


ORIGINAL ARTICLE

Allergen-Specific Immunotherapy and Biologics

Allergen immunotherapy and/or biologicals for IgE-mediated food allergy: A systematic review and meta-analysis

Debra de Silva¹  | Pablo Rodríguez del Río²  | Nicolette W. de Jong³ |
 Ekaterina Khaleva⁴  | Chris Singh⁵ | Anna Nowak-Węgrzyn⁶  | Antonella Muraro⁷  |
 Philippe Begin⁸  | Giovanni Pajno⁹ | Alessandro Fiocchi¹⁰  | Angel Sanchez¹¹ |
 Carla Jones¹² | Caroline Nilsson¹³  | Carsten Bindslev-Jensen¹⁴  | Gary Wong¹⁵  |
 Hugh Sampson¹⁶  | Kirsten Beyer¹⁷ | Mary-Jane Marchisotto¹⁸ |
 Montserrat Fernandez Rivas¹⁹  | Rosan Meyer²⁰  | Susanne Lau²¹  |
 Ulugbek Nurmatov²²  | Graham Roberts⁴  | the GA²LEN Food Allergy Guidelines Group

¹The Evidence Centre, London, UK²Niño Jesus University Children's Hospital, Madrid, Spain³University Medical Centre Rotterdam, Rotterdam, The Netherlands⁴University of Southampton, London, UK⁵The Evidence Centre, Wellington, New Zealand⁶NYU Langone Health, New York, New York, USA⁷Padua University Hospital, Padua, Italy⁸Univerisite de Montreal, Montreal, QC, Canada⁹Policlinico Hospital-University of Messina, Messina, Italy¹⁰Bambino Gesù Childrens' Hospital IRCCS, Rome, Italy¹¹AEPNAA Spanish Association for People with Food and Latex Allergy, Madrid, Spain¹²Allergy UK, London, UK¹³Karolinska Institutet and Sachs' Children and Youth Hospital, Stockholm, Sweden¹⁴Odense University Hospital, Odense, Denmark¹⁵Chinese University of Hong Kong, Hong Kong, Hong Kong¹⁶Mount Sinai School of Medicine, New York, New York, USA¹⁷Charité-Universitätsmedizin Berlin, Berlin, Germany¹⁸EAACI Patient Organisation Committee Chair, New York, New York, USA¹⁹Hospital Clínico San Carlos, Madrid, Spain²⁰Imperial College, London, UK²¹Charité - Universitätsmedizin Berlin, Berlin, Germany²²Cardiff University, Cardiff, UK**Correspondence**

Debra de Silva, The Evidence Centre, London, UK.

Email: debra@evidencecentre.com**Funding information**

Global Allergy and Asthma European Network (GA2LEN)

Abstract**Background:** There is substantial interest in immunotherapy and biologicals in IgE-mediated food allergy.**Methods:** We searched six databases for randomized controlled trials about immunotherapy alone or with biologicals (to April 2021) or biological monotherapy (to**Abbreviation:** NNT, number needed to treat.This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial](https://creativecommons.org/licenses/by-nc/4.0/) License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited and is not used for commercial purposes.© 2022 The Authors. *Allergy* published by European Academy of Allergy and Clinical Immunology and John Wiley & Sons Ltd.

September 2021) in food allergy confirmed by oral food challenge. We pooled the data using random-effects meta-analysis.

Results: We included 36 trials about immunotherapy with 2126 mainly child participants. Oral immunotherapy increased tolerance whilst on therapy for peanut (RR 9.9, 95% CI 4.5–21.4, high certainty); cow's milk (RR 5.7, 1.9–16.7, moderate certainty) and hen's egg allergy (RR 8.9, 4.4–18, moderate certainty). The number needed to treat to increase tolerance to a single dose of 300 mg or 1000 mg peanut protein was 2.

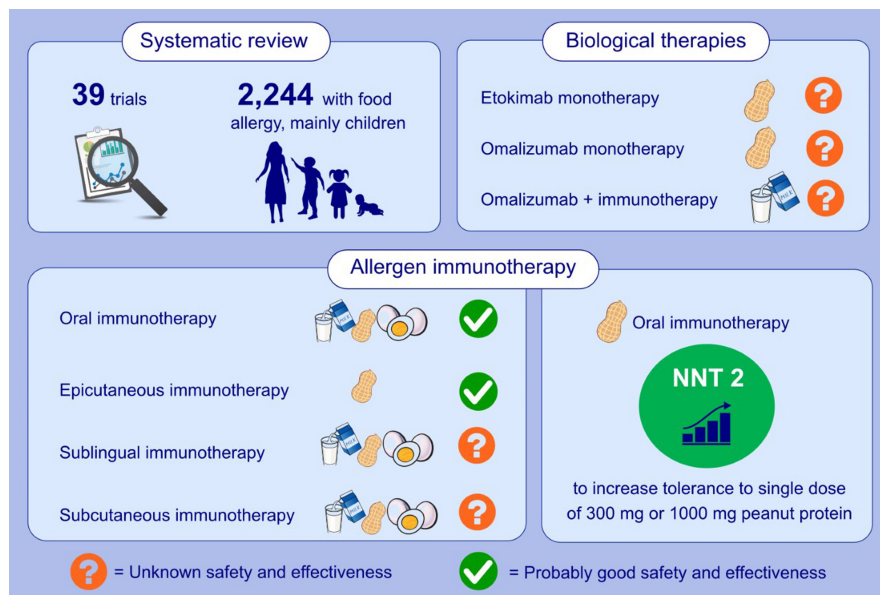
Oral immunotherapy did not increase adverse reactions (RR 1.1, 1.0–1.2, low certainty) or severe reactions in peanut allergy (RR 1.6, 0.7–3.5, low certainty), but may increase (mild) adverse reactions in cow's milk (RR 3.9, 2.1–7.5, low certainty) and hen's egg allergy (RR 7.0, 2.4–19.8, moderate certainty). Epicutaneous immunotherapy increased tolerance whilst on therapy for peanut (RR 2.6, 1.8–3.8, moderate certainty). Results were unclear for other allergies and administration routes.

There were too few trials of biologicals alone (3) or with immunotherapy (1) to draw conclusions.

Conclusions: Oral immunotherapy improves tolerance whilst on therapy and is probably safe in peanut, cow's milk and hen's egg allergy. More research is needed about quality of life, cost and biologicals.

KEYWORDS

biological, food allergy, IgE-mediated, immunotherapy, peanut



GRAPHICAL ABSTRACT

We systematically reviewed 39 randomized controlled trials about allergen-specific immunotherapy and/or biologicals in 2244 people with IgE-mediated food allergy, mostly children. We found that oral immunotherapy is probably safe and effective in peanut, milk and egg allergy. The number needed to treat (NNT) to increase tolerance to a single dose of 300 mg or 1000 mg peanut protein was 2.

Abbreviation: NNT, number needed to treat

1 | INTRODUCTION

1.1 | Background

Around 6% of people live with immunoglobulin E (IgE)-mediated food allergy¹ which affects quality of life, social activities, anxiety and

nutrition.^{2,3} Patients are advised to avoid the allergen and use medications to relieve symptoms, but accidental exposure is common and can be life-threatening.⁴

There is growing interest in allergen-specific immunotherapy (hereafter immunotherapy) and biological therapies. However, there are conflicting results, with some studies finding improved

allergen tolerance and others emphasizing increased adverse reactions.⁵

Past reviews sometimes combined studies of various designs and therapies, focused on only one type of food allergy or are outdated.⁶⁻¹⁰ We compiled an up-to-date systematic review about the efficacy and safety of immunotherapy and/or biologicals to inform forthcoming Global Allergy and Asthma European Network (GA²LEN) guidelines and add to existing guidelines.^{11,12}

1.2 | Objectives

We prioritized the following review questions after feedback from people with food allergy, patient advocates, healthcare professionals, teachers and policymakers. No industry representatives were involved.

1. What is the efficacy, safety and cost-effectiveness of a) immunotherapy alone, b) immunotherapy with a biological or c) biologicals alone for children and adults with any IgE-mediated food allergy compared to no active treatment agent?
2. What is the efficacy, safety and cost-effectiveness of immunotherapy administered by different routes for children and adults with any IgE-mediated food allergy?

2 | METHODS

A task force of allergy specialists, patient representatives, primary care doctors, psychologists, other clinicians, teachers and methodologists from 19 countries undertook the review.

The full methods are available in the protocol (International Prospective Register of Systematic Reviews PROSPERO registration: CRD42021250940) so methods are only briefly summarized here.

2.1 | Eligibility criteria

Studies meeting the following criteria were eligible:

1. Population: infants (<3 years), children (3–17 years) or adults (18+ years) with IgE-mediated food allergy confirmed using oral food challenge.
2. Intervention: allergen-specific immunotherapy alone, with a biological or biological alone.
3. Comparator: placebo, no intervention or routine management without active treatment. For review question 2, the comparator was immunotherapy using a different route.
4. Outcomes: quality of life, desensitization (ability to tolerate the allergen whilst being treated), sustained unresponsiveness (ability to tolerate the allergen after discontinuing therapy), adverse reactions, severe adverse reactions and cost-effectiveness, all as defined by the original studies.

5. Study types: randomized controlled trials (hereafter trials) published from the beginning of databases (1946) to 30 April 2021 for immunotherapy and trials and controlled comparisons up to 30 September 2021 for biological monotherapy.

2.2 | Study selection

Clinicians, patients and information specialists developed a search strategy (Supplement S1). Methodologists (CS, DdS) searched six databases (CINAHL, Cochrane Library, EMBASE, ISI Web of Science, MEDLINE, Scopus), reviewed bibliographies of reviews, guidelines and identified studies and contacted experts in the field for additional research.

Two methodologists independently screened the titles, abstracts and full text of potentially relevant studies (CS, DdS). Shortlisted studies were rescreened by the task force for consensus. Some studies included in previous reviews did not meet our stringent criteria (S2).

2.3 | Data extraction

Pairs of methodologists (MG, DdS, CS) and task force members (all authors) extracted study characteristics and outcomes independently. Clinicians independently extracted additional data about adverse reactions and thresholds (PRdR, EK, GR, PB, Awn, ADG, SA, ME, TZ), including the different definitions used (S3). A senior clinician acted as an arbitrator if needed, but there was consensus (GR).

We had most data about peanut allergy so we compiled the proportion able to tolerate 300 mg (level at which there is a substantial reduction in risk from products labelled with 'may contain')¹³ and 1000 mg peanut protein as both a single last tolerated and cumulative dose. Our approach was conservative, so when someone was reported to tolerate 300 mg to 600 mg peanut protein we classified them as tolerating a 300 mg dose. We used a range of 1000 mg to 2000 mg for the 1000 mg threshold. We used these ranges because an individual's threshold may vary by at least a factor of two when they are challenged twice within a short time.¹⁴

2.4 | Risk of bias in individual studies

Four methodologists and clinicians independently assessed the risk of bias in individual studies using the Cochrane Risk of Bias tool 2 (ROB2)¹⁵ (pairs of all authors). Arbitration was available if needed from a senior clinician (GR) but there was agreement in the risk of bias assessments.

2.5 | Synthesis of results

We used the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach to synthesize data about each outcome.¹⁶

We pooled intention-to-treat data using random-effects Mantel-Haenszel meta-analysis (Revman 5.4) because the studies included different populations, regimes and time periods and to avoid over-weighting large but imprecise studies.

We divided studies based on the food allergy and therapy route. We undertook subgroup analysis based on risk of bias, age, allergy severity, comparator and threshold tolerated. In sensitivity analysis, we used a continuity correction (adding 0.05 to numerators and denominators) where there were no events in each study arm for severe or life-threatening events, anaphylaxis and adrenaline use.

We used funnel plots to help assess publication bias. We quantified the heterogeneity of studies using the I² statistic, with values <25% indicating low heterogeneity.¹⁷

All task force members developed conclusions by consensus, recognizing any potential conflicts of interest, which were declared in advance. We used standardized GRADE statements to summarize the conclusions¹⁸ (S4 lists our wording conventions). We used the word 'may' to represent low certainty evidence, 'probably' for moderate certainty and 'resulted in' for high certainty evidence.

3 | RESULTS

3.1 | Study characteristics

We included 36 trials of immunotherapy with 2126 participants, mainly children, and 3 trials about biological monotherapy with 118 participants, mainly teenagers and adults. (Table 1 and Figure 1).

The GRADE certainty of evidence was generally low to moderate (S6). The certainty of evidence was mainly downgraded due to risk of bias (S5), indirectness and imprecision. About one quarter of studies were at low risk of bias (28%), half at moderate risk (47%) and quarter at high risk (25%).

Tables 2–4 list the key findings, with details in S6 and S7. Trends were broadly similar for people with mild/moderate or severe allergy and studies at lower and higher risk of bias (S7). There was insufficient information to be able to distinguish immunotherapy with raw vs. cooked foods or to draw conclusions about the most effective regimen or duration of treatment.

3.2 | Peanut allergy (Table 2)

3.2.1 | Desensitization

Most studies about peanut allergy enrolled children (Table 2). Oral immunotherapy resulted in a large increase in the proportion able to tolerate peanut during therapy (absolute difference 62%, relative risk (RR) 9.9, 95% confidence interval (CI) 4.5–21.4, high certainty). Those receiving oral immunotherapy were six times more likely than

controls to tolerate a single dose of 300 mg peanut (roughly one peanut, number needed to treat (NNT) 2) and 17 times more likely to tolerate 1000 mg (NNT 2). Before immunotherapy, the mean maximum tolerated dose was only about 34 mg (S5).

Epicutaneous immunotherapy probably increased the proportion able to tolerate peanut during therapy (absolute difference 29%, RR 2.6, 95% CI 1.8–3.8, moderate certainty). Those receiving epicutaneous immunotherapy were twice as likely as controls to be able to tolerate a single dose of 300 mg peanut (NNT 6).

Sublingual immunotherapy may result in a large increase in the proportion able to tolerate peanut during therapy (absolute difference 55%, RR 4.7, 95% CI 1.6–13.8, low certainty). It is unclear whether subcutaneous immunotherapy had any impact because the certainty of evidence was very low.

3.2.2 | Sustained unresponsiveness

Peanut oral immunotherapy may increase the proportion of children able to tolerate peanut after stopping therapy (absolute difference 31%, RR 8.8, 95% CI 1.2–61.6, low certainty). No data were available about sustained unresponsiveness using other administration routes.

3.2.3 | Adverse reactions

There was no statistically significant increase in the proportion of people who had adverse reactions due to peanut immunotherapy, regardless of the administration route, though oral immunotherapy was on the borderline for increasing adverse reactions (RR 1.1, 95% CI 1.0–1.2, $p = .06$, low certainty).

The most common adverse reactions were gastrointestinal, including swelling and itching in the mouth, vomiting, abdominal pain and diarrhoea. Most symptoms (80%–90%) were mild in severity and <10% withdrew from treatment as a result. Some experienced respiratory and skin symptoms such as rhinitis, wheezing, dyspnoea, asthma, laryngeal oedema, urticaria, angioedema and erythema. These ranged in severity but were usually responsive to treatment. Immune system disorders, infections, eye symptoms, ear and labyrinth disorders and cardiovascular events were not frequently reported. Eosinophilic esophagitis was rare. The frequency of adverse reactions appeared to reduce with increasing duration of immunotherapy.

Skin reactions were the most common adverse reactions to peanut epicutaneous immunotherapy. Most cutaneous reactions were mild, limited to the patch site and generally occurred in the first month of treatment. Skin manifestations extending beyond the borders of the patch were uncommon, as were extra-cutaneous reactions (respiratory, thoracic and mediastinal disorders, immune reactions or eye symptoms).

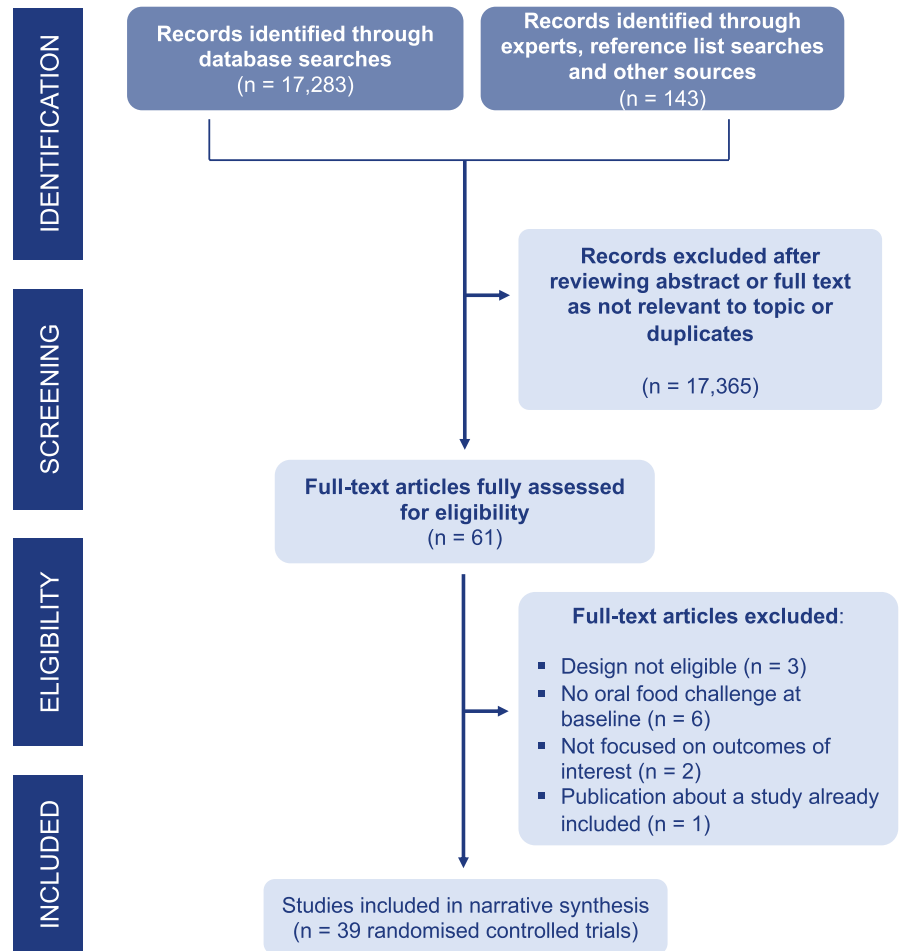
No deaths were reported due to immunotherapy, and there was no increase in anaphylaxis or life-threatening reactions (S7).

TABLE 1 Characteristics of included studies

Allergy	Administration	Studies	Participants	Allergy severity	Region
Peanut (13 studies)	Ora ²⁴⁻³⁰	7	1031 children 55 mixed age	1 study moderate 6 studies mixed	4 studies Europe 2 studies USA 1 study multiple
	Epicutaneous ³¹⁻³³	3	356 children 295 mixed age	2 studies mild/moderate 1 study mixed	1 study USA 2 studies multiple
	Sublingual ³⁴	1	40 adults	Mild/moderate	1 study USA
	Subcutaneous ³⁵	1	8 mixed age	Severe	1 study USA
	Oral vs. sublingual ³⁶	1	21 children	Mild/moderate	1 study USA
Cow's milk (11 studies)	Ora ³⁷⁻⁴⁴	8	91 infants 144 children 42 mixed age	3 studies mild/moderate 2 studies severe 3 studies mixed	1 study Asia 6 studies Europe 1 study USA
	Epicutaneous ⁴⁵	1	19 mixed age	Mixed	1 study Europe
	Oral vs. sublingual ⁴⁶	1	30 children	Mixed	1 study USA
	Oral + biological ⁴⁷	1	16 children	Severe	1 study Asia
	Ora ⁴⁸⁻⁵⁴	7	327 children	3 studies mild/moderate 1 study severe 1 study mixed	2 studies Asia 5 studies Europe
Other (1 hazelnut, 1 peach, 1 wheat, 2 multiple foods)	Ora ⁵⁵⁻⁵⁷	3	69 children 49 mixed age	2 studies mild/moderate 1 study mixed	2 studies Europe 1 study USA
	Sublingual ^{58,59}	2	78 adults	Mixed	1 study Europe
	25 studies oral 4 epicutaneous 1 subcutaneous 3 sublingual 2 oral vs. sublingual 1 oral +biological	36	2126 2 studies infants 23 children 3 adults 8 mixed age	12 studies mild/moderate 1 moderate 5 severe 18 mixed	4 studies Asia 20 studies Europe 9 studies USA 3 studies multiple
Biological monotherapy	1 etokimab ¹⁹ 1 omalizumab ²⁰ 1 TNX-901 ²¹	3	118 2 studies 13+ years 1 study half children and half 13+ years	3 studies mixed	3 studies USA

Note: Allergy severity was based on definitions in individual studies and descriptions of inclusion criteria.

FIGURE 1 PRISMA diagram showing study selection



3.3 | Cow's milk allergy (Table 3)

All but one study about cow's milk allergy enrolled children (Table 3). Oral immunotherapy probably resulted in a higher proportion able to tolerate cow's milk protein during therapy (absolute difference 53%, RR 5.7, 95% CI 1.9–16.7, moderate certainty).

An increased proportion may have experienced adverse reactions (absolute difference 67%, RR 3.9, 95% CI 2.1–7.5, low certainty), but few studies focused solely on reactions caused by the therapy (S7) and there was no significant difference in the 3 studies comparing with placebo.

The most common adverse reactions were mild gastrointestinal symptoms. A small number experienced respiratory symptoms. It was unclear whether oral immunotherapy increased severe reactions because the certainty of evidence was very low. Reports of severe reactions, anaphylaxis, use of adrenaline and discontinuation were rare. No hospital admissions or deaths were reported due to treatment.

There was insufficient evidence to draw conclusions about other administration routes in cow's milk allergy.

3.4 | Hen's egg allergy (Table 4)

All studies about hen's egg allergy were in children and all but one compared with an elimination diet (Table 4). Oral immunotherapy probably

resulted in a large increase in the proportion of children able to tolerate hen's egg during therapy (absolute difference 79%, RR 8.9, 95% CI 4.4–18, moderate certainty). It may increase the proportion able to continue tolerating hen's egg after therapy ends (absolute difference in sustained unresponsiveness 30%, RR 7.1, 95% CI 1.7–29.4, low certainty).

Egg oral immunotherapy probably resulted in a large increase in the proportion of children experiencing adverse reactions (absolute difference 71%, RR 7.0, 95% CI 2.4–19.8, moderate certainty), but few studies focused only on reactions caused by the treatment. The one study that compared with placebo found no significant difference in adverse reactions. It was unclear whether there was any impact on severe reactions because the certainty of evidence was very low.

Around 95% of reactions were mild. They occurred in about 1 in 20 doses during the build-up phase and decreased to 1 in 40 doses during the first months of maintenance. The most frequently reported symptoms were oral pruritus and gastrointestinal pain. Anaphylaxis or symptoms that were severe enough to discontinue immunotherapy were rare.

3.5 | Other food allergies and outcomes

We identified few studies about other food allergies or directly comparing immunotherapy routes to present meaningful results (see S6 and

TABLE 2 Summary of findings about immunotherapy for peanut allergy

Outcome	% active	% control	Absolute difference	Relative risk (95% CI)	NNT	Certainty of evidence	Comparisons & participants
Oral immunotherapy							
Desensitization	68	6	62%, $p < .05$	9.9 (4.5–21.4)	2	High	7 ($n = 1023$)
Tolerate single dose of 300 mg	76	13	63%, $p < .05$	5.7 (4.0–7.9)	2	Moderate	5 ($n = 820$)
Tolerate single dose of 1000 mg	56	2	54%, $p < .05$	16.6 (8.0–34.4)	2	High	5 ($n = 906$)
Sustained unresponsiveness	35	4	31%, $p < .05$	8.8 (1.2–61.6)	4	Low	1 ($n = 85$)
Adverse reactions	98	89	9% $p > .05$	1.1 (1.0–1.2)	NA	Low	7 ($n = 953$)
Severe adverse reactions	4	2	2%, $p > .05$	1.6 (0.7–3.5)	NA	Low	6 ($n = 950$)
Epicutaneous immunotherapy							
Desensitization	46	17	29%, $p < .05$	2.6 (1.8–3.8)	3	Moderate	3 ($n = 651$)
Tolerate single dose of 300 mg	30	13	18%, $p < .05$	2.4 (1.5–3.8)	6	Low	3 ($n = 333$)
Adverse reactions	78	61	17%, $p > .05$	1.2 (0.95–1.6)	NA	Low	4 ($n = 676$)
Severe adverse reactions	6	2	4%, $p > .05$	2.0 (0.8–5.1)	NA	Low	4 ($n = 676$)
Sublingual immunotherapy							
Desensitization	70	15	55%, $p < .05$	4.7 (1.6–13.8)	2	Very low	1 ($n = 40$)
Tolerate single dose of 300 mg	25	15	10%, $p > .05$	1.7 (0.5–6.1)	NA	Very low	1 ($n = 40$)
Severe adverse reactions	0	0	0	Not calculated	NA	Very low	1 ($n = 40$)
Subcutaneous immunotherapy							
Desensitization	33	0	33%, $p > .05$	1.5 (0.1–22.6)	NA	Very low	1 ($n = 4$)

Note: Rounded to nearest whole number. Absolute difference is % active minus control.

Adverse reactions and severe adverse reactions are all reactions, not necessarily linked to the therapy. Multiple definitions of severe reactions were used (see S3). In general these involved marked impact on participants (eg symptomatic bronchospasm, hypotension) and need for medical intervention. Online supplement S7 contains additional data such as the proportion of doses experiencing reactions and adverse events linked to therapy. 'Comparisons' means the number of comparisons between active and control groups. In most cases this is the total number of trials contributing the meta-analysis but some studies compared different doses with placebo. Each comparison was included separately in the meta-analysis. Data about threshold reactivity at 1000 mg peanut protein were only available for oral immunotherapy.

Abbreviations: CI, confidence interval; NA, not applicable as no statistically significant difference; NNT, number needed to treat.

TABLE 3 Summary of findings about oral immunotherapy for cow's milk allergy

Outcome	% active	% control	Absolute difference	Relative risk (95% CI)	NNT	Certainty of evidence	Trials and participants
Desensitization	68	15	53%, $p < .05$	5.7 (1.9–16.7)	2	Moderate	7 ($n = 249$)
Adverse reactions	85	17	67%, $p < .05$	3.9 (2.1–7.5)	2	Low	6 ($n = 210$)
Severe adverse reactions	3	0	3%, $p > .05$	7.0 (0.4–124.8)	NA	Very low	4 ($n = 204$)

Note: The note under Table 2 also applies to this table. There was one study about epicutaneous immunotherapy which reported events by dose (see supplement S7).

TABLE 4 Summary of findings about oral immunotherapy for hen's egg allergy

Outcome	% active	% control	Absolute difference	Relative risk (95% CI)	NNT	Certainty of evidence	Trials and participants
Desensitization	84	5	79%, $p < .05$	8.9 (4.4–18.0)	2	Moderate	6 ($n = 259$)
Sustained unresponsiveness	35	4	30%, $p < .05$	7.1 (1.7–29.4)	4	Low	2 ($n = 91$)
Adverse reactions	79	8	71%, $p < .05$	7.0 (2.4–19.8)	2	Moderate	6 ($n = 291$)
Severe adverse reactions	6	0	6%, $p > .05$	3.4 (0.6–19.6)	NA	Very low	4 ($n = 211$)

Note: The note under Table 2 also applies to this table.

S7). There was also little information about the impact on quality of life, despite being key to whether people are motivated to continue immunotherapy (S6). None of the included studies reported cost-effectiveness. We did not find a clear relationship between the duration of treatment and desensitization, sustained responsiveness or safety (S7).

3.6 | Biological therapies

There were too few studies to draw meaningful conclusions about biologicals alone or added to immunotherapy (S6). In those aged 13+ years, there was a trend towards improved tolerance of peanut during biological monotherapy, with few side effects. However the certainty of evidence was very low, with only three studies, each about different therapy.¹⁹⁻²¹

4 | DISCUSSION

4.1 | Summary of evidence

Proactive treatments are needed to reduce the burden of food allergy. Our review suggests that oral immunotherapy may be safe and effective for increasing tolerance whilst on therapy in children allergic to peanut, cow's milk or hen's egg. Three-quarters receiving peanut oral immunotherapy tolerated a single dose of 300 mg peanut protein at the end of therapy and a half a single dose of 1000 mg, which would protect against most accidental exposure. About one-third may maintain tolerance after stopping therapy, at least in the short term (3 months). Oral immunotherapy was usually well tolerated. It is likely to result in more adverse reactions, but mainly mild. Clinicians and families will need to weigh up the benefits vs. harms when considering whether immunotherapy is appropriate for individuals.

Epicutaneous immunotherapy may also be safe and effective amongst children with peanut allergy, but less is known about this for other food allergies, or about sublingual or subcutaneous immunotherapy for any food allergy. We found insufficient evidence to draw conclusions about benefits or harms from biologicals.

4.2 | Comparison with previous research

Many studies, reviews and opinion pieces have explored immunotherapy for people with food allergy, sometimes with inconsistent results.²² Our review differs from others because it includes the highest quality and most up-to-date evidence, divided by type of food allergy and administration route. We excluded trials that did not use food challenges to confirm food allergy before treatment, as this may introduce bias into absolute event rates. We examined tolerated thresholds in detail, which we believe is the first analysis of its kind. Our review supports others suggesting that clinicians could consider immunotherapy for some groups of patients.^{6,7}

4.3 | Implications for research

There is now a good pool of studies about oral immunotherapy for peanut allergy, but we can only draw limited conclusions about other food allergies, administration routes and biologicals due to sparse good quality evidence.

An important area not explored in our review is patient preferences and motivation to use immunotherapy and/or biologicals. Our findings suggest that (oral) immunotherapy may improve tolerance whilst people continue the therapy, but gains may not be sustained after stopping therapy. Therefore, people need to consider whether they are willing to continue therapy for an extended period. Future research using standardized threshold levels for each allergen may help patients make more informed decisions.

Future studies could create core outcome sets²³ and use standardized definitions and measures of quality of life, desensitization, sustained unresponsiveness and adverse reactions to allow robust comparisons across populations, regions and types of immunotherapy. Standardized immunotherapy regimens would also assist comparisons. More high quality trials are needed to directly compare different administration routes and to explore the impacts of adding biologicals.

4.4 | Strengths and limitations

A strength of our review is that it was conducted by a large group of clinicians, allied health professionals, patient representatives, teachers and researchers from different parts of the world.

By analyzing detailed data about desensitization thresholds, we showed that only 2 children needed to be treated with peanut oral immunotherapy to increase 1 child's reactivity threshold up to 300 mg and 1000 mg. This would reduce the chance of reactions from accidental consumption of packaged food containing peanut.¹¹ Given variability in reactivity thresholds,¹² achieving tolerance to a single dose of 1000 mg is likely protective to real-life exposures.

However, our conclusions are limited by methodological variations in the available studies and a lack of eligible studies about many topics. We found that adverse reactions tended to increase, but we do not know whether these reactions were due to the therapy, accidental exposure or unrelated causes. This limits conclusions about the safety profile. Some studies excluded patients with previous anaphylaxis, which may also affect generalizability.

A number of trials have pragmatic designs and do not confirm food allergy at the outset using oral food challenges. We excluded these studies to ensure that participants definitely had food allergy, but there is an argument for including such research in decision-making if the selection criteria reflect real-life clinical practice.

5 | CONCLUSIONS

There may be merit in allergen-specific immunotherapy and/or biologicals for a carefully selected group of patients, but there are also

downsides including (mainly mild) reactions to manage, relatively long treatment periods and benefits potentially only lasting whilst people maintain the regimen.

Immunotherapy is also specific to the culprit food(s) and requires exposure to allergens, which may be off-putting for some. We know little about how patient motivation to sustain the therapy may differ in various parts of the world or based on patient characteristics. When making patient-centred shared decisions about whether to offer immunotherapy and/or biologicals to an individual, clinicians and patients need to weigh up factors such as patient preferences, motivation, accessibility and cost alongside the evidence about safety and effectiveness.

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CONFLICT OF INTEREST

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AUTHOR CONTRIBUTION

All authors conceptualized the work, extracted or checked data, undertook risk of bias assessments, provided substantive comments and approved the review for submission. In addition, CS and DdS undertook searches and meta-analysis and constructed summary of findings tables. PRdR, NdJ, GR, EK, ANW, PB and ADG extracted

additional data and contributed to analysis. DdS, GR and EK managed the process.

CONTRIBUTORS

Susanne Halcken, Hans Christian Andersen Children's Hospital, Odense University Hospital, Denmark. Margitta Worm, Charité - Universitätsmedizin Berlin, Germany. Audrey Dunn-Galvin, University College Cork, Ireland. Liz Angier, University of Southampton, England. Amena Warner, Allergy UK, England. Antoine Deschildre, University Lille, France. Antonella Cianferoni, University of Florence, Italy. Barbara Ballmer, UniversitätsSpital Zürich, Switzerland. Berber Vlieg-Boerstra, OLVG Hospital, the Netherlands. Bertine Flokstra-de Blok, University of Groningen, the Netherlands. Bright Nwaru, University of Gothenburg, Sweden. Carina Venter, Children's Hospital Colorado, USA. Celine Demoulin, Association Française pour la Prévention des Allergies Siège social, France. Clare Mills, University of Manchester, England. Gary Wong, Chinese University of Hong Kong, Hong Kong. Giovanni Pajno, Policlinico Hospital-University of Messina, Italy. Hania Szajewska, Medical University of Warsaw, Poland. Hasan Arshad, University of Southampton, England. Jennifer Gerdtts, Food Allergy Canada, Canada. Josefine Gradman, Hans Christian Andersen Children's Hospital, Odense University Hospital, Denmark. Kate Grimshaw, Salford Care Organisation, England. Lars K. Poulsen, Copenhagen University Hospital, Denmark. Lynne Regent, Anaphylaxis Campaign, England. Marcia Podestà, Food Allergy Italia, Italy. Matthew Geromi, The Evidence Centre, USA. Mika Makela, Helsinki University Hospital, Finland. Montserrat Alvaro Lozano, Hospital Sant Joan de Déu, Esplugues, Spain. Montserrat Fernandez Rivas, Hospital Clínico San Carlos, Spain. Motohiro Ebisawa, Sagami National Hospital, Japan. Pete Smith, Griffith University School of Medicine, Australia. Richard Loh, Perth Children's Hospital, Australia. Robert Wood, John Hopkins Bloomberg School of Public Health, USA. Ronald Van Ree, Amsterdam UMC, the Netherlands. Sabine Schnadt, DAAB, Deutscher Allergie- und Asthmabund e.V, Germany. Stefania Arasi, Bambino Gesù Children's Research Hospital, Italy. Torsten Zuberbier, Charité - Universitätsmedizin Berlin, Germany.

ORCID

Debra de Silva  <https://orcid.org/0000-0001-8413-5487>

Pablo Rodríguez del Río  <https://orcid.org/0000-0002-0783-1988>

Ekaterina Khaleva  <https://orcid.org/0000-0002-2220-7745>

Anna Nowak-Wegrzyn  <https://orcid.org/0000-0002-0960-9854>

Antonella Muraro  <https://orcid.org/0000-0002-5026-5862>

Philippe Begin  <https://orcid.org/0000-0002-9089-4604>

Alessandro Fiocchi  <https://orcid.org/0000-0002-2549-0523>

Caroline Nilsson  <https://orcid.org/0000-0003-2040-8428>

Carsten Bindslev-Jensen  <https://orcid.org/0000-0002-8940-038X>

Gary Wong  <https://orcid.org/0000-0001-5939-812X>

Hugh Sampson  <https://orcid.org/0000-0003-1613-8875>

Montserrat Fernandez Rivas  <https://orcid.org/0000-0003-1748-2328>

Rosan Meyer  <https://orcid.org/0000-0002-5710-5570>

Susanne Lau  <https://orcid.org/0000-0002-5189-4265>

Ulugbek Nurmatov  <https://orcid.org/0000-0002-9557-8635>

Graham Roberts  <https://orcid.org/0000-0003-2252-1248>

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SUPPORTING INFORMATION

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