beyond 6 months old.

- Hydrolyzed formula (vs. cow's milk) may be used in at-risk infants to prevent or modify food allergy.
- Maternal diet during pregnancy or lactation should not be restricted to prevent food allergy.
- Children should be vaccinated with the measles, mumps, and rubella (MMR) and measles, mumps, rubella, and varicella (MMRV) vaccines (even with an egg allergy).
- Patients with severe egg allergy reactions should not receive the influenza vaccine without consulting the primary practitioner for an analysis of the risks vs. benefits (see also Chapter 6, Immunizations).

A summary of the National Institute of Allergy and Infectious Diseases guidelines is provided by McBride (2011) and Burks, Jones, Boyce, et al, (2011).

The clinical manifestations of food allergy may be divided as follows (American Academy of Pediatrics, 2014):

Systemic: Anaphylactic, growth failure

GI: Abdominal pain, vomiting, cramping, diarrhea

Respiratory: Cough, wheezing, rhinitis, infiltrates

Cutaneous: Urticaria, rash, atopic dermatitis

Food allergies usually occur either as an immunoglobulin E (IgE)–mediated or non–IgE-mediated immune response; some toxic reactions may occur as a result of a toxin found within the food. Food allergy is caused by exposure to **allergens**, usually proteins (but not the smaller amino acids), that are capable of inducing IgE antibody formation (sensitization) when ingested. **Sensitization** refers to the initial exposure of an individual to an allergen, resulting in an immune response; subsequent exposure induces a much stronger response that is clinically apparent. Consequently, food allergy typically occurs after the food has been ingested one or more times. The National Institute of Allergy and Infectious Diseases report indicates that sensitization alone is not sufficient to classify as a food allergy; rather, an immune-mediated response *and*