

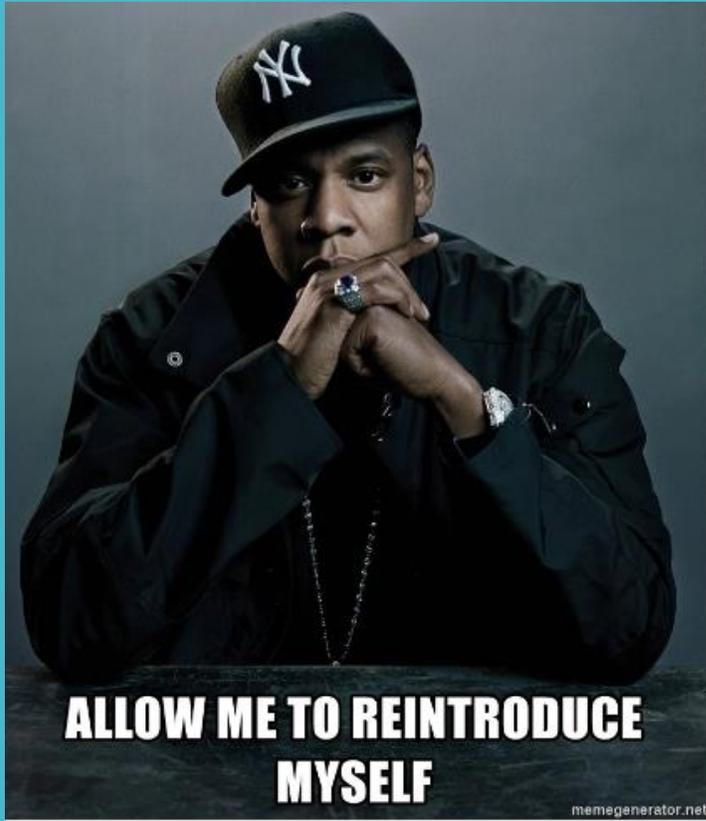
Literature Review

(and random stuff 😊)

Tom Chacko

www.chackoallergy.com

Atlanta Area



- Been doing OIT since about 2015
- 3 doctors with me (all 3 about 3 years out of fellowship)
- Multiple offices in the metro Atlanta areas
- High volume- See about 10-15+ new second opinion/food allergy cases weekly

Real-world safety and effectiveness analysis of low-dose preschool sesame oral immunotherapy



Gilbert T. Chua, MBBS,^{a,b,c} Lianne Soller, PhD,^d Sandeep Kapur, MD,^{e,f} Mary McHenry, MD,^{e,f} Gregory A. Rex, MD,^{e,f} Victoria E. Cook, MSc, MD,^{d,g} Scott B. Cameron, MD, PhD,^{d,g} Edmond S. Chan, MD,^d Joanne Yeung, MD,^d and Stephanie C. Erdle, MD^d *Hong Kong SAR and Shenzhen, China; Vancouver and Victoria, British Columbia, and Halifax, Nova Scotia, Canada*

TABLE I. Protocol for sesame OIT with 200 mg maintenance dose

Visit no.	Food protein (mg)	Absolute quantity of food measured*
1†	3	7 mg sesame flour
2	6	15 mg sesame flour
3	12	30 mg sesame flour
4	25	62 mg sesame flour
5	50	124 mg sesame flour
6	80	0.4 mL tahini
7	120	0.6 mL tahini
8	160	0.8 mL tahini
9	200	1 mL tahini

Exact allergen content may vary according to brand; it is crucial to confirm dose calculations of protein content for brand or form of food before providing dosing suggestions. Dose increases are performed every 2-4 weeks using this protocol.

*Sesame flour (Kevala Organic Sesame Flour, Dallas, Tex) contained 40.32 g sesame protein per 100 g sesame flour. Tahini (Organic Fair Trade Sesame Tahini, Nuts to You Nut Butter, Brantford, Ontario, Canada) contained 200 mg sesame protein/mL tahini.

†Optional.

- 28 Preschoolers
- 33.5 months
- 91% did 200 mg protein for year
- 85% of the challenges tolerated 2g sesame protein
- Conclusion- 200mg maintenance protein safe and effective in pre-schoolers



on Thu, May 29, 2025 at 10:24 AM Sofia Edwards-Salmon <dredwards@chackoallergy.com> wrote:

I have a 14 year old who's mom is a physician you said OK to do OIT at home- she is sesame allergic, sesame IgE is 43, ses i 1 is 31. What schedule would you follow for home up dosing and how frequently would you have them check in?

Clinical Communications

Sesame oral immunotherapy outcomes in a pediatric cohort

Ami Shah, MD^a, Amanda L. Cox, MD^a,
Marion Groetch, RD^a, Jacob D. Kattan, MD^a,
Allison Schaible, RD^a, Scott H. Sicherer, MD^a,
Angela Tsuang, MD^a, Julie Wang, MD^a, and
Roxanne C. Oriel, MD^a

JACI in Practice

April 2025

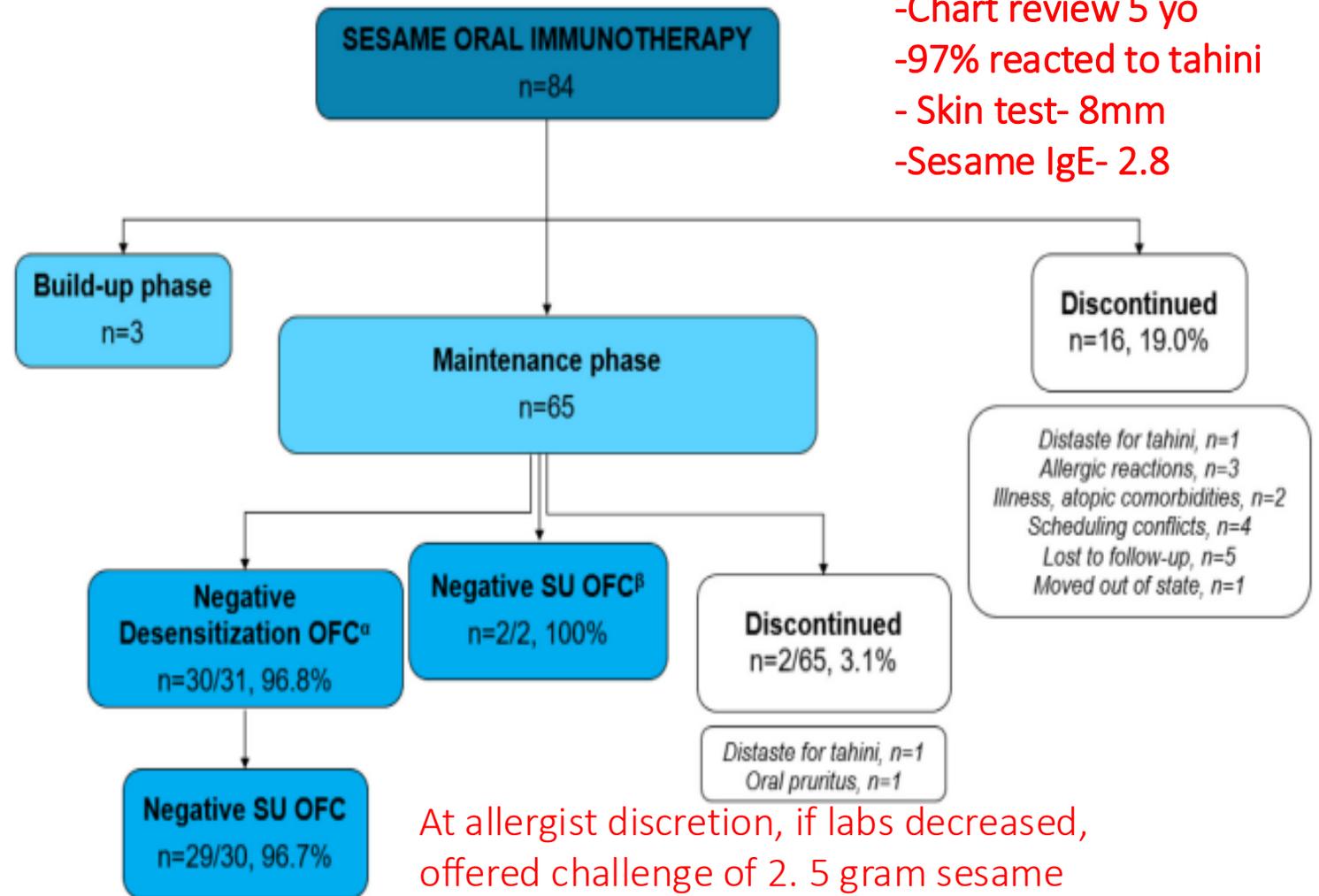
Clinical Implications

Oral immunotherapy to sesame with crushed sesame seeds and tahini can be a safe and effective way to manage patients with sesame allergy. Our results suggest that it may help these patients achieve sustained unresponsiveness.

TABLE E1. Standard sesame oral immunotherapy protocol

Phase	Step	Dose	Approximate amount of sesame protein, mg
Initial	1	12 crushed sesame seeds	6
Escalation	2	24 crushed sesame seeds	12
Escalation	3	48 crushed sesame seeds	24
Escalation	4	1/32 tsp tahini	26
Escalation	5	1/16 tsp tahini	52
Escalation	6	1/8 tsp tahini	104
Escalation	7	1/4 tsp tahini	208
Escalation	8	1/2 tsp tahini	417
Maintenance	9	1 tsp tahini	833

VOLUME ■, NUMBER ■



- Started treatment 2 yo
- Chart review 5 yo
- 97% reacted to tahini
- Skin test- 8mm
- Sesame IgE- 2.8

At allergist discretion, if labs decreased, offered challenge of 2.5 gram sesame protein

FIGURE 1. Number and percentage of patients at various stages of sesame oral immunotherapy. ^aOne patient with positive desensitization.

oitadvisors@googlegroups.com ▼

ello all! I am starting SLIT and wondering about freezing milk, liquid egg white and tree nut milks. V

5 year old avoids all forms milk and egg (as well as PN,TN). Total IgE 670. Milk IgE 80. Casein 50. Egg IgE >100. Ovomuroid >100.

- A.SLIT
- B.OIT
- C.Xolair
- D.Xolair with OIT
- E. Do nothing

The use of grocery-sourced real-food solutions in sublingual immunotherapy for food allergies

Brock A. Williams, PhD^{*†}; Ally Baaske, BSc^{*}; Lianne Soller, PhD^{*}; Stephanie C. Erdle, MD^{*†}; Tiffany Wong, MD^{*†}; Raymond Mak, MD^{*†}; Nikhila D. Schroeder, MD[‡]; Edmond S. Chan, MD^{*†}

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Annals of Allergy, in Press

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ABSTRACT

Background: Sublingual immunotherapy (SLIT) is a safe, effective therapy for the treatment of food allergy. Studies demonstrating SLIT efficacy have primarily used pharmaceutical glycerinated food extracts for the administration of food allergens, which may limit accessibility due to extract cost and availability.

Objective: To develop novel sample protocols and resources for the preparation of grocery-sourced real-food SLIT solutions, which could help more clinicians incorporate food SLIT into their practice and increase accessibility to this treatment. Second, to describe our site's experience with real-food SLIT implementation.

Methods: Three- and five-dose build-up protocols were developed using powdered- or liquid-based forms of food allergens, with a maintenance dose of 2 to 4 mg protein/d. Patient adherence and satisfaction data were collected through online surveys. After 1 to 2 years of daily real-food SLIT maintenance dosing, patients were offered a low-dose oral food challenge (cumulative dose, 330-340 mg protein).

Results: Sample protocols for real-food SLIT were developed for 31 foods, including peanut, cow's milk, cashew, egg, and sesame. At our site, 305 patients have undergone or are currently undergoing real-food SLIT. Of 162 satisfaction survey respondents, 99% (n = 160) were satisfied or very satisfied with their care. Adherence surveys revealed that 82% of the respondents (n = 105/128) reported consistently taking their SLIT dose. Among a subset of 33 patients, 57 low-dose oral food challenges were performed, of which 70.1% (n = 40) were successful.

Conclusion: Grocery-sourced real-food SLIT solutions present another food SLIT option that may expand the feasibility and accessibility of this safe and effective food allergy immunotherapy.

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- 2 to 4 mg protein
- 305 patients (August 2020 to Sept 2024)
- Various foods- salmon, shrimp
- 99% satisfaction 82% adherence
- 33 patients (10%) did 57 low dose OFC. 70% passed

Practical Tips for Starting SLIT Using Real Foods^a

Recommendation area	Practical tips/recommendations
Eligible food allergens and types of clinical outcomes that can be achieved by SLIT	1. Currently, peanut and other legumes, soy, tree nuts, sesame, cow's milk, egg, wheat, salmon/cod, mustard, sunflower seed, and other allergens are offered in our program. SLIT for other food allergies may be provided on the recommendation of the allergist.

Who could benefit from SLIT (indications)

1. Anyone with an accurate diagnosis of IgE-mediated food allergy.
2. The FAIT program offers SLIT for children aged 6 y and older and adolescents or preschool children who were determined by their allergist to be at too high risk for OIT based on their previous reactions and/or other criteria. Other experienced SLIT practices may offer their versions of SLIT protocols to even younger ages. Given success in adolescents, SLIT is also an option for adults.
3. SLIT could be considered as an alternative to OIT to be discussed with any individual with food allergy who desires an active treatment process. It may especially be beneficial for those unable to tolerate oral treatment or for those who are concerned about the risks of OIT due to its higher rates of severe reactions and adverse effects, including anaphylaxis and EoE.

Contraindications

1. Previous history of anaphylaxis to the targeted food is not a contraindication for SLIT.

3. For patients with allergy to multiple foods, the preferred approach is to treat multiple foods simultaneously. There is no clinical limit to the number of foods that can be treated concurrently. However, there are practical considerations, the main ones with real-food SLIT being family time and effort. Treating approximately 5 foods concurrently is acceptable to many families, but treatment of >5 food allergens concurrently can be time consuming for food acquisition, storage, preparation, and dose administration. The decision should be made through shared decision-making with the treating team and involve the entire family.

Concerns: Too high risk? 30% failed challenges-not much details on challenges -- passed PN challenges versus milk or egg (baked or visible) versus shrimp/salmon

Long-term comparison of high- and low-dose oral immunotherapy in children with anaphylactic cow's milk allergy

Yu Ito ^{1 2}, Ken-Ichi Nagakura ^{1 3}, Sakura Sato ¹, Motohiro Ebisawa ^{1 2}, Noriyuki Yanagida ¹

Affiliations + expand

PMID: 39891491 DOI: 10.1111/pai.70033

Pediatric Allergy and
Immunology, Feb 2025

Abstract

Background: Long-term evidence on maintenance doses of oral immunotherapy (OIT) for anaphylactic cow's milk allergy is insufficient.

Methods: We retrospectively compared the three-year safety, efficacy, and adherence between OIT with a maintenance dose of 200 mL of cow's milk (HOIT, 2009-2013) and 3 mL of cow's milk (LOIT, 2013-2019). Patients aged 6-18 years with a history of anaphylaxis reacting to ≤ 3 mL of cow's milk during oral food challenge (OFC) were included. Adverse symptoms, OFC negative rate after 2 weeks of avoidance, dropout rate, and immunological changes were compared.

Results: The median ages in the HOIT (n = 78) and LOIT (n = 99) groups were 8.1 and 7.8 years, with milk-specific IgE levels of 56.5 and 49.2 kUA/L, respectively. The percentages of doses triggering symptoms were 20.88%, 13.73%, and 7.31% in the HOIT group and 11.81%, 8.15%, and 6.30% in the LOIT group during years 1, 2, and 3, respectively. After 3 years, 29% of patients in the HOIT group passed the OFC with 200 mL, and 47%, 8%, and 5% of patients in the LOIT group passed the OFC with ≥ 25 mL, ≥ 50 mL, and 100 mL of cow's milk, respectively. After 3 years, the dropout rates were 24% and 11% in the HOIT and LOIT groups and milk-specific IgE levels decreased by 88% and 78% in the HOIT and LOIT groups, respectively.

Conclusion: HOIT enables higher dose consumptions. LOIT might be safer and have higher adherence in patients with anaphylactic cow's milk allergy.

Keywords: anaphylaxis; comparison; cow's milk allergy; long-term; maintenance dose; oral immunotherapy; protocols.

After 3 years of 3 ml of milk, 47% passed OFC of ≥ 25 ml of milk

Home multfood oral immunotherapy microdosing with Dartmouth Spoon Sheets



Sarah Hughes, MPAS, PA-C^{a,b},

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Brinda Prasanna Kumar, MD^{a,b}, and

Marcus S. Shaker, MD, MS, FAAP, FACAAI, FAAAAI^{a,b}

JACI in
Practice
Jan 2025

Clinical Implications

Multifood oral immunotherapy using Dartmouth Spoon Sheets with microspoons and small home-dose escalations can be a safe and effective treatment option.

Spoon Sheet 1: Starting out... Black spoon!



Measure one level "Black (6-10 mg) SuperDosing Static-Free Micro Spoon" of "PB2 Original Powdered Peanut Butter" and Mix well into 3 oz of Apple Sauce
MIX, MIX, MIX!



On day...	Give this amount of apple sauce-peanut mixture...	✓	Date/Time/Notes
1	5 mL	<input type="checkbox"/>	
2	10 mL	<input type="checkbox"/>	
3	15 mL	<input type="checkbox"/>	
4	20 mL	<input type="checkbox"/>	
5	25 mL	<input type="checkbox"/>	
6	30 mL (1 oz)	<input type="checkbox"/>	
7	1 oz (oz) + 5 mL	<input type="checkbox"/>	
8	1 oz + 10 mL	<input type="checkbox"/>	
9	1 oz + 15 mL	<input type="checkbox"/>	
10	1 oz + 20 mL	<input type="checkbox"/>	
11	1 oz + 25 mL	<input type="checkbox"/>	
12	1 oz + 30 mL	<input type="checkbox"/>	

- Using dosing at home with microspoons
- Virtual visit with PA q 6-8 weeks
- Average age 3.5-4.5 yo
- Peanut (57%), TN (34%), milk (16%), egg (26%) -
- Goal 300-400mg as maintenance
- Home OIT with DSS versus larger incremental doses every 2 weeks at home
- First 100 patients
- July 2024 45 patients get to maintenance (15% dropped out)
- Makes sense, seems like would work

oitadvisors@googlegroups.com ▼

ello all! I am starting SLIT and wondering about freezing milk, liquid egg white and tree nut milks. V

5 year old avoids all forms milk and egg (as well as PN,TN). Total IgE 670. Milk IgE 80. Casein 50. Egg IgE >100. Ovomuroid >100.

- A. SLIT
- B. OIT
- C. Xolair
- D. Xolair with OIT
- E. Do nothing

- For SLIT Milk and Egg: When they challenge the baked milk or baked egg, do you do the 2 egg muffin and 1 1/3 dried milk powder recipes, or do you do a lower amount?

Baked egg- About 500-600 mg egg protein (about 5 ml egg white liquid or about 600 mg egg white protein powder)
Baked milk- 30 ml milk- (about 33 mg/ml)- about 900 mg protein

Assessments

1. Allergy with anaphylaxis due to eggs, subsequent encounter - T78.08XD (Primary)

Treatment

1. Allergy with anaphylaxis due to eggs, subsequent encounter

Clinical Notes:

--

05/30/2025

Anaphylaxis to egg - Labs have trended down previously. Total IgE was 565, Egg White 80.2, Ovomuroid 39. Currently, Total IgE 560, Egg White 34, Ovomuroid 27. We plan to have her come in for a baked egg challenge next. The recipe was provided today. She will need to bring the muffins with her for the day of the challenge. Regarding the 600-milligram powder, she is running out of doses. We will have her switch over to liquid. She can go to the last 4.3 dose first and then go back up to the 6 milliliters. That will be her maintenance dose moving forward. Follow-up for the baked challenge next.

Safety and effectiveness of peanut oral immunotherapy in children under 12 months



Sarah R. Johnson, MD^a, Kara McNamara, MD^b,
Jaclyn Bjelac, MD^b, Leigh Ann Kerns, MD^b,
Ahila Subramanian, MD, MPH^b, Alice E.W. Hoyt, MD^c,
Rachel Whitsel, APRN, CNP^b, and Sandra J. Hong, MD^{b,*}

JACI in Practice Nov 2023

Clinical Implications

Peanut oral immunotherapy is an option for the treatment of peanut allergy. Our study suggests that peanut oral immunotherapy in children aged less than 12 months is safe and effective.

- Retrospective Chart Review
Cleveland Clinic
- Started 18 mg PP and build to 500 mg PP
- 22 patients
- 9.2 months old
- Mean Peanut IgE 6.8 (high?- tertiary care center)
- 1 discontinue (recurrent illnesses/logistics)
- - 2/3 mild symptoms- most self resolved
- 10 negative full dose peanut challenges
- Conclusion- All patients tolerated 500mg PP and high % of patients tolerated full PN servings

Infant and Toddler Peanut Oral Immunotherapy: Initiation Before Age 2 Increases *Ad Libitum* Peanut Consumption

JACI in Practice April 2025

S. Shahzad Mustafa, MD^{a,b}, Peter Capucilli, MD^{a,b}, Linh-An Tuong, MD, MSc^a, Denise Sanchez-Tejera, MD^a, Karthik Vadamalai, MD^{c,d}, and Allison Ramsey, MD^{a,b} Rochester, NY; and Houston, Texas

TABLE II. Protocol for peanut oral immunotherapy

Visit	Measuring spoon	Peanut protein (mg) PB2 powder	Approximate numbers of Peanuts
1	Black spoon	2	Fraction
	Red spoon	3	Fraction
	Mustard spoon	6	Fraction
2	1/64 tsp	16	Fraction
3	1/32 tsp	31	Fraction
4	1/16 tsp	63	1/4
5	1/32 tsp + 1/16 tsp	94	1/3
6	1/8 tsp	125	1/2
7	1/4 tsp	250	1
8	1/2 tsp	500	2
9	1/2 tsp + 1/4 tsp	750	3
10	1 tsp	1000	4
11	1 tsp + 1/2 tsp	1500	6
12	2 tsp	2000	8
13	2 tsp + 1/2 tsp	2500	10
14	1 tbsp	3000	12

Consumption of 1 tbsp of PB2 powder + *ad lib* consumption at least 2× weekly for 2 weeks.

Discontinue PB2 powder and continue with *ad lib* peanut consumption at least 2× weekly.

Visits will be scheduled every 2 weeks

TABLE I. Infant peanut food challenge protocol

Step	Measuring spoon (teaspoon)	Peanut protein (mg) PB2 powder	Approximate number of peanuts
1	1/32	31	Fraction
2	1/8	125	1/2
3	1/2	500	2
4	2	2000	8

- 6 mo to 4yo
- Goal 3000 mg protein
- 60 children- median age 16 mo
- 10% discontinue- adverse events or inability to consume
- 85% completed (median 7 months)
- Conclusion: Infant/toddler high dose POIT well tolerated and can lead to *ad lib* “free eating,” especially if started before 2 yo.

Makes sense 😊

Safety and Feasibility of Peanut, Tree Nut, and Sesame Oral Immunotherapy in Infants and Toddlers in a Real-World Setting

JACI in Practice Jan2025



Jenny Huang, MD^a, Leah H. Puglisi, MS^b, Kevin A. Cook, MD^a, John M. Kelso, MD^a, and Hannah Wangberg, MD^a San Diego, Calif

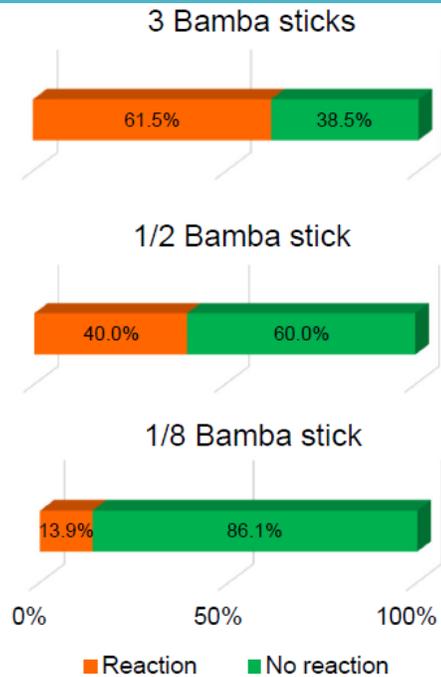


FIGURE 1. Bamba stick tolerance in peanut-allergic infants and toddlers during initial OFC. This figure assumes that 1 Bamba stick is approximately 100 mg peanut protein.

varied, and higher eliciting doses were observed for peanut (144.8 mg peanut protein) compared with cashew (1 mg cashew protein) (Table III). Most subjects (86.1%) tolerated 1/8 or 1/4 Bamba stick (~12.5 mg peanut protein) on initial OFC with no reaction (Figure 1).

- 52 patients - 24 mo and younger
- 84% single food
- 48 patients PN (92%)
- Peanut mean IgE 4.75
- Cashew (9 patients) mean IgE 6.2
- 73% updosed at home

CONCLUSIONS: OIT in infants is safe and feasible to perform in a real-world setting using commercially available food products with at-home up dosing, thus increasing the availability of OIT for patients. © 2024 American Academy of Allergy,

Food item	Amount	nut protein (mg)	Timing (dose escalation desired)*	desired)
Bamba puffs (sticks only, not the rings)	1/8 of 1 puff	12.5 [†]	Observe 30 min and if no reaction, advance to next dose	Observe for at least 60 min before sending home
	1/4 of 1 puff	25	Observe 30 min and if no reaction, advance to next dose	
	1/2 of 1 puff	50	Observe 30 min and if no reaction, advance to next dose	
	1 puff	100	Observe 30 min and if no reaction, advance to next dose	
	2 puffs	200	Observe 30 min and if no reaction, advance to next dose	
	4 puffs	400	Observe 30 min and if no reaction, advance to next dose	
	8 puffs [‡]	800	Continue advancing or can stop and wait at least 60 min before sending home [‡]	

*Dose escalations during initial OFC should be approached with careful consideration of the pros/cons of dose advancement on a case-by-case basis.

[†]If a patient was believed to have previously reacted to very trace amounts of peanut protein, the provider has the option of starting the OFC with a lower starting dose using weighed peanut flour, or (depending on the child's other food allergies) 1/8 of a Mission MightyMe multinut puff. However, we have found that most peanut-allergic children younger than 24 months tolerate a starting dose of 1/8 of 1 Bamba stick.

[‡]Realistically, infants and toddlers may not be willing to continue dose escalations to a full serving of 21 Bamba in 1 food challenge done in this manner and/or time is often a limiting factor. Thus, if an infant makes it to 8-10 puffs with no reaction, the provider may consider recommending continued home dose escalations over the next few weeks eventually to a full serving of Bamba after which parents should be advised to continue peanut protein ingestion at least once per week with the goal of peanut allergy prevention because this may be a child who is sensitized but not clinically allergic. If an allergic reaction occurs at home with this approach (suggestive of a very high threshold peanut allergy), the provider may transition to OIT with daily doses. If parents or providers are not comfortable with continued home dose escalations, they may schedule another food challenge to expose the child to higher doses of peanut protein in a supervised setting.

TABLE E2. Sample TN initial OFC for OITEFA

Food item	Amount	Approximate nut protein, per nut (mg)	Timing (dose escalation desired)*	Timing (no dose escalation desired)
Mission MightyMe multinut butter puffs [†]	1/8 of 1 puff	<1	Observe 30 min and if no reaction, advance to next dose	Observe for at least 60 min before sending home
	1/4 of 1 puff	1.125	Observe 30 min and if no reaction, advance to next dose	
	1/2 of 1 puff	2.25	Observe 30 min and if no reaction, advance to next dose	
	1 puff	4.5	Observe 30 min and if no reaction, advance to next dose	
	2 puffs	9	Observe 30 min and if no reaction, advance to next dose	
	4 puffs	18	Observe 30 min and if no reaction, advance to next dose	
	8 puffs [‡]	36	Continue advancing (transition to nut butter or nut flour) or can stop and wait at least 60 min before sending home	

ONLINE REPOSITORY

Conversion factors for calculating protein content of commercially available food products used in OIT:

- Peanut
 - 1 Bamba = 100 mg peanut protein
 - 1 Mission MightyMe multi-nut puff = 4.5 mg peanut protein
 - 1 Mission MightyMe peanut puff = 43 mg peanut protein
 - 1 tablespoon peanut butter = 3500 mg peanut protein
- Cashew
 - 1 tablespoon cashew butter = 2500 mg cashew protein
- 1 Mission MightyMe multi-nut puff = 4.5 mg cashew protein
- Sesame
 - 1 sesame seed (crushed) = 0.5 mg sesame protein
 - 1 tablespoon tahini = 2500 mg sesame protein
- Pistachio
 - 1 tablespoon pistachio butter = 3500 mg pistachio protein
- Almond
 - 1 tablespoon almond butter = 3500 mg almond protein
 - 1 Mission MightyMe multi-nut puff = 4.5 mg almond protein

How does this study impact current management guidelines? Patients younger than 24 months should be offered oral immunotherapy for food allergy with treatment initiation as soon as possible. Home up dosing can safely be offered to patients, increasing accessibility and feasibility.

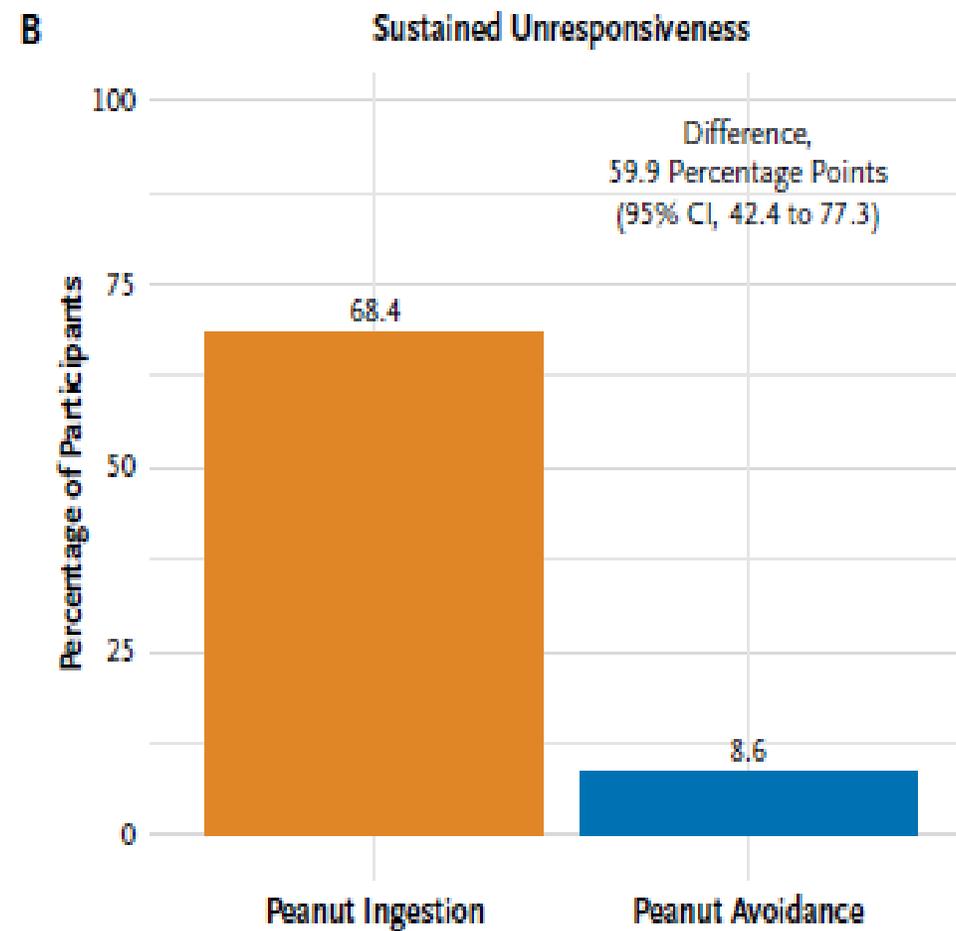
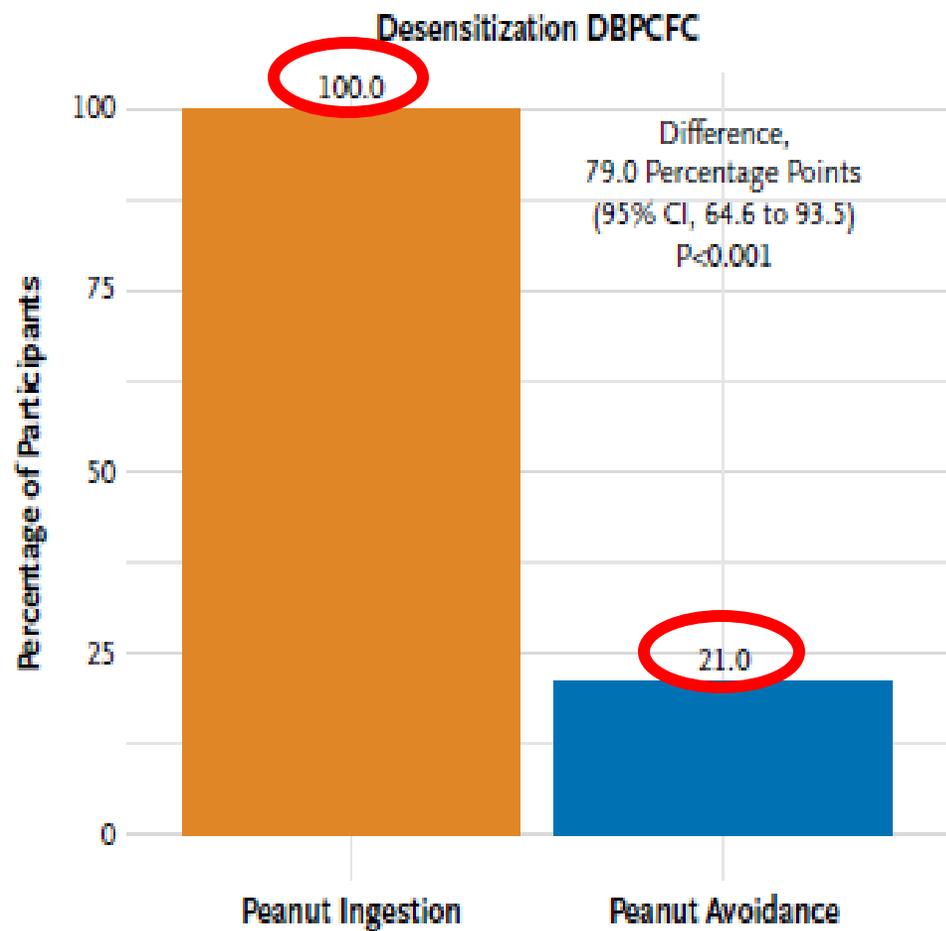
**** **Makes sense** 😊

ORIGINAL ARTICLE

Peanut Oral Immunotherapy in Children with High-Threshold Peanut Allergy

Scott H. Sicherer, M.D.,¹ Supinda Bunyavanich, M.D., M.P.H., M.Phil.,¹ M. Cecilia Berin, Ph.D.,² Tracy Lo, R.N.,¹ Marion Groetch, M.S., R.D.N.,¹ Allison Schaible, M.S., R.D.N.,¹ Susan A. Perry, R.N.,³ Lisa M. Wheatley, M.D., M.P.H.,³ Patricia C. Fulkerson, M.D., Ph.D.,³ Helena L. Chang, M.S.,⁴ Mayte Suárez-Fariñas, Ph.D.,⁴ Hugh A. Sampson, M.D.,¹ and Julie Wang, M.D.¹

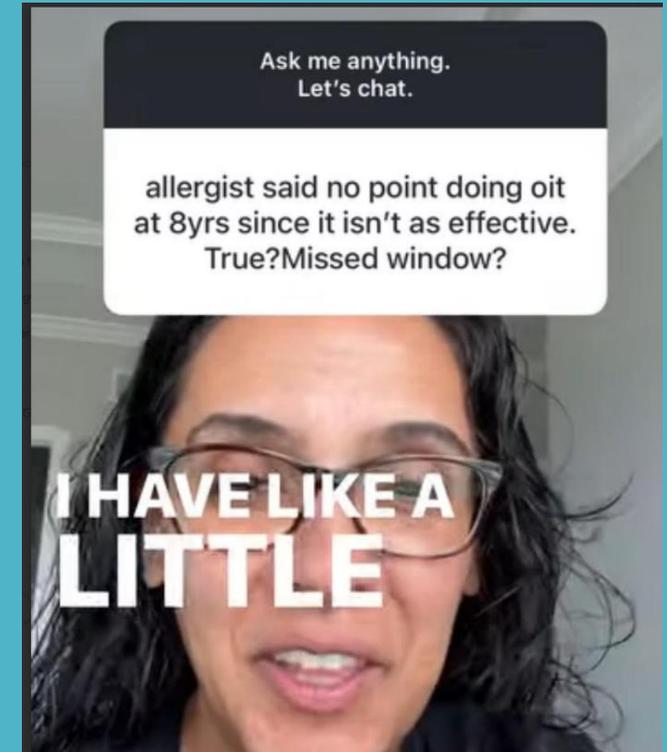
- 4 to 14 yo (average about 6-7 yo)
- Reacted at 443 to 5043 mg peanut protein
- Home dose PB versus avoidance
- Peanut IgE -5.5 Ara H2 – 3.8



8 yo has hives on chest/back with about ½ teaspoon peanut butter when baby. Scratch 5 x 8.

Total IgE 115 IgE Peanut- 4 Ara H2 – 1.75

- A. OIT
- B. SLIT
- C. Avoidance
- D. Xolair (and potential OIT later)



- IMO 😊 previously though shipped sail. Maybe not. If treat, can potentially eat PB & J by high school.
- Not a function of age...likely more so sensitivity

17 yo Indian doctor's kid senior high school going to GA Tech. Known PN allergy as baby. IgE 700. PN IgE – 80 Ara H2 – 45. Parents about accidental exposures before college.

- A. OIT (low dose)
- B. SLIT
- C. Avoidance
- D. Xolair

Home > 'Very Low-Dose' Peanut Oral Immunotherapy Helps Desensitize

'Very Low-Dose' Peanut Oral Immunotherapy Helps Desensitize

By: Jenifer Goodwin in Food Allergy, Food Allergy News
Published: February 28, 2023



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Very Low-Dose OIT Shows Efficacy for Peanut-Allergic Kids

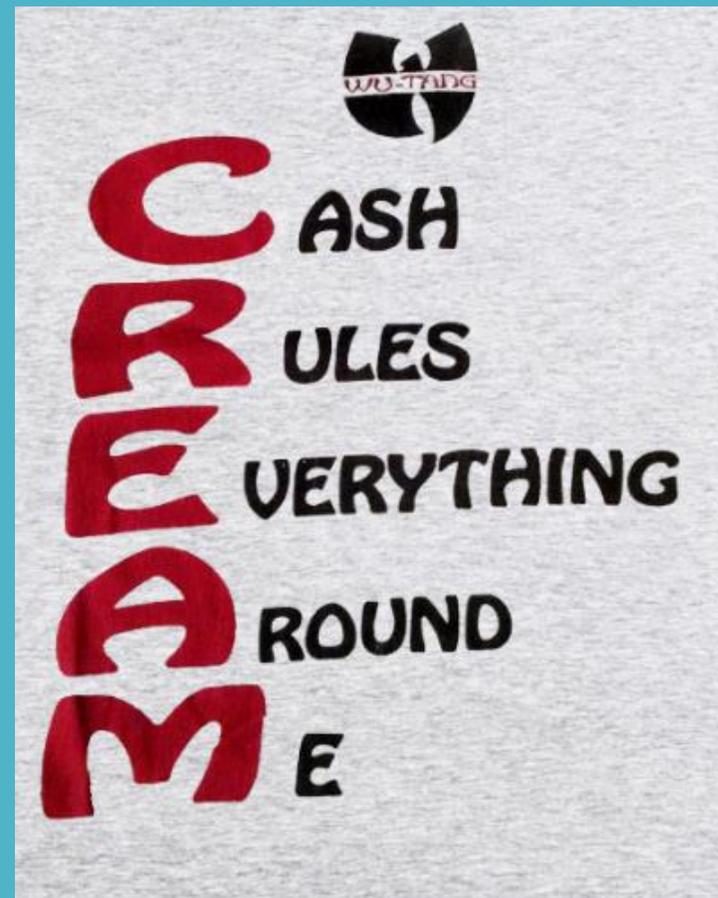
— Plus, for sesame-allergic kids, oral desensitization effective with crushed sesame seeds, tahini

How low can we go: preliminary efficacy of low dose peanut OIT

Upton et al. Abstract AAAAI 2023

Results

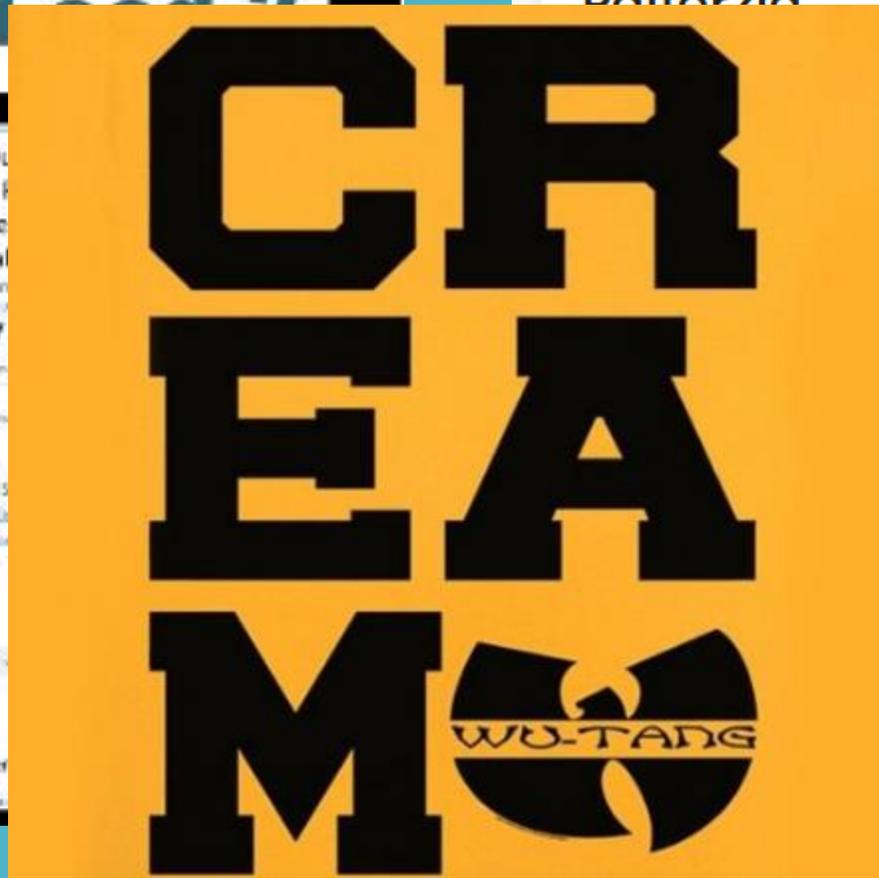
- Median age 10 yo
- PP tolerant 44 mg on entry (older, likely higher IgEs)
- VLOIT- 12/15 completed 1 year,
- 300mg OIT- 9/15 complete 1 year
- VLOIT- 10/12 tolerated 443mg, 5/12 tolerated >1043 mg
- Conclusion- VLOIT increased threshold of reactions and may allow for the simplified OIT regiments
- Waiting further data but clinically makes sense to me



Food is Medicine ... Medicinizing Food?



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Phase 3 Trial of Epicutaneous Immunotherapy in Toddlers with Peanut Allergy

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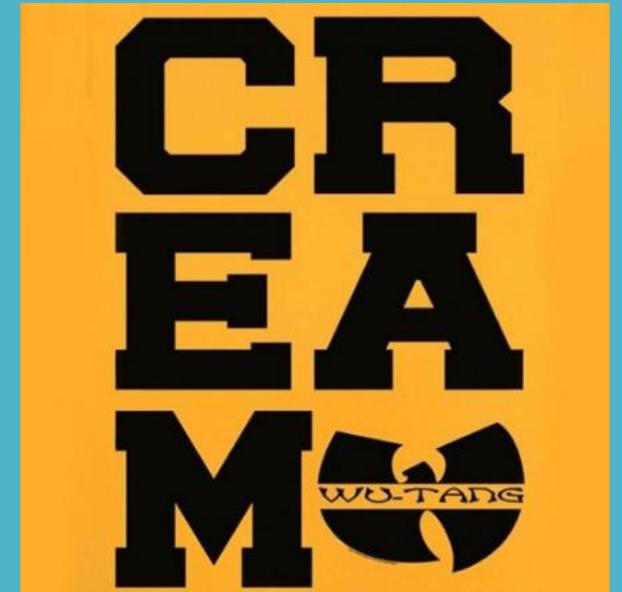


- June 2025 Meeting to continue to enroll 1-3 yo for this study (personal communication)
- Half will likely get placebo (in 2025, is that standard of care as may lose window)?
- 10K per patient enrolled?

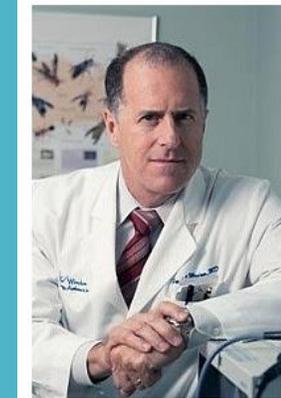
How does this study impact current management guidelines? Patients younger than 24 months should be offered oral immunotherapy for food allergy with treatment initiation as soon as possible. Home up dosing can safely be offered to patients, increasing accessibility and feasibility.

Makes sense?

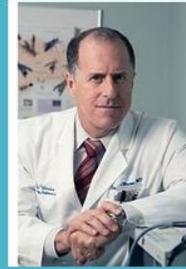
C.R.E.A.M?



- All OIT is not the same (like saying all allergy shots are the same)
- What's the narrative



RZA- The Mastermind Behind Wu Tang



Thank you