

Dear Readers: This is the free newsletter of the Asthma & Allergy Foundation of America, Texas Chapter. If you do not wish to receive other newsletters from AAFA-TX, please request we remove your address. To subscribe, email your request to info@aafatexas.org. Addresses are never shared. Thank you. Please add new sender's email (joanhart@aafatexas.org) to your address book to ensure delivery.

Air It Out – Electronic Version. Vol. 15, Issue 1, #1 January 2008 HAPPY NEW YEAR!

Asthma & Allergy Foundation of America, Texas Chapter, 9101 Quarter Horse Lane
Ft. Worth, TX 76123 817-297-3132 888-933-2232 info@aafatexas.org www.aafatexas.org

A FOLLOW-UP VISIT WITH THE DOCTOR – MORE ON ASTHMA & ALLERGIES

AAFA-TX has again asked Dr. Richard Herrscher, MD, Board Certified in Internal Medicine and Allergy and Immunology, for help in answering some difficult questions. Dr. Herrscher has offices on Communications Parkway in Plano (972-473-7544).

* **A.I.O.:** What are some signs of a **food allergy in an infant** that a parent should look for?

* **Dr. Herrscher:** Food allergy in infants can take **various forms** with the major difference being between immediate anaphylactic reactions (severe allergic reaction) and those with non-anaphylactic reactions. Non-anaphylactic food allergy reactions (mild reactions) can show up in infants as *eczema, itchy skin, chronic hives, chronic nasal congestion or asthma* and even *recurrent sinus or ear infections*. Some *gastrointestinal diseases* typified by inflammation in the colon, small bowel or esophagus can result from food allergy, too. There may be little or no relation to eating the food allergen and the appearance of symptoms, especially if the food is eaten frequently (more than 3X per week). In this situation the degree of allergy is usually low and wouldn't normally cause an anaphylactic (life-threatening) reaction. If the suspected food is removed from the diet for at least 2 weeks, and symptoms improve then return when that food is re-introduced, it might indicate an allergy to that food.

* **A.I.O.:** How can a parent know if the **infant** or toddler's food allergy has triggered an **anaphylactic** reaction?

* **Dr. Herrscher:** Anaphylactic food reactions (life-threatening) should show symptoms within the first hour after eating the allergic food, usually within 30 minutes and often immediately within 1-5 minutes. **Symptoms can be difficult to interpret as anaphylaxis: behavioral changes** (crying, fussing, irritability, inappropriate drowsiness or fright), **flushing** (a reddish tint to the face or body), **hoarseness** or change in vocal sounds from throat swelling (may also see drooling), **spitting up** or vomiting, **loose stool** or diarrhea, **colicky** or abdominal pain. **Symptoms may be more obvious for anaphylaxis: hives** or skin rash (urticaria), **swelling** of the face or hands or feet, trouble breathing with **wheezing, coughing or choking**, sudden profuse **vomiting**, cardiovascular collapse with **sweating, pale tint** or blue tint to skin, and **unresponsiveness**. It is important to realize that **only one or any combination** of the above symptoms **may show up** during a reaction. Infants can have immediate vomiting or colic after eating a food they are severely allergic to, with no other symptoms. At times **anaphylactic reactions** may manifest as **immediate spitting out of the food and gagging**. I recently skin tested a child that had a large positive reaction to peanut. On questioning, his parents said that twice he had eaten peanuts and immediately spit them out with some gagging but they saw no rash or other symptoms. They had assumed that he did not like peanuts, but never suspected that he might be allergic to peanuts. Obviously, some of the symptoms listed above, while consistent with an anaphylactic reaction to a food don't amount to a true full blown anaphylactic reaction requiring treatment with epinephrine. However, in these circumstances if enough food is ingested and stays down, then a full blown anaphylactic reaction is likely and an epinephrine injection is required immediately.

* **A.I.O.:** What are the differences between **Asthma** and **COPD** (Chronic Obstructive Pulmonary Disease)?

* **Dr. Herrscher:** Asthma is not the same as COPD, though there are some similarities and much overlap between these two diseases. **Asthma is characterized by bronchial hyper-reactivity and airflow obstruction that is completely or at least partially reversible with bronchodilator treatment. COPD is characterized by fixed or non-reversible airflow obstruction that does not improve much with treatment**, though some patients can show some degree of improvement. Asthma can improve and can go into remission with complete disappearance of symptoms. COPD doesn't go into remission and usually leads to death. Asthma is also characterized by allergic eosinophilic inflammation of the airways. In **asthma the inflammation is normally restricted to the bronchial tubes without destruction of lung tissue**. Asthma is also a disease that usually is first seen in childhood, though adult onset forms do exist. **COPD** is only seen in late **adulthood**, the inflammation is neutrophilic and non-allergic and **involves both the bronchial tubes and lung tissue with destruction of lung tissue**. Over time, there is a progressive decline in lung function resulting in total failure to breathe without oxygen support, eventually often leading to death. COPD is most commonly seen in smokers as emphysema, though there are genetic forms of this disease that occur in non-smokers.

* **A.I.O.:** Can someone have both asthma and COPD?

* **Dr. Herrscher:** Patients **can have features of both diseases**. Asthmatics that smoke may develop COPD later in life and still have asthmatic characteristics or symptoms. Also there are some forms of asthma characterized by extensive thickening or scarring of the connective tissue in the airways that can lead to fixed airway obstruction and a progressive decline of lung function over time similar to COPD. While uncommon in most asthmatics, this thickening in the connective tissue of the airways can progress to the symptoms and features more characteristic of COPD later in life. For more information on asthma and allergies, contact AAFA-TX and see our website: www.aafatexas.org

Upcoming Free AAFA-TX Programs: **1) Tues. Jan. 8**, 9 am-noon, "**Asthma Management & Education**" a CE program for nurses worth 3 contact hrs, Hanna HS, Price Rd., Brownsville **2) Fri. Feb. 29**, 9 am-noon, "**Asthma Management & Education**" a CE program for nurses worth 3 contact hrs, Lake Highland HS, Richardson. **3) Fri. Feb 29**, 1-3 pm, "Recognition & Treatment of Anaphylaxis" a CE program for nurses worth 2 contact hrs, Lake Highland HS, Richardson, Eric Schmitt, MD, instructor. Pre-registration required. For more information, contact AAFA-TX.

Information contained in this publication should not be used as a substitute for responsible professional care to diagnose and treat specific symptoms and illness. Any reference to products and procedures is not an endorsement. AAFA-TX and all parties associated with this Bulletin will not be held