

Medical Director of Pediatric Allergy

Peanut AIT (Who, Why, and How)


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Objectives

- At the conclusion of this program you should be able to
 - Identify appropriate candidates for food allergen immunotherapy
 - Outline the strengths and weaknesses of available treatments for peanut allergy
 - Explain the options available for peanut AIT – peanut drug, retail peanut, extract SLIT, and retail SLIT



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Who?

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Indications for Food Allergy Immunotherapy

- History of an IgE-mediated reaction to a food
 - Proximate (less than two years) history of any reaction
 - Any history of a severe reaction
 - Demonstration of food-specific IgE
 - Patient and family (as appropriate depending on age) motivation
- No history of an IgE-mediated reaction to food
 - Food-specific IgE strongly suggestive of a high risk of reaction
 - Positive basophil activation test
 - OR
 - Positive oral food challenge
 - Patient and family (as appropriate depending on age) motivation

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Contraindications for OIT – Absolute

- Less than six months of age
- Active or uncontrolled systemic disease
- Active or poorly managed asthma, eczema or gastrointestinal disease
- Currently up dosing with another immunotherapy
- Inability or unwillingness to treat anaphylaxis with prompt administration of epinephrine
- Poor adherence to treatment and safety recommendations
- Pregnancy (for treatment initiation)
- Uncontrolled psychiatric or eating disorder

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Contraindications – Conditional

- Cardiac disease
- Conditions which increase the risk of anaphylaxis (e.g., mastocytosis)
- History of severe life-threatening anaphylaxis
- Medications that may interfere with anaphylaxis treatment (i.e., beta-blocker or ACE inhibitor)
- Poor understanding of OIT
- Prior eosinophilic esophagitis or eosinophilic gastrointestinal disease
- Controlled eating disorder

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Why?

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Standard of Care For Patients and Families with Peanut Allergy is the Avoidance Management Strategy (AMS)

- The (AMS) treatment plan
 - Careful avoidance of exposure by label reading and avoidance of risky settings (i.e., social isolation)
 - Reaction recognition and timely treatment with epinephrine
- AMS results in reactions
 - 12% to 35% of patients experience accidental exposures
 - >200,000 ER visits/year – est. 90,000 for anaphylaxis
 - Only 25% of severe reactions treated with epinephrine
 - <30 deaths/year
 - Most anaphylactic deaths caused by allergens the victim was avoiding
- Psychosocial consequences are not addressed

Boycie JA, Assa'ad A, Burks RW, Jones SM, Sampson HA, Wood RA. J Allergy Clin Immunol. 2010 Dec; 126(6 Pt 2): 51-58.
 Clark S, Eghniza J, Raddler SA, Benerji A, Camargo CA Jr. Frequency of US emergency department visits for food-related acute allergic reactions. J Allergy Clin Immunol. 2011;127(3):683-683.
<https://www.allergicliving.com/2018/03/26/er-visits-for-kids-with-severe-food-allergies-split6-150/> Accessed April 26, 2021

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AMS Distorts Patient Life

The New York Times
 In a Children's Theater Program,
 Drama Over a Peanut Allergy
The conflict over accommodating a child's allergy turned into a legal battle that highlights the isolation that people with food allergies often face.



• Anxiety about having a reaction

- Fear of hidden ingredients or contaminants
- Fear of epinephrine use
- Relationships with friends and family members

• Patient limitations

- Isolation – no play dates or sleepovers
- The peanut table
- 40% have been bullied

"We hear this all the time, where people isolate kids, tell them they can't go places, tell them they can't participate in after-school activities or that their parents have to be there if they're in a soccer game," Dr. Baker said. "The child starts to feel like he or she is the problem."

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AMS Distorts Family Life

- Parental anxiety
 - Duration of the disease in the absence of a cure is unpredictable at best, may be life long
- Anxiety about having a reaction
 - Fear of hidden ingredients or contaminants
 - Accidental reactions may occur from trace amounts, reaction severity is poorly predictable
 - Fear of epinephrine use
 - Conflict with schools and other parents
 - Disrupts relationships with friends and family members
- Family limitations
 - Restaurants – many families never eat out
 - Vacation travel is severely limited or avoided completely

Cohen DL, et al. JACI 2004; 114:1159-63.
 Gupta et al JAMA Pediatr 2013; 167: 1026-31.
 Greenhawt M. Ann Allergy Asthma Immunol 2014; 113: 506-12.
 Anagnostou et al Lancet 2014: [http://dx.doi.org/10.1016/S0140-6736\(13\)62301-6](http://dx.doi.org/10.1016/S0140-6736(13)62301-6).

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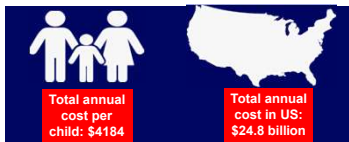
Anorexia in Early Childhood Following an Accidental Ingestion of Nuts

- 5 yo with known peanut/tree nut allergy given food with “may contain” label by her teacher after she asked if it contained nuts
- Immediate reaction of tongue itch that lasted 36 hours without other GI, respiratory or cutaneous symptoms
- For the subsequent six weeks she refused to eat at school, lost 5lbs and became dependent on Peditasure
- With education, reassurance, immediately available epinephrine and support, feeding normalized

Poster Presentation ACAAI, 2018. Hernandez-Trujillo, V. With permission.

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Food Allergy Avoidance Management Strategy Results in Significant Costs to Families and Society



- Food allergy costs patients and society a lot of money, annually
- These cost estimates include obvious and somewhat latent sources, and heavily weight costs from lost opportunities
- These cost figures are not experienced proportionally!

Gupta, RS et al. JAMA Pediatr 2013: 1026-1031. Slide courtesy of Ruchi Gupta, adapted

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Options for Food Allergy Patients

- The Avoidance Management Strategy (AMS)

The New York Times
Is a Childhood Thruout Program, Drama Over a Peanut Allergy



The Peanut Table



Parties



- "FDA-Approved" peanut drug treatment
- Peanut food treatment – oral immunotherapy or OIT
- Peanut extract sublingual immunotherapy – SLIT
- Peanut food sublingual immunotherapy – SLIT


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How?

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The AIT Process

- Parents of appropriate patients are offered the opportunity to have their child treated
- Parents and patients hear an explanation of the process including a discussion of reaction risks and ELORS (Eosinophilic esophagitis-Like OIT-Related Syndrome)
- A written description and explanation of OIT and SLIT processes is provided
- Parents are given a custom consent form
- Approximately two weeks before Day 1, patients are evaluated for stability of asthma and allergy and perform a pulmonary function test if they are able



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The Process at DFAC – Day 1 OIT

- Patients arrive and are examined
 - Vital signs, weight, epinephrine, IV diphenhydramine and oral cetirizine doses are recorded on the flow sheet
- Dosing is initiated with 200µg of peanut protein
- Serially diluted suspensions of peanut flour/peanut butter powder are used
- Before each dose the patient is asked how they feel,
- Up to 5 doses are administered at 20 minute intervals
- Two-hour observation after the last dose



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Dose Escalation Protocols

- Initial dose
 - Regimen based (DAFC) – the same starting dose for all patients
 - Challenge based
 - Challenged as an outpatient until reaction occurs
 - Challenged inpatient to a target dose (Israeli approach)
- Dose increases
 - Typically, 50-100% of the previous dose
 - Multi-dose rechallenge to a new target (Israeli approach)
- Dosing interval
 - 7 or 14 days
 - Four weeks (Israeli approach)

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Escalation at the Dallas Food Allergy Center

- After the first day, dose increases are usually a doubling of the previous dose
 - Near the target, the dose increases are as small as 25%
- Doses of powder, nuts, Bamba are weighed
- Patients take the dose tolerated in the office once daily for at least seven days
- Return to the office for a challenge to the next dose
- Interval history is obtained and the patient is examined
- Dose is administered
- Patients are observed for 45 minutes



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Dallas Food Allergy Center Peanut Dosing

Day #	Schedule	Frequency of dosing	Concentration	Volume, mL	Type of food	Dose (mg)	Peanut Weight (g)	Peanut Protein (mg)	Dose (mg)	Dose (g)	Peanut Butter (mg)	Peanut Butter (g)	Peanut Butter (mg)	Peanut Butter (g)
1	Day 0	QD	200mg/mL	2	Peanut powder solution	0.4	0.2	0.2						
2	Day 1	QD	200mg/mL	4	Peanut powder solution	0.8	0.4	0.4						
3	Day 1	QD	200mg/mL	0.8	Peanut powder solution	0.4	0.4	0.4						
4	Day 1	QD	200mg/mL	1.6	Peanut powder solution	0.8	1.6	0.8						
5	Day 1	QD	200mg/mL	3.2	Peanut powder solution	1.6	3.2	1.6						
6	Escalation	QD	200mg/mL	4.5	Peanut powder solution	2.25	4.5	2.25						
7	Escalation	QD	200mg/mL	6.5	Peanut powder solution	3.25	6.5	3.25						
8	Escalation	QD	200mg/mL	1	Peanut powder solution	10	10	10						
9	Escalation	QD	200mg/mL	1.5	Peanut powder solution	30	15	15						
10	Escalation	QD	200mg/mL	2	Peanut powder solution	40	20	20						
11	Escalation	QD			Peanut fraction	0.1	28	0.1	5.11				0.2	
12	Escalation	QD			Peanut fraction	0.2	13	0.2	5.16				0.4	
13	Escalation	QD			Peanut fraction	0.3	9	0.3	5.16				0.7	
14	Escalation	QD			Peanut fraction	0.4	6.5	0.4	5.2				0.8	
15	Escalation	QD			Peanut fraction	0.6	3.8	0.6	5.3				1.3	
16	Escalation	QD			3 Peanut (Even consumption)	0.25	120	1.4	5.5	1.4	2	1.3		
17	Escalation	QD			3 Peanut	1.9	500	1.0	5	1.0	3	4.2		
18	Escalation	QD			3 Peanut	2.85	750	1.6	5.5	1.6	3	6.2		
19	Escalation	QD			4 Peanut (accidental ingestion)	3.8	1000	1	7	1	6	8.3		
20	Escalation	QD			8 Peanut	5.7	1500	1.1	5	1.1	10	13.5		
21	Escalation	QD			8 Peanut	7.6	2000	1	5	1	14	17		
22	Escalation	QD			10 Peanut	9.5	2500	1.1	5	1.1	17	21		
23	Escalation	QD			12 Peanut	11.4	3000	1	5	1	20	25		
Challenge					24 Peanut	22.8	6000	6	5	6	40	50		
Maintenance	QD				8 Peanut	7.6	2000	2	5	2	14	17		

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OIT Administration



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OIT Day One – Pre-pandemic



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Goals of Peanut AIT

- Trace safety
 - The eliciting dose has been raised above the level expected to be in a food labeled "manufactured in a facility..."
 - Impossible to know the correct amount, an estimate
 - 100mg of peanut protein is probably enough
 - Label reading still required but manufactured food choices expanded
- Bite proofing
 - 300mg of peanut protein protects against 95% of accidental exposures
 - Label reading still required but anxiety reduced and QoL improved
- Free eating
 - The patient is able to routinely incorporate the food into the diet
 - A peanut butter sandwich contains ~6000mg of peanut protein
 - Label reading not required
- Sustained unresponsiveness
 - Desensitization endures in the absence of frequent ongoing exposure
 - The Holy Grail of OIT – realistic for only some patients

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Age and Peanut IgE Predict Outcome

Wasserman, et al. 2018 JACI:IP7:418-425

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Maintenance at the Dallas Food Allergy Center

- Dose
 - Peanut free eaters ~2 g protein
 - Patients continuing avoidance and children <4 yo ~1 g protein
- Dose frequency
 - 7/7 days a week until six months on maintenance
 - 6/7 days a week after six months
 - Frequency reduced may be reduced annually based on decreases in sIgE
 - Shared decision-making based on the burden of dosing and the available data

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Maintenance Regimens

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Maintenance Regimens

- Dose
 - The higher the better to suppress sIgE
 - The lower the better to maintain adherence

Davis, et al, JACI:PI 10:566, 2021

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Maintenance Regimens

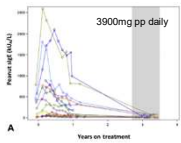
- Dose
 - The higher the better to suppress sIgE
 - The lower the better to maintain adherence
- Dose frequency
 - More frequent dosing promotes the fall in sIgE
 - Less frequent dosing reduces the burden of care and improves quality of life

Davis, et al. JACI:PI 2021; 10:566
 Nachshon, et al. Pediatr Allergy Immunol. 2018; 29:519-526
 Blumchen, et al. Allergy, Asthma and Clin Immunol. 2023; 19:21

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- Duration of dosing
 - Depends on the goal
 - Indefinite at some frequency?

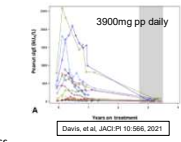


Davis, et al. JACI:PI 2021; 10:566
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- The ideal maintenance dose, dosing frequency and dosing duration is



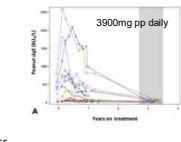
Davis, et al. JACI:PI 2021; 10:566
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UNKNOWN



Davis, et al. JACI:PI 2021; 10:566
 Nachshon, et al. Pediatr Allergy Immunol. 2018; 29:519-526
 Blumchen, et al. Allergy, Asthma and Clin Immunol. 2023; 19:21

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Sustained Unresponsiveness Challenge

- Criteria
 - At least three years of maintenance dosing with no maintenance reactions during the previous 2 years
 - Fall in specific IgE to <1-2 kU/L
- Patients were instructed to completely avoid the allergenic food for one month before sustained unresponsiveness challenge
- All challenges were performed in an allergy office setting
- About 2/3's of patients decline the challenge
- Passing the challenge means sustained unresponsiveness, achievement of true tolerance is uncertain
- **37/43 (86%) patients passed the challenge**

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OIT Risks

- Anaphylaxis requiring epinephrine treatment
- Systemic allergic reaction that is self-limited or treatable with antihistamine
- ELORS – Eosinophilic esophagitis-Like, **ORal** immunotherapy Syndrome
- Mild GI symptoms
- Mild peri-oral hives
- Oral itch
- Food aversion, especially to peanut
- Family disruption around dosing
- Anxiety

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Foods For Peanut Oral Immunotherapy

- Peanut flour has been monopolized by Aimmune and is no longer available
- Tru Nut Powder is tree nut free – 50% peanut protein
- PB Powder is not tree nut free – 42- 46% protein
tsp = 0.8-1 gm protein (3-4 peanuts)
- Peanut butter ~1 tsp = 4-5 peanuts
 - **Jif and Santa Cruz Organic** are tree nut free
 - **Peanut Butter & Co.** 1 tsp = 4 peanuts
 - Cinnamon Raisin Swirl
 - White Chocolate Wonderful
 - Dark Chocolate Dream
 - The Bee's Knees
 - Mighty Maple



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Alternative Peanut Products

- Bamba
 - An average Bamba stick weighs 850 mg
 - Contains ~100 mg peanut protein
 - ~3 Bamba sticks = 1 peanut
 - Alternatives may be different
- Peanut M&M's (regular size)
 - ~1/3rd of peanut/M&M
- Reese's Pieces Candy (candy shell)
 - ~50 mg protein/piece
- Reese's Peanut Butter cups:
 - 1.5 oz package = ~7 peanuts
 - Wrapped gold foil
 - 1 piece weighs ~9 g
 - Contains ~3 peanuts



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Managing Peanut Aversion

- Store peanut products in the freezer
- Homemade single dose chocolate peanut and raisin disks (store in the cold)
- Mix peanut butter powder in a vehicle such as applesauce or pudding
 - Minimize the volume
 - Mask with mint, orange, or raspberry extract
- Mix peanut butter powder with salsa and eat with chips
- Mix peanut butter powder with curry
- Make a smoothie and mask with fruit extract

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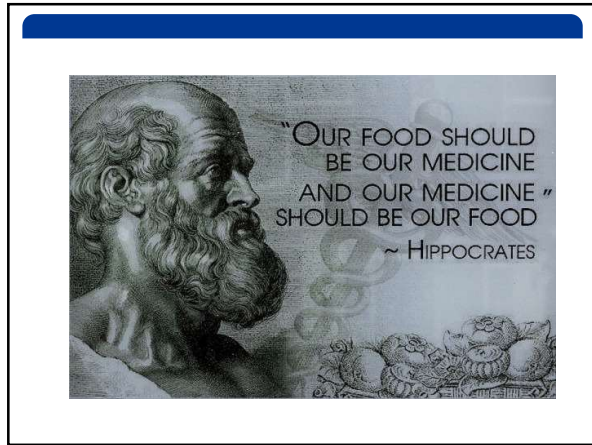
Evidence Supporting the Need for a "Standardized", GMP-Produced Product for Peanut Allergy Treatment

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Peanut Drug Pros and Cons


Pros	Cons
FDA Approved	Risk Evaluation and Mitigation Strategy
"Standardized" protein content	Standardization is not data supported
Pre-made capsules	Limited peanut forms for dosing
No ad hoc dose preparation	Multiple capsules per dose
No variations caused by different foods	Customization of dosing is difficult
16 dose levels vs 20-25 using retail food protocols	Per package insert recommends high initial and day one target doses
	Large dose increments result in more reactions in the office
	Peanut avoidance is required; free eating is not an option
	No option for Sustained unresponsiveness
	Peanut (Arachis hypogaea) Allergen Powder - \$1133.20/ 30 capsules (300mg) vs peanut butter powder - \$15.99/lb

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SLIT: where does it fit?



- A 'ladder' to OIT
- Salvage treatment after failed OIT
- Stand alone desensitization
- A waste of time, too weak

Adapted by permission, Dr. Hugh H. Windom

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Literature Review: The Science Behind SLIT



- 11 pediatric participants peanut SLIT treated + 7 placebo
- 6-month buildup, 6-month maintenance (2 mg pp)
- No epinephrine use
- 1 year OFC: 1700 mg pp median cumulative dose vs 85 mg placebo

Kim EH. J Allergy Clin Immunol 2011;127:640-6
Adapted by permission, Dr. Hugh H. Windom

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CoFAR Peanut SLIT



- 20 SLIT vs 20 placebo
 - 12-40 year olds (tough crowd)
- 42-week buildup, 2-week Maintenance of 1.4 mg pp
- OFC 2.5 gm (10 nuts), none passed
 - Epinephrine used once
 - However, the median dose went from 3.5 to 496 mg pp

Fleischer DM. J Allergy Clin Immunol 2013;131:119-27
Adapted by permission, Dr. Hugh H. Windom

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CoFAR 3 Year Follow up Study


- 20 placebo patients crossed over to 3.7 mg pp SLIT
- Annual OFC's, high dropout rate
 - 14/40 remained, no Epinephrine use
- 3rd year OFC 5 g peanut protein after 8 weeks avoidance
 - 2/5 in the cross over group passed
 - 2/9 in the 3 year SLIT group passed



Burke AW. J Allergy Clin Immunol 2015;135:1240-8
Adapted by permission, Dr. Hugh H. Windom

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Peanut SLIT vs OIT




- 21 participants 7-13 yo
 - 5 d/c 1st year, 4 in OIT group
- SLIT 3.7 mg pp (n=10), OIT 2 gm/day (n=11)
- Epinephrine in 4 OIT pts (36%), none in SLIT
- OFC after 1 y on maintenance
 - OIT group: 141-fold increase threshold
 - SLIT group: 22-fold SLIT (21 to 496 mg pp)

Narisety SD. J Allergy Clin Immunol 2015;135:1275-82
Adapted by permission, Dr. Hugh H. Windom

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Long term Peanut SLIT



- 3-5 years of 2 mg peanut protein SLIT
- 47 1-11 yo participants
 - 37/47 completed (79%)
 - 2 dropped because of GI symptoms
- No epinephrine use
- 32% passed 5 gm pp OFC
- 86% tolerated \geq 750 mg

Kim EH. J Allergy Clin Immunol 2019;144:1320-6
Adapted by permission, Dr. Hugh H. Windom

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Long Term Peanut SLIT Extended


- 55 participants
 - Ages 1-11 years with challenge proven peanut allergy
 - +positive OFC 0-425 mg, median 0, mean tolerated dose 48mg
- 4 mg peanut protein open label SLIT x 4 years
 - 47/55 completed 48 months of SLIT and DBPCFC
 - OFC to 5000 mg peanut protein
- Mean tolerated dose 2723 mg
- 70% tolerated >800mg
- 36% tolerated 5000mg
- SLIT discontinued for 1-17 weeks
 - Modeled loss of clinically significant desensitization was 22 weeks

Kim, et al. 2023. JACI; 151:1558-1565

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The Right Treatment for the Right Patient: SLIT vs OIT

- SLIT may be better for
 - Scary, highly allergic patient
 - Too busy for regular visits
 - Unable to avoid exercise
 - Long distance from center
 - Concerns about EoE, ELORS
 - Unable to afford OIT
 - Older children and adolescents
- OIT may be better for
 - Staple foods (culturally determined)
- Free eating
- Children under 5



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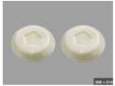
Unanswered SLIT Questions



- Does SLIT really need a slow build up?
- What is the appropriate maintenance dose?
- What is the duration of daily dosing? Indefinite?
- Should patients be transitioned to OIT?
 - If so, how?

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Does Food SLIT Need Dose Escalation?


SCIT buildup	SLIT (e.g. Odactra)
1:1,000	House Dust Mite <i>(Dermatophagoides farinae and Dermatophagoides pteronyssinus)</i> Allergen Extract Tablet for Sublingual Use 12-SCq-HDM 1 tablet 
0.1 / 0.2 / 0.4	
1:100	
0.1 / 0.2 / 0.4	
1:10	
0.05 / 0.1	
1:10	
0.15 / 0.2	
1:10	
0.3 / 0.4	
1:1 : 0.05	
1:1 : 0.1	
1:1 : 0.15	
1:1 : 0.2	
1:1 : 0.3	
1:1 : 0.4	
1:1 : 0.5	

Adapted by permission, Dr. Hugh H. Windom

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Peanut SLIT Dosing Regimens

	Commercial Extract ¹	Peanut Powder ²
Initial dose	0.25 mcg PP	1 mcg
Maintenance dose	1000 mcg PP	4 mg (5 or 6 mg)
Updoses	21	16
Office visits	21	7
Product cost	>\$10,000 for 36 months of treatment	\$15.99 for hundreds of patients




1. Sakina Bagowala, MD adapted from Kim, et al. JACI. 2011;127:640-6.e1
2. Hugh Windom, MD

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“Primum non nocere” (First do no harm)

- OIT
 - Nachson L. JACI:IP 2022;10:1170-6
 - 1,270 OIT patients
 - Escalation epinephrine **15.7%**
 - Solar L. JACI:IP 2022;10:1113-6
 - 352 preschoolers treated with OIT
 - Escalation epi in **1.6%** of <13 mo
 - Escalation epi in **5.9%** of 13-70 mo
 - Dallas Food Allergy Center: Jan, 2021-April 2023
 - 141 patients, multiple foods
 - Escalation epi in **0.7%**
- SLIT
 - Many SLIT studies
 - Epinephrine use – **0 to rare**



Adapted by permission, Dr. Hugh H. Windom

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SLIT versus OIT for Food Allergy

SLIT	OIT
Stable extract or mixed locally	Needs to be mixed in house – must train staff
Expensive - high dose SLIT can cost >\$10K for a 36-month course	Material costs are low
Less taste aversion than OIT	Taste aversion is a problem for many
New technique to learn – can be difficult for toddlers/young children	Suitable for all age groups
Can bypass gut with hold/spit method	Theoretical risk of triggering EoE
Shorter exercise restriction than OIT	5-15% may need epi during escalation
Favorable safety profile – low rates of systemic reactions	Mild to moderate GI reactions are common
Local reactions (oropharyngeal itching) are common	Enables free eating
Can achieve high levels of tolerated doses and very rarely sustained unresponsiveness	Some patients can achieve sustained unresponsiveness

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Mini-Dose OIT

- Who?
 - infants and toddlers too young for SLIT
- Why?
 - Provides cross contamination protection and some degree of accidental ingestion protection
 - Reactions and epinephrine use are rare
 - Reduced burden of care – fewer office visits
 - Low dose makes home dosing easier
- How?
 - Eliciting dose OFC to a limited target dose (133mg of peanut protein)
 - Daily dosing
 - After 6-12 months measure sIgE and consider repeat eliciting dose challenge to a higher target

Adapted from multiple publications of Motohiro Ebisawa

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Who Would You Rather Be?

Food Allergist Not Doing AIT Food Allergist Providing AIT





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You Can Change Lives!

(When you and your practice are ready)

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Published Resources

Original Article

Real-World Experience with Peanut Oral Immunotherapy: Lessons Learned From 270 Patients

Richard L. Wasserman, MD, PhD^{1,2}, Angela R. Hagan, PA-C³, Deanna M. Pence, RRT⁴, Robert W. Sigeman, MD^{5,6}, Stacy K. Shinn, MD^{7,8}, Joanne S. Robin, PA-C⁹, and Marky Harbut, PhD¹⁰ *Dallas and Austin, Texas*

J ALLERGY CLIN IMMUNOL PRACT. 2021; 7:418-426

Special Article

An Approach to the Office-Based Practice of Food Oral Immunotherapy

Richard L. Wasserman, MD, PhD^{1,2}, Jeffrey Factor, MD³, Hugh H. Windom, MD⁴, Elissa M. Abrams, MD⁵, Philippe Rogin, MD, PhD, FRCPC⁶, Edward S. Chen, MD, FRCPC⁷, Matthew Greenblatt, MD, MBA, MSc⁸, Nathan Hess, MD⁹, Douglas P. Mack, MD, MSc¹⁰, London Marshall, MD, MSc, Ben Shalhan, MD¹¹, David R. Shinn, MD¹², Timothy Vander Griend, MD¹³, and Marcella Steiner, MD, MPH¹⁴ *Dallas and 12 Pac. Coast, West. Medford, Conn., Toronto, Pa., Winnipeg, MB, Canada; Montreal, QC, Canada; Vancouver, BC, Canada; Atlanta, Ga.; Billingsport, Pa.; Hamilton, ON, Canada; Columbia, Ohio; Edmonton, AB, Canada; and Haaver and Lehigh, NY*

J ALLERGY CLIN IMMUNOL PRACT. 2021; 9:1826-1838



J Food Allergy. 2022; 4:17-161

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Ongoing OIT Support

- OITAdvisors – A closed Google Group with >550 members that functions as a listserv for questions relating to food allergy diagnosis and treatment. Open to all Board Certified allergists and their staffs. Contact Neetu Talreja, neetutalreja.com to join.
- FASTOIT.org – The website of the Food Allergy Support Team, a non-profit organization that supports OIT allergists. Slide decks from FAST 2021, FAST 2022, and FAST 2023 are available for download

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