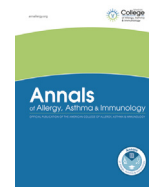




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Guidelines

Addendum guidelines for the prevention of peanut allergy in the United States: Report of the National Institute of Allergy and Infectious Diseases—sponsored expert panel

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Background: Food allergy is an important public health problem because it affects children and adults, can be severe and even life-threatening, and may be increasing in prevalence. Beginning in 2008, the National Institute of Allergy and Infectious Diseases, working with other organizations and advocacy groups, led the development of the first clinical guidelines for the diagnosis and management of food allergy. A recent landmark clinical trial and other emerging data suggest that peanut allergy can be prevented through introduction of peanut-containing foods beginning in infancy.

Objectives: Prompted by these findings, along with 25 professional organizations, federal agencies, and patient advocacy groups, the National Institute of Allergy and Infectious Diseases facilitated development of addendum guidelines to specifically address the prevention of peanut allergy.

Results: The addendum provides 3 separate guidelines for infants at various risk levels for the development of peanut allergy and is intended for use by a wide variety of health care providers. Topics addressed include the definition of risk categories, appropriate use of testing (specific IgE measurement, skin prick tests, and

oral food challenges), and the timing and approaches for introduction of peanut-containing foods in the health care provider's office or at home. The addendum guidelines provide the background, rationale, and strength of evidence for each recommendation.

Conclusions: Guidelines have been developed for early introduction of peanut-containing foods into the diets of infants at various risk levels for peanut allergy.

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Peanut allergy is a growing public health problem. In 1999, peanut allergy was estimated to affect 0.4% of children and 0.7% of adults in the United States,¹ and by 2010, peanut allergy prevalence had increased to approximately 2% among children in a national survey,² with similar results reported in a regional cohort.³ Peanut allergy is the leading cause of death related to food-induced anaphylaxis in the United States,^{4,5} and although overall mortality is low, the fear of life-threatening anaphylactic reactions contributes significantly to the medical and psychosocial burden of disease. In the majority of patients, peanut allergy begins early in life and persists as a lifelong problem. Therefore, cost-effective measures to prevent peanut allergy would have a high effect in terms of improving public health, reducing personal suffering, and decreasing health care use and costs.

Abbreviations used: CC, Coordinating Committee; EP, Expert Panel; GRADE, Grading of Recommendations Assessment, Development and Evaluation; LEAP, Learning Early about Peanut Allergy; NIAID, National Institute of Allergy and Infectious Diseases; OFC, Oral food challenge; sIgE, Specific IgE; SPT, Skin prick test. Corresponding author: Susan F. Cooper, MSc, Division of Allergy, Immunology, and Transplantation, National Institute of Allergy and Infectious Diseases, National Institutes of Health, 5601 Fishers Lane, Room 7C28, Rockville, Md 20892; E-mail: coopersu@niaid.nih.gov.

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The "Guidelines for the diagnosis and management of food allergy in the United States"⁶ were published in December 2010 by an Expert Panel and a Coordinating Committee convened by the National Institute of Allergy and Infectious Diseases (NIAID). These guidelines did not offer strategies for the prevention of food allergy and particularly peanut allergy because of a lack of definitive studies at the time. The guidelines indicated that "insufficient evidence exists for delaying introduction of solid foods, including potentially allergenic foods, beyond 4 to 6 months of age, even in infants at risk of developing allergic disease." This statement differed from previous clinical practice guidelines in the United Kingdom⁷ and United States,⁸ which recommended the exclusion of allergenic foods from the diets of infants at high risk for allergy and is consistent with more recent recommendations regarding primary allergy prevention.⁹⁻¹²

Network, the New England Society for Allergy, UCLA/Harbor Heiner Lectureship, Medscape, the Western Michigan School of Medicine, the Canadian Society of Allergy and Clinical Immunology, and the Pennsylvania Society for Allergy and Immunology. R. S. Gupta has consultant arrangements with BEFORE Brands and DBV Technologies; has received grants from the NIH, FARE, and Mylan LLC; has received payment for lectures from Grand Rounds; and has received royalties from Createspace Independent Publishing Platform. S. M. Jones is on the Research Advisory Board for FARE; is on the Scientific Advisory Board for Aimmune; has consultant arrangements with Stallergenes; has received grants from the NIH/NIAID (Consortium of Food Allergy Research and Immune Tolerance Network—IMPACT Trial), FARE, Aimmune Technologies, DBV Technologies, and the National Peanut Board; has received payment for lectures from the Kansas City Allergy Society, Mercy Children's Hospital, Riley Children's Hospital, Southwestern Medical School—Children's Medical Center, the European Academy of Allergy & Clinical Immunology, the New York Allergy & Asthma Society, the University of Iowa Paul M. Seeborn Lectureship in Allergy, and the Iowa Society of Allergy, Asthma, and Immunology. A. Muraro has consultant arrangements with Meda, Novartis, and Menarini; is employed by Padua University Hospital; and has received payment for lectures from Meda and Menarini. L. J. Rosenwasser is a board member for the World Allergy Organization. H. A. Sampson has consultant arrangements with Allertein Therapeutics, Genentech/Roche, Sanofi, Stallergenes, Danone, and Merck; is employed part time as Chief Scientific Officer for DBV Technologies; has received grants from the NIAID and the Immune Tolerance Network; has received royalties from UpToDate and Elsevier; has been offered stock options in DBV Technologies; and is chairman of PhARF Award Selection Committee for Thermo Fisher. L. C. Schneider is on the Medical Advisory Board for FARE, has received a grant from DBV Technologies, and has received stock/stock options in Antera Therapeutics. S. H. Sicherer has received grants from the NIAID, FARE, and HAL Allergy; has received royalties from UpToDate; and is serving as Associate Editor for the *Journal of Allergy and Clinical Immunology: In Practice*. R. Sidbury has received travel support from the NIH and the Hawaii Dermatology Seminar, has consultant arrangements with Anacor, has provided expert witness testimony on behalf of Roche in Accutane—inflammatory bowel disease cases, has received a grant from Epidermolysis Bullosa Research Partnership, has received payment for lectures from the Taiwanese Dermatological Society, and has received royalties from UpToDate. J. Spergel has consultant arrangements with DBV Technologies and Danone; has received grants from DBV Technologies, Aimmune Therapeutics, and the NIH; has received payment for lectures for Dartmouth College, the ACAAI, and the Florida Allergy Society; and has received stock/stock options in DBV Technologies. D. R. Stukus has received payment for lectures from the ACAAI. C. Venter has consultant arrangements with Danone and Nestle, has received payment for lectures from Mead Johnson, and has received travel support from Thermo Fisher. The rest of the authors declare that they have no relevant conflicts of interest.

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