Australian Paediatric Society

8TH ANNUAL APS ALLERGY MASTERCLASS WORKSHOP 2025

EVENT PROGRAM

VENUE – PULLMAN SYDNEY AIRPORT

Welcome

Dear Colleagues,

The Australian Paediatric Society (APS) welcomes you to the 8th Annual APS Allergy Workshop!

Our first allergy workshop was held face to face in 2015 in a case-based format. It has evolved to include virtual attendance in order to increase accessibility to those paediatricians and child allergy teams restricted by on-call obligations, remoteness, cost, or family commitments.

The APS is an active participant in the National Allergy Council (NAC) initiatives to deliver quality paediatric allergy services in rural, regional, and suburban Australia. The APS is the joint lead in the NAC "Shared Care" initiative after being jointly awarded (with NAC) an ASCIA grant to facilitate an allergy upskilling initiative, the Associateship of Clinical Allergy, for paediatricians and general practitioners.

For some years, we have discussed the value of an Australia-wide Community of Practice for general paediatricians who manage children with allergy. We are in process of creating a Paediatric Clinal Allergy Network to centralise and share resources, learn from each other, and provide mentoring and peer support.

We acknowledge and appreciate the very generous input of our illustrious speakers. They have given up time and part of their weekend to increase the knowledge of those of us who work at the regional clinical coalface.

The workshop would not be possible without our sponsors. We acknowledge and thank our Gold Sponsors Aspen, Stallergenes-Greer, Ego Pharmaceuticals, CSL Sequirus, Nestle / Nestle Health Sciences, Nutricia and Silver Sponsors, Viatris and Sanulac. Each virtual delegate has been supplied with this program booklet and with a list of sponsor contacts. Please visit the sponsor displays on site and/or read about their new products.

Again, we express our appreciation to Gary Smith, Armchair Medical, for assistance with the virtual and recording component of the program.

Thank you also to the Organising Committee David Bannister and Mike Nowotny. We invite you all to submit ideas, speakers (including yourselves) to continue to produce such a collegiate and successful workshop!!

Thank you all again for committing and contributing to the 8th Annual APS Allergy Masterclass Workshop in order to produce the best possible outcomes for children with allergy!

Peter Goss

Chair APS Allergy

PROGRAM

Saturday 12th July 2025

9.00am	Welcome and NAC update	Peter Goss
9.10am	Managing Fruit and Vegetable Allergy	Ana Dosen
9.55am	Idiopathic Anaphylaxis	Paulina Alhucema
10.40am	MORNING TEA	
11.00am	Common Child Allergy Myths	Connie Katelaris
12.00am	Oral Food Challeges - How and Where?	Shruti Swamy
12.20am	Oral Food Challeges - the Ballarat Model	Ballarat Allergy Team
12.50pm	LUNCH	
13.30pm	A to Z Management of Allergic Rhinoconjunctivitis	Shruti Swamy
14.15pm	Paediatrician / Dietician Allergy Teamwork	Wendy Birks
15.05pm	AFTERNOON TEA	
15.25pm	Challenging Allergy Cases	Michael Nowotny
16.05pm	Regional Allergy Transition	David Bannister
16.35pm	Allergy Community of Practice	Peter Goss
16.50pm	FINISH	

Cases

PRESENTATION 1:

Managing fruit & vegetable allergy

Ana Dosen

CASE 1:

6 year old girl Amy with history of seasonal rhinitis reacts to watermelon flesh, avocado and the skins (but not flesh) of certain fruits including apples and pears. Reaction comprises perioral urticaria and lip and mouth itch, easily managed with antihistamine. Negative on skin prick test to avocado, apple but positive to birch, cypress, olive, rye grass, timothy and cocksfoot grasses.
Can tolerate home grown strawberries but same reaction to strawberries from the supermarket.

QUESTIONS

1. *Is this Oral Allergy Syndrome?*
2. *Why are the skin prick tests negative?*
3. *Should we test the fruit skin as well as flesh as a routine?*
4. *If SPT is not available, what specific IgE testing should could be done?*
5. *Will these reactions disappear in time?*

CASE 2:

14 year old boy Tom, known seasonal allergic rhinitis but otherwise well, felt itchiness in the mouth and throat on consuming watermelon. On one occasion he ingested 3 tablespoons of watermelon and recalled biting a watermelon seed on that occasion. This resulted in wheeze, sensation of throat closing and difficulty speaking for 10 minutes before resolving but no rash, swelling or vomiting. Also reacts to grape, avocado and dates with itchy mouth and throat.
Skin prick tests – Histamine 5mm, grape 11mm, watermelon flesh 0mm, watermelon seed 5mm, date 5mm, avocado 4mm rye grass 20mm olive 5mm birch 1mm

QUESTIONS

1. *Is the seed of the watermelon a significant allergen?*
2. *Do seeds of other fruits trigger allergy?*
3. *If SPT is not available, what specific IgE testing should could be done?*

PRESENTATION 2:

‘Idiopathic’ Anaphylaxis

Paulina Alhucema

CASE 1:

A 10 year old boy Philip, had an episode, 20 minutes after lunch, of feeling tight in his chest, with difficulty breathing, coughing and wheezing and became pale and drowsy. An ambulance officer administered adrenaline which helped significantly. Philip was taken to hospital, observed for 4 hours and discharged fully recovered.
Lunch contained all food ingredient that Philip had previously eaten without reaction. Philip had not been exercising or takings NSAIDs. No previous history of food reactions, asthma, hayfever or eczema.
Referred for assessment of possible “idiopathic anaphylaxis”.

CASE 2:

A 15 year old girl, Tanya, with history of viral induced asthma and allergic rhinitis, had sudden onset of becoming unwell when she was outside in a park with friends. She felt dizzy, weak, became pale, and began coughing and wheezing.
The event occurred 2-3 hours after breakfast where she ate her usual muesli with cow’s milk, toast with vegemite and orange juice.
An ambulance officer administered adrenaline with elimination of symptoms. Tanya then developed an urticarial rash on her face and chest.

QUESTIONS

1. *What elements of the history may assist in determining the cause of these episodes?*
2. *Which investigations may be useful when cause of anaphylaxis is unclear?*
3. *What are the management strategies if a causative trigger cannot be found?*

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ASCIA: Australasian Society of Clinical Immunology and Allergy.

References: 1. Ryaltris Approved Product Information. **2.** ASCIA, Allergic Rhinitis Clinical Update. Available at: allergy.org.au/images/stories/pospapers/ar/ASCIA_HP_ Allergic_Rhinitis_2022.pdf. Accessed July 2024.
3. Data on file. IQVIA™ National Sales Audit, Retail Pharmacy Channel, S4 nasal corticosteroids without anti-infectives (R01A1), Volume and Value for 3 Moving Annual Totals to June 2024.

CSL Seqirus

Cases

PRESENTATION 3:

Common Child Allergy Myths

Prof. Connie Katelaris AM

CASE 1:

17 year old boy Michael presents with a history of a large local reaction to a bee sting 10 years ago. Michael was prescribed an Epipen from the ED and his parents advised the next reaction will likely be anaphylaxis. Michael hasn't been stung since was told he needs and Epipen for life.

QUESTIONS

1. *Has Michael been subject to an evidence-based approach to management?*
2. *How do we manage Michael and are there any tests that can be helpful?*

CASE 2:

2 year old Freddie referred with an episode 8 weeks previously with definite generalised hives for 3 days which returned 2 days later for a 24 hour period. No swelling. No obvious food trigger though grandmother suggested garlic. Parents convinced that changing both the laundry detergent and the shampoo coincided with resolution of the rash. They have brought the original detergent and shampoo for testing and wish to know about low allergy brands and whether this needs to be a life long avoidance ?

QUESTIONS

1. *How common is urticaria*
2. *What is your approach to dispelling common myths?*

CASE 3:

14 year old Linda has several year history of significant nose congestion, eye itch and sneezing fits after waking in the morning but allergy tests are negative to house dust mite, mould and there are no pets in the house. The parents have been told that with negative tests, this scenario cannot be allergy.

QUESTIONS

1. *What is the approach to investigation and management?*

PRESENTATION 4:

Oral Food Challenges

Dr Shruti Swamy

CASE 1:

4-year-old girl Taylor experienced anaphylaxis to 1 teaspoon well-cooked scrambled eggs at 7 month of age requiring adrenaline. Initial SPT egg white 8mm (ssIgE 8KU/l) at 9 months of age when first seen. Tolerated baked egg home challenge following 24 month review when SPT 5mm (ssIgE 2KU/l). Now SPT egg white 3mm. Otherwise well, no asthma. Parents competent and keen to challenge cooked egg?

QUESTIONS

1. *Would you challenge cooked egg yet?*
2. *If so, where – home / vicinity of health service/ medically supervised?*

CASE 2:

13 year old boy Jack with IgE mediated cashew anaphylaxis noted to be sensitized to peanut (SPT 10mm) when first seen at 12 months of age. No exposure to peanut ever.
SPT has dropped to 2mm and Ara H2 0.03 KU/L. But ss IgE very high 31KU/l. Otherwise well, no asthma. Parents competent and keen to challenge peanut.

QUESTIONS

1. *Would you challenge peanut on these results?*
2. *If so, where – home / vicinity of health service/ medically supervised?*

PRESENTATION 4 (PART 2):

Oral Food Challenges - Ballarat Model

Dr Nelu Jayawardena, Mandy Wilson, Lauren Malone and Sarah Baker

Different regions of Australia have different resources, different support structure and differing personnel with a variable skill set Those delivering health services in those regions share a common desire to provide local children with the best service possible for their region. In regional paediatrics, we have much to learn from each other, where a trail has been blazed and how a local team has faced and overcome challenges to deliver a best practice service. Lets hear how Ballarat have done that with Oral Food Challenges!

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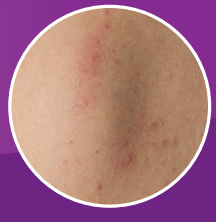
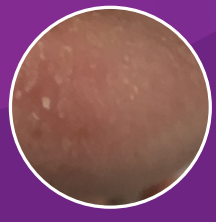


Mild eczema



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1. Spada F, Harrison IP, Barnes TM, Greive KA, Daniles D, Townley J et al. A daily regimen of a ceramides-dominant moisturizing cream and cleanser restores the skin permeability barrier in adults with moderate eczema: a randomized trial. Dermatol Ther 2021 May 13;e14970. **2.** Consumer satisfaction survey on people with mild or moderate eczema. n=48. Participants confirmed condition status through a declaration. Survey conducted by beautyheaven on behalf of Ego Pharmaceuticals Pty Ltd. 2021.

Cases

PRESENTATION 5:

A to Z Management of Allergic Rhinoconjunctivitis

Dr Shruti Swamy

CASE 1:

13 year old girl Eva presents with 5 year history of constant sniffing and nasal congestion, early morning sneezing and frequent nose rubbing. Hates being the snotty girl in class. Tried many brands antihistamine without effect. Nasonex helped but told she should not use not for more than 6 weeks. Pet cat sleeps in her room. On e large soft toy in bed given by grandmother. Symptoms sometimes resolve completely on holiday.

QUESTIONS

1. *What is your approach to investigation and management?*

CASE 2:

8 year old Mark, from mid NSW, presents with severe hay fever – missed 5 days of school last year with swollen eyes and severe eye and nose itch with constant runny nose between October and December. Tried 5 different types of antihistamine with maximum dose according to packet. Has had antihistamine eye drops and Montelukast. Hates nose spray and no allergy blood tests because fear of needles.

QUESTIONS

1. *What is your approach to investigation and management?*

PRESENTATION 6:

Paediatrician/Dietician Allergy Teamwork

Wendy Birks

CASE 1:

3-year-old boy, Harry, with known IgE peanut allergy, has an episode of acute urticaria, lip swelling and vomiting at a birthday party after consuming food that was donated by all parents attending the party. Harry was not being observed when he raided the food table. Harry can tolerate egg, almond, pine nut and sesame. Foods that could have been consumed include Woolworth hummus, homemade honey joys, Nutella in Aldi meringue, Safeway banana bread and home-made baklava.

QUESTIONS

1. *What potential allergens could be contained in these foods?*
2. *How do we determine on history of previous food ingestion whether the trigger may be peanut or another food?*
3. *What is the best approach to empower parents to gain knowledge of foods t o be avoided after an allergen is identified?*

CASE 2:

A 7-month-old baby, Mia, is referred with a history of infant distress with screaming from 3 weeks of age, with frequent 8/day watery green mucousy stools with flecks of blood whilst being breast fed. Had been a 36-week gestation baby who was fed a combination of Nan Supreme and breast milk from birth.

HCP suggested the problem might be a lactose intolerance so at 3 months, mother (Sarah) advised to remove dairy products and complimentary feed with lactose free formula (Aptamil Gold Lactose free). Mia's temperament improved but still with some blood, so soy and wheat removed from mother's diet and stools became formed and temperament improved.

When solids, including eggs, wheat, lactose free yogurt and cheese introduced, the gut and temperament issues returned. Sarah wanted to breast feed until 12 months but is very confused about what she should and should not eat and has searched the internet and found 12 food elimination diets. Sarah is feeling very guilty. Mia is growing well but sleeps poorly waking frequently.

QUESTIONS

1. *Did the formula given in the nursery contribute to Mia's issues?*
2. *Why did the lactose free formula help but relapse of symptoms on lactose free yogurt?*
3. *How do we assist Sara's nutritional state?*

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Efficacy for allergic rhinitis symptom or combined symptom/medication scores); lasting benefits refer to benefits lasting ≥1 year after AIT cessation, as per the EAACI definition of long-term AIT benefits.

References **1.** Klimek *et al.* Allergen immunotherapy in house dust mite-associated allergic rhinitis: efficacy of the 300 IR mite tablet. Allergo J Int (2023) 32:10–17 **2.** Worm M *et al.* Safety of 300IR house dust mite sublingual tablet from pooled clinical trial and post-marketing data. World Allergy Organ J. 2024; 17(7): 100924. **3.** Okamoto *et al.* Efficacy of house dust mite sublingual tablet in the treatment of allergic rhinoconjunctivitis: A randomized trial in a pediatric population. Pediatr Allergy Immunol. 2019;30:66–73. **4.** Klimek *et al.* Update about Oralair® as a treatment for grass pollen allergic rhinitis. Hum Vaccin Immunother. 2022;18(5):2066424. **5.** Didier *et al.* Prolonged efficacy of the 300IR 5-grass pollen tablet up to 2 years after treatment cessation, as measured by a recommended daily combined score. Clini. Transl. Allergy 2015; 5:12 **6.** Keating *et al.* Allergen extract suspension for subcutaneous injection (Alustal®; Phostal®): a guide to its use for allergen-specific immunotherapy. Drugs Ther Perspect 2015; 31, 175–182. **7.** Valero *et al.* Efficacy of subcutaneous house dust mite immunotherapy in patients with moderate to severe allergic rhinitis. Immunotherapy. 2022; 14(9): 683-694. **8.** Sablayrolles *et al.* Grass pollen immunotherapy in children: Any symptoms 3 years after stopping the treatment? [French] Revue française d'allergologie 2012; 52: 311–316 **9.** Roberts *et al.* EAACI Guidelines on Allergen Immunotherapy: Allergic rhinoconjunctivitis. Allergy. 2018;73:765–798.

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Cases

PRESENTATION 7:

Challenging Allergy Cases

Dr Michael Nowotny

CASE 1:

Emily, age 16, presents with a 2-year history of recurrent erythematous rash with possible lower lip swelling, stomach cramps, and a choking sensation previously attributed to anaphylaxis. Suspected triggers include green cabbage, red cabbage, vegetable oil, and chipotle aioli.
Emily presented to ED x 3 with throat tightness, subjective breathing difficulties and nausea. She received adrenaline on two occasions due to her "known" cabbage allergy. She had previously been given adrenaline at home on one of these occasions. Emily's symptoms typically resolve within 45 minutes of taking Loratadine. Recent allergy testing has revealed no sensitisation to these substances.

QUESTIONS

1. *What further history may assist and should we consider to be the differential diagnosis?*
2. *Are there any other investigations that may assist?*
3. *What is your management plan?*

CASE 2:

15 year old girl Zoe, referred to Paediatric Consultant Immunologist and Allergist from experienced Paediatrician allergist with persisting chronic spontaneous urticaria from October 2024, associated abdominal and back pain, very painful feet and hands and allergic rhino-conjunctivitis- ryegrass sensitized. Management with high dose antihistamine and steroids ineffective.

QUESTIONS

1. *When expected control not attained, what should be our next line of investigation?*
2. *What other Differential Diagnoses should be considered?*
3. *What did the Consultant do and what response was there?*

PRESENTATION 8:

Regional Allergy Transition

David Bannister

CASE 1:

18 year old girl (Michelle), Year 12 attends with her mother. Last seen 3 years ago. Problems include:

1. Peanut allergy from 1 year of age, walnut from 2 year
2. Anaphylaxis to cashew at 3 years of age requiring adrenaline and hospitalisation. Has Epipen.

Michelle has avoided all nuts since. No accidental exposures since age 3 years. Asthma from 4 years of age. On ICS preventer. (Flixotide). Still has occasional bouts of asthma triggered by colds. Seasonal hayfever from12-13 years of age controlled with antihistamines and nasal steroids over the pollen season. Eczema for the first two years and still has sensitive skin (dry and itchy) controlled with intermittent topical moisturiser.
Examination. Normal growth. Chest clear. Skin dry but no eczema. Mild swelling of nasal mucosa consistent with rhinitis.
SPT. Histamine 10mg/ml 5mm. Neg control 0 Peanut 15mm Cashew 12mm. Pistachio 14mm. Walnut 10mm. Pecan 8mm. HDM (DF) 10mm. Rye grass 15mm.

QUESTIONS MICHELLE & HER MOTHER ASK

1. *What follow up should she have once she leaves school?*
2. *She wants to go to University and live away from home. How easy is it to get into an adult allergist close to where she will be living?*
3. *What kind of information does she need to take with her?*
4. *Does she still need to continue with the Epipen and who can provide them for her?*
5. *Will she ever grow out of her food allergies?*
6. *We have heard about desensitisation to foods. Can she be desensitised in the future?*

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REFERENCES: 1. Gold et al. 2022 Nutrients May 30;14(11):229. **2.** Vandenplas et al. 2022. Nutrients. Jan 26;14(3):530. **3.** Puccio, G. et al. JPGN 2017; 64: 624–631. **4.** Berger, B. et al. 2020; 11(2): e03196-19.

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References: 1. Slenyto Product Information. **2.** Gringras et al. J Am Acad Child Adolesc Psychiatry 2017; 56(11): 948-957. **3.** Maras et al. J Child Adolesc Psychopharmacology 2018; 28 (10);699-710. **4.** Schroder, et al. J Autism Devel Disorders 2019; 49:3218-3230.

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