



Specific allergen immunotherapy for children 6–11 years

Read first



Initial asthma treatment for children 6–11 years



Trigger avoidance strategies for children 6–11 years



Allergy and asthma



Recommendation

For children with allergic asthma and symptoms triggered by clearly identified but unavoidable allergens, consider referral to an allergist or clinical immunologist to undergo assessment for specific allergen immunotherapy.

Do not advise parents that allergen immunotherapy will control asthma symptoms in children sensitised to common aeroallergens.

The potential benefits, risk of adverse effects, cost, and treatment protocol should be carefully explained to parents considering allergen immunotherapy.



Alert

Subcutaneous immunotherapy should only be administered in healthcare settings with capability for managing severe allergic reactions/anaphylaxis



Alert

In patients with severe asthma, allergen immunotherapy should not be started until good symptom control has been achieved and risk factors for exacerbations managed

Sources & rationale

Recommendation type: Consensus recommendation

Specific allergen immunotherapy involves administration of allergen extracts in precisely calculated doses to induce desensitization and/or tolerance. There are two approaches: subcutaneous immunotherapy and sublingual immunotherapy.

The Australasian Society of Clinical Immunology and Allergy advises that specific-allergen immunotherapy can be considered when indicated in children 5 years and over, based on practical considerations and clinical trial evidence, but not an absolute limitation.[\[ASCIA 2024\]](#)

In most patients sensitised to aeroallergens, allergen immunotherapy reduces, but does not eliminate, allergic reactions.[\[ASCIA 2024\]](#)

The role of allergen immunotherapy in clinical asthma management is not well established.[\[Kappen 2023\]](#)

Subcutaneous allergen immunotherapy: Few clinical trial of subcutaneous allergen immunotherapy to house dust mite have been conducted only in children, or have reported results for children separately.[\[Agache 2019\]](#) A 2020 systematic review of allergen immunotherapy in children (≤ 18 years) with asthma reported that subcutaneous allergen immunotherapy reduced ICS requirement (moderate strength of evidence), and improved asthma-related quality of life and lung function (low strength of evidence).[\[Rice 2018\]](#)

Asthma, especially severe or uncontrolled asthma, has been identified as a major risk factor for severe and fatal adverse reactions to subcutaneous allergen immunotherapy. [Epstein 2021]

Subcutaneous immunotherapy should only be prescribed and administered by practitioners with training and experience in allergy testing and in the formulation and administration of subcutaneous immunotherapy. Standardized extracts should be used, where available.

Sublingual allergen immunotherapy: There is limited evidence demonstrating effects of sublingual allergen immunotherapy on asthma exacerbations and quality of life. [Fortescue 2020] A 2020 Cochrane review of 66 trials of sublingual immunotherapy for allergic rhinitis in adults and children, in which at least 80% of participants also had allergic asthma, concluded that addition of sublingual allergen immunotherapy to asthma treatment may reduce the risk of asthma exacerbation requiring OCS or healthcare visits (low strength of evidence). [Fortescue 2020] However, results for children <12 years were not reported separately. [Fortescue 2020]

Ragweed sublingual immunotherapy reduced asthma symptoms, SABA use, and nocturnal awakenings during peak ragweed season, compared with placebo, in a randomised clinical trial in children 5 to 17 years with ragweed pollen-induced allergic rhinitis and asthma. [Nolte 2020]

Sublingual allergen immunotherapy for patients with asthma sensitised to house dust mite is better supported in adults than children. [Wonsa 2022] A 2022 systematic review reported that the single included study in children with mild-to-moderate asthma found that house dust mite sublingual allergen immunotherapy had no benefit. [Wonsa 2022]

The rate of serious adverse events associated with sublingual allergen immunotherapy in randomised clinical trials (all ages) has been estimated at $\leq 1\%$. [Fortescue 2020]

References

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Resources

ASCIA's [Allergen immunotherapy e-training for health professionals](#)

ASCIA's [list of TGA-approved allergen immunotherapy products](#)

ASCIA's treatment plans for [sublingual immunotherapy](#) and [subcutaneous immunotherapy](#)

Notes

The Australian Register of Therapeutic Goods lists a wide range of allergen preparations for sublingual or subcutaneous immunotherapy. [\[ARTG, ASCIA 2023\]](#) Availability of allergen immunotherapy products is limited by supply shortages and approval processes. [\[ASCIA 2023\]](#)

A sublingual immunotherapy commercial preparation of house dust mite allergens is approved by TGA for the treatment of children aged ≥ 5 years diagnosed with house dust mite allergy. [\[Australian PI Actair\]](#)

A subcutaneous allergen immunotherapy children commercial preparation of house dust mite allergens is approved by TGA for the treatment of children with dust mite allergy manifesting as perennial rhinitis, conjunctivitis, rhinoconjunctivitis with or without associated asthma. [\[Australian PI Alustal 2024\]](#)

Sublingual immunotherapy commercial preparations of grass pollen allergens are approved by TGA for the treatment of grass pollen allergic rhinitis with or without conjunctivitis in children ≥ 5 years. [\[Australian PI Oralair 2023, Australian PI Grazax 2021\]](#)

A subcutaneous immunotherapy commercial preparation of grass pollen allergens is approved by TGA for the treatment of children with grass pollen allergy manifesting as perennial rhinitis, conjunctivitis, rhinoconjunctivitis with or without associated asthma. [\[Australian PI Alustal 2024\]](#)