



Australian Paediatric Society

9TH ANNUAL APS ALLERGY MASTERCLASS WORKSHOP

Event Program

2026



DATE: SATURDAY 30TH MAY (ONSITE AND VIRTUAL)

VENUE: THE LANGHAM, SOUTHBANK VIC



Welcome 2026

The Australian Paediatric Society (APS) warmly welcomes you to the 9th Annual APS Allergy Masterclass Workshop. Our aim is to provide an update on contemporary developments in allergy practice and broaden the knowledge base of general paediatricians, paediatrician allergists and GP allergists, with a virtual component to include clinicians and allergy teams who may otherwise be limited by on-call obligations, geographic remoteness, cost, or family commitments.

The APS remains an active participant in initiatives of the National Allergy Council (NAC) to support the delivery of high-quality paediatric allergy services across rural, regional and suburban Australia. The APS Position Paper Clinical Allergy services in Regional Australia is available on the APS website at Australian Paediatric Society.

We sincerely acknowledge and appreciate the generous contribution of our distinguished speakers, who have given up their time and part of their weekend to share their expertise and support those of us working at the regional clinical coalface.

This workshop would not be possible without the support of our sponsors. We gratefully acknowledge and thank our Gold Sponsors: Aspen Pharmacare, Bioclect, CSL Seqirus, Ego Pharmaceuticals, Nestlé Health Science, Nestlé Nutrition, Nutricia, Sanofi, Sanulac Nutritionals, Stallergenes Greer and Viatrix.

Each delegate has been provided with this program booklet, which includes sponsor

information and contact details relevant to the presentations. We encourage onsite delegates to visit the sponsor displays and virtual delegates to review sponsor materials and advertisements. Please feel free to contact the listed representatives, who will be happy to connect you with your local State representative.

We also express our sincere appreciation to Gary Smith and Armchair Medical for their ongoing assistance with the virtual delivery and recording components of the program.

Finally, thank you to the Planning Committee, David Bannister, Mike Nowotny, Paulina Alhucema, Ania Hargrove and Amanda Day for their significant contribution to the success of this workshop. We warmly invite all participants to continue contributing ideas for future workshops, including speaker suggestions (and perhaps even presenting yourselves) so that we may continue to foster such a collegiate and successful educational forum.

Thank you again for your commitment to and participation in the 9th Annual APS Allergy Masterclass Workshop, and for your shared dedication to achieving the best possible outcomes for children and young people living with allergic disease.

A handwritten signature in black ink, appearing to read 'Peter Goss'.

Peter Goss

Chair APS Allergy

Date 30th May 2026

8.50am	Welcome and NAC update	Peter Goss
9.00am	NAC ACA Allergy Upskilling Course	Michael Nowotny
9.10am	Emerging Treatments for Anaphylaxis	Paulina Alhucema
9.50am	Managing Fish and Seafood Allergy	Dean Tey
10.30am	MORNING TEA	
10.50am	Oral Immunotherapy - Are We There Yet?	Tim Brettig
11.30am	Eczema - Evidence and Application	Dean Tey
12.10pm	Challenging Allergy Cases	Panel (Paulina Alhucema, Michael Nowotny, Ania Hargrove)
13.00pm	LUNCH	
13.40pm	Food Ladders for IgE allergy	Vicki McWilliam
14.20pm	Update on Difficult Child Asthma	Shivanthan Shanthikumar
15.00pm	Which Formula and When?	Vicki McWilliam
15.40pm	AFTERNOON TEA	
16.00pm	Clinical Application of Pollen Counts	Janet Davies
16.40pm	Allergy in Schools and Early Childhood Centres	Peter Goss
17.00pm	FINISH	

APS Allergy Presentations

Presentation 1

0900: 0910

NAC ASSOCIATESHIP OF CLINICAL ALLERGY (ACA) UPSKILLING COURSE

PRESENTER: Michael Nowtowny

Michael is a General Paediatrician and Paediatric Allergist who trained through RCH Melbourne who has worked in rural/regional areas including Darwin and Gippsland and now working primarily in child allergy on the Mornington peninsula. He holds post graduate qualification in medical education, contributes to RACP and Monash Children's teaching and is ACA Course Director.

The Associateship for Clinical Allergy is a specialised clinical allergy course sponsored through a grant from ASCIA and administered by the National Allergy Council. The program was established as a two-year pilot program comprising 10 non-metropolitan trainees (5 GPs, 5 paediatricians). The program consists of four comprehensive academic units with an emphasis on practicality and clinical reasoning:

Case 1: Anaphylaxis and Foundational Principles

- Allergy focussed history taking
- Use and interpretation of investigations including skin prick testing

Case 1: Food Allergy

- Comprehensive principles of diagnosis and management of food allergy

Case 3: Environmental Allergy

- Assessment and management of allergic rhinitis, including immunotherapy

Case 4: Allergy and the skin

- Includes comprehensive assessment and management of urticaria and eczema as well as many other skin conditions

The ACA Course curriculum has been refined over the past 3-4 years by an expert writing group of senior ASCIA members. The program emphasises case-based and workplace-based learning, combining quizzes and interactive sessions with supervised clinical placements and problem-based learning through real clinical cases.

Successful completion of the ACA Course leads to a Certificate of Completion and represents one formal recognition pathway to the Associateship of Clinical Allergy (endorsed by ASCIA and NAC) for practitioners with additional allergy training and experience. The program has also fostered a strong national community of practice among trainers and participants.

The pilot program is now entering formal evaluation, with results expected to be published over the next 12 months.

A new cohort will commence in 2027.

Acknowledgement for Outstanding Services to Paediatrician Allergists: David Bannister

David practised as a general paediatrician on the Mornington Peninsula for 28 years before working exclusively in paediatric allergy for a further 23 years. Now retired from clinical practice, he remains actively involved in allergy education, mentoring, and teaching.

APS Allergy Presentations

Presentation 2

0910: 0950

EMERGING TREATMENTS FOR ANAPHYLAXIS

PRESENTER: Paulina Alhucema

Paulina Alhucema is a general paediatrician with subspecialty expertise in Paediatric Allergy & Immunology, with interests in food allergy, eczema, allergic rhinitis, and chronic spontaneous urticaria. She contributes to the 250K Youth Project through the National Allergy Council and is involved in allergy research through the Australian Food Allergy Foundation via Epworth Healthcare. She also works in clinical allergy at Royal Children's Hospital Melbourne and Sunshine Hospital.

Case 1: A 15-year-old boy (70 kg) with poorly controlled asthma and a history of anaphylaxis to peanut and macadamia. He is inconsistent in carrying his adrenaline autoinjector. His father, who is frequently the primary carer at sporting events, is disengaged with his allergy and asthma management. What are the management issues?

Case 2: An 11-year-old boy (35kg) presents following his fourth bee sting. Previous stings resulted in small local reactions, progressing to a large local reaction. On this occasion, while playing on a trampoline at home, he was stung; the stinger was removed promptly. He subsequently developed generalised urticaria, abdominal pain, and vomiting. He is described as adventurous and inquisitive. His parents are seeking advice regarding future risk and treatment options.

Case 3: A 6-year-old girl with confirmed cow's milk allergy and prior severe anaphylaxis. At 4 months of age, ingestion of cow's milk formula led to immediate urticaria, vomiting, coughing, and wheeze requiring adrenaline and ICU admission. There have been no inadvertent exposures since. Current testing shows SPT 15 mm to cow's milk extract and specific IgE 21 kU/L. She has adrenaline autoinjectors at home and school, but her parents are very reluctant to administer adrenaline. They request additional devices for grandparents and after-school care.

CSL SEQIRUS (Neffy):

Stuart.Hawkes@seqirus.com

VIATRIS (epipen):

Alyssa.truong@viatris.com

APS Allergy Presentations

Presentation 3

0950:1030

MANAGING FISH AND SEAFOOD ALLERGY

PRESENTER: Dean Tey

Dean is a consultant paediatric allergist and immunologist with more than 15 years' experience across tertiary and private practice settings. He is Director of Allergy & Immunology at Royal Children's Hospital Melbourne and Co-Founder of MACCS Medical Group. His major clinical interest is oral immunotherapy for peanut and tree nut allergy, alongside research and service development in paediatric allergy care. He is also a Board Member of The Buddee Foundation and has strong interests in leadership and improving outcomes for children with allergic disease.

Case 1: A 10-year-old girl presents with a history of oral tingling, lip swelling, and generalised urticaria occurring immediately after a single bite of a fish finger 8 weeks ago. She has previously tolerated multiple fish species, although fish is not a regular part of her diet. Since the reaction, she has tolerated canned tuna and calamari. The family is concerned about future risk and asks whether she can eat other fish (including shark) and whether all seafood, including crustaceans (prawns) and molluscs (scallops), should be avoided.

They also seek allergy testing, including:

- *Whether to perform skin prick testing and which fish species to include (e.g. fresh vs commercial extracts)*

- *The role of specific IgE testing*

Case 2: A 4-year-old boy presents with a history of profuse, repetitive vomiting occurring approximately 3 hours after ingestion of various fish, including barramundi, flathead, and salmon. There are no associated cutaneous or respiratory symptoms. He has avoided all fish for the past 6 months.

What is the management and expected prognosis?

Case 3: A 12-year-old boy with long-standing eczema, including involvement of his hands, presents following an acute allergic reaction. He is a keen fisherman and has frequently used prawns as bait. On Christmas Day, he consumed a cooked king prawn and immediately developed oral and throat pruritus, hoarseness, dysphagia, and generalised urticaria. He subsequently vomited three times. Paramedics administered intramuscular adrenaline with good effect.

He reports that he had tolerated a full serving of the same king prawns the previous Christmas and is keen to continue eating prawns, crab, and calamari.

How would you manage this patient?

BIOELECT:

SRandall@bioelect.com

SANOFI:

amber.geddes@sanoficonnect.com

APS Allergy Presentations

Presentation 4

10.50:11.30

UPDATE ON ORAL IMMUNOTHERAPY - ARE WE THERE YET?

PRESENTER: Tim Brettig

Tim completed paediatric and advanced allergy training at Royal Children's Hospital Melbourne and was awarded a PhD in 2024 for research focused on improving the diagnosis of peanut and tree nut allergy. Since 2019, he has practised as an allergist at MACCS Medical Group and also works as a Postdoctoral Researcher at Murdoch Children's Research Institute and Program Medical Lead for the ADAPT Oral Immunotherapy Program through the National Allergy Centre of Excellence.

One case will peanut reaction age 7 months, another possibly cashew at 2 years (to discuss)

Case 1: A 9-month-old girl living approximately 100 km from Melbourne was referred locally with severe infantile eczema and mixed IgE/non-IgE mediated cow's milk allergy. Her eczema has improved dramatically following dietary modification and appropriate topical therapy.

She has subsequently developed reactions to multiple foods. On her first exposure to approximately ¼ teaspoon of peanut butter in December, she developed immediate perioral urticaria, facial angioedema, coughing and became limp, consistent with anaphylaxis. She also developed facial rash with extension to the neck following her first exposure to egg white.

She is currently avoiding cow's milk, egg, peanut and tree nuts. Skin prick testing demonstrated: Histamine: 5 mm, Fresh cow's milk: 10 mm, Egg white: 9 mm, Egg yolk: 1 mm Peanut: 15 mm, Cashew: 0 mm

Is this girl a candidate for oral immunotherapy?

Case 2: A 10-year-old boy with isolated persistent IgE-mediated cow's milk allergy presents for review. He has no history of anaphylaxis, no asthma, and otherwise enjoys good health. All other foods are tolerated without issue. He continues strict cow's milk avoidance with good adherence and no significant accidental exposures. Skin prick testing demonstrates Cow's milk extract 12 mm and fresh cow's milk 15 mm

A baked milk challenge in 2025 was unsuccessful, with development of perioral urticaria after ingestion of approximately half a muffin volume.

Is this boy a candidate for oral immunotherapy

SANULAC:

Beverly.PERERA@au.lactalis.com

NESTLE:

celine.khalil=au.nestle.com@
nestlehealthscience.nestle.com

ASPEN NOVALAC:

sharon.brouillard@aspenpharmacare.com.au

NUTRICIA:

Colin.JOHNSTON@danone.com

APS Allergy Presentations

Presentation 5

1130:1210

ECZEMA - EVIDENCE AND APPLICATION

PRESENTER: Dean Tey

Dean is a consultant paediatric allergist and immunologist with more than 15 years' experience across tertiary and private practice settings. He is Director of Allergy & Immunology at Royal Children's Hospital Melbourne and Co-Founder of MACCS Medical Group. His major clinical interest is oral immunotherapy for peanut and tree nut allergy, alongside research and service development in paediatric allergy care. He is also a Board Member of The Buddee Foundation and has strong interests in leadership and improving outcomes for children with allergic disease.

Case 1: A 10-year-old boy is referred with long-standing, poorly controlled atopic dermatitis. The parents are separated. Multiple treatments have reportedly been tried, including various emollients and topical corticosteroids, with limited sustained benefit. The child dislikes treatment and is reported to deteriorate following time spent with the father.

On examination, the boy is wearing long sleeves. There are long, unclean fingernails and toenails. The skin shows widespread dry, scaly, lichenified dermatitis with excoriations, including on the buttocks. There are weeping, crusted lesions involving the face, neck, and post-auricular areas, suggestive of secondary infection.

DERMCARE:

julia.esposito@egopharm.com

SANOFI:

amber.geddes@sanoficonnect.com

APS Allergy Presentations

Presentation 6

1210:1300

CHALLENGING CASES

PANEL: Paulina Alhucema (Chair), Ania Hargrove, Michael Nowotny

Ania Hargrove became an FRACP Consultant Paediatrician in 2004 and subsequently completed additional training in Paediatric Allergy at RCH Melbourne. She has a broad paediatric practice encompassing general, developmental, and behavioural paediatrics, with a particular interest in paediatric allergy

Case 1: A 17-year-old boy presents for review with a history of widespread urticaria and facial swelling reaction to a bee sting at age 7. No features suggestive of anaphylaxis. No further stings in the subsequent 10 years. He currently carries an EpiPen and is due to finish school later this year, with likely transition to work, travel and increased independent activity.

What are the important issues in reassessment and long-term management?

Case 2: A 13-year-old girl commenced sublingual immunotherapy (SLIT) for house dust mite allergy due to severe allergic rhinoconjunctivitis. Six weeks after commencing treatment, her parents contact you reporting that she consistently develops variable abdominal pain approximately 30 minutes after her morning SLIT dose. Symptoms settle spontaneously and there are no associated respiratory symptoms, vomiting, urticaria or collapse.

What are the important considerations in assessment of this symptom, and what management strategies may be appropriate?

Case 3– A 10-year-old girl with a previous walnut allergy has undergone repeat allergy assessment over the preceding 12 months. Skin prick testing to walnut was 0mm and 2mm serum specific IgE to walnut is low at 0.50 kU/L. Despite this, the girl develops objective allergic symptoms during a supervised oral food challenge (OFC) to walnut, confirming persistent clinical reactivity.

What are the important issues in interpretation of this discordance between testing and clinical outcome, including:

- *The relative reliability and limitations of commercial skin prick reagents versus fresh food ("prick-prick") testing*
- *The impact of testing technique, lancet type and operator variability*
- *The predictive value and limitations of low or negative serum specific IgE results*
- *Potential explanations for false negative testing*
- *How negative predictive value should be interpreted in the context of prior clinical allergy*
- *Whether repeat testing should be performed prior to OFC, and whether this is best undertaken on the same day or at a separate visit*

BIOSELECT:

SRandall@bioclect.com

DERMCARE:

julia.esposito@egopharm.com

STALLERGENS:

Yasmin.saffouri@stallergenesgreer.com

APS Allergy Presentations

Presentation 7

1340:1420

FOOD LADDERS FOR IGE ALLERGY

PRESENTER: Vicki McWilliam

Vicki is Senior Allergy Dietitian in the Department of Allergy and Immunology at RCH Melbourne, Clinician-Scientist Fellow at MCRI, and Honorary Senior Research Fellow at the University of Melbourne. Her primary expertise is paediatric food allergy, with roles spanning clinical care, teaching, training, resource development, and research.

Case 1: A 12-month-old boy with IgE-mediated cow's milk allergy presents for review. He is tolerant of baked milk in muffin form but develops urticaria and nausea following ingestion of approximately ½ teaspoon of baked cheese.

Skin prick testing demonstrates Cow's milk extract: 5 mm, Fresh cow's milk: 6 mm

Should we introduce a milk ladder approach?

Case 2: An 8-month-old girl with significant eczema presents following a reaction to egg. On her first known exposure to approximately ¼ teaspoon of well-cooked egg, she developed anaphylaxis.

Skin prick testing demonstrates Egg white 10 mm.

Should we introduce an egg ladder approach?

Case 3: A 2-year-old girl is reviewed following reactions to peanut. She is able to tolerate small amounts of peanut, approximately ¼ to

½ teaspoon, but develops facial urticaria and nausea with larger exposures.

Skin prick testing demonstrates Peanut: 3 mm and 4mm. Initial SPT at 9 months was 6mm.

Should we introduce a peanut ladder approach?

SANULAC:

Beverly.PERERA@au.lactalis.com

NESTLE:

celine.khalil=au.nestle.com@
nestlehealthscience.nestle.com

ASPEN NOVALAC:

sharon.brouillard@aspenspharmacare.com.au

NUTRICIA:

Colin.JOHNSTON@danone.comu

APS Allergy Presentations

Presentation 8

1420: 1500

UPDATE ON DIFFICULT CHILD ASTHMA

PRESENTER: Shivanthan Shanthikumar

Shiv is a paediatric respiratory physician who trained and works at RCH Melbourne with interests across paediatric respiratory medicine, including asthma, chronic cough, exercise-induced breathing difficulty, and shortness of breath. Shiv is actively involved in research, teaching, and supporting families through practical, evidence-based respiratory care.

Case 1: A Case 1: A 14-year-old boy with a history of peanut anaphylaxis at age 2 and persistent allergies to egg, cow's milk, sesame and house dust mite presents for review. He otherwise tolerates all other foods. He also has poorly controlled respiratory disease.

He reports reduced exercise tolerance, becoming wheezy and requiring Ventolin 2–3 times during a basketball game. He wakes every morning congested with repetitive sneezing before leaving his bedroom. He is poorly compliant Symbicort 200 twice daily. Despite being prescribed an EpiPen, he does not routinely carry it.

His mother has undertaken her own research and emails prior to the consultation asking:

1. *Whether he meets PBS eligibility criteria for Xolair or Dupixent*
2. *Whether Xolair could adequately replace his current inhaler therapy*
3. *What effect Xolair or Dupixent may have on food allergy severity or reaction risk*

4. The risks, limitations and long-term considerations associated with biologic therapy

What are the key clinical issues in this case, and what management strategies are likely to be most effective?

Case 2: A 16-year-old girl with severe uncontrolled asthma presents for review. She has no food allergies but is sensitised to house dust mite and spring grass pollen. Her allergic rhinitis is managed with a once-daily combined intranasal corticosteroid/antihistamine spray. She reports good adherence with both her nasal therapy and Seretide 250 twice daily and appears motivated and engaged with treatment.

Despite this, asthma control remains poor. Office spirometry demonstrates an FEV1 of 65% predicted. She also has moderately severe eczema, reasonably controlled with regular topical corticosteroid therapy.

Over the preceding 12 months she has required three inpatient hospital admissions for asthma and six courses of oral prednisolone

What are the major issues in assessment and management of this patient, and what escalation strategies or biologic therapies should be considered?

SANOFI:

amber.geddes@sanoficonnect.com

CSL SEQIRUS:

Stuart.Hawkes@seqirus.com

VIATRIS:

Alyssa.truong@viatris.com

APS Allergy Presentations

Presentation 9

1500:1540

WHICH MILK FORMULA AND WHEN?

PRESENTER: Vicki McWilliam

Vicki is Senior Allergy Dietitian in the Department of Allergy and Immunology at RCH Melbourne, Clinician-Scientist Fellow at MCRI, and Honorary Senior Research Fellow at the University of Melbourne. Her primary expertise is paediatric food allergy, with roles spanning clinical care, teaching, training, resource development, and research.

Case 1: A 4-month-old boy, otherwise exclusively breastfed, develops an IgE-mediated allergic reaction consistent with anaphylaxis following exposure to standard cow's milk formula.

The mother is preparing to return to work, and the grandparents will assist with care. The family now requires a suitable supplementary formula option for occasional top-up feeds. They specifically want to know the additional value of formulae with additives such as probiotics

Case 2: A 6-month-old girl was fed a whey based infant formula from birth. At approximately 4 weeks of age, she developed florid eczema, significant infant distress and mucousy stools with intermittent blood specks. Following transition to a rice-based formula, there has been marked improvement in temperament, gastrointestinal symptoms and eczema, which is now relatively easy to control.

What are the important issues in assessment

and management, including parent inquiring about

- *timing and approach to cow's milk reintroduction or challenge.*
- *whether further investigation or allergy testing is indicated,*
- *an alternative milk formula as supply in her region has been troublesome*
- *introduction of other allergenic foods and monitoring for development of IgE-mediated allergy?*

Case 3: An 8-month-old boy has experienced three separate episodes of delayed profuse vomiting following ingestion of cow's milk-based yoghurt, clinically consistent with Food Protein-Induced Enterocolitis Syndrome to cow's milk. He is otherwise breastfed and thriving. Breastfeeding is expected to cease within the next 2 months, and his parents are seeking advice regarding the most appropriate formula for transition feeding. He has not yet been introduced to rice.

SANULAC:

Beverly.PERERA@au.lactalis.com

NESTLE:

celine.khalil@au.nestle.com@
nestlehealthscience.nestle.com

ASPEN NOVALAC:

sharon.brouillard@aspenspharmacare.com.au

NUTRICIA:

Colin.JOHNSTON@danone.com

APS Allergy Presentations

Presentation 10

1600:1640

CLINICAL APPLICATION OF POLLEN COUNTS

PRESENTER: Janet Davies

Janet is Head of the Allergy Research Group at Queensland University of Technology and Co-Chair of the Respiratory Allergy Stream at the NACE. She previously led the NHMRC AusPollen Partnership and contributed to international pollen allergy diagnostic guidelines for EAACI. Her research focuses on molecular allergy and environmental health.

Case 1: A 15-year-old boy with seasonal allergic rhino-conjunctivitis and thunderstorm asthma risk has a history of poor adherence to preventer therapy outside peak pollen periods. He reports that symptoms “come out of nowhere” each spring and that he only restarts treatment once wheezing begins. He and his family are unaware of the Melbourne Pollen Count and Forecast App and similar pollen forecast and alert systems used in other Australian states.

What practical education should be provided on:

- *Monitoring daily pollen forecasts and thunderstorm asthma risk alerts*
- *Timing of preventer therapy commencement before peak pollen periods*
- *Adjusting outdoor activity during extreme pollen days*
- *The role of pollen forecasts in improving adherence and self-management*
- *Limitations of pollen forecasting and the importance of symptom monitoring?*

Case 2: A 16-year-old boy from Sydney with seasonal allergic rhinitis and grass pollen-triggered asthma is planning interstate travel to Victoria during spring for a national tennis tournament. His symptoms are usually well controlled in Sydney with preseason intranasal corticosteroid/ antihistamine nasal spray and inhaled preventer therapy.

His parents ask whether pollen exposure and thunderstorm asthma risk may differ interstate, and whether the family should continue monitoring pollen forecast apps while travelling.

Case 3: A 14-year-old girl from Melbourne with allergic rhinitis and mild asthma has traditionally experienced symptoms during high grass pollen periods. During the previous pollen season, however, her family noticed repeated “Extreme Other Pollen” alerts on the Melbourne Pollen Count and Forecast App despite relatively modest grass pollen counts.

Her parents ask what “other pollen” actually means and whether these alerts should alter management.

STALLERGENS:

Yasmin.saffouri@stallergenesgreer.com

BIOELECT:

SRandall@bioelect.com

CSL SEQIRUS:

Stuart.Hawkes@seqirus.com

VIATRIS:

Alyssa.truong@viatris.com

APS Allergy Presentations

Presentation 11

1640:1700

ALLERGY IN SCHOOLS AND EARLY CHILDHOOD CENTRES

PRESENTER: Peter Goss

Peter Goss is a general paediatrician, allergist, and diabetes specialist with particular interests in the management of these conditions within schools and early childhood settings. He was lead author of the ISPAD position statement on diabetes management in schools and recently provided expert evidence on allergy and diabetes management to the Senate Inquiry into ECEC on behalf of the APS.

Case 1: A 2-year-old girl with known IgE-mediated cow's milk allergy was inadvertently fed cereal containing approximately 50 mL of cow's milk by a staff member in an early childhood education and care setting. The staff member had no allergy-specific food preparation training and no anaphylaxis training.

The child subsequently became pale and floppy and developed coughing and wheezing. When a senior educator from another room identified the child's condition, the staff member reportedly stated that she believed the child was "just sleepy with a cold".

Intramuscular adrenaline was administered immediately and an ambulance was called. During transport to hospital, approximately 30 minutes away, the child required a further six doses of adrenaline before stabilisation.

What are the key clinical, governance and systems issues raised by this case,

Case 2: A 6-year-old boy with known peanut allergy attending a Victorian government primary school inadvertently consumed chocolate containing peanut after sharing food with a friend.

He subsequently developed generalised urticaria, vomiting and a husky voice, consistent with evolving anaphylaxis. Despite mandatory anaphylaxis training requirements, school employees were reluctant to administer adrenaline. An EpiPen was eventually administered by ambulance personnel, and the child was transported to hospital.

What are the important clinical, educational and medico-legal issues raised by this case? Who is responsible for ambulance costs in this situation, and what advice should families be given regarding potential ambulance expenses and insurance or subscription arrangements in Victoria? Is it the same for other states?

DERMCARE:

julia.esposito@egopharm.com

STALLERGENS:

Yasmin.saffouri@stallergenesgreer.com

GOLD SPONSORS:

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