THE magnitude of the problem of allergic disease in children was brought out by the U.S. National Health Survey,\(^1\) which showed that 32.8% of children less than 17 years of age with chronic illness had an allergic disease. The purpose of this statement is to discuss the relationship between the child's primary physician and the pediatric allergist to help bring adequate care to the child with allergies.

Children may be referred to or consult an allergist for various reasons: (1) An allergic survey may be necessary because earlier efforts failed to control allergic symptoms or because an allergy may be involved in recurring otitis, sinusitis, bronchitis, pneumonia, or other infections. (2) The child's physician may feel that desensitization is necessary, but he may not have the time, expertise, or the inclination to treat the child. (3) The parents may recognize what they believe to be an allergic problem or they may feel that prior management has not brought satisfactory relief; therefore, they may seek advice and therapy on their own.

The goal of treatment of the child with allergy is to provide effective relief of symptoms and prevent the development of complications. An early comprehensive study of a child with allergy can be a prophylactic measure. Children should never be expected to "outgrow" their allergic symptoms. Some children appear to outgrow them; but, chronic sinusitis, bronchitis, or emphysema may develop later. Buffum urged, "When asthma begins, get it under control quickly. Patients treated early do better."

Not every child with allergy needs to be seen by an allergist. Most can be adequately managed by the physician who will take the time—and it may require considerable time and effort—to teach the child and his parents about allergy in general, how to use the various methods of avoidance of allergens, and how to employ good symptomatic therapy.

What should the relationship be between the pediatrician and the allergist? The principal function of the pediatric allergist is to assist the referring physician in the management of allergic problems. This relationship is most likely to succeed when the two physicians establish adequate communication and fully understand each other's philosophy. They should agree on how to help the child lead a normal life by avoiding excessive dietary restrictions, insuring full activity, and improving physical fitness. They should discuss views on pets, multiple causes of allergy, significance of negative and positive skin tests, and the occasional need for a team approach with a chest physician, dermatologist, otolaryngologist, or psychiatrist. They should consult as often as the child's condition warrants. The procedures of some allergists are not acceptable to all pediatricians, and vice versa. If the pediatrician and the pediatric allergist come to know each other well and are frank in discussions of their respective views and needs, there should be no barrier to excellent cooperation in an atmosphere of mutual respect.

What does the pediatric allergist expect of the pediatrician? He will be helped by records which indicate: (1) The allergic disease or episodes, their severity, date, and possible causes (Table 1). (2) The occurrence of other illnesses, injections, medications, and reactions to drugs. (3) The names of all drugs prescribed by the pediatrician and when they were used. (4) The dates and amounts of injections of extracts, with any immediate or delayed reactions.

If the pediatrician feels he cannot main-
tain these records, then a simple record should be kept by the parent (Fig. 1).

The pediatrician should know what to expect of allergy management in respect to: (1) treatment of asthmatic attacks; (2) treatment of acute anaphylactic reactions; (3) length of treatment; (4) results of treatment; (5) proper use of measures that employ avoidance of common allergens such as dust, molds, dogs, cats, birds, pollutants, chilling, odors, fumes, and so forth; (6) a good knowledge of drugs useful in childhood allergy; and (7) indications for referral.

What should the pediatrician expect of the allergist?

The referring physician should receive from the allergist a resume of the salient points of the allergy history, results of the skin tests and other investigations, and recommendations made to the parents about both symptomatic and specific treatment. Such a report should be sent to the child's physician even if he did not refer the patient.

It is the duty of the allergist to provide the physician administering injections with a schedule on which the dates and amounts of injections and any reactions are recorded. Many physicians note only whether or not the child had an adverse reaction to the injections. Although this information is important, there should be a place on the treatment record to note other information necessary for the patient's periodic reevaluation by the allergist. It is important at the time of each injection to make notations about how the patient is getting along, medication or other injections the patient is receiving, and any intercurrent disorders. In particular, adverse reactions to drugs should be noted. If the child has an exacerbation of his allergy, notes about the possible cause may often be vital. The physician, by asking leading questions, teaches the parents what to look for as a possible cause of the allergy. Some of these allergens, with particular reference to asthma, are noted in Table I.

If desensitization by injections is to be administered, the allergist should recommend that the child's physician give them. However, the parents may prefer to have the allergist do this. This slightly uncomfortable situation may be eased, or avoided, if the pediatrician tells the parents ahead of time that he can give the injections if they are recommended.

There is no reason why desensitization cannot be given by the child's physician, and several reasons why it should be. The number of physicians the child must visit is reduced and continuity of care is provided. If the child's physician is responsible for

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**TABLE I**

<table>
<thead>
<tr>
<th>Trigger Source</th>
<th>Source of Allergic Reactivity</th>
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<tbody>
<tr>
<td>Infection</td>
<td>Coryza; other respiratory infections, usually undifferentiated clinically.</td>
</tr>
<tr>
<td>Epidermoids</td>
<td>Play with animals; visits to zoo, circus, or farm; sleeping away from home with feather pillows or wool blankets.</td>
</tr>
<tr>
<td>Dusts</td>
<td>Vacuum cleaner, attic, chicken coop, crawling under bed, wrestling on floor or gym mat, dusty books, feed mill, grain mill, eraser dust, construction dust.</td>
</tr>
<tr>
<td>Foods</td>
<td>Failure to follow diet; eating away from home at restaurant or birthday party; gift of playmate or neighbor.</td>
</tr>
<tr>
<td>Pollens</td>
<td>Automobile rides into country; mowing lawn; exposure to flowers with antigenic pollen, especially those related (goldenrod, chrysanthemum, and so forth).</td>
</tr>
<tr>
<td>Odors</td>
<td>Paint, smoke, perfume, flowers, moth balls, chemicals, burning leaves.</td>
</tr>
<tr>
<td>Stresses</td>
<td>Conflicts in school, within family, with friends; visit to physician or dentist; illness or death in family or among friends; death or injury of pet.</td>
</tr>
<tr>
<td>Miscellaneous (primary and secondary factors)</td>
<td>Reaction to desensitization injections; active exercise after injections; wet feet, caught in rain, improper drying after shower, chlorinated pool, bare head and legs in cold weather, chilling fog, dampness, drafts, air conditioning, falling barometer, exertion; hay rides, playing in hay, playing in barns, dried leaves, excitement, fatigue, drug reactions, Christmas trees, and menses.</td>
</tr>
</tbody>
</table>
these treatments, his interest in the study of allergic disease will be stimulated and his experience and competence in this field will be increased.

The relationship described here is ideal, but it is not often achieved. In a study of 200 successive patients to whom injections were given by the referring physician, aede-
Adequate records were kept and made available to the allergist for only slightly more than half the patients. Because the records were incomplete, many patients failed to receive full benefit from the allergic study, particularly when they reported for periodic reevaluation by the allergist. Visits to the allergist for reevaluation should be at least yearly, and more often if necessary. The allergist should have a copy of the medical record available to him for each of these visits, and he should send the child’s physician a copy of his comments and recommendations.

The parents must know the names of any medications prescribed, and the druggist should be instructed to indicate names on the label. A recent study indicates that the importance of this labeling must be stressed to the druggist, and that parents must insist on adequate labeling. It is particularly important for parents to know the names of all drugs to which the patient reacts adversely and to feel free to remind the prescribing physician of these reactions.

There is far more to proper treatment by desensitization than blindly following the instructions, however explicit these instructions may be. The physician must use a certain amount of independent judgment, and he or his nurse must show a personal interest in the child at the time of each injection.

Ideally, the injections should be given by the child’s physician or the allergist. However, this is often impractical and may add to the expense of the treatments; therefore, a nurse or another allied health worker may be designated to do this task. In such instances, the person selected should be experienced in giving injections to children, and the physician should review the child’s allergy record and specific instructions with them before treatment is begun.

Some common errors made by those giving desensitizing injections are:

1. Failure to study the recommendations made by the allergist in detail.
2. Failure to distinguish between asthmatic attacks which occur fortuitously and those which result from too large a dose of allergen.
3. Failure to recognize the need to increase the amount of extract or to give the injections often enough.
4. Failure to alternate administration of the injections between the right and left arm.
5. Failure to appreciate that the proper treatment for anaphylactic shock employs epinephrine 1:1,000 and antihistamines—not steroids.
6. Failure to give a scheduled injection only because the patient was wheezing mildly (epinephrine, 1:1,000, can be given concurrently at a second site).
7. Discontinuance of desensitization too soon. In general, the patient should be doing well while receiving one injection every 4 weeks for 1 to 2 years before therapy is discontinued.

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tions should be promptly lowered. If the infant's recovery is gradual, the oxygen concentrations should be lowered by 10% decrements, guided by blood gas measurements.

8. It should be appreciated that oxygen is toxic to other organs (e.g., lungs), which may be damaged even if the foregoing criteria are adhered to.

9. A person experienced in recognizing retrolental fibroplasia (retinopathy of prematurity) should examine the eyes of all infants born at less than 36 weeks' gestation or weighing less than 2,000 gm (4.2 lb) who have received oxygen therapy. This examination should be made at discharge from the nursery and at 3 to 6 months of age.

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ERRATA

The statement “The Interrelationship Between the Patient, His Family, the Referring Physician and the Pediatric Allergist,” which appeared in the March issue of the Journal, was prepared by the Committee on Communications and approved by the Section Committee of the Section on Allergy of the American Academy of Pediatrics. The names of the members of the Committee on Communications of the Section Committee were inadvertently omitted from the statement:

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An erratum has been published regarding this article. Please see the attached page for:

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