CONGRESS REPORT

KIDZ 'N ALL 2004

The Kidz 'n All combined congress of the SA Paediatric Association, the SA Association of Paediatric Surgeons and ALLSA, held in the Cape Town International Convention Centre in August, brought together health professionals from different disciplines with a common purpose – improving the care they offer their patients. Overseas speakers added an international component by reporting on the latest developments worldwide.

The August issue of *Current Allergy & Clinical Immunology* contained all the ALLSA abstracts and some articles based on talks presented at the congress, so this report highlights just a few of the presentations.

Prof Eugene Weinberg addressed the question of **allergic rhinitis in the infant**, 'a condition that doesn't exist in the medical literature' though his slides of a very unhappy little boy showed that it clearly exists in practice. He commented on the extremely limited information available, including one study which stated that seasonal AR is not observed in the first 2 years of life – 'they're barking up the wrong birch tree!' Typical symptoms in infants are: noisy breathing – 4 S signs – snuffle, snoring, sneezing and snorting; irritability; restless, disturbed sleep; failure to thrive because of inability to feed; persistent, watery nasal discharge; often bilateral otitis media; cough/wheeze; and they rub their noses against their pillows, bedding and their mothers. In establishing diagnosis nothing replaces a careful allergic history: ask about family history of allergy, any previous episode of atopic dermatitis, itchy nose, the 4 S signs. Examination should include looking for signs of mouth breathing and tongue thrusting, puffiness under the eyes from constant rubbing, and dry lips. Looking in the nose is very difficult because the child won't allow the nose to be touched, but mucosa will be pale, wet and swollen. Treatment is also difficult for the same reason. Nose drops of a saline/bicarbonate of soda solution are most effective, as is cromoglycate, but decongestants cause problems and antihistamines are very unsatisfactory. Intranasal steroids are not permitted in infants, but parents are resistant to their use anyway.

Dr Nceba Gqaleni of the Nelson Mandela School of Medicine spoke on the **effect of indoor air quality on allergy**. Depending on the nature of their work, many people spend most of their time in an indoor environment where they are exposed to the following indoor allergens:

- house dust mites (HDM)
- cockroaches
- pets
- moulds.

Dr Nceba Gqaleni with Dr Mohammed Jeebhay (centre) answering delegates' questions between sessions.

Exposure can affect the skin, eyes, ears and lungs, and inhalation offers the longest period of exposure as particles remain airborne for longer and enter the 'bioaerosol trap' of the human respiratory tract. Dr Gqaleni's research in Durban is investigating the occurrence of moulds and the relationship between all indoor allergens. HDM and moulds thrive in the same environmental conditions (e.g. humidity), and in terms of avoidance programmes, people can't see HDM whereas they can see mould and can therefore respond to it. Research so far has shown that 42% of the buildings studied contain mould and damp; common sites are ceiling fans, walls, shelves, carpets, windows and bathrooms. Severe mould (areas >3 m^2) was found in state hospitals, and mould problems are also present in private hospitals. Many workplaces show signs of 'sick building syndrome' with workers complaining of lethargy, headaches and blocked noses. Poor ventilation and inadequate maintenance lead to stress in the work environment as workers are concerned about the effect on their health. Tests have shown that exposure to indoor allergens does lead to sensitisation and often workers tend to be sensitised to more than one allergen.

Visiting speaker from Denmark, Prof Ronald Dahl, presented the first paper of the GLORIA (Global Resources in Allergy) symposium, on **Immunotherapy**. The WHO position paper of 1998 defines allergen immunotherapy as 'the administration of gradually increasing quantities of an allegen vaccine to an allergic subject, reaching a dose which is effective in ameliorating the symptoms associated with subsequent exposure to the causative agent.' As the quality of the vaccine is critical for successful treatment, standardisation is essential to ensure that extracts produced by different companies have comparable potency – allergen content in µg/ml is the main type of standardisation. Prof Dahl's personal experience is that 10 µg/ml is necessary for all types of immunotherapy to be effective. Although the risk of a fatal or near-fatal systemic reaction is extremely small, because it is possible, there are strict recommendations about the number of people present and the equipment required, e.g. oxygen, during administration. Contraindications include: immunopathological diseases and immunodeficiencies, malignancies, severe psychological disorders, beta-blocker treatment, poor compliance (patients need to be talked through the whole process and understand what is entailed), severe or uncontrolled asthma, sigificant cardiovascular diseases. Long-term benefits have been shown in various studies to last 3-5 years after treatment and the prevention of development of asthma in children with allergic rhinitis is significant. The WHO recommendations for allergen immunotherapy include guidelines about suitability: patients sensitive to a single allergen benefit more than those who are polysesitised; it is

more effective in children and young adults; patients with non-allergic triggers may not benefit (e.g. it is not suitable for exercise-induced asthma); and it should be initiated as early as possible, in the earliest phases of the disease, to prevent additional sensitisation and/or the development of asthma.

Prof David Meyer of the University of Stellenbosch gave an interesting outline on **diagnosis and treatment of allergic conjunctivitis**. The conjunctiva has different zones: limbal, bulbar, fornix (pouches) and palpebral (eyelid). Different diseases manifest in different regions, so he stressed: 'Before diagnosing allergic conjunctivitis, please examine the eye!' He listed five simple tests: (i) visual acuity – pinhole test, for children use 'fix and follow'; (ii) pupillary reaction – consensual reaction; if you shine a light in one eye, the other should also contract; (iii) red reflex test; (iv) intra-ocular pressure – use fingers, like feeling a pulse; (v) eclipse test.

Once conjunctivitis has been diagnosed, it needs to be established if it is allergic or infective (may be bacterial, viral or chlamydial). Infective clues are: subconjunctival haemorrhages, purulent discharge, severe kemosis, follicles in the fornices. Bacterial infection may be crusted or purulent – if the eyelids are closed never force them open as the liquid may squirt into your own eyes. Allergic clues are: dermatological changes, swelling and oedema, watery discharge and no follicles. Generally allergic eyes are itchy and scratchy, but there is no pain and no loss of vision. Squamous carcinoma can present with the same symptoms as allergic conjunctivitis; it is important to be aware of this, especially in immunocompromised patients. Prof Meyer advocates a step-up approach to treatment, starting with avoidance of allergens, dilution with artificial tears, ice packs (most underutilised patient treatment), vasoconstrictors and antihistamines (topical) before moving on to other drug treatment which depends on the severity of the condition.

A number of awards were presented at the congress dinner held at Moyo's restaurant, Spier. ALLSA honoured the overseas speakers, Prof Susan Prescott and Prof Ronald Dahl with life membership of the society, and also conferred it on Dr Ann Orren and Mr Ed Finlay in recognition of their contribution to allergy. Journal awards for the Best Article and Best Photograph published in *Current Allergy & Clinical Immunology* over the past year went to Dr Andreas Lopata and Dr Harris Steinman respectively. ALLSA research awards (sponsored by UCB Pharma and GlaxoSmithKline) were awarded to Ms Roslynn Baatjies, Ms Heidi Smuts and Dr Michael Levin.

Anne Hahn

Overseas speaker Prof Susan Prescott enjoying a congress lunch.

Mr Ed Finley receiving his Life Membership award from ALLSA chairman, Prof Cas Motala.

Congress co-convenor Dr Sharon Kling with overseas speaker Dr Ronald Dahl (centre) receiving his award from Prof Cas Motala.

Dr Michael Levin receiving his research award from Dr Mohamed Jeebhay.

Winner of the Best Article award, Dr Andreas Lopata.