The UK’s phobia of allergen immunotherapy

In the UK, desensitisation is seen as a last resort in allergy treatment. This is despite us having the unenviable status as one of the most allergic nations in the world, with one in five children presenting with symptoms of allergic rhinitis, compared with one in eight children around the globe.1

On page 13, Lizanne Noronha et al. report on our approach to the management of allergic rhinitis in children and its detrimental impact on quality of life factors, especially education. For most, oral non-sedating antihistamines and nasal steroids are simple and effective treatments, yet for a significant minority the problems will persist and allergen immunotherapy, also known as desensitisation, should be considered.

“Allergen immunotherapy is a proven, safe treatment that is underutilised in the UK, particularly compared with our European counterparts,” say the authors, with 250 children currently desensitised in France for every one child desensitised in the UK. Often it is “only undertaken at a limited number of specialist centres…[so patients] may have to travel considerable distances to the nearest centre.”

So why the disparity? Desensitisation is not a new therapy, and considering the UK’s current resistance it is ironic that it was first used in 1911 at St Mary’s Hospital in Paddington, London. During the 1950s and 1960s, it was not unusual for patients presenting with symptoms of allergy to be given a subcutaneous allergen injection, but between 1957 and 1986, 26 deaths were recorded in the UK due to anaphylaxis and bronchospasm, usually because the patient had unstable asthma or was not monitored for sufficient time post-injection.

Since then, desensitisation has almost shuddered to a halt in the UK, while other nations have adapted and refined it so that it is now a safe and effective treatment that recently celebrated the milestone of achieving one billion sublingual courses given worldwide with no fatal reactions.2

Today, allergen immunotherapy is available as a three-year course either with subcutaneous injections or sublingually as tablets or sprays, and has been demonstrated to result in a long-term reduction in symptoms of allergic rhinitis. Treatment is now conducted under standardised protocols that carefully monitor patients and restrict its use in those who exhibit signs of unstable asthma. Side-effects are short-term and localised, mostly restricted to urticaria around the area of administration.

With recent headlines proclaiming that the ‘Holy Grail’ of allergy cures could soon be within reach3 after experiments involving genetic modification in mice to desensitise the immune system, perhaps allergen immunotherapy will also become outdated. Until this next generation of medicine is even considered though, surely it is time that the UK finally sheds its chequered past with desensitisation and catches up with the rest of the world?

References

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