Introduction

Food allergy seems to be increasing in prevalence, significantly decreasing the quality of life for patients and their families, therefore, it has become a common diagnostic and management issue for the pediatrician.

Food allergy, defined as an adverse immune response to food proteins, affects as money as 6% of young children and 3% to 4% of adult. Food induced allergic reactions are responsible for a variety of symptoms involving the skin, gastrointestinal tract and respiratory tract and might be caused by IgE mediated and non-IgE-mediated mechanism ***(Sicherer and Sampson, 2006)***. Immunological mediated reactions to food are expressed clinically by a diversity of signs and symptoms form abdominal pain to generalized anaphylaxis ***(Bahna, 2006)***.

The prevalence of food hypersensitivities is greatest in the first few years of life, affecting about 6% of infants less than 3 years of age and decreasing over the first decade. Virtually all infant who have cow's milk allergy have it in the first year of life, with clinical tolerance developing in about 80% by their fifth birthday about 60% of infants with cow's milk allergy experience IgE-mediated reaction, and about 25% of these infants retain their sensitivity into the second decade of life, with 35% going on to have other food allergies ***(Sampson, 2004)***.

A part from immunoglobulin E (IgE) mediated atopic manifestations, T cell mediated reaction have been demonstrated in infants with CMA. The clinical spectrum ranges from immediate type reactions, to intermediated and late onset reaction. The exact mechanism of these disorders are still poorly understood ***(Heine et al., 2002)***.

Food allergy may present with a variety of respiratory tract symptoms that generally involve immunoglobulin E antibody mediated responses. Exposure is typically through ingestion, but in some cases, inhalation of air bone food particles may trigger these reaction ***(James, 2003)***.

Both acute reaction (Hives and anaphylaxis) and chronic disease (asthma, a topic dermatitis and gastrointestinal disorders) may be caused or exacerbated by food allergy. The foods most commonly causing these reactions in children are milk, egg, peanuts, soy, wheat, tree nuts, fish and shellfish. ***(Scott and Sichere, 1999)***.

Adverse reaction to foods may be toxic or non toxic. Toxic reactions are not related to individual sensitivity but occur in any one who ingests a sufficient quantity of tainted food. In contrast, non toxic adverse reactions to food depend on individual susceptibility and are either non immune mediated i.e., food intolerance, or immune mediated..i.e., food allergy ***(Scott H. Sicherer, 1999)***.

The pediatrician is faced with evaluating a panoply of skin rashes, a subset of which may be induced by food allergy. Acute urticaria is a common manifestation of on allergic skin response to food, but food is rarely a cause of chronic urticaria ***(Wesley Burks, 2003)***.

Several studies have shown that the stronger the family history of allergy, the higher the incidence of allergy in the offspring ***(Bahna, 2006).***

The diagnosis of food allergy requires a careful search for possible causes depends on careful history, physical examination, and confirmation of causes with supporting tests, including specific tests (skin tests, radioallergosorbent tests) and in some cases, oral food challenges.

Treatment consists of elimination of the causal food (s) along with medical treatment antihistamines, Na chromoglycate, corticosteroid and the prompt self administration of epinephrine in the event of a serious reaction

Prevention of food allergy depends on identifying the at risk families, prevention of prenatal sensitization and post natal sensitization by encouraging breast feeding for long period, delaying introduction of solid food until 6 months of age and evaluation of infants at 4 months, 1 year, yearly thereafter by multi test, skin test and IgE level ***(Schmitz, 2005)***.