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From tertiary centre to tiny island – navigating allergy guideline application across settings



In my 15-year career as a dietitian, I have been fortunate and privileged to work across a range of different clinical settings. My two most recent NHS roles were in one of the country's leading Paediatric Tertiary Centres and in a remote Scottish island community. Combined, these roles helped me develop skills in providing the best possible paediatric allergy care in the context of the available resources.

There are many different UK and international best-practice guidelines for the management of children with cow's milk allergy (CMA), with similarities and some differences. Whilst guidelines serve as a foundation to our practice, their interpretation, and implementation in the clinical setting, requires flexibility and a context-dependent approach.

Guidelines and their limitations

As clinicians we can focus heavily on guidelines. However, the intricacies and slight differences between guidelines on allergy remind us of the importance of keeping the family we are supporting as the primary focus. In my practice I apply guidance in the context of the individual child and their family situation.

The challenges these families face are significant, and much of what is asked of them can feel daunting. For example, when asking families to reintroduce cow's milk (either via breastmilk or standard formula) to confirm a CMA diagnosis, or by taking the bold step of checking for tolerance acquisition at 9-12 months of age. While the tertiary centre often has better facilities to address these needs, access to frequent and approachable healthcare professionals, such as those available in a remote setting can be as valuable, if not more, for families.

Allergy rates and remote and rural challenges

Remote and rural populations face a unique set of healthcare challenges, specifically in paediatric allergy care. This includes difficulty accessing specialist care due to distance, weather and transport constraints.¹ Whilst working in the remote and rural setting I experienced firsthand the limited access to skin-prick testing (SPT), with a SPT service from the closest specialist centre visiting only once a year. For urgent cases, there was the option to refer patients into the regional specialist service, requiring very significant travel distances for appointments. At a point in allergy care where we are moving towards more proactive management, aiming for earlier food challenges for tolerance acquisition, the absence or limited acute paediatric services in many remote regions can make 'cautiously bold' decisions more challenging.



Applying guidelines in urban vs rural settings

The examples below demonstrate how geography may influence care-planning, even in the context of the same clinical experience and use of the same guidelines.

The stark contrast between these highlights differences in the approach that is needed. For many of us, our clinical practice is somewhere between the rural and tertiary setting, thus it is essential that we interpret guidelines in a context-specific way. We should also bear in mind that the support families feel they receive may be the single most valuable thing, rather than the clinical intricacies of the allergy treatment itself.

What it boils down to

Framing clinical decisions by considering the risks of doing *something*; e.g. the risk associated with asking a family to trial cow's milk at home, versus doing *nothing*; e.g. the risk associated with an additional 6 months wait for a SPT, really helped me navigate work in the remote and rural setting.

Our nearest Specialist Allergy multi-disciplinary team (MDT) service and the allergy nurses in particular, were hugely supportive. This reaffirmed that communication with colleagues in other centres is absolutely key in the delivery of good patient care. I met the allergy nurses socially when they visited the annual SPT clinic – this was among the most useful things I did in my time as a remote and rural dietitian, allowing us to establish a good working relationship which was of huge benefit over the following months.

Having worked across a range of settings, I believe that excellent allergy care is achievable for children in all communities. Its success hinges on excellent intra-centre communication, a supportive wider team of colleagues, and decision-making processes which are bold when in the patient's best interest. The differences we see in allergy guidelines remind us that a patient-centered, flexible approach is needed. 🙌



Guideline recommendation	Urban setting considerations 	Remote and rural setting considerations 
The home challenge to test tolerance acquisition	Acute paediatric care is generally accessible for families in the event of a severe reaction, including high-dependency/intensive care.	Limited or no access to acute paediatric care – in the event of a severe reaction or need for respiratory support the child would need to be airlifted.
Introduction of allergens in an infant with severe atopic eczema	SPT is likely to be available and accessible; access to specialist acute paediatric care quickly if needed.	Longer time to arrange and travel for SPT; time could increase the risk to the infant of developing a food allergy; home introduction risks a reaction with limited local resources to manage this.
A formula-fed infant has not responded to the extensively hydrolysed formula (eHF) and requires an amino acid formula (AAF) or hydrolysed rice formula (HRF) trial	I will likely be able to obtain a supply of the formula the same day and arrange for an ongoing supply.	There may not be availability of these formulas locally; delivery may take time. During winter months, or spells of poorer weather, island ferries may be cancelled affecting supplies.

Reference

1. Health, Social Care and Sport Committee. RCGP Scotland response: Healthcare in Remote and Rural Areas consultation. [Online]. Available at: www.rcgp.org.uk/getmedia/eb01ba6c-3271-449d-9c0e-53d2e478d4a3/RCGP-Scotland-response-to-Healthcare-in-Remote-and-Rural-Areas-consultation.pdf.

