Selections from international journals

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WAO - ARIA consensus on chronic cough: Executive summary

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Acute cough is a highly prevalent symptom in clinical practice. Chronic cough is a complex disease with significant impact on quality of life. The mechanistic pathways of chronic cough in cough-comorbid clinical phenotypes are elusive. Mounting evidence suggests presence of a hypersensitive cough reflex and implication of transient receptor potential channels and P2X receptors in cough neuronal pathways. Previously, the World Allergy Organization (WAO)/Allergic Rhinitis and its Impact on Asthma (ARIA) Joint Committee on Chronic Cough published updated experimental and clinical data on chronic cough, in addition to a multidisciplinary care pathway approach to its management. The goal of this manuscript is to provide clinicians with a succinct summary of chronic cough pathophysiology, clinical phenotypes, and management strategies in both primary and cough specialty care. This executive summary is a primer for clinicians on chronic cough. Increasing awareness on the topic among primary care physicians will improve the outcome of management of patients with chronic cough.

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EAACI guidelines on the management of IgE-mediated food allergy

Alexandra F Santos, Carmen Riggioni, Ioana Agache, Cezmi A Akdis, Mubeccel Akdis, Alberto Alvarez-Perea, Montserrat Alvaro-Lozano, Barbara Ballmer-Weber, Simona Barni, Kirsten Beyer, Carsten Bindslev-Jensen, Helen A Brough, Betul Buyuktiryaki, Derek Chu, Stefano Del Giacco, Audrey Dunn-Galvin, Bernadette Eberlein, Motohiro Ebisawa, Philippe Eigenmann, Thomas Eiwegger, Mary Feeney, Montserrat Fernandez-Rivas, Alessandro Fiocchi, Helen R Fisher, David M Fleischer, Mattia Giovannini, Claudia Gray, Karin Hoffmann-Sommergruber, Susanne Halken, Jonathan O'B Hourihane, Christina J Jones, Marek Jutel, Edward F Knol, George N Konstantinou, Gideon Lack, Susanne Lau, Andreina Marques Mejias, Mary Jane Marchisotto, Rosan Meyer, Charlotte G Mortz, Beatriz Moya, Antonella Muraro, Caroline Nilsson, Lucila Camargo Lopes de Oliveira, Liam O'Mahony, Nikolaos G Papadopoulos, Kirsten P Perrett, Rachel Peters, Marcia Podesta, Lars K Poulsen, Graham Roberts, Hugh Sampson, Jürgen Schwarze, Peter Smith, Elizabeth Tham, Eva Untersmayr, Ronald Van Ree, Carina Venter, Brian Vickery, Berber Vlieg-Boerstra, Thomas Werfel, Margitta Worm, George Du Toit, Isabel Skypala.

This European Academy of Allergy and Clinical Immunology (EAACI) guideline provides recommendations for the management of IgE-mediated food allergy and was developed using the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) approach. Following the confirmation of IgE-mediated food allergy diagnosis, allergen avoidance and dietary

advice (with support of a specialised dietitian, if possible) together with the provision of a written treatment plan, education on the recognition of allergic symptoms and prescription of medication including adrenaline using an auto-injector are essential. Patients with significant anxiety and requirement for coping strategies may benefit from support from a clinical psychologist. As immunomodulatory interventions, omalizumab is suggested for treatment of IgE-mediated food allergy in children from the age of 1 and adults; and oral allergen-specific immunotherapy is recommended for children and adolescents with peanut allergy and suggested for milk and egg allergies (generally after 4 years of age for milk and egg). Sublingual and epicutaneous immunotherapy are suggested for peanut allergy but are not yet available at the point of care. Future research into disease modifying treatments for IgE-mediated food allergy are highly needed, with standardised and patient-focused protocols and outcomes.

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Global change, climate change, and asthma in children: Direct and indirect effects - A WAO Pediatric Asthma Committee Report

Peter N Le Souëf, Yuichi Adachi, Eleni Anastasiou, Ignacio J Ansotegui, Héctor A Badellino , Tina Banzon, Cesar Pozo Beltrán, Gennaro D'Amato, Zeinab A El-Sayed, Rene Maximiliano Gómez, Elham Hossny, Ömer Kalayci, Mário Morais-Almeida, Antonio Nieto-Garcia, David B Peden, Wanda Phipatanakul, Jiu-Yao Wang, I-Jen Wan, Gary Wong, Paraskevi Xepapadaki, Nikolaos G Papadopoulos

The twenty-first century has seen a fundamental shift in disease epidemiology with anthropogenic environmental change emerging as the likely dominant factor affecting the distribution and severity of current and future human disease. This is especially true of allergic diseases and asthma with their intimate relationship with the natural environment. Climate change-related variables including increased ambient temperature, heat waves, extreme weather events, air pollution, and rainfall distribution, all can directly affect asthma in children, but each of these variables also indirectly affects asthma via alterations in pollen production and release, outdoor allergen exposure or the microbiome. Air pollution, with its many and varied respiratory consequences, is likely to have the greatest effect, as it has increased globally due to rapid increases in fossil fuel combustion, global population, crowding, and megacities, as well as forest burning and trees succumbing to an increasingly hostile environment. Human activities have also caused substantial deterioration of the global microbiome with reductions in biodiversity for molds, bacteria, and viruses. Reduced microbiome diversity has, in turn, been associated with increases in Th2 allergic responses and allergic disease. The collective effect of these changes has already shifted allergy and asthma disease patterns. Given that changes in climate have been relatively small to date, the unavoidable, much greater shifts in climate in the future are concerning. Determining the relative scale of the direct versus indirect effects of climate change variables is needed if effective avoidance and adaptive measures are to be implemented. This would also require much more basic, epidemiological, and clinical research to understand the causal mechanisms, the most relevant climate factors involved, the regions most affected and, most importantly, effective and actionable adaptation measures. We suggest that allergy and respiratory health workers should follow current guidance to reduce present risks related to climate change and watch for new recommendations to reduce future risks. Since the respiratory system is the one most affected by climate change, they also need to call for more research in this area and show strong leadership in advocating for urgent action to protect children by reducing or reversing factors that have led to our deteriorating climate.

Rheumatology (Oxford). 2025; 64(2):798-804.

Predictors of lack of response to methotrexate in juvenile idiopathic arthritis associated uveitis

Chiara Mapelli, Elisabetta Miserocchi, Marco Nassisi, Gisella B Beretta , Luca Marelli, Gaia Leone, Achille Marino, Cecilia Chighizola, Gilberto Cincinelli , Teresa Giani, Paolo Nucci , Francesco Viola, Giovanni Filocamo, Francesca Minoia; Pediatric Rheumatology Associated Group of the Milan Area

Objectives: To investigate clinical features associated with lack of response to MTX in juvenile idiopathic arthritis associated uveitis (JIA-U). Methods: Clinical records of JIA-U patients were retrospectively reviewed. Differences among variables were assessed by Mann-Whitney and $\chi 2$ or Fisher's exact tests as appropriate. Association between predictors and requirement of a biological disease-modifying antirheumatic drug (bDMARD) was evaluated by univariate Cox regression analysis and Kaplan-Meier curves. A multivariable logistic model was applied to estimate strength of association, adjusting for potential confounders. Results: Data from 99 JIA-U patients treated with MTX were analysed (82.8% female), with a mean follow up of 9.2 years and a mean age at uveitis onset of 5.7 years. In 65 patients (65.7%) at least one bDMARD to control uveitis was required. Children requiring a bDMARD for uveitis had lower age at JIA and uveitis onset, more frequent polyarticular course, higher frequency of bilateral uveitis at onset and higher prevalence of systemic steroids' use. Despite similar frequency of ocular damage at onset, MTX non-responders showed a higher percentage of ocular damage at last visit. Younger age at JIA onset, polyarticular course and a history of systemic steroids' use resulted independent factors associated to lack of response to MTX at Cox regression analysis. Kaplan-Meier curves and the multivariate model confirm the independent role of both polyarticular course and systemic steroids' use. Conclusions: Younger age at JIA onset, polyarticular course and a history of systemic steroids' use are predictors of a worse response to MTX in JIA-U.