9%, respectively). IgE to soy was detected in only 2 infants with an adverse reaction to soy. Adverse reactions to soy formula were more common in younger (<6 months) than in older (6–12 months) infants (5 of 20 vs 3 of 60, respectively; *P = .01*).

**Conclusions.** Soy formula was well-tolerated by most infants with IgE associated and non–IgE-associated cow’s milk allergy. Development of IgE-associated allergy to soy was rare. Soy formula can be recommended as a first-choice alternative for infants ≥6 months of age with cow’s milk allergy.

**Reviewer’s Comments.** This is a very useful clinical investigation with practical applications. The study data demonstrate that only 10% of infants with cow’s milk allergy have any kind of adverse reaction after the ingestion of soy formula. Moreover, severe allergic reactions or development of IgE-mediated allergy to soy was found to be very uncommon in infants with cow’s milk allergy. This investigation is a nice corollary to a previous publication by Zeiger et al (J Pediatr. 1999;134:614–622.) that found the prevalence of soy allergy in children with IgE-mediated cow’s milk allergy to be 14%. Cow’s milk allergy affects approximately 2.5% of infants with possible alternative including soy formula, extensively hydrolyzed protein formula, and amino acid formulas. Of these choices, soy formulas provide the most affordable and palatable choice while meeting the nutritional needs of these infants.

**John James, MD**
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**THE IMPACT OF CHILDHOOD FOOD ALLERGY ON QUALITY OF LIFE**


**Purpose of the Study.** Food allergy affects 6% to 8% of children. Many patients and their families live in constant vigilance and fear, which can potentially impact their daily life activities. This study evaluates the impact of food allergy on quality of life.

**Study Population.** Two hundred fifty-three parents of children with food allergy who are members of the Food Allergy and Anaphylaxis Network (Food Allergy Network) participated in answering the Children’s Health Questionnaire (CHQ-FP50) self-administered questionnaire. The mean age of the food allergic children was 10.8 years (range: 5–18 years). Fifty-nine percent were male; 68% were allergic to 1 or 2 foods; 32% were allergic to 2 or more foods; 13% had atopic dermatitis; and 33% had asthma.

**Methods.** The CHQ-FP50 questionnaire is a generic health status tool used to gauge pediatric health-related quality of life from the parent’s perspective. The questionnaires, along with an introductory letter and additional demographic questions, were sent to a random sample of 400 FAAN members, of which 253 (63%) responded.

**Results.** Ninety-three percent of the returned forms were completed by the mothers of the food-allergic child and 7% were completed by the fathers. Scores from the questionnaire were compared with the general US population (control). Four areas were found to show significant differences from the general public: general behavior, parental impact-emotional, family activities, and family cohesion. Among the food-allergic group, the first 3 areas mentioned above showed a decrease in the food-allergic population and the latter area showed an increase. Scores were in general lower for those with >1 food allergy and also in those with other atopic diseases. The lowest scores were found among those with food allergy in conjunction with atopic dermatitis and asthma.

**Conclusions.** Although additional food allergies and co-morbid conditions further compound the impact on quality of life in regard to general health, they did not demonstrate much impact in areas of physical functioning, emotional/behavioral problems, or self-esteem and actually found higher scores in the area of family cohesion.

**Reviewer’s Comments.** As the author mentions, there may have been a bias in sampling because the study recruited families who were members of the FAAN. The bias is stated to be toward recruiting more severely allergic children. However, this bias also may be the reason why the other areas did not show a significant difference because members of the FAAN may benefit from receiving education and support. This study brings home the point that food allergy does impact quality of life for the food-allergic child and family.

**Sally F. Joo, MD**
Robert A. Wood, MD
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**NUT ALLERGY IN SCHOOLCHILDREN: A SURVEY OF SCHOOLS IN THE SEVERN NHS TRUST**

**Watura JC. Arch Dis Child. 2002;86:240–244**

**Purpose of the Study.** Peanut and tree nut allergy can be fatal. Many such reactions occur in school settings. How prepared are the schools to deal with these reactions?

**Study Population.** Primary and secondary schools attended by 21,868 children in the United Kingdom.

**Methods.** Questionnaire.

**Results.** The total number of nut-allergic children in all the schools was 87 (0.4%). Fifty-four percent of schools had at least 1 nut-allergic child. Only 31 (36%) children had medication available in school. Forty-four percent of schools with at least 1 nut-allergic child had no staff trained to administer medication. Thirty-three percent of schools with at least 1 nut-allergic child could not state a single sign of a severe acute allergic reaction.

**Conclusions.** Schools are not sufficiently well-informed about nut allergy and management of acute allergic reactions.

**Reviewer’s Comments.** Because severe and even fatal food allergy reactions often occur at school, we need to better educate schools on how to be prepared for and deal with the reactions. Injectable epinephrine needs to be immediately available. School staff members need to be able to recognize the early signs and symptoms of anaphylaxis, and know how to administer epinephrine and activate emergency medical services.

**John M. Kelso, MD**
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**HOW DANGEROUS IS FOOD ALLERGY IN CHILDHOOD? THE INCIDENCE OF SEvere AND FATAL ALLERGIC REACTIONS ACROSS THE UNITED KINGDOM AND IRELAND**


**Purpose of the Study.** To evaluate the incidence of fatal and severe allergic reactions to foods in a large population of children.

**Study Population.** A retrospective search for fatalities in children 0 to 15 years old from March 1990–February 1998.
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Pediatrics 2003;112;459

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