WORKING GROUP MEETING MINUTES: Allergy Working Group

19th March 2026
REG Summit Palma de Mallorca

Meeting details	
Meeting location	Meliá Palma Marina hotel, Palma de Mallorca/ MS Teams
Meeting date	Thursday 19th March 2026
Meeting time	14:00 – 15:00 CET
Chair(s)	Désirée Larenas-Linnemann
Objectives	
1	Discussion of 'AIT Missed Opportunities' project
2	Discussion of 'Persistent to Chronic Rhinosinusitis' project
3	Other new project possibilities
4	Other Business

Attendees
Online: Susanne Thum-Oltme (STO)
In-person: Désirée Larenas-Linnemann (DLL), Helena Emery (HE), Dermot Ryan (DR), Nikos Popadopoulos (NP), Michael Walker (MW), Athanasios Nenes (AN)

Items	
Discussion of 'AIT Missed Opportunities' project	HE and DLL introduced the project: Allergen Immunotherapy Missed Opportunities and Resource Expenditure in the UK (AIMORE-UK) aims: 1. **Identify patients who would benefit from AIT** using systematic review estimates and primary/secondary healthcare data (CPRD/HES). 2. **Assess the extent of missed opportunities** by quantifying how many eligible patients do not receive AIT. 3. **Evaluate the healthcare costs** associated with missed AIT, including increased healthcare utilization and resource expenditure. 4. Provide evidence to support **more effective identification and treatment** of eligible AIT patients to reduce healthcare burden and improve patient outcomes. HE we are currently revisiting the proposal to reduce the project budget. The main issue is the cost of data, we had

	initially planned on using CPRD and HES data but this is very expensive, I have now looked at getting AIT data from the BSAIC AIT database which is much cheaper but only has data on those who are receiving AIT so we would need to use data about those not receiving AIT from data in published manuscripts, which might limit the work and be less appealing to funders. Any thoughts or suggestions about this project, particularly regarding data sources and budget? NP – This is a nice idea. MW – We have spoken to 8 companies, they all want a publication like this and the UK is a good model due to the poor use of AIT so a good opportunity to model the missed opportunities. However, the data is expensive. We need to make the project cheaper, can we do this project bibliographically? Or using BSAIC data alongside publication data? NP – We want to show how the health system has spent XX amount more on patients not on AIT. So we can't really do that only bibliographically. Could we use OPCRD? MW – OPCRD still costs about £50,000 for the data. NP – How much are AIT companies willing to pay for this sort of project? DR – First for us, we need to identify allergic vs non-allergic rhinosinusitis. NP – Can we get enough data from primary care? A lot is done at the specialist level. NICE might like this project DR – Allergic rhinitis diagnosis is much smaller in GP records compared to actual allergic rhinitis. The eligibility criteria for this project will need to be "patients that might benefit" instead of missed opportunities of those who would qualify for AIT. NP – The problem isn't the proposal it's the costs MW – The data needs to come from the primary care, specialists in the UK are limited

	NP – Primary care often don't think about allergic rhinitis, the bulk of patients about 50% of diagnosis and 50% reported symptoms but we know a larger proportion suffer but don't see the GP. Only a sub group go to the GP for treatment. Would a reduced/restricted dataset make it cheaper? MW – The data size isn't an issue, the cost is per data slice not size of dataset. Could we extract data from sites and aggregate it to make our own database? DLL – If we had some UK sites then yes NP – If CPRD has a large enough population, we can look at days from diagnosis of allergic rhinits to developing asthma DR – The problem is that AIT data is normal l secondary care not primary NP – Could look at the patients what have allergic rhinitis and see who get asthma and look at those that received AIT and see if there is a difference. DLL – We need a large overview, not just one centre MW – If we used the AIT data in BSAIC and make assumptions to say this is the AIT population in the UK then went to look at the rest of the UK population and estimate the number of AR and infer from that? NP – We know that from patients receiving immunotherapy that it is cost effective and AIT is a dominant treatment DR – NICE don't approve based on global costs, only on methods. Is the UK the right place to do this study? NP – UK has a lot of morbidity and a low number of specialists. We dot need AIT patients, just allergic rhinitis patients. DR – Can patients get medicine over the counter in the UK? NP – You can look at the prescription of steroids and outcomes 5 years later and asthma diagnosis or treatment?

	MW – Is there a way to do this work with published data? NP – What is the cost need a comparison? DLL – is it best to look at patents that have AR and progress to asthma? MW – Ca we look at using the ISAR data? would they have patient history of AR? NP – I don't think so. MW – What about the study MASK AIR? Is there follow up data there? NP – What are the AIR companies plans for AIT in the UK? It is a small market. MW – the UK is the best site to document this sort of study, so we can make it work as its really relevant here and informs globally. NP – Need to try and reduce the price of the data somehow. AN – Can you approach the data sites for data at a reduced cost? NP – We have had links with allergy companies and explore their interest. DR – Is CPRD raw data and OPC data in a curated form? MW – When we ask for data, we provide a data dictionary in the request and they fulfil the request NP – Need data that is old and don't need too many parameters, do they have long term outcomes of asthma? HE – in BSAIC, an asthma diagnosis at the point of joining the registry or later on can be added by the doctor or patient, but how well that is recorded is uncertain.

Discussion of 'Persistent to Chronic Rhinosinusitis' project	HE and DLL introduced P2C-RS - Persistent to Chronic Rhinosinusitis: From Presentation to Referral aims: 1. **Track the progression of patients** from persistent to chronic rhinosinusitis. 2. **Explore comorbidities** between rhinosinusitis and other respiratory conditions, assessing how the timing and treatment of one condition impacts the others within the framework of United Airways. 3. **Evaluate the healthcare burden** of persistent and chronic rhinosinusitis evaluating GP visits, hospitalizations, prescription use, and their economic impact. 4. Identify potential gaps in care, **delayed diagnoses** and **referrals** and **chronic cases**, which may result in higher costs and missed workdays. HE – there has been little interest in this from funders. MW – Is this chronic to persistent a thing? NP – Not sure, not in these terms.
Other new project possibilities	HE – so this idea **of 'Effectiveness of biologics in CRSwNP patients with obesity'** came from a seminar where co-morbidities, particularly obesity was of interest but a gap in the information available. We know that obesity has been shown to impact some biologics effectiveness in other diseases. NP – We need more time for there to be sufficient data to look at this. HE – This again came out of listening to a seminar and current literature where **The timing of biologic therapy initiation and surgery in CRSwNP** patients is somewhat debated or questioning if the current guidelines need to be updated. DLL and NP – we need some ENT specialist to advice on this HE – Okay, thank you I will reach out to some and see what they think

	HE – this was raised by DLL: **the use of biologics in treating severe allergic rhinitis** DLL – it is an area of interest currently. NP – these patients are a bit of a grey area. They could have mild asthma but severe allergic rhinitis so don't qualify for biologics but would likely benefit and prevent asthma worsening. This would be of interest as it is a new patient group DLL – Yes funders might be interested in this project NP – We could develop a merit system and tool to identify populations of rhinitis and asthma How to select patients and define thresholds, look for patterns If we get a large number of patients with asthma of rhinitis we could cluster them into groups or patients too look for groupings and trends DR – we could do a Delphi first then data driven follow up? DLL - **Possible review paper/opinion piece suggestions** we would like to produce something from this working group and this could be a low cost option to explore