

## Food allergy frequently asked questions (FAQs)

The following frequently asked questions (FAQ) and answers about food allergy are based on inquiries that have been received by the Australasian Society of Clinical Immunology and Allergy (ASCIA) since 1999. This document is regularly updated as new questions are received or new information becomes available.

### Why is food allergy increasing?

We currently do not understand why food allergy has increased so rapidly in recent years, particularly in young children. It appears to be a complex interplay between a western lifestyle and environment and a genetic predisposition with no single one trigger factor.

Proposed explanations include:

- Hygiene hypothesis, which proposes that less exposure to infections in early childhood, is associated with an increased risk of allergy. A more recent version of the hygiene hypothesis proposes that the make-up and type of the micro-organisms to which the mother, baby and infant is exposed and colonised with may alter allergic risk.
- Delayed introduction of allergenic foods such as egg, peanut or tree nuts.
- Methods of food processing, such as roasted versus boiled peanuts.
- Development of allergy to food by skin exposure such as the use of unrefined nut oil based moisturisers.

These areas require additional research studies, several of which are underway.

### Does food allergy run in the family?

Many children with food allergy will have a parent or a sibling who suffers from some type of allergic disease (eczema, asthma, hay fever, food allergy). Most of the time, children with food allergy do not have parents with food allergy. However, if a family has one child with food allergy, their brothers and sisters are at a slightly higher risk of having food allergy themselves, although that risk is still relatively low.

Some parents may want to have their other children tested for food allergy. If the allergy tests are negative, that may be reassuring, but this does not mean that the other child will never develop an allergy in the future. If any of their allergy tests are positive, it is not always clear whether it definitely represents allergy. In this situation, a food challenge (under medical supervision) may be required to confirm allergy. Screening of siblings for food allergy is generally not recommended.

### If I have a positive allergy test, does this mean I am allergic to the food/s?

It is important to know that a positive skin prick allergy test or allergy blood test means that the body's immune system has produced a response to a food, but does not mean that the person is necessarily allergic to that food. Approximately 1 in 3 of people with positive allergy tests to foods will not be allergic, especially if they have not previously experienced an allergic reaction to that same food when eating it. For this reason, it is not generally recommended to screen people for allergies to foods using these tests and it is important to confirm the significance of a positive allergy test (in some circumstances) with a medically supervised food challenge. In a child with a positive test of uncertain meaning, this is often done under medical supervision. Interpretation of test results (and whether challenge should be undertaken) should be discussed with your medical practitioner.

**Does cooking the food remove the allergen?**

Cooking may reduce the allergic potential in some foods (e.g. baked egg, baked milk), however this is highly variable. The decision to give an individual (usually a child) a food containing a cooked food allergen (e.g. baked egg or baked milk in a muffin or biscuit) should be made by your child's clinical immunology/allergy specialist. If a specialist thinks an individual is likely to tolerate baked milk or egg, the individual will usually have an oral food challenge. Oral food challenges may be done in a hospital setting where medical assistance and facilities are available, as severe reactions can, and do, occur.

Whilst there are exceptions for some individuals with particular food allergies (e.g. raw versus cooked vegetables and fish allergy versus canned tuna), most individuals who are allergic to food products cannot eat them whether they are in cooked or uncooked form, unless advised otherwise by their treating specialist.

**Can food allergies be prevented?**

Information about allergy prevention is available on the ASCIA website:  
[www.allergy.org.au/patients/allergy-prevention](http://www.allergy.org.au/patients/allergy-prevention)

**Are there any foods I should avoid feeding my child when solids are introduced?**

ASCIA recommends the introduction of complementary "solid" foods around 6 months but not before 4 months of age and preferably whilst breastfeeding. There is some evidence that breast feeding is protective against the development of allergic disease.

It is important to note that infants differ in the age that they are developmentally ready for complementary "solid" foods. When your infant is ready, introduce foods according to what the family usually eats, regardless of whether the food is considered to be a common food allergen. Raw egg is not recommended.

Cow's milk or soy milk (or their products, such as cheese and yoghurt) can be used in cooking or with other foods if dairy products/soy are tolerated.

There is good evidence that for infants with severe eczema and/or egg allergy, regular peanut intake before 12 months of age can reduce the risk of developing peanut allergy. If your child already has an egg allergy or other food allergies or severe eczema, you should discuss how to do this with your doctor.

**Some infants will develop food allergies. If there is any allergic reaction to any food, that food should be stopped and you should seek advice from a doctor with experience in food allergy.**

In children with confirmed cow's milk and soy allergy, appropriate formula is available on prescription from your doctor. Any dietary restrictions or modifications should be discussed and supervised by your doctor, who may also recommend you see a dietitian.

**If I can't breastfeed, which formula is useful in preventing allergies?**

If an infant is not breastfed or is partially breastfed, commercial infant **formula** should be used until 12 months of age.

Based on a recently published review of studies, there is no consistent convincing evidence to support a protective role for partially hydrolysed formulas (usually labelled 'HA' or Hypoallergenic) or extensively hydrolysed formulas for the **prevention** of eczema, food allergy, asthma or allergic rhinitis in infants or children.

**Is soy milk or goat's milk better at preventing allergies in my child than cow's milk formula?**

No. Studies have shown that the use of soy milk or goat's milk formula does not prevent the development of allergies in children. Regular cow's, goat's milk (or other mammal derived milks), soy milk, nut and cereal beverages are *not recommended* for infants as the main source of milk before 12 months of age.

**If I am allergic to cow's milk, can I use goat's or sheep's milk?**

Most people allergic to cow's milk protein will also react to similar proteins in goat's and sheep's milk and milk from other animals. You should discuss the use of other mammalian milks with your medical practitioner.

**Are some formulae unsuitable for children with cow's milk allergy?**

Yes. Children allergic to cow's milk are usually allergic to a number of proteins present in dairy products. Since similar proteins are present in other animal milks such as goat milk and horse milk, these products can also trigger allergic reactions, and should be avoided. So-called "A2 milk" (from specially bred cows) is claimed to have a number of health promoting properties, but is also unsuitable for cow's milk allergic children. Partially hydrolysed cow's milk based formula is also **not** suitable to be used as treatment for cow's milk allergic children.

**Are all reactions to milk due to allergy?**

No. Lactose intolerance is caused by the lack of the enzyme lactase, which helps to digest the milk sugar lactose. The symptoms are diarrhoea, vomiting, stomach pain and gas, which are similar to some of the symptoms of milk allergy. This condition is uncomfortable but not dangerous, and does not cause symptoms of food allergy such as hives, swelling or anaphylaxis. In lactose intolerance, small amounts of cow's milk are usually tolerated, and yogurts and hard cheeses are usually better tolerated than milk, as they contain less or easier to digest lactose than cow's milk. Treatment may involve reducing or avoiding consumption of dairy products containing lactose and substituting these with a lactose free formula or milk.

**Is immunotherapy (or desensitisation) available for food allergy?**

Whilst there are some food allergen desensitisation research studies occurring in Australia, food allergen immunotherapy remains in the realm of ongoing research at this time.

**Are all food allergies severe?**

No. Fortunately, the majority of food allergies are not dangerous. Mild symptoms include hives, sickness in the stomach or vomiting. However, symptoms such as difficulty breathing due to throat swelling or asthma, or dizziness due to a drop in blood pressure, indicate a potentially life threatening severe allergic reaction (anaphylaxis).

**Does having an allergy to one meat mean I will be allergic to all meats?**

Meat is a major source of protein in Western diets, and allergic reactions to beef and chicken are rare food allergies but the most common of meat allergies. Recent studies suggest that individuals allergic to one meat

may have sensitivities to similar allergens present in multiple mammalian meats. You should discuss the need to avoid all meats with your medical practitioner.

### Are allergic reactions to inhaled foods common?

No. Allergic reactions to food in the form of fine dust are uncommon. Most food proteins are quite heavy and do not easily disperse as aerosols. Food handlers may suffer from these reactions, including soy beans in processing plants, seafood allergens in some factories and wheat dust in bakeries. Foods which are more likely to cause a reaction in the home environment on allergic people include steam from cooking seafood and dried egg powder. Sometimes people with severe food allergies find that even the smell of foods can trigger symptoms. Fortunately, this is a relatively rare complaint and symptoms are almost never dangerous or severe.

### If I am allergic to peanuts or tree nuts, will I also be allergic to coconut?

Allergic reactions to peanut and tree nuts are relatively common, estimated to occur currently in around 1/100 infants and 1/200 to 1/500 adults. By contrast, allergic reactions to coconut are relatively rare. Some people with coconut allergy do have allergic to tree nuts like walnut and hazelnut. Others are allergic only to coconut only.

### Should schools and childcare services ban foods?

Avoiding known allergens is the basis of food allergy and anaphylaxis management. A range of risk minimisation strategies should be implemented and these will vary depending on whether it is a school or childcare service, possible routes of exposure to known allergens and the age of the child.

Blanket food bans are not recommended by ASCIA, although restricting some important food allergens (such as nuts) may have a place in reducing the risk of accidental exposure in very young children who are too young to be relied upon to avoid contact with potential allergic triggers themselves, either by ingestion or cross contamination of equipment like toys or play services.

Blanket food bans or attempts to totally eliminate food allergens in schools and childcare are **not** recommended by ASCIA for the following reasons:

- It is not possible to guarantee complete removal of an allergen such as peanuts from the school community, regardless of policies to do so.
- Blanket food bans may give parents/carers and allergic individuals a false sense of security, assuming that the school or childcare is 'nut free' for example.
- Children can be at risk of anaphylaxis from many foods, insect stings or bites. Therefore, it is not possible, nor practical to ban all food or insect allergens from a school or childcare service.
- It is more important for schools and childcare services to implement a range of age appropriate risk minimisation strategies and consider children with severe allergies when planning activities. This may also include asking that nut products, for example, are not sent to school in lunch boxes for young children in childcare, pre-school and early primary school. This is not the same as banning the food. Not using some foods in cooking classes or science experiments or not using some allergens in foods supplied by preschools are other issues to consider.

ASCIA guidelines for prevention of anaphylaxis in schools, pre-schools and childcare were recently published in the Journal of Paediatrics and Child Health and are available from the ASCIA website:

[www.allergy.org.au/health-professionals/papers/prevent-anaphylaxis-in-schools-childcare](http://www.allergy.org.au/health-professionals/papers/prevent-anaphylaxis-in-schools-childcare)

**Can I use a hand sanitiser to remove a food allergen from my hands?**

When it comes to allergen avoidance or minimisation, the aim of hand washing is to remove allergens rather than disinfect. Soap and water are ideal, but if they are unavailable hand sanitiser wipes may be used. Liquid sanitiser (not wipes) that is not rinsed off is not recommended.

**What is Pollen Food Syndrome?**

About 1 in 10 people with allergies to some grass or tree pollens will complain that some uncooked vegetables or fresh fruits and nuts will make their mouth and throat itchy or swell. This is known as Pollen Food Syndrome (also known as Oral Allergy Syndrome). In this condition, people are allergic to proteins that are present in pollens as well as these foods. Usually the allergy to the pollens predates the food allergy symptoms. If the food is heated, the protein is often destroyed, as the cross reactive proteins in pollens and food are often quite fragile. This is why many people with PFS can eat the cooked food without a problem. It is rare to have serious allergic reactions in PFS, but some foods which commonly cause PFS can also cause normal food allergy and can give rise to anaphylaxis. It is important that your doctor confirms what type of food allergy you or your child suffers from.

**Further information**

[www.allergy.org.au/patients/food-allergy](http://www.allergy.org.au/patients/food-allergy)  
[www.allergy.org.au/health-professionals/anaphylaxis-resources](http://www.allergy.org.au/health-professionals/anaphylaxis-resources)

Patient support organisations:

Allergy & Anaphylaxis Australia [www.allergyfacts.org.au](http://www.allergyfacts.org.au)  
Allergy New Zealand [www.allergy.org.nz](http://www.allergy.org.nz)

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Website: [www.allergy.org.au](http://www.allergy.org.au)  
Email: [info@allergy.org.au](mailto:info@allergy.org.au)  
Postal address: PO Box 450 Balgowlah NSW 2093 Australia

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