, typically a few days after direct skin contact. Common causes include nickel, chemicals, plants, cosmetics, perfumes and ointments.

Allergic contact dermatitis is common

Allergic contact dermatitis is a common skin condition which causes an itchy and weeping rash localised to the area in contact with the allergic trigger (allergen).

It usually develops two or more days after contact with the allergen. It lasts as long as contact continues and for a short time (typically one to two weeks) afterwards.

Nickel metal is the most common cause of allergic contact dermatitis.

Approximately 8 per cent of the population is allergic to nickel and the prevalence is higher among females than males.

Nickel may be found in the metal of costume jewellery, watch straps, bra clips and jeans studs. The ears are often affected by wearing of non-gold earrings.

The usual precipitant is piercing of the ears. Two days after contact with the metal, an itchy rash develops which may blister and weep.

This rash will continue for several days or longer, if further contact with the metal continues.

(Image: Nickel allergy to bra clip)



Plants may also cause allergic contact dermatitis

Some plants can trigger allergic contact dermatitis. Rashes often appear on exposed areas of the body after being outdoors.

Allergic rashes may be triggered by direct contact with the plant, or a combination of sunlight plus contact, so called "photo-contact dermatitis". Examples of plants in Australia that may cause contact dermatitis are chrysanthemums, primula, tomato plants, grevillea, English ivy and occasionally Rhus trees.

Lantana or vegetables such as parsnip or celery may cause photo-contact dermatitis. *(Image: Grevillea allergy)*



Other causes include chemicals, creams and ointments

Other common causes of allergic contact dermatitis include chemicals in rubber, leather and dyes. Contact dermatitis to shoes is common, and any one of these chemicals could be the cause.

Creams and ointments used on the skin may also cause allergic contact dermatitis.

The cause may be the base ingredient (such as lanolin), or the active agent (such as neomycin, an antibiotic).

The first time the cream or ointment is applied, the rash will generally not appear for 10 to 14 days.

If it is applied again, it will usually take only two days to develop.

Perfumes, either on their own, or in cosmetics, can also cause allergic contact dermatitis. Even sunscreens can cause problems.

Patch testing can identify the cause of allergic contact dermatitis

There are many causes of allergic contact dermatitis, particularly where individuals are working in industry and in contact with chemicals.

If the cause of your allergic contact dermatitis is not obvious, patch testing can be helpful. This is usually performed by a medical specialist (dermatologist or allergist/clinical immunologist) and involves placing a sample of the substance on your back, and seeing if a reaction occurs after a few days.

While it is not always easy to find cause of contact allergy, intensive patch testing usually provides an answer.



Spring into Skin

ECZEMA, CREAMS/LOTIONS AND SENSITISATION TO FOOD ALLERGENS

If you have a skin inflammation such as eczema, using skin cream that contains food ingredients could lead to an allergic reaction, according to a letter to the editor published in the *Journal of Allergy and Clinical Immunology: In Practice*.

Aussie researchers reported the case of a 55-year-old woman who had a life-threatening reaction after eating two mouthfuls of a salad containing goat cheese. Although the woman suffered from eczema and seasonal asthma throughout her life, she had no history of reactions to food. But after conducting tests to track down the problem ingredient, doctors found that she was allergic to goat's milk.

Further investigation revealed that the woman frequently used a moisturizer containing goat's milk to soothe her eczema, although she stopped using it when her condition worsened. Rubbing the cream into inflamed skin, however, presumably sensitized her. When she ingested goat cheese, it triggered a reaction that escalated within minutes, requiring emergency treatment with adrenaline.

The researchers believe that this is the first direct evidence that humans can become sensitised to a food allergen by exposure through the skin. However, previous studies suggest that people with eczema have developed food allergies after using soaps and oils that contain wheat, oat, peanut and goat's milk. The authors advise eczema patients to avoid skin care products and cosmetics that contain food ingredients.

Allergic reactions to bites and stings

With the warmer weather, insects are also springing into action so ASCIA has some helpful information on bites and stings, different reactions and how to avoid being bitten.

More information can be found at www.allergy.org.au.

Most insect bites and stings result in a localised itch and swelling that settles within a few days. Severe allergic reactions (anaphylaxis) to insects are usually due to bees, wasps or the Australian Jack Jumper Ant.

Fortunately, effective treatments are available to treat some allergic reactions to bites and stings.

Stinging insects are a common cause of anaphylaxis

Allergies to venoms from stinging insects are one of the most common causes of severe allergic reactions (anaphylaxis) in Australia. Symptoms include an all over rash, swelling of tongue or throat, trouble breathing, abdominal pain, diarrhoea, vomiting or a drop in blood pressure (shock).

Although the insects are all hymenoptera (which means membranous winged insects), their venoms are very different. Allergy to one type of stinging insect does not usually increase the risk of reaction to another.

The Honey Bee is the most common insect to cause an allergic reaction in Australia'

Paper Wasps and European Wasps can sting multiple times. The European Wasp is becoming an increasing problem in Australia, is particularly aggressive and likes to get inside drink cans at barbecues, although the more familiar Paper Wasp is responsible for the majority of serious stings.

The Australian Jack Jumper Ant (*Myrmecia pilosula*) is a medium-sized black bull ant prevalent down the eastern side of Australia and Tasmania. It can be recognised by its characteristic hopping motion when it walks. It is a very aggressive ant and its sting can cause severe local pain. Severe allergic reactions are much more common than is seen with more common bull ants.

Native Australian Bees and the Green Ant of Queensland can also cause allergic reactions.

Bites are a less common cause of anaphylaxis than insect stings

Mosquitoes and March flies can cause itchy bites. However, severe allergic reactions are very rare, even when the swellings are very large and uncomfortable.

Caterpillars can cause severe irritation from touching their spines, which are attached to venom sacs underneath the skin. In rare cases they can trigger anaphylaxis.

Ticks (which are arachnids) also bite. Sometimes large local swelling and inflammation can arise at the site of a bite and last several days. Such reactions are usually due to mild allergy to the tick. Severe allergic reactions (anaphylaxis) have also been described to the Australian paralysis tick, *Ixodes holocyclus*. Severe allergic reactions (anaphylaxis) occur when the tick is disturbed. It is important, therefore that the tick is removed appropriately. See more on tick allergy removal and the risk of developing mammalian meat allergy after a tick bite at <http://www.tiara.org.au/>

Anaphylaxis following snake bites has also been reported, although this is very rare.



Spring into Skin

Common Bull Ants can occasionally cause anaphylaxis.

The major cause of anaphylaxis from ant stings is the Australian Jack Jumper Ant and to date, a successful desensitisation program only exists in Tasmania.

Natural history of allergic reactions

Bites

Local reactions to biting insects (such as mosquitoes and midges) tend to become less severe with time.

Stings

Reactions to stinging insects (particularly when severe) tend to persist, although children are more likely to improve than adults.

Isolated local reactions

Individuals who have had a rash or large local swelling alone have a less than one in 10 chance of developing serious allergic reactions with further stings. Allergen immunotherapy is not indicated.

Generalised reactions without life threatening features

Symptoms of generalised hives (urticaria) without difficulty breathing or a drop in blood pressure are uncomfortable but not dangerous. This type of allergic reactions is more common in children than adults and has less than a 1 in 10 chance of progressing to anaphylaxis. Allergen immunotherapy is not indicated in children who have reactions confined to the skin but is indicated in adults.

Anaphylaxis

Individuals who are at greatest risk of further serious reactions are those who have previously had a severe allergic reaction (e.g. difficulty breathing, drop in blood pressure) following a sting. Adults are at greater risk than children. Anyone with a history of a generalised reaction (even without life threatening features) to an insect sting should be referred to a medical specialist (clinical immunology/allergy specialist).

Prevention is better than cure

Bites from midges and mosquitoes are best avoided by covering up as much as possible. Avoid being outdoors in the early morning or at dusk, and use an insect repellent containing DEET.

After being outdoors, check for ticks if living in an endemic area. Ticks should not be removed from allergic individuals until the individual is in an emergency medical facility. This is because allergic reactions often occur when the tick is removed.

Honey Bees normally only sting in self-defence. The best protection is light coloured clothing, covering much of the

body (particularly the feet) and avoiding perfumes.

Wasps tend to nest in logs, walls or underground. They are generally more aggressive than bees and attracted to food and drink, so it is important that you don't drink blindly from open drink cans when outdoors.

Avoid wearing perfumes and bright colours, which attract bees. It is preferable to wear dark, white or muted coloured clothing, such as tan or green.

Stings often occur on bare feet so people with allergies to bites or stings should always wear shoes when outdoors.

When gardening, wear long sleeves, long pants and gloves. Tuck shirt into pants and pants into socks to prevent tick bites.

Avoid provoking bees and wasps.

Where possible, drive with the windows up.

Have nearby nests (ant, bee, wasp) removed by professionals. This is also relevant to schools and childcare services, particularly if they have children enrolled with stinging insect allergy. Be sure to organise for nest removal when children are not at school.

Diagnosing the cause of your allergy

Your doctor will normally ask a series of questions that may help to narrow down the list of likely cause of your reaction. This approach will also help to exclude conditions that can sometimes be confused with anaphylaxis. Skin test or blood allergy testing can help confirm or exclude potential triggers.

First Aid is adequate for the treatment of minor reactions

Bees usually leave their barbed sting in the skin and die. Flicking the sting out as soon as possible (preferably within 30 seconds) will reduce the amount of venom injected. Use the edge of your fingernail, a car key or credit card, being careful not to squeeze the venom sac, as this will only increase the amount of venom injected. By contrast, wasps and bull ants rarely leave their sting in the skin. Cold packs and soothing creams often help for minor reactions. Antihistamines usually do not help. Very large and uncomfortable local reactions may sometimes need cortisone (steroid) tablets to settle the swelling.

Severe allergic reactions can be fatal

Anaphylaxis from stinging insect allergy results in an average of three deaths per year in Australia. Older individuals and those with severe difficulty breathing are at greatest risk and should be seen by a medical specialist (clinical immunology/allergy specialist) to develop a strategy for dealing with subsequent stings. Those with



Spring into Skin

insect allergy need to be aware that severe reactions often happen very soon after the bite or sting (often quicker than allergic reactions to food)

Effective treatment for severe allergic reactions is available

Patients with at risk of anaphylaxis are usually advised to:

1. Have an ASCIA Action Plan for Anaphylaxis and adrenaline autoinjector (EpiPen or Anapen) readily available to treat anaphylaxis.
2. Wear a medical identification bracelet, which will increase the likelihood that adrenaline will be administered in an emergency.
3. Avoid medication (where possible) that may increase the severity of anaphylaxis or complicate its treatment. Beta blockers (and perhaps ACE inhibitors) fall into this group.
4. Seek urgent medical assistance if stung.

Allergen immunotherapy can reduce the severity of allergy

Allergen immunotherapy (desensitisation) can help to switch off the allergic reaction over time. This is effective for the treatment of bee and wasp stings. Unfortunately, there is currently only limited access to vaccine for treating Jumper Ant Allergy and there is currently no vaccine available for treating tick allergy or reactions triggered by some other species of ants and wasps.

It is important to realise that allergen immunotherapy is not helpful in patients with large local swellings alone and may not be necessary in patients with isolated rashes. For these reasons, patients should be evaluated by a clinical immunology/allergy specialist before initiation of immunotherapy is considered. The duration of treatment is generally for at least three to five years.

More information on tick allergy, jumper ants, insect stings and immunotherapy can be found at ASCIA's website www.allergy.org.au ■

Victoria Support Group

*Come along to our festive END OF YEAR meeting.
Mark your calendar:*

TIME: 7.30pm

DATE: Thursday 13 November 2014

ADDRESS: Craig Family Centre,
7 Samarinda Avenue,
Ashburton Vic 3147 (Melways Ref: 60 E10)

BYO: Plate of food! (see below)

We are very fortunate to have paediatric food allergy dietitian Vicki McWilliam as our guest for the November meeting. Vicki has kindly agreed to share her practical tips on how to manage allergies whilst maintaining nutritional balance. There will also be plenty of time for questions and informal discussion. If you would like to nominate any specific questions or topics for Vicki to cover on the evening, please email them to priya.milton1@gmail.com



To celebrate the end of year, all guests are encouraged to bring a plate of their favourite allergy-friendly food to the meeting – please remember to bring a list of each and every ingredient! This should be a great opportunity to see how others manage to celebrate with food whilst avoiding their family's particular allergen/s.

- Entry is by gold coin donation

- A range of Allergy & Anaphylaxis Australia information and other paraphernalia will be available at the meetings

ENQUIRIES: to priya.milton1@gmail.com ■



Recipe



Herbed Hash Browns

Makes 12

Ingredients

- potatoes, peeled
- 2 cloves crushed garlic
- 2 sprigs rosemary, picked and finely chopped
- 3 tablespoons (60g) olive oil

METHOD

Coarsely grate potatoes, then using hands, squeeze out as much excess liquid as possible and put into a bowl.

Add garlic and rosemary and season well with sea salt and cracked pepper.

In a large nonstick frying pan, add one tablespoon of oil and heat until shimmering but not smoking.

Place 4 x quarter-cup portions of potato mixture in the pan and gently flatten each using a spatula.

Cook over medium heat for 2 minutes or until browned.

Turn and cook the other side until crisp and golden brown. Remove hash brown and drain on absorbent paper.

Repeat with remaining mixture. These are also delicious served as a side with a meal.

From 4 Ingredients Allergies, page 22



Egg and nut free rocky road

Ingredients

- 150-200 grams sweet William choc chips
- 1 Allens killer python
- 10-12 Allens small red frogs
- 10-12 Surf Sweets Gummi bears
- 6-8 Pascal marshmallows

All ingredients used are nut and egg free but always check packet to be sure

METHOD

Melt chocolate in microwave for one-and-a-half minutes.

Cut all ingredients in to small pieces.

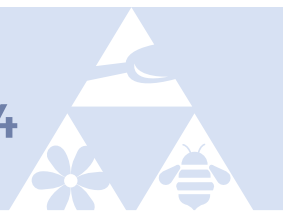
And add to melted Sweet William chocolate.

Mix together and place on a tray lined with baking paper, flatten out to desired size and place in fridge for an hour or until rocky road sets.

ENJOY

Sent in by the Payne family





Managing cow's milk and egg allergy

Earlier this year, Allergy & Anaphylaxis Australia hosted a webinar earlier this year entitled Managing Life with Cow's Milk and Egg Allergy. We published the highlights from two speakers, Dr Brynn Wainstein and Associate Professor Alyson Kakakios.

Nina Kingon, Senior Dietitian for Allergy and Special Needs at the Children's Hospital, Westmead, presented on dietary management of milk and egg allergy.

Here is an excerpt.

The role of the Dietitian is dietary management not food allergy diagnosis. It is always for the allergist to make the diagnosis. They may refer a patient to a Dietitian experienced in food allergy for:

- single or multiple food allergies;
- concerns about growth;
- feeding difficulties;
- social factors affecting dietary adequacy;
- limited variety of foods;
- suspected nutrient deficiencies – particularly in case of multiple food allergies.

On referral, a Dietitian will record your child's clinical information, including the age of diagnosis, history of allergic reactions, medical management of allergies, other medical issues (such as bowel management), relevant blood results, fluid intake, current supplements and medications.

Dietary information

When we chat to you about your child's diet, we will ask you about the day in the life of your child: when they eat, how much they eat, where they eat, whether it's a happy environment or stressful, their feeding skills, and behaviours and attitudes towards food: whether happy to try new foods or fearful around foods.

With this information, we'll do an assessment and look at whether their allergen is being avoided, whether their diet is adequate and then we'll consider some strategies.

Key dietary advice

Our role is teaching you how to find the allergen, what foods they are in, hidden sources, how to read a food label, and how to buy a substitute food.

We aim to teach you how to keep food and mealtimes fun, and encourage new foods.

Infants with cow's milk allergy

Breast is best.

It [breastfeeding] can usually continue in the presence of cow's milk allergy and the allergist will decide if the allergen should be avoided by the breast feeding mother.

The dietitian's role is to help optimise the diet for breastfeeding.

If breastfeeding is not an option, there are a range of appropriate infant formula substitutes. These specialised formulas have a changed protein form to prevent them causing an allergic reaction, but they need a prescription by an allergist or gastroenterologist, or a paediatrician in consultation with one of the two specialists. These specialists will decide which is best for your child.

The dietitian's role is to help with the acceptance and taste of these formulas, because they can be an acquired taste and may need a bit of flavouring to help.

Milk substitute for over 12 months

Where the diet is adequate, milk substitutes are used instead of formula. Many cow's milk substitutes are now available, e.g. soy, rice, almond, oat etc.

Other animal milks, for example goat and sheep, are not suitable because the protein is quite similar to that of cow's milk protein.

Not all substitutes are the same and your dietitian can help you ensure your child receives adequate calcium, protein and calories.

They will also talk to you about developmental milestones, such as changing from a bottle to a cup, and the balance of milk and food intake.

The dietitian's advice is required on the type and amount of milk substitute. With calcium fortified milk, you are aiming for 120mg per 100ml. Aim to limit this quantity to 500ml for one to three year olds.

This amount will change as they get older.

What's missing?

When you remove cow's milk from the diet, the key nutrients missing are calcium, protein, fat, Vitamin D and B12. All of these nutrients can be found in other foods if you change the amounts.

Substitute foods include soy or specialised formula; calcium fortified soy, rice, nut or oat drink; poultry; meat, legumes; nuts; wholegrains; soy beverage.



Managing cow's milk and egg allergy

What can you use instead?

Cow's milk – soy drink or other substitutes, e.g. rice drink
Yoghurt – soy yoghurt (dairy free). It's important to note that some of these use a dairy starter.

Cheese – soy cheese, soy cream cheese (dairy free). These are not a good source of calcium but can be used for variety.

Egg – egg replacer (commercial or homemade). While these won't be good for Pavlova or scrambled eggs, they are good in cakes and muffins. It is not equivalent in nutrition, but useful in cooking.

Adequate protein

One of the key challenges that a lot of parents report is getting adequate protein. When you remove milk or egg out of the diet, you need to increase protein from other foods to meet protein requirements.

Breakfast is an opportunity to give more protein, for example:

- Baked beans on toast;
- Soy drink and soy yoghurt;
- Whole grains, ground nuts and seeds in cereals
- Nut spreads on toast.

If your child has multiple food allergies and these options are not open to you, I would encourage you to talk to your dietitian.

What is enough?

Another key challenge is – how do I know it's enough?

The key point here is that a hungry child will eat well. Infants and children can self-regulate their intake if they are allowed the opportunity to feel hungry or to feel full. It's also important to provide a positive environment with no force feeding and to remember what your role is and the child's role.

The parent's role is the type of food and the time. Aim for two-and-a-half to three hours between meals, e.g. 7.30am, 10.00am, 12.30pm, 3.30pm, and 6.30pm.

And the child's role is how much they wish to eat.

For more information, see the Australian Guide to Healthy Eating 2013.

A key point to remember is that children need time to eat, time not to eat and time to play.

Dietary supplements

As dietitians, we always aim to meet nutritional requirements from foods first.

It's important to note that dietary supplements don't contain calories or protein but they might be needed if requirements can't be met with food, e.g. multiple food allergies.

A common at-risk nutrient in cow's milk allergy is calcium, and there are a range of supplements, however medications and supplements can contain allergens. They have different labelling laws to food, so it's important to consult your pharmacist.

Dietitians help

Dietitians provide:

- support
- reassurance
- information
- practical strategies
- create normality
- encourage shared responsibilities
- direct to support networks.

If you missed the webinar, you can watch it www.youtube.com/watch?v=dVjVSBgO1FI.





Managing cow's milk and egg allergy

QUESTIONS

Our webinars have resulted in many questions. Here are some.

Q. Is it possible for children/adults to have both food allergy and food intolerance?

Answer: Yes

Q. If antihistamine cannot interrupt anaphylaxis from progressing, why is this the first step on the ASCIA Action Plan?

Answer: The ASCIA Action Plan for Anaphylaxis covers both a mild/moderate allergic reaction - i.e. not anaphylaxis - AND a severe reaction - i.e. anaphylaxis.



Those with an allergy to food often - but not always - start with mild/moderate symptoms. When an allergic reaction to food is at this level, you can administer an antihistamine if it's on the ACTION Plan to help the person feel more comfortable.

However, because administering the antihistamine does not prevent a mild/moderate reaction becoming severe, if that is what is going to happen during that particular reaction, you must still watch for signs and symptoms of a severe allergic reaction.

You cannot tell if an allergic reaction will progress to

anaphylaxis in early stages so you can treat mild/moderate symptoms with antihistamine and watch for any signs and symptoms to do with breathing or level of consciousness - dizziness, floppy child, collapse - and then give the adrenaline auto-injector.

Many people think that they can prevent anaphylaxis by giving antihistamine, but the truth is if an allergic reaction does not progress to anaphylaxis, it was never going to in the first place.

Administration of antihistamine does not 'prevent' anaphylaxis and in fact giving an antihistamine 'prophylactically', for example before your child attends a birthday party, may actually serve to mask the milder symptoms of an allergic reaction (like itching). As a result it may take longer to realise that a reaction is occurring, which can be dangerous.

We must always remember that allergic reactions are unpredictable and we must always be prepared. FOLLOW instructions on the ASCIA Action Plan for Anaphylaxis closely, remembering also that sometimes severe symptoms develop without first developing mild ones.

Q. We have been told to ALWAYS use antihistamine before adrenaline. Is that right?

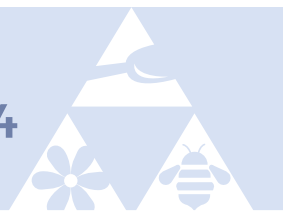
Answer: Using antihistamine before adrenaline if features of a severe (anaphylaxis) reaction are present is incorrect and should not be recommended.

It is only ever appropriate to give an antihistamine first if there are ONLY signs of a mild/moderate reaction and NO signs of a severe reaction at the time.

Again, FOLLOW instructions on the ASCIA Action Plan for Anaphylaxis.

If someone has signs and symptoms of a SEVERE allergic reaction lie the person down and GIVE ADRENALINE AUTOINJECTOR FIRST and then call the ambulance.

Antihistamine can be given after other medication or even when they arrive at the hospital as it does not reverse signs and symptoms of anaphylaxis but makes person feel more comfortable by decreasing skin symptoms and drying up runny nose. ■



Nuts on Planes: myths, media and facts

Two big stories about serious allergic reactions allegedly due to nuts being consumed on airplanes had widespread British media coverage during August and were picked by worldwide media. This stoked up the familiar myths and real fears about anaphylaxis occurring at 30 thousand feet.

By Dr. Andrew Craig

Two big stories about serious allergic reactions allegedly due to nuts being consumed on airplanes had widespread British media coverage during August and were picked by worldwide media. This stoked up the familiar myths and real fears about anaphylaxis occurring at 30 thousand feet. There was plenty of speculation about what had really happened on board, the risks of eating nuts in confined spaces, who was responsible and what should happen to avoid this in future. Coincidentally, information also appeared at the same time from very reliable sources to counter the biggest myths with facts. I've highlighted this factual evidence about nuts on planes in this article because it specifically addresses the myths and fears many have about nut snacks on planes and puts the risks of allergic reactions occurring because of snacking on nuts during flight into perspective.

The news story of most interest from the standpoint of what are the risks of something adverse happening when a bag of snack nuts are opened and consumed in a confined space of an airline cabin happened in mid-August as a family was travelling on a UK budget airline back from a holiday in Spain. A 4 yr old girl with a known peanut allergy was on board. Her parents alerted the cabin crew in advance and they made an announcement asking passengers to not open or consume any nut snacks they had brought on board. Obviously the airline did not distribute any bagged nut snacks either. Nonetheless, the girl's mother reported that about 20 minutes after the announcement her daughter began to show signs of swelling around her face, had throat constriction and increasing breathing difficulty. She lost consciousness. The mother had an adrenaline (epinephrine) auto injector and a paramedic passenger administered it. Afterwards the little girl regained consciousness and was stable enough for the plane to continue to London where she was given medical assistance.

The media handling of the story when it broke in the tabloid Mail on Sunday newspaper and online was interesting, if predictable. All reporting focused on the "selfish passenger" sitting four rows in front of the family who had thoughtlessly endangered the child's life by failing to heed requests not to open and consume a package of nuts – said later to be "mixed nuts" – when asked to do so. The media reported

that his actions had obviously caused her potentially fatal allergy attack. The airline later banned the nut-eating passenger for two years but no further action was taken. (1)

The scenario sounds simple enough, but was it? Something serious did happen to this child in mid-flight and contact with nuts in some way seems to have been involved. But what? Some media morphed the bag of "mixed nuts" into "peanuts" in their reports, simply because the child was reported to have a peanut allergy. In fact, there is no evidence that the "mixed nuts" included any peanuts at all. Very quickly, however, the "nuts on planes" myth machine was in high gear, not helped by a prominent UK allergy organisation commenting on the incident on its website that, "Airborne particles from nuts have the potential to kill those who are allergic to them. These particles are even more readily inhaled from the recycled conditioned air in an aircraft." That certainly sounds pretty frightening. But is it true?

Just at the height of the media wave (the main tabloid story attracted 2730 comments), a voice of sense and reason from Dr. Matthew Greenhawt (paediatric allergist at the University of Michigan) was heard in the allergic consumer magazine Allergic Living. (2) He began by tackling the thorny question, With a food allergy to peanut or tree nuts, is it likely for an allergic reaction to occur from one person opening a bag of nuts on a plane, four rows ahead?

The expert's short answer is that "it is highly unlikely for a passenger to inhale nut protein from someone consuming nuts a few rows in front of him/her. There is no evidence that has been able to show that such dust circulates." Five studies in the past 10 years had investigated this question and found favourable conclusions which should reassure any airline passenger with a nut allergy. Briefly they are:

- close (12 inches) exposure to inhaling peanut butter aroma produced no reactions in severely peanut allergic people. Smelling peanuts may make concerned passengers uncomfortable, but there are no active proteins involved in breathing in the aroma of re-heated or pre-roasted nuts;
- peanut particles (dust) could not be detected in the air from stomping on peanuts on the floor or from opening an airline-style bag;
- peanut dust and peanut butter residues are both easily cleaned from hands and surfaces using soap and warm water or hand cleansers (but hand sanitisers and plain water don't work).



Camp Allergy Management Checklist

This checklist helps both camp staff and groups attending camps prepare for a safer camp experience for those at risk of anaphylaxis. The list is meant as a guide and does not include every safety measure a facility could implement.

- Have majority of staff (including chef/cook) had specific anaphylaxis training?
- Have relief staff been trained?
- Are all staff aware of attendees with FOOD and INSECT allergies? (i.e. attendees that have an ASCIA Action Plan for Allergy/Anaphylaxis +/- an adrenaline autoinjector)
- Who is responsible for the camps catering? Do they have information on attendees and what food they are allergic to?
- Has the catering supervisor/chef spoken directly with attendee with food allergy/their parent?
- Can the allergen be removed or minimised? (Remember: food bans do not work and are not to be trusted).
- Always keep labels so food content can be checked. If food arrives without a label, call manufacturer and ask for printed ingredient list .e.g. bread from bakery.
- Be aware of cross contamination of foods during storage, preparation, cooking and serving of foods. (for detailed information on appropriate food preparation for those with food allergy, consider purchasing A&AA Food Service Kit through our online shop www.allergyfacts.org.au).
- Designated staff member (that has done anaphylaxis training) to be introduced to attendee/s with food allergy at beginning of camp. This staff member is to be available at meal times to facilitate reading labels and checking of food.
- Can you create a safer dining table for the attendees with specific food allergy? (especially if primary school aged) e.g. no milk in cups or bowls of cereal on the table where an attendee with milk allergy is sitting.
- Have you considered inviting an attendee to supply their own food (especially attendees with multiple food allergy)? If so, how will you manage storage, preparation and serving of their food?
- Are there any activities planned that involve food? Consider non-food activities/rewards.
- Are attendees allowed to bring snacks and treats from home? How will this be managed?
- Always have attendees' adrenaline autoinjectors and ASCIA Action Plan for Anaphylaxis easily accessible (either in unlocked central location or with the attendee/their group supervisor).
- Has each attendee with an ASCIA Action Plan for Anaphylaxis brought TWO adrenaline autoinjectors to facility?
- Is there a camp "Emergency Response Plan"? Does it consider mobile phone reception, emergency access to property 24/7, is there a clearing of land for a rescue helicopter to land if needed etc? Do you practise your emergency response plan? (i.e. similar to fire drill).
- Who will be responsible for carrying the medication on activities?
- Are there any non-teaching staff attending the camp (e.g. parent volunteers)? Are they aware of attendees at risk of anaphylaxis?
- Have camp staff discussed attendees with severe allergy with coordinator of group attending camp? Have roles, responsibilities, allergy policy been discussed/sent to this person?
- If primary school age, has the school/facility considered asking the parent of the child with severe allergy to attend?





Camp Allergy Management Checklist

INSECT SPECIFIC

Checks specific to insect allergy

- Mow grass areas before arrival of attendees where possible.
- Get professionals to remove insect nests when no attendees are present.
- Have insect repellent available (containing DEET).
- Have a MUST wear shoes when outside policy.
- Consider activities away from areas known to have bees/wasps nests/ant mounds if possible.
- Avoid tick infested areas if possible.
Check attendees for ticks after activity.
(See tick specific information at www.tiara.org.au)

What we say to children with food allergy

- Wash hands before and after eating.
- Don't accept food from your friends unless a trusted adult says it is OK.
- Always check that your food is appropriate - ASK & READ.

- If in doubt about the food, don't eat it. Eat your own snacks from home.
- Ask for help from staff immediately if they feel unwell.
- Always have medication close by (easily accessible).
- Older students/individuals to read labels of any packaged foods before eating.

What we say to friends of children with food allergy

- Know what your friend is allergic to.
- Don't share food with your friend with food allergy.
- Wash hands after eating.
- Don't tease/trick or make fun of your friend with severe allergy.
- If your friend looks sick get an adult straight away even if your friend does not want you to!
- Take food and insect allergy seriously!

For more information on management go to www.allergyfacts.org.au and www.allergy.org.au.
If you have a specific query, call 1300 728 000 ■

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• Inhaling (thereby ingesting) a dose of an airborne allergen is very unlikely on an airplane because there is little "recirculation" and commercial jets are required to frequently refresh the cabin air and subject it to HEPA filtration and there is no evidence to show that peanut or tree nut circulates in the air, as opposed to it quickly settling on surfaces.

So the widespread and often repeated belief about dangerous particles becoming airborne from opened nut packets (known as aerosolisation) is a myth. But that is not the end of the story, for Dr. Greenhawt cautioned that the problem such as the little girl experienced coming from Spain back to London could be from nut allergens in peanut or tree nut dust and residues that may accumulate on surfaces such as tray tables, seats, carpets and surrounding areas. A nut allergic person – such a small child - could potentially touch a surface that hadn't been wiped down first, and theoretically ingest some level of allergen thus presenting far more risk than nut particles, if they even get into the air, being inhaled. Wiping down seats and tray tables first may be a way of countering this theoretical risk of unintentional and unnoticed ingestion. Of course, regular and thorough cleaning of airline interiors is an obvious answer but with

high volume, quick turnaround budget flying that is not going to happen easily.

Another positive and reassuring feature on the nuts on planes issue appeared shortly after Dr. Greenhawt's, this time by Dr. Steven Stukas, allergist at Nationwide Children's Hospital in Columbus, Ohio. (3) Writing on a well-known allergy website "Don't Pass the Nuts"™, Dr. Stukas answered a wide range of questions including the vexed one about nut encounters on planes. Pointing to many reports of in-flight reactions, with anaphylaxis occurring in up to 1/3 of all reactions, Dr. Stukas said the evidence was that these were "not believed to be due to airborne food allergen, but from contact with seats, pillows, seat trays, etc. The universal theme with almost all cases of reported anaphylaxis is lack of use of epinephrine, either due to no availability or improper recognition/treatment." And he gave this good advice to allergic travellers: "The focus should be on preparation and awareness rather than fear of risk from unlikely sources of contact. However, there are a few steps passengers can take to help mitigate risk, including wiping the tray table with a cleaning cloth, avoiding use of airline supplied pillows and blankets."

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Bunya Nuts

Allergy & Anaphylaxis Australia was recently contacted by a vacation care facility in Queensland asking whether an allergy to bunya nuts existed as it was planning to make a cake with the nuts, and with the help of some tribal elders.

The centre had a child with a tree nut allergy enrolled and, having done their risk assessment, did not want to introduce nuts into the centre. Staff were unsure of the level of risk bunya nuts could pose to children with a tree nut allergy or any undiagnosed children.

The centre has adrenaline auto-injectors for general use and they have had anaphylaxis first aid training but felt it was worth seeking for advice before proceeding with this new activity.

A&AA responds:

Well done to such an allergy-aware vacation centre. Thinking ahead and doing a risk assessment when introducing a new allergen into an activity is an essential part of being allergy aware.

A&AA sought additional advice, as we had little knowledge on bunya nuts. We contacted Nuts for Life and asked about bunya nuts and risk to those with nut allergy. Nuts for Life referred to Professor Katie Allen, a paediatric gastroenterologist and allergist undertaking research in the evolving field of food allergy. Professor Allen is the principal investigator of the HealthNuts study - the largest single centre population-based study of food allergy in children ever mounted.

We have been told there have been no reported cases of allergy to bunya nuts, including from dieticians at the Children's Hospital in Queensland.

What we can tell you is that the bunya nut is native to Queensland and the tree can grow 30 to 40 metres in height. It bears cones the size of footballs, which are very heavy when they fall, weighing 5 to 10 kilograms.

The cones contain the edible nuts – seeds – which are encased in a shell. Bunya nuts were a rich source of food for the Aborigines of south-east Queensland and, from our research, are nutritionally similar to chest nuts. By boiling them in their shell for 20-30 minutes, the texture becomes waxy and can be easily sliced or pureed. The nuts can then be roasted, sliced or pureed and used in cooking. The nuts can also be milled to a flour and then used in baking.

Unfamiliar names

This does lead onto another subject, and that is unfamiliar nut names. Products imported from European countries that fall under the European Union (EU) labelling regulation are required to list the types of vegetable oil used in food, such as palm oil.



This is not required under the Australian Food Code.

A member recently contacted us saying they had noticed on the ingredient label of a packet of McVities Dark Chocolate Digestive biscuits "shea nut, illipe nut, sal nut and kokum nut".

These are names we are not familiar with in Australia.

What is shea nut?

Shea nuts are obtained from the shea tree that is indigenous to many parts of Africa. The shea nut is the seed of the fruit of the shea tree. The fruit portion is typically removed to retrieve the hard-shelled nut. Shea nut is a very oil-rich seed. Should shea nuts or shea nut products be a concern to consumers with tree nut or peanut allergy?

Food Allergy Research and Resource Program (FARRP) in the US says: "Certainly, shea nuts are tree nuts. However, shea nuts as such are not eaten in most parts of the world (we are uncertain if they are eaten locally in Africa).

"The primary article of commerce is shea nut butter, also known as shea nut oil. Shea nut butter is a cold-pressed oil that is refined, bleached, and deodorised. Shea nut butter is used in foods primarily in confectionery products as a cocoa butter substitute. Shea nut butter is also used in various cosmetic applications where the primary exposure would be skin contact. Shea nut oil or shea nut butter is primarily the fat fraction of this nut."

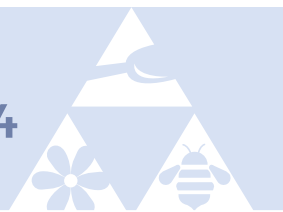
Does shea nut butter posed any risk to tree nut- or peanut-allergic consumers?

FARRP says an exhaustive search of the worldwide clinical literature provided no evidence to indicate that any allergic reactions have ever been reported to shea nut butter. Allergic reactions to shea nuts have not been described either, although they are not widely eaten.

"Recent research indicates that shea nut butter does not contain any detectable protein residues and does not contain detectable residues of proteins from peanut or various known allergenic tree nuts (walnut, almond, pecan, hazelnut)," FARRP says. "Since allergens are proteins, this research indicates the absence of detectable allergens in shea nut butter.

"Thus, refined shea nut butter does not pose any known or likely allergenic risk to consumers including individuals with pre-existing peanut or tree nut allergies. Products containing refined shea butter can be safely used by all consumers."

A&AA says this is a reminder to always read labels – the full ingredients - not just the allergen advice warning statement. If you are unsure of an ingredient it is best to contact the manufacture and ask further questions, followed by speaking to your allergy specialist. ■



What you need to know about food challenges

Swapnik is in Year 7, and his teacher asked the class to write a story about their 'Greatest Moment'. Swapnik decided to write about his great food allergy moment and here is his short story.

GREATEST MOMENT

Many people believe that their greatest moments may be passing the Selective test or winning a sporting and other competition however, mine is a little more personal. I was only 5 and starting school when I was called up for an allergy test.

You see, I was and still am allergic to a great many things (which I won't go into) and had not gotten over any. My most dangerous allergies were peanuts and dairy. This time I was called up for a peanut test as the doctor thought I may have gotten over it.

As I reached the doctor's surgery I was told to sit down and wait. The time eventually came and I was called into a room. In the room the nurses conducted several tests of which I have no memory.

However, the actual test was far from done. A small portion of peanut butter was smeared onto my lip and left to see if it would induce any reaction. After approximately 30 minutes I was given a small piece of bread with peanut butter and told to eat it. This process kept going on and on until I was told to eat an entire peanut butter sandwich. This produced no reaction. I was clear and could now eat peanuts freely without any worry of causing an anaphylactic reaction.

It had been five hours since the entire process had started. Even though I was cleared of all doubts, the process was not over. I was kept under observation for another hour to see if any last minute reactions occurred. The wait was finally over and I was clear to go home beyond all doubt. To put it simply, I was ecstatic. The only thing I could think of was going out and eating every peanut-related thing that I could eat until I could eat no more. It was the best feeling to be able to walk into a store and pick up peanuts /products off the shelf without hesitating. I could eat peanuts and there was no need for my EpiPen. My peanut allergy was gone. You may think that what is the big deal and why I am so happy but the answer is that I had gotten over the most difficult allergy to get over and the greatest thing was that I was only five.

Getting over my peanut allergy would definitely be one of the greatest moments of my life however I am only 11 years old. So far nothing can compare to this feeling of absolute joy and it is one moment that I will never forget!

Swapnik, NSW, A&AA member.

A&AA responds:

Thank you for sharing your story with us! We know you still have allergies to egg, milk, tree nuts and seafood so to read of your excitement at losing your peanut allergy is really inspiring. You know, sometimes we feel badly done by because we live with food allergy or insect sting allergy, but we really can make the most of what we do have and not make what we cannot have the focus of our lives.

YOUR QUESTIONS ANSWERED

The way we look at food allergy and food allergy challenges has changed significantly over the past decade, thanks to research and a better understanding of food allergy.

However, this also means there has been a lot of misconception and confusion.

As a result, the Australasian Society of Clinical Immunology and Allergy has recently put together a document of frequently asked questions, which we have published with permission.

What is a food allergen challenge?

A food allergen challenge is a procedure where small and incremental amounts of a particular food are fed to a person while under medical supervision, and monitored to determine if the food being tested causes an allergic reaction in the person.

Most challenges involve a time period of about two to three hours to eat the required doses of food, followed by two hours of observation.

Occasionally the food is given in one serving for rare types of food allergy, such as Food Protein Induced Enterocolitis Syndrome (FPIES).

If an allergic reaction occurs, the challenge:

- May take longer.
- Is usually stopped and if necessary, treatment for the allergic reaction is given.
- Is usually called 'positive' and the person is diagnosed as allergic to the food.

If the challenge is completed without an allergic reaction:

- It is called 'negative'.
- The person will then be asked to regularly include the food in their diet.



What you need to know about food challenges

Who can perform food allergen challenges?

Food allergen challenges should only be performed:

- In carefully selected patients by specialist immunology and allergy physicians or appropriately qualified and experienced medical practitioners, in consultation with specialist immunology and allergy physicians.
- Under medical supervision with immediate access to emergency treatment for a severe allergic reaction (anaphylaxis).

Why are food allergen challenges performed?

Food allergen challenges are mainly used to determine if a:

- Person has outgrown an existing food allergy.
- Suspected food allergy is an actual allergy, when the history or allergy tests are unclear.
- Positive food allergy test in a person who has never before reacted to that food, is associated with an actual allergy to that food.
- Person with confirmed food allergens can safely eat alternative foods. For example, a soy challenge may be used to determine if a person with cow's milk allergy and a positive skin prick test to soy, is also allergic to soy.

What are food allergen challenges not useful for?

Due to the incremental and controlled nature of food allergen challenges, it is possible for a person to have a mild allergic reaction at challenge, and then have a severe allergic reaction (anaphylaxis) to the same food in a different setting.

Therefore a food allergen challenge may not completely identify the risk of anaphylaxis due to the future ingestion of a food in a person. However it may provide an indication of the risk.

For example, if a mild allergic reaction occurs after only a very small amount of food, that person may be considered at increased risk due to accidental exposure in the future.

Why are food allergen challenges sometimes performed following other food allergy tests?

A positive food allergy test (using skin prick tests or blood tests for allergen specific IgE) means that a person's immune system has produced an antibody response to that food. We call this being sensitised.

However, sometimes false positives can occur, which means that the test is positive yet the person can eat the food without any symptoms. For this reason, it can be important in some circumstances to confirm the significance of a

positive allergy test with a food allergen challenge.

What are the implications of a successful (negative) food allergen challenge?

If the challenge is successful and does not result in any allergic reaction, the challenge food will need to be regularly included in the diet. This is very important as some people who do not eat the food for long periods may become sensitised once more and have allergic reactions again.

It is recommended that the food is eaten at least once a week. If you think this will be difficult, you should discuss this with your doctor before undertaking the food allergen challenge.

What are the implications of an unsuccessful (positive) food allergen challenge?

If an allergic reaction occurs during the challenge:

- This will be treated with whatever medications and other measures are needed.
- It will be necessary to stay under medical supervision for a period of time after the challenge.
- The food must continue to be avoided.

Unfortunately, the severity of the allergic reaction during the challenge does not provide any information regarding the severity of any future reactions. For example, if a person has only a mild allergic reaction during the challenge, a reaction on another occasion could be much more serious and even be life-threatening (anaphylaxis).

How do you prepare for a food allergen challenge?

You may be asked to bring in the challenge food on the day, depending on what food allergy is being assessed.

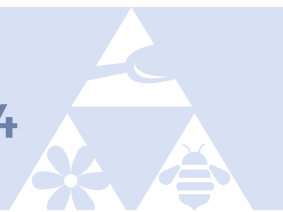
The person being challenged must be well on the day of the challenge with no fever and if asthma is present, it must be stable with no recent wheezing.

If the person being challenged has a prescribed adrenaline autoinjector this should be brought to the food allergen challenge. If a severe allergic reaction occurs, it may be an opportunity for the person (if old enough and well enough) or parent to administer the adrenaline autoinjector in a controlled setting. Staff will always have a supply of adrenaline available even if you have your adrenaline autoinjector with you.

If your child is having a food allergen challenge ...

Talk to them beforehand and ensure they are aware that if they have an allergic reaction this will be managed.

Bring things to occupy them, as the food allergen challenge



What you need to know about food challenges cont.

can take some time.

You may be asked to bring in a soft or liquid food which your child is not allergic to and likes to eat, to help with the challenge process. It can be used to mix with the challenge food.

Treatment of anaphylaxis

Food allergen challenges are performed in a controlled medical environment with medical and nursing staff experienced in treating anaphylaxis, so the way an allergic reaction is managed in a hospital may vary slightly from the instructions on the ASCIA Action Plan for Anaphylaxis. This is because hospital staff have ready access to blood pressure and oxygen checks, oxygen masks and other equipment. Although management in a hospital may be different, it is important that you closely follow instructions on the ASCIA Action Plan for Anaphylaxis when not in a hospital setting.

Continued from page 29

The evidence about the perceived risks of eating nuts on planes has been clearly presented by Drs. Greenhawt and Stukas writing in well-known allergy consumer publications. But the comments of nut allergic individuals following their articles show that many simply do not believe the evidence and are very ready to offer contrary and passionate views based on personal or family experiences of nut reactions while on airplanes. Just presenting the facts isn't going to make this opinion go away. There is currently an online petition on the US website "No Nut Traveler" calling for a Bill of Rights for Food Allergic Children/Adult Passengers which has attracted thousands of supporters and growing media attention. (4) Citing the policy of Air Canada, the petition asks that once cabin crew are informed that a nut allergic person is traveling, "the crew create a buffer zone at least three rows in front and three rows behind the allergic person. The crew member should ask customers seated in the buffer zone to refrain from consuming any nut containing products that they have brought onboard and the crew will not serve any nut containing products to these rows." Whether this petition will have political clout and result in regulations remains to be seen.

Nothing in this article is meant to denigrate the concerns of people and families affected by serious nut allergies. Quite the opposite. At the moment, the evidence and expert clinical opinion based on it all points to very low to negligible risks from fellow passengers opening packets and consuming nuts on airplanes. Where large groups

Will there be other people having food allergen challenges on the same day?

Yes. Challenges are generally performed in a food challenge clinic with several people having challenges to different foods in the clinic on the same day.

Medical and nursing staff in these clinics are trained to take care to not cross-contaminate foods they are challenging separate patients with.

Children are encouraged to eat when next to their parents and then play with toys, so that communal toys are not contaminated with different foods. By doing this, skin reactions such as hives are less likely to be attributed to accidental touch reactions from the environment.

Where can I obtain more information?

www.allergy.org.au/patients/food-allergy ■

of people, such as airline passengers, are concerned the question of rights versus risks has to be carefully negotiated and balanced. Simply repeating myths about the supposed dangers of inhaling nut particles or the aroma of nuts on airplanes is part of the problem and does not help find the solution.

You can see APC London's tweets on this story and its media consequences @USA_peanuts_UK

1. www.mailonsunday.co.uk/news/article-2724684/Nut-allergy-girl-went-anaphylactic-shock-plane-passenger-ignored-three-warnings-not-eat-nuts-board.html
2. <http://allergicliving.com/2014/08/21/anaphylaxis-in-the-air-two-recent-airline-incidents/1/> based on data in Greenhawt M et al 2013. "International study of risk-mitigating factors and in-flight allergic reactions to peanut and tree nut". J Allergy Clin Immunol: In Practice 1:186-94. <http://dx.doi.org/10.1016/j.jaip.2012.01.002>
3. <http://allergicgirl.blogspot.co.uk/2014/07/food-allergy-counseling-interview-with.html>
4. www.nonuttraveler.com/Default.aspx and www.forbes.com/sites/tedreed/2014/08/30/united-alters-policy-on-peanut-allergies-as-mom-pushes-airlines-for-change

Dr Andrew Craig is the European Health Consultant for the American Peanut Council. This article has been reprinted with permission. ■



New Products: Vitasoy Almond Milk Blends and Coconut Milk

Vitasoy have launched a new range of products in September this year; they include:

Soy & Almond Milk

Oat & Almond Milk

Coconut Milk Original

Coconut Milk Unsweetened



These new products contain either almond oil or coconut cream.

Measures are in place to avoid cross contamination.

At Vitasoy we have a cleaning management process that is implemented for all of our products. Our equipment is cleaned with an automated cleaning process after the coconut milk or almond blends are run to ensure a stringent allergen quality control in accordance with best practice guidelines.

Therefore, please rest assured we do not envisage any likelihood of cross contamination, and as a result this is not referenced as a warning on our other products.



Should you have any questions or feedback, please contact our Customer Care team on 1800 677 852.



Food Alerts

UNDECLARED PEANUT ALERT

16/10/14

Recall Detection: Customer reported the product after allergic reaction. Food Description: Health Food Bar Product Name: 1. Macro Wholefoods Market Raw Food Bar Chocolate Flavoured 2. Macro Wholefoods Market Raw Food Bar Chocolate and Mint Flavoured Package Description: 1. Brown flow-wrapped bar, 50g 2. Green flow-wrapped bar, 50g Date: All best before dates currently in the marketplace. Batch Identification: 1. 9300633242626 2. 9300633242633 Country of Origin: Australia Manufacturer Name: Sun Health Foods P/L Company Information: Products sold through Woolworths, Thomas Dux and Woolworth convenience stores. Affected states and territories: National Public Contact: 1300 244 999



TREE NUT ALERT

15/10/14

Reason for Recall: Undeclared tree nut (almond) Recall Detection: Customer reported the product. Food Description: Chocolate Product Name: CocoaBelgian Milk Chocolate 350g Package Description: Brown flow-wrapped family chocolate bar, 350g Date: Best before 10th January 2015 Batch Identification/APN/EAN: 9339346970977 Country of Origin: China Manufacturer Name: Eden Chocolates - SIP Eden Chocolates Co Ltd Company Information: Product sold through Big W Affected states and territories: National Public Contact: 1300 244 999

SOY ALERT

2/10/14

Reason for Recall: Undeclared SOY Recall Detection: This recall is the result of international government testing Food Description: Pasta Product Name: 1. PASTAALGAR FULLKORN 2. PASTAALGAR Package Description: Plastic packaging, 500g Date: All dates in the marketplace... Batch Identification/APN/EAN: 1. 9300633209629 1. 1.201.396.14.0007 2. 1.001.124.32.0004 Country of Origin: Germany Importer name: FRIGOSCANDIA DISTRIBUTION PTY LTD Manufacturer Name: Keck Spezialitäten GmbH Company Information: IKEA PTY LTD Affected states and territories : NSW, QLD, VIC, SA, WA through IKEA stores Public Contact: Please contact Food Standard Australia New Zealand

NUT SPREAD ALERT

30/09/14

Reason for Recall: Undeclared Peanut and tree nuts. Peanut allergens are present in the cashew spread and the almond spread; tree nuts allergens are present in the peanut spreads. Recall Detection: This recall has been extended to further products due to routine testing by the company Food Description: Nut spreads Product Name: 1. Macro Natural Almond Spread 25...0g 2. Macro Natural Cashew Spread 250g 3. Macro Organic Peanut Butter Crunchy 375g 4. Macro Organic Peanut Butter Smooth 375g 5. Macro Organic Peanut Butter Crunchy 800g 6. Macro Organic Peanut Butter Smooth 800g Package Description: 1-4. A clear glass jar with a metal cap 5-6 Plastic tub with lid Date: All dates in the marketplace Batch Identification/APN/EAN: 1. 9300633209629 2. 9300633209636 3. 9337803000069 4. 9337803000052 5. 9337803004388 6. 9337803004371 Country of Origin: Australia Manufacturer Name: HealthFarm Fine Foods Pty Ltd Company Information: Woolworths Ltd Affected states and territories : National - Woolworths, Woolworths Small stores and Thomas Dux Public Contact Number: Woolworths Ltd on 1800 103 515.

PEANUT ALERT

26/09/14

Reason for Recall: The presence of an undeclared allergen peanut Recall Detection: The recall is the result of routine testing by the company Food Description: Nut spread Product Name: Macro Almond, Brazil and Cashew spread Package Description: Glass jar with metal cap Package Size: 250g are currently in the market place to and including 30 APR 2015 Batch Identification: APN/EAN 9300633209...643 Country of Origin: Australia Manufacturer Name: HealthFarm Fine Foods Pty Ltd Company Information: Woolworths Ltd Affected states and territories : National - Woolworths, Safeway Supermarkets, Thomas Dux Public Contact Number: Woolworths Ltd on 1800 103 515.



GLUTEN ALERT

2/9/14

Reason for Recall: The presence of an undeclared allergen gluten. Recall Detection: The recall is the result of testing by retailer
Food Description: Chickpea Crisps. Product Name: 'Has no' Chick Pea Crisps - Sour cream and chives. Package Description
Package Size: laminate plastic/foil bag Approx. 100x200mm 175g. Date Marking Best Before: Batch Identification. Best Before:
24/07/2015. Batch Code: APN/EAN 205160. Country of Origin: Australia. Manufacturer Name: K & S Indian Foods. Manufacturer
Details: 2/14 Bent Street St Marys NSW 2760. Affected states and territories: State/Territory. Retail Outlets (point of sale) NSW:
Yes. Aldi ACT: Yes. Aldi QLD: Yes. Aldi VIC: Yes. Aldi TAS: No. Aldi SA: No. Aldi NT: No. Aldi WA: No Public Contact Number K&S
Indian Foods 02 4647 0673

SESAME ALERT

1/8/14

Coles wishes to advise that there has been a change to the allergens in Coles Simply Gluten Free breads. All four lines listed
below now contain egg. Should you have any questions or feedback please contact our Customer Care team on 1800 063 562. •
Coles Simply Gluten Free Chia & Seed Bread • Coles Simply Gluten Free Four Seed Bread • Coles Simply Gluten Free White
Bread • Coles Simply Gluten Free Fruit Bread

WHEAT & GLUTEN ALERT

25/7/14

Reason for Recall: The presence of an undeclared allergen wheat/gluten. Recall Detection: The recall is the result of detection
by retailer. Food Description: Spanish style doughnuts. The product is sold frozen, and is par cooked to be finished off by the
customer. The product has a 9 month shelf life. Product Name: Spanish Doughnuts Flavour Filled Churros. Package Description:
Cardboard box - red background with picture of 3 different flavours. Package Size: 12 pack, 900g. Date Marking Best Before: All
best before dates up to and including 30 APR 2015. Batch Identification. Batch Code: Best before date is batch code: 9 346882
000075. Country of Origin: Australia. Manufacturer Name: Spanish Doughnuts Foods Pty Ltd. Affected states and territories
Costco stores in NSW, ACT, QLD and VIC. Public Contact Number: 03 9350 1555

COW'S MILK ALERT

15/7/14

Reason for Recall: The presence of an undeclared allergen (dairy). Recall Detection: The recall is the result of routine testing
by manufacturer. Food Description: Liquid Stock. . Product Name: 1. Chefs Cupboard Simply Stock Beef. 2. Chefs Cupboard
Simply Stock Chicken. 3. Chefs Cupboard Simply Stock Vegetable. 4. Chefs Cupboard Simply Stock Salt Reduced Chicken.
Package Details: Tetra pack. Package Size: 1 litre. Date Marking Best Before: 30 DEC 2015 and 31 DEC 2015. 26 DEC 2015
and 30 DEC 2015. 24 DEC 2015. 25 DEC 2015 and 26 DEC 2015. Batch Identification. 57117, 57120, 57300.56502, 57306, 56496,
56499, 57303, 57309. 57318. 4. 55407, 57324. Batch Code: 1. 2201 0995 2. 2201 0988 3. 2608 8334 4. 2614 0285. Country of Origin:
Australia Manufacturer Name: Pactum Australia Pty Ltd. Retail Outlets (point of sale) Aldi stores. NSW, ACT, QLD, VIC. Public
Contact Number: 02 8814 8166

SESAME ALERT

1/7/14

Food Product: Cereal and cereal products. Brand Name: Macro Natural Five Grain Porridge. Best before date: 24th
April 2015 APN/EAN/TUN Number: 9300633143442. Pack Description: 750g resealable pouch. Country of Origin:
Australia. Distribution: National. Reason for Recall: Undeclared SESAME. Company Responsible: Woolworths Limited.
For Recall Information: 1800 103 515

FOR MEMBER SUPPORT INFORMATION

Call 1300 728 000, leave a message
and we will get back to you within 48 hours.

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