School Nurse Perspectives on School Policies for Food Allergy and Anaphylaxis

PURPOSE OF THE STUDY. To characterize food allergy policies currently being used in schools and their use and potential barriers to implementation from the perspective of school health care professionals.

STUDY POPULATION. School nurses and administrators were surveyed.

METHODS. Participants were recruited at the 2016 National Association of School Nurses meeting and through the Allergy and Asthma Network listserv. The school nurses completed an electronic survey developed by pediatricians, allergists, survey researchers, and school nurses. Survey domains included school characteristics; current food allergy policies; acceptability, effectiveness, and feasibility of current policies; and desired food allergy policies.

RESULTS. There were 242 completed surveys, 95.9% of which were completed by school nurses (mostly from public elementary and/or middle schools). All regions of the United States were represented (two-thirds from the Northeast and Midwest). Of respondents, 31.8% reported that at least 1 severe allergic reaction occurred at their school in the previous year, and 34% of these reported >1 allergic reaction. Policies varied, but 96.7% of respondents had policies for the training of school staff on allergic reactions and anaphylaxis and the use of an epinephrine autoinjector. Of respondents, 88.4% reported that lunchroom staff were trained on food allergies, 84.3% reported having lunchroom cleaning procedures, 81.7% had stock epinephrine, and 79.2% had policies that allowed for children to carry their medications. The least frequent policies included the labeling of school lunch items with allergen information (31.4%), specific food policies for after-school activities (29.6%), and having emergency (stock) epinephrine that is taken with groups outside of school (28%). Schools with a full-time nurse or schools reporting at least 1 severe reaction in the previous year were more likely to have stock epinephrine. Schools with younger students were more likely to have designated lunch areas for students with food allergies.

CONCLUSIONS. School food allergy policies are diverse, and most involve the training of staff on the recognition and treatment of reactions. Stock epinephrine was common. Policies related to after-school activities were less common. Policies related to food allergen containment in the lunchroom or classroom were shown to have the greatest variability. Most school nurses favored most of the policies but acknowledged barriers to implementation.

Food Allergy and Anaphylaxis

Characteristics of allergic reactions, highlighting the need of increased education. The fact that almost one-third of reactions occur under nonparental adult supervision suggests that additional educational interventions can be targeted for this group. Boys and children with peanut allergy are at higher risk of unsupervised reactions, another group that may need more intensive education. More education on reading food labels is also needed because more than two-thirds of respondents admitted ignoring the food label, although the children had known food allergies. These issues should be considered as we diagnose food allergy and educate children with food allergies and their families.

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control groups. Pediatric subjects with a food allergy scored significantly higher on the Multidimensional Anxiety Scale for Children, including higher scores for humiliation-rejection and social anxiety indices, compared with subjects in the control group. There were no significant differences found in regard to depression by using the Children’s Depression Inventory. There were also no significant differences between groups in regard to caregiver anxiety or depression symptoms.

CONCLUSIONS. Children with a food allergy had more frequent symptoms of anxiety compared with those without a food allergy, but there were no differences in regard to depression symptoms. No significant differences in anxiety or depression symptoms were found between caregivers with and without food allergies.

REVIEWER COMMENTS. This is an important study in which the authors sought to determine the frequency of anxiety and depression in a low-SES, ethnic minority population, which is typically understudied regarding food allergy. Children with a food allergy display more anxiety compared with their peers without a food allergy, which may be related to concerns of accidental exposure to food allergens that could result in allergic reactions.

Preliminary Psychometric Analyses and Clinical Performance of a Caregiver Self-efficacy Scale for Food Allergy Self-management

Greenhawt M, DunnGalvin A. Ann Allergy Asthma Immunol. 2018;120(1):73–79

PURPOSE OF THE STUDY. To examine the reliability, validity, and clinical performance of a novel food allergy self-efficacy tool to help assess caregiver burden in food allergy.

STUDY POPULATION. The study was a cross-sectional, observational study of caregivers of children who are food allergic (n = 2308).

METHODS. A self-administered, 8-item Food Allergy Self-Efficacy Questionnaire (FASEQ) was coadministered with the Food Allergy Quality of Life Parental Burden (FAQ-L-PB) (a 17-item questionnaire that is used to measure the effect of pediatric food allergy on caregivers) index to 2 populations: (1) caregivers self-reporting a child who is food allergic recruited by online advertising (group A, n = 2003) and (2) caregivers with children managed at a food allergy referral center (group B, n = 305). FASEQ split-half reliability, 2-week recall, factor analysis, and construct and discriminative validity were assessed. Multiple linear regression was used to assess predictive associations between the FAQ-L-PB and the FASEQ.

RESULTS. The mean FASEQ score was 2.69 (95% confidence interval [CI]: 2.66–2.73) on a point scale of 0 to 4 (lower scores used to indicate less burden) and was lower among group A (2.52; 95% CI: 2.49–2.56) versus group B (3.75; 95% CI: 3.66–3.84; P < .001). Validity was demonstrated by a FASEQ Cronbach α of 0.87 and the 2-week intraclass correlation coefficient (ICC) of 0.75. Total and 6 of 8 individual FASEQ domain scores were significantly lower among caregivers with children having anaphylaxis or epinephrine use versus none and peanut or tree nut allergy versus milk or egg allergy, demonstrating good discriminative validity. Total FASEQ score was associated with FAQ-L-PB score (ICC: 0.13; 95% CI: 0.06–0.19; P < .001), with 6 of 8 FASEQ individual domains significantly associated (ICC range: 0.17–0.3; P < .01 for all).

CONCLUSIONS. The FASEQ is a valid tool to use to assess caregiver food allergy self-efficacy.

REVIEWER COMMENTS. Self-efficacy is used to describe an individual’s perceived capabilities for learning or performing actions to manage a situation. Research has revealed an association between caregiver health-related quality of life and food allergy status among their dependents. With this study, insight is provided into the usefulness of the FASEQ to help gauge caregiver burden. Inaccuracy in self-reported food allergy is common compared with physician-diagnosed food allergy, which may be reflected by inherent differences in the knowledge and understanding of food allergies between groups A and B in this study, accounting for the lower FASEQ score in those self-reported food allergy.

Quantitative Assessment of the Safety Benefits Associated With Increasing Clinical Peanut Thresholds Through Immunotherapy


PURPOSE OF THE STUDY. To calculate the clinical benefit (risk reduction of allergic reactions) of increased peanut tolerance threshold in patients who are allergic, such as those who undergo peanut immunotherapy.

STUDY POPULATION. Included in this study is a projected model of individuals with peanut allergy who consume...
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