Introduction
Food allergy has become an increasingly common condition in the paediatric community over recent decades. Many of these patients are at risk of developing anaphylaxis following exposure to food allergens. Adrenaline Auto-Injector (AAI) devices are prescribed to these patients to be used in the event of anaphylaxis following accidental exposure.

Guidance
The Irish Food Allergy Network (IFAN) recommends that patients who are prescribed AAIs should carry two AAIs at all times. For school-going children, it is recommended that two AAIs should be stored in their school in the event of accidental exposure.

Aims
To evaluate parental compliance with carriage of AAI devices according to guidelines.

Methodology
A one-page questionnaire was compiled, which was approved by Tallaght University Hospital Clinical Audit Committee.

We invited parents of children attending the paediatric allergy outpatient and day-ward services who had been prescribed AAI devices to complete this questionnaire anonymously and return it to clinical staff.

This audit was carried out from October 2018 to January 2019 in five outpatient and four day-ward clinics each month. Data was compiled in a spreadsheet and interpreted.

Results
53 parents completed our questionnaire. Patients ranged from nine months to sixteen years of age.

71% (n=38) reported carrying AAI devices. Of these, 66% (n=35) carried two devices.

88% (n=47) reported that their AAIs were within date.

Of those without devices, 15% (n=8) reported AAIs were left in the car while another 11% (n=6) stated their AAIs were left at home.

Regarding confidence in AAI training, 75% (n=40) of parents surveyed felt confident in knowing when an AAI should be given, giving a score of 4 or 5 on a scale of 1 to 5. 86% (n=46) were confident in knowing how to administer an AAI device.

Conclusion
Our audit shows that 1 in 3 patients who were prescribed AAIs did not carry the recommended two devices with them when attending our outpatient services. Only 75% of patients and parents felt confident in knowing when they should give an AAI. This audit highlights the importance of taking the time to educate and re-educate patients and parents. Emphasis should be made on the importance of carrying AAIs at all times.

REFERENCES
Using Pearson Chi Square test to evaluate the correlation between children with monosensitisation and polysensitisation with the degree of control asthma we have obtained a p value > 0.05, statistically insignificant.

Using Pearson Chi Square test to evaluate the correlation between children with < 2 exacerbations and ≥ 2 exacerbations with mono and polysensitisation in children with allergic asthma we have obtained a p value > 0.05, statistically insignificant.

Conclusion In this study of children with atopic asthma, mono and polysensitisation does not influence the degree control and also hasn’t influenced the asthma exacerbations during one year.

P14 EGGSTRA SPECIAL TREATMENT: IN HOSPITAL FOOD CHALLENGES FOR EGG ALLERGY: ARE WE DOING TOO MANY?

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Aim To assess compliance of our paediatric department with internationally recommended standards for the assessment and management of egg allergy.

Methods Written records of all egg challenges performed in a paediatric assessment unit were collected from 2013–2018. We divided reactive symptoms into three categories; GI, respiratory (mild wheeze) and mucocutaneous involvement. We compared the reactions in children with pre-existing risk factors to those without. The British Society for Allergy and Clinical Immunology (BSACI) recommends that children with mild egg reactions have incremental forms of egg at home. They recommend in-hospital food challenges are reserved for children with co-existing asthma or previous anaphylaxis. We compared our practice with their 2010 egg allergy management guidelines.

Results There were 161 challenges over five years. 92% of those challenged passed (n=149). 27.9% (n=45) had no reaction. 42 charts were available for more detailed assessment.

In the charts reviewed 47% (n=20) had asthma and 57% (n=24) had previous history of anaphylaxis. Of those with asthma, 73.6% (n=14) passed the challenge and 26% (n=5) failed and developed anaphylactic symptoms. The median age of those who failed in this asthma cohort was 9.4yrs and 10.7yrs in those that passed. One patient developed all three symptoms, and 9 developed two symptoms. In the non-asthma cohort (n=22) two patients developed all three, 11 had two symptoms, six patients had one symptom.

Of the 24 children with an anaphylaxis history 79% (n=19) passed the challenge and 20.8% (n=5) failed - all of whom also had asthma. Older patients were more likely to pass – median age 11 vs 9.7yrs.

Conclusion The natural course of egg allergy is to diminish with age. This combined with the BSACI recommendation that clinical diagnosis is sufficient for most children who are not high-risk, removes the need for in-hospital food challenges. Our results show older children were more likely to pass reinforcing the predictability of the natural history. We also showed that even in the ‘at risk’ group a high percentage were passing and their reactions weren’t significantly worse than those without asthma. We currently do not implement BSACI guidelines. This is expensive and may preclude true high-risk candidates from specialist assessment. This study raises some questions: Could children with mild asthma be observed reintroducing baked egg rather than going through a formal challenge? Is it possible to predict who is going to react from risk factors?