Anaphylaxis Canada

Helping people live with deadly allergies

October 22, 2009

Ms. Maryam Sanati
Editor-in-chief
Chatelaine
Rogers Media Inc.
One Mount Pleasant Road
Toronto, Ontario
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Dear Ms. Sanati,

Re: The facts about food allergy

As the Executive Director and Medical Advisor of Anaphylaxis Canada, we are writing on behalf of the organization in response to an article published in the December 2009 issue of your magazine entitled, "It's just nuts", by Ms. Patricia Pearson.

Anaphylaxis Canada is a national, non-profit group advocating for individuals with severe allergies and their families. Approximately 1.2 million Canadians suffer from food allergies, the most common cause of anaphylaxis.

Our organization advocates for a balanced approach to keeping at-risk individuals, especially children, safe. This approach is focused on community engagement, understanding, and respect. We recognize individual schools and communities must find their own practical strategies – what works in one may not work in another. We believe that everyone's interests are best served when measures that lessen the risk of an allergic reaction are adopted in a climate of compassion and cooperation, not fear or confrontation.

At the suggestion of your researcher, Ms. Megan Griffith-Greene, we have prepared a detailed response to what we believe is misconstrued, poorly supported, or simply incorrect information.

But let us be clear: Our primary concerns with this article are its overall insensitivity in tone (both words and the main photograph), its use of disingenuous comparisons, and the inclusion of selective research minus any relevant context.

Some highlights of our specific concerns include the following:

Advancing the myth of "fear"

- While there are gaps in understanding about food allergy, we do not believe that "parents and schools are cowering in fear of the tiny peanut" as the author states. Further, we do not have evidence of widespread fear reported by our parent groups or school boards from across the country. The fact is there are approximately 15,000 publicly funded schools plus thousands of private schools, camps, and child care centres which are working hard to keep kids safe, and doing so very effectively.

- There is no mention of an attempt by the writer to speak with school principals, teachers, or parents (with and without children with food allergies) who have to live with school food policies. Their perspectives would have provided context around why school communities have adopted certain policies, given the realities of their environments.

- Despite our colleague Beatrice Povolo mentioning the importance of Sabrina's Law, Ms. Pearson does not reference it. The law, the first of its kind worldwide, groundbreaking for Ontario schools, is grounded in the implementation of reasonable solutions to ensure that students at risk are identified and staff is trained to recognize and respond to an allergic reaction. Ontario's legislation has inspired other provinces to act with their own balanced policies aimed at keeping kids safe.

A failure to put peanut allergy into perspective

We agree that there is heightened awareness around peanut allergy and that, collectively, more needs to be done to increase understanding of peanut and other food allergies. Schools and other communities need to work with parents to find ways to reduce the risk to children with other food allergies – such as milk, egg, and sesame – to name a few. Still, there are more than 90,000 students with peanut allergy in the Canadian school system (based on a 1.6% estimate of school-aged children) and this is not an insignificant number.

- The author wonders "why, exactly does the tiny peanut loom so large a threat?", yet fails to provide facts commonly found in several peer-reviewed medical journals including findings from a review she referenced by world-renowned allergists, Drs. Sampson and Sicherer:
  - Peanut allergy is typically lifelong, often severe, and potentially fatal.
  - Because reactions can occur from small amounts of peanuts, the allergy presents patients with significant obstacles to avoid allergic reactions.
  - In North America and the UK, prevalence rates among schoolchildren are now in excess of 1%, framing an increasing public health concern.
  - Fatalities: food anaphylaxis fatality registries in the US implicate peanut as a trigger for 59% of 63 deaths.
  - Currently the only proven therapy for the treatment of peanut allergy and food allergy in general is strict avoidance of the peanut-containing foods and education of patients to recognize and treat allergic reactions caused by accidental exposure.

- Citing results of studies on casual contact with peanut, which were meant to alleviate parental concern about the smell of or skin contact with peanut butter, the author notes that unless peanut allergic kids are "licking the desk" peanut residue should not be a problem for them. What she did not include were the researchers' comments that exposure can result from a transfer of an allergenic substance from hand to mouth. As quoted from the article:
  "These results should help allay some of the concern families may have about inadvertent casual exposure to peanut, particularly when no peanut is visible on the surfaces, but the results do not indicate a change in approach to management of peanut allergy in schools with regard to care about transfer of peanut to the mouth of young children. In addition, inadvertent exposure can occur from innocent oral exposure such as through shared utensils, straws or kissing."

- The use of the gun analogy – "a peanut butter sandwich is like a loaded gun" – is most unhelpful to those who are trying to foster a reasoned discussion on food allergies. Demonizing an allergen, whether peanut or any other food, is counterproductive to teaching children to learn to be careful, not fearful of food allergens.

- The author minimizes the risk of a life-threatening reaction by focusing on hyperbolic examples (such as the bus incident highlighted in the article by Dr. Christakis) and dismissing the very real challenges faced by families of children with severe food allergies. For anyone who has watched a child struggle for life's breath after eating something to which they were allergic, particularly a parent, the incentive to avoid re-living that experience can be overwhelming. It can also create heightened concern for those who are tasked with their care. However, identifying the most extreme reaction is out of context to how the vast majority of Canadian families manage their children's allergies.

- The author's poorly chosen comparison of death by lightning strikes vs. death from peanut fails to recognize an important distinction: there are steps that people can take to avoid being caught outside in lightning and reduce their risk of being struck. Also, unlike avoiding lightning storms, eating is a daily necessity.

Incomplete and inadequate research

The article states that the author "dove" into the research for this article. Regrettably it was a shallow dive.

- On food allergy prevalence – the article dismisses increasing food allergy prevalence as a "claim". It is, in reality, a fact. Her reference to 'the blind leading the blind' in relation to the so-called lack of prevalence information is offensive and ignores the published studies on prevalence in the peer-reviewed scientific literature. The studies that are cited in the article all conclude that the current prevalence of peanut allergy is between 1-2% of children, including those quoted by Dr. Hugh Sampson (Mount Sinai Hospital, New York), and Dr. Ann Clarke (McGill University). In fact, Dr. Clarke's prevalence study, based on rigorous diagnostics, reported a higher percentage of children with peanut allergy in Canada (1.6%) compared to the US (0.8%).

- On number of fatalities – the author misquoted the study which is available on our website entitled "A study of 32 Food-Induced Anaphylaxis Deaths in Ontario; 1986-2000". The author states that there were no allergy related deaths in schools or camps from 1984-2000, which is incorrect. The study specifically notes that there were no reports of death in an Ontario schools or camps after 1994.

Unclear explanations about allergy testing and oral immunotherapy

- The author implies that heightened awareness about peanut allergy has resulted in more allergy tests being performed, some of which have resulted in false positives. She also implies that without a history, the results of these tests are hard to interpret. While there may be some truth to the above, it reinforces the point that skin testing should not be carried out in people with no history. The exception may be a sibling of a food-allergic child prior to the introduction of a specific food.

- In regards to oral food challenges, it is not necessary to feed a person the food in question to confirm an allergy if they have had a clinical history (an allergic reaction), and a positive skin prick test. These are generally sufficient for an allergist to confirm a diagnosis. The routine use of oral food challenges to confirm diagnosis is both risky and unnecessary. They may be used to confirm a diagnosis which is unclear or to assess whether a person has outgrown an allergy, and then, only under strict medical supervision.

- In her closing comments, the author points to Oral Immunotherapy as a "dizzying about-face from the traditional view that infants and young children should be kept firmly away from foods they might be sensitive to." She goes on to refer to a limited study which showed that peanut allergy was much

lower in Israel, a country where young children are fed a peanut snack from infancy, compared with a population of Jewish children with peanut allergy in the UK, whose families had strictly avoided feeding them peanut. It is important to note that these studies address two different issues.

In Oral Immunotherapy (OIT) studies, children with known peanut allergy are being fed small amounts of peanut (under strict medical supervision) to desensitize them, a practice which aims to retrain the immune system from reacting. While the results of some OIT studies provide hope, the numbers of subjects are very small and researchers all warn that these are early days. This long and laborious OIT process, coupled with adverse reactions, is not the equivalent of haphazard food exposure in the food-allergic person. The standard of care is still to avoid the allergenic food.

In contrast, the study which compares the prevalence of peanut allergy in Israeli children vs. UK children highlights the question as to whether early exposure to an allergen such as peanut may be beneficial in developing tolerance to peanut. It addresses the question of how we might prevent allergy from developing in the first place, a different situation than treating the food allergic. Researchers acknowledge this may be just one of several factors which contribute to the development of food allergy, and more definitive studies are ongoing.

Conclusion

The portrait of anaphylaxis management in schools painted by Ms. Pearson is simply not the reality being experienced in schools or communities across the country. The fact is this should be a positive news story. Most families understand the risks, take the necessary precautions and work together with other members of the community to keep people safe.

Anaphylaxis Canada extends an open invitation to you and your colleagues at Chatelaine to meet with us to discuss not only the specific issues raised in your article and this letter but to provide you with a more complete overview of how communities are successfully managing food allergies – including the latest research in this area. It is our conviction that balanced and respectful dialogue is a key element in efforts to safely manage food allergies.

We sincerely look forward to opening this dialogue with your magazine. It is in all our interests to keep food allergic individuals safe.

Regards,

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