EAACI 2026

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Congress Review

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THE HISTORIC city of Istanbul, Türkiye, provided the backdrop for the 70th Annual Congress of the European Academy of Allergy and Clinical Immunology (EAACI), bringing together the international allergy and immunology community for a landmark meeting celebrating scientific progress, collaboration, and innovation. Reflecting the Congress theme of 'Vision Zero', the meeting highlighted EAACI's ambition to reduce the global burden of allergic and immune-mediated diseases through advances in prevention, education, research, and patient-centred care.

Situated between Europe and Asia, Istanbul has long been a centre of cultural exchange, science, and commerce. With a rich history shaped by the Byzantine and Ottoman eras, the city's blend of historic landmarks and modern international influence provided a fitting setting for a Congress centred on global collaboration and the advancement of allergy and clinical immunology.

OPENING ADDRESSES AND WELCOME REMARKS

The opening ceremony marked a significant milestone as EAACI celebrated 70 years of advancing allergy and immunology. President Maria Torres and Vice President Andre Moreira welcomed delegates, reflecting on the Academy's growth into a global organisation connecting clinicians, researchers, educators, and patient communities.

With membership approaching 20,000 professionals and strong engagement from junior members, EAACI highlighted the importance of maintaining a multidisciplinary approach to addressing the increasing burden of allergic diseases and immune disorders worldwide. Torres outlined the Academy's continued focus on quality improvement, education, sustainability, and transparency, highlighting initiatives such as the EAACI Quality Centres programme and the EAACI Nexus platform, which support collaboration and knowledge exchange across the specialty.

The ceremony also emphasised EAACI's wider role in advocacy and healthcare policy. The Declaration of Salamanca was highlighted as an important step towards strengthening the integration of allergy and clinical immunology education within medical training programmes across Europe.

SCIENTIFIC PROGRAMME: ADDRESSING CURRENT AND FUTURE CHALLENGES

The Congress' scientific programme showcased the breadth of modern allergy and immunology through plenary lectures, thematic symposia, oral presentations, poster sessions, flash talks, workshops, 'Meet the Expert' sessions, and educational activities. The hybrid format enabled wider participation through both onsite attendance and digital access.

Key discussions explored emerging research, clinical advances, education, and strategies to improve patient outcomes. Sustainability was also incorporated into the Congress vision through the concept of a "healthy planet, healthier people," highlighting the relationship between environmental factors and human health.

A major highlight of the opening ceremony was the keynote lecture, which addressed the growing challenge of misinformation in healthcare, including the impact of inaccurate health information, particularly online, on public understanding and medical decision-making. There was an emphasis on the importance of trust-based communication, with the speaker introducing an empathetic refutational approach that focuses on understanding the concerns behind beliefs before addressing misconceptions with evidence-based information.

HONOURING EXCELLENCE IN ALLERGY AND IMMUNOLOGY

The opening ceremony also recognised outstanding contributions to the field through the EAACI Congress 2026 awards. These honours celebrated achievements across research, clinical practice, education, and leadership.

The Clemens von Pirquet Award was presented to Antonella Cianferoni, University of Pennsylvania, Philadelphia, USA; and Walter Canonica, Humanitas University, Milan, Italy, recognising their contributions to allergy and immunology. The Paul Ehrlich Award was awarded to Thomas Bieber, Bieber Dermatology Consulting, Bonn, Germany, while the Charles Blackley Award recognised Cezmi Akdis,

Swiss Institute of Allergy and Asthma Research (SIAF), Davos, Switzerland; and Rudolf Valenta, Medical University of Vienna, Austria. The Daniel Bovet Award was presented to Isabel Skypala, Royal Brompton & Harefield NHS Foundation Trust, UK.

Early-career achievements were also celebrated, with the Cezmi Akdis Prize 2026 awarded to Sadhbh Hurley, Royal College of Surgeons in Ireland, Dublin, Ireland; and Katri Korpela, University of Helsinki, Finland. The EAACI Allergopharma Award 2026 recognised Mahmoud Ismael Abdel-Aziz, Department of Respiratory Medicine, Amsterdam UMC, University of Amsterdam, the Netherlands, while the EAACI Early Career Research Award 2026 was presented to Juan Luis Paris Fernández de la Puente, Instituto de Investigación Biomédica de Málaga, Spain.

EAACI also recognised new Clinical and Research Fellows, celebrating the continued development of future leaders within allergy and clinical immunology.

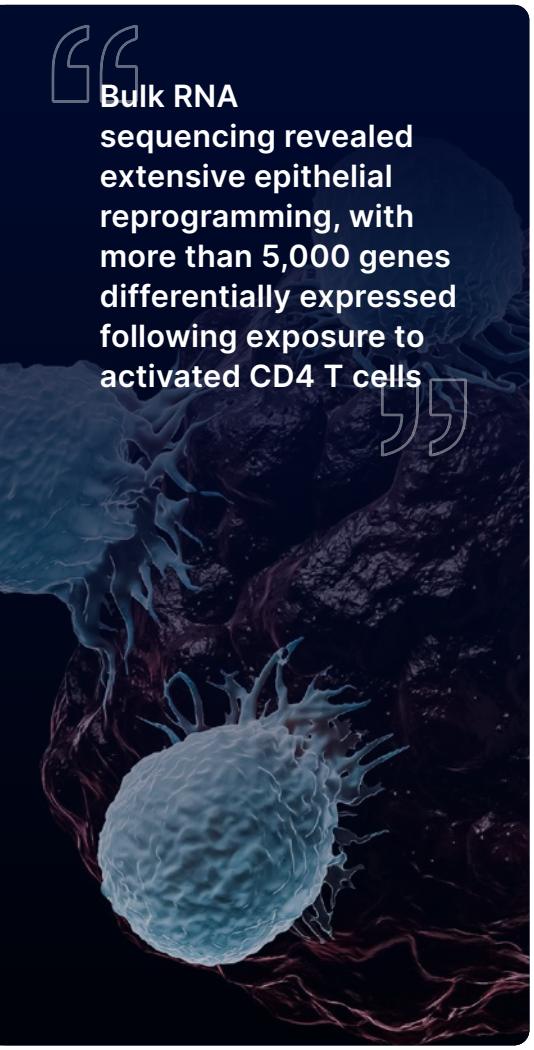
A CELEBRATION OF COLLABORATION

The opening ceremony concluded with a performance by Fire of Anatolia, celebrating Türkiye's cultural heritage and providing a memorable introduction to the congress week. As delegates gathered for the welcome reception, the evening reflected the central message of EAACI 2026: that continued progress in allergy and immunology depends on collaboration, innovation, and a shared commitment to improving global health.

CD4 T Cells Drive Oesophageal Barrier Dysfunction Epithelial Changes

A NEW study presented at EAACI 2026 provides further insight into how immune–epithelial interactions contribute to the development of eosinophilic oesophagitis (EoE). The research investigated the direct effects of activated cluster of differentiation (CD)4 T cells on oesophageal epithelial function using an *in vitro* model.[1]

EoE is a chronic, immune-mediated disease characterised by oesophageal inflammation, epithelial barrier disruption, and immune cell infiltration. Although CD4 T cells and their Type 2 inflammatory mediators are known to play a central role in disease pathogenesis, the precise mechanisms through which they affect epithelial cells remain incompletely understood.



To explore this, the investigators isolated primary CD4 T cells from healthy donor blood samples and activated them through T cell receptor stimulation using anti-CD3/CD28 antibodies. These activated or non-activated CD4 T cells were then co-cultured with differentiated EPC2 oesophageal epithelial cells grown under air–liquid interface conditions, allowing assessment of epithelial barrier function, inflammatory signalling, and transcriptional changes.

The findings demonstrated that activated CD4 T cells directly impaired epithelial barrier integrity. Co-culture with stimulated T cells resulted in a 25% reduction in transepithelial electrical resistance and a two-fold increase in epithelial permeability compared with non-activated controls, indicating increased barrier leakage.

This functional disruption was accompanied by marked reductions in epithelial barrier-associated genes, including *DSG1* and *FLG*, both of which have previously been linked to EoE-related epithelial dysfunction. In addition, epithelial cells exposed to activated CD4 T cells developed a pro-inflammatory secretory profile, releasing immune mediators including IL-15, granulocyte-macrophage colony-stimulating factor (GM-CSF), chemokine (C-X-C motif) ligand 9 (CXCL9), and CXCL10, suggesting that epithelial cells actively participate in sustaining inflammatory responses.

Bulk RNA sequencing revealed extensive epithelial reprogramming, with more than 5,000 genes differentially expressed following exposure to activated CD4 T cells. Comparison with transcriptomic signatures from oesophageal biopsies of patients with EoE showed that 1,295 genes overlapped between the experimental model and patient disease profiles.

Further analysis demonstrated enrichment of pathways associated with interferon (IFN)-γ and IFN-α responses, as well as epithelial-to-mesenchymal transition, processes implicated in chronic inflammation and tissue remodelling.

The authors concluded that activated CD4 T cells are capable of directly inducing epithelial barrier failure and disease-associated transcriptional changes resembling those observed in patients with EoE. These findings highlight immune–epithelial crosstalk as a key mechanism in EoE pathogenesis and suggest that targeting interactions between immune cells and epithelial barriers may represent a future therapeutic strategy.

MAIT Cells Show Potent Immunomodulatory Response to IL-33

MUCOSAL-associated invariant T (MAIT) cells displayed a potent immunomodulatory phenotype when stimulated with IL-33 and IL-12, according to new research presented at EAACI 2026, highlighting the ability of MAIT cells to reshape inflammatory immune responses through enhanced production of interferon (IFN)-γ and other immune mediators.[2]

MAIT cells are unconventional T cells that are recognised for their rapid response to microbial infections through the detection of microbial riboflavin-derived antigens and inflammatory cytokines. While their antimicrobial functions have been well described, their response to epithelial-derived inflammatory mediators, known as alarmins, remained unclear.

Researchers investigated the effects of the alarmins IL-25, IL-33, and thymic stromal lymphopoietin (TSLP), administered alone or alongside established MAIT cell stimuli, including the microbial antigen 5-OP-RU and IL-12. The investigators also examined how activated MAIT cells influenced other immune cell populations, including cluster of differentiation (CD)14 positive monocytes and CD4 positive T cells. Multiparametric flow cytometry, quantitative PCR, ELISA, and proteomic analysis were used to characterise cellular responses.

The study found that IL-33, but not IL-25 or TSLP, acted synergistically with IL-12 to induce a pronounced Th1- and cytotoxic-biased MAIT cell phenotype. This response was characterised by enhanced secretion of IFN-γ and granzyme B.

Proteomic profiling demonstrated that activated MAIT cells also secreted several additional immune mediators, including TNF, vascular endothelial growth factor, leukaemia inhibitory factor, and C-C motif chemokine ligand 20. These findings suggest that MAIT cells may contribute not only to inflammatory signalling but also to vascularisation and immune cell recruitment.

Conditioned media collected from MAIT cells stimulated with IL-33 and IL-12 promoted polarisation of CD14-positive monocytes towards a pro-inflammatory M1-like phenotype. In addition, exposure to alarmins and IL-12 resulted in reduced expression of the Th2-associated genes *IL5* and *IL13* in CD4-positive T cells.

Taken together, these findings indicate that MAIT cells can adopt a broader immunomodulatory role when polarised towards a Th1 programme. The authors concluded that this phenotype has the capacity to influence multiple immune compartments and noted that ongoing studies are investigating the extent to which activated MAIT cells may shape Th2 immune responses.

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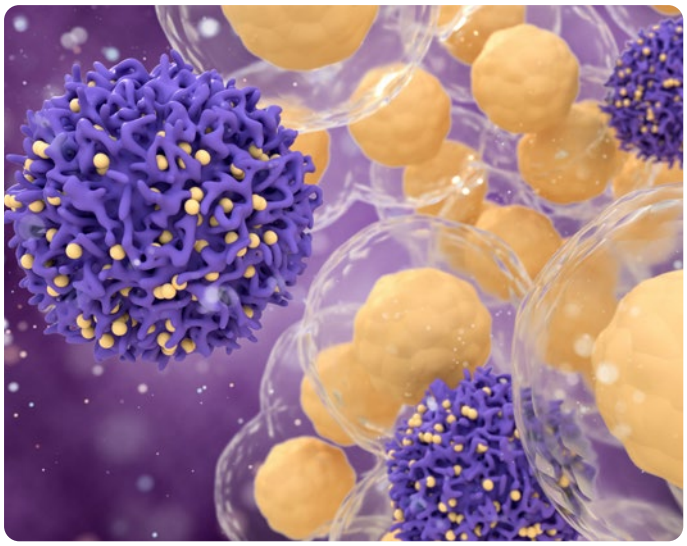


Safe Early Skin Testing After Immediate Hypersensitivity Reactions to Chemotherapy

SAFE AND RELIABLE allergological evaluation of immediate hypersensitivity reaction (IHR) to chemotherapy (CHT) can be performed within an earlier period, potentially assisting in reducing treatment delays and unnecessary empiric drug desensitisations, according to a new study presented at EAACI 2026.[3]

Recommendations suggest that skin testing (ST) should be performed in patients 4–6 weeks to 6 months after IHR to CHT. However, oncological treatment regimens often do not align with this window and comprise predefined cycles that range from weekly to every 4 weeks.

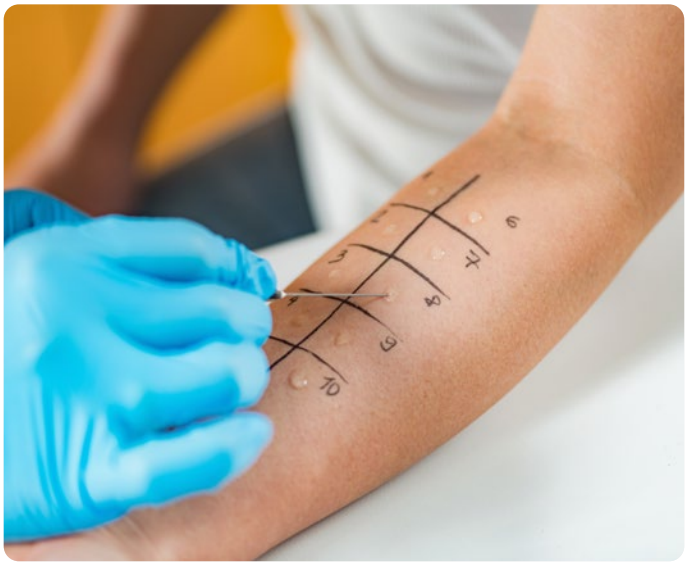
Patients who experience delayed referrals after reactions to platins are at a higher risk of receiving false-negative ST results; however, data on false negatives when performing early ST is limited. In this study, researchers looked to determine whether it was possible to safely implement early ST in IHR to CHT.

> **Early ST could therefore be an important clinical tool to assist in the avoidance of treatment delays and unnecessary empiric drug desensitisations**

A total of 209 patients, primarily consisting of women (F=187) who experienced suspected IHR to CHT, were consecutively referred to the Immunoallergology Unit at Careggi University Hospital in Florence, Italy, from October 2019–May 2025. A drug provocation test (DPT) was provided to those patients who received a negative ST, had a mild–moderate reaction, and had no other risk factors. Patients were stratified into three groups based on time between reaction and ST evaluation: 'early' (within 4 weeks), 'ideal' (1–6 months), and 'late' (>6 months). ST evaluation was performed in 159 (76.1%) patients in the 'early' group, 35 patients (16.7%) in the 'ideal' group, and 15 patients (7.0%) in the 'late' group.

There was no significant difference in positive ST results between the 'early' group (25.8%) and the 'ideal' group (34.3%). In the subgroup of ST-negative patients, positive DPT responses were observed in 13 individuals (12.0%) in the 'early' group compared with two individuals (9.5%) in the 'ideal' group, with no statistically significant difference between groups (p=not significant). Multivariate analysis showed no significant difference in ST or DPT results between the two groups after adjusting for confounding factors.

Overall, researchers demonstrated the possibility of implementing early allergological evaluation of IHRs to CHT in a safe and reliable way. Early ST could therefore be an important clinical tool to assist in the avoidance of treatment delays and unnecessary empiric drug desensitisations. However, the authors noted that the study was limited by its cohort distribution, and that confirmation of these findings would require ST after IHR to CHT to be carried out in a more evenly distributed population.



Novel Method for Quantifying Conjunctival Provocation Test

A RETROSPECTIVE study presented at EAACI 2026 suggested that a novel synthetic symptom metric (SSM) may predict treatment efficacy after 6 months by integrating conjunctival provocation test (CPT) readouts across multiple allergen dilutions and combining subjective and objective measures into one value.[4]

Monitoring immunotherapy effectively requires the quantification of provocation tests. Current methods commonly use the Symptom Severity Score (SSS), which evaluates a patient's reaction to an allergen.

The SSS readout is the highest allergen dilution at which the SSS exceeds a predefined threshold, which is usually SSS ≥3. Researchers noted that the primary limitation of the SSS is that the same readout can be obtained despite substantially different symptom severity.

During treatment, the highest allergen dilution at which the SSS threshold is reached may increase. However, this readout fails to account for a substantially higher symptom score at this new dilution level. As a result, the authors expressed caution when interpreting the SSS alone as evidence of reduced allergen sensitivity. To address the limitations of the conventional SSS, researchers proposed a new method that would bring together symptom scores from multiple allergen dilutions into one metric.

The study involved a retrospective analysis of a clinical study that validated an AI platform (AllergoEye, AI-MedImaging, Dresden, Germany) that quantifies CPTs. CPT was performed in 41 patients at multiple allergen dilutions, which enabled researchers to develop a formula that integrates five measures, including three subjective patient-reported symptoms, one semi-quantitative nurse-assessed eye-redness score, and one quantitative AllergoEye eye-redness measurement.

The efficacy of treatment could be predicted after 6 months when applying an SSM to CPT data from 41 patients undergoing immunotherapy. To assess robustness, the SSM was recalculated while omitting one or more dilutions for a given CPT and comparing these values.

These findings suggest that, in comparison to the traditional SSS, an SSM increases sensitivity by combining subjective and objective measures into one value and incorporating results from multiple allergen concentrations. Importantly, treatment response may be predicted as early as 6 months when the metric is applied to longitudinal immunotherapy data.

Asthma Biologics May Restore Key Immune Regulatory Cells in Children with Persistent Asthma

NEW RESEARCH presented at EAACI 2026 suggests that biologic therapies may help restore levels of regulatory B cells (B reg) in children and adolescents with persistent asthma. Patients receiving biologic treatment had B reg levels comparable to healthy controls and significantly higher than those seen in patients not receiving biologics.[5]

B regs play an important role in controlling allergic inflammation through the production of IL-10, an immunomodulatory cytokine. Previous research has shown that children with allergic asthma have lower levels of these cells compared with healthy individuals. However, the impact of asthma biologic therapies on B reg levels has remained unclear.

Researchers investigated B reg frequencies in children and adolescents with persistent asthma, comparing patients receiving biologic therapy, patients not receiving biologic therapy, and healthy age-matched controls. Blood samples were collected from participants, and peripheral blood mononuclear cells were analysed using flow cytometry to quantify IL-10-producing B regs within a previously established asthma-associated B cell subset.

The study included 51 participants with persistent asthma and 17 healthy controls. Among the asthma cohort, 42 participants were not receiving biologic treatment, while nine were being treated with the biologics dupilumab, benralizumab, or tezepelumab. Participants ranged in age from 3–21 years, with a median age of 11 years.

Researchers found that children with persistent asthma who were not receiving biologic therapy had significantly lower levels of B regs than healthy controls (median: 0.20% versus 0.69%; p=0.002). In contrast, B reg levels in participants receiving biologic therapy were not significantly different from those observed in healthy controls (median: 0.59% versus 0.69%; p=0.590). Furthermore, B reg frequencies were significantly higher in patients receiving biologic treatment than in those not receiving biologics (median: 0.59% versus 0.20%; p=0.033).

The findings suggest that biologic therapies targeting Type 2 inflammation may help normalise B reg levels in paediatric asthma. According to the authors, this restoration of B regs could contribute to improved physiological control of allergic airway inflammation and may represent an additional mechanism through which biologic therapies exert their clinical benefits.

The study was limited by its small sample size, particularly in the biologic therapy group, and larger studies are needed to confirm these findings. Further research will also be required to determine whether B regs could serve as a useful biomarker for disease control or treatment response in paediatric asthma.

These results provide early evidence that biologic therapies may influence key immune regulatory pathways in children and adolescents with persistent asthma, highlighting a potential role for B regs in both disease pathophysiology and therapeutic monitoring.

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Oral Food Challenge Refines Infant Peanut Allergy Diagnosis

ROUTINE oral food challenges may help avoid unnecessary peanut allergy treatment in infants, according to findings from Australia's nationally standardised ADAPT Oral Immunotherapy (OIT) Program presented at EAACI 2026.[6]

Peanut allergy is an immune-mediated condition in which exposure to peanut proteins can trigger symptoms ranging from mild skin reactions to anaphylaxis. OIT aims to increase tolerance to peanut exposure, but approaches to diagnosis and treatment vary widely across healthcare systems.

The study assessed infants through the ADAPT OIT Program, which introduced threshold oral food challenges (TOFC) before treatment in infants with a history of Consortium for Food Allergy Research (CoFAR) Grade 1 or 2 peanut reactions. The aim was to confirm allergy status and identify an appropriate starting dose for immunotherapy.

Between April 2024–October 2025, 1,244 infants were assessed across 10 public hospital sites, with 783 (median age: 13 months) undergoing TOFC. The challenge was positive in 65.4% of infants, while 34.6% had a negative result despite a previous clinical reaction and evidence of peanut sensitisation. This suggests that more than one-third of infants who underwent TOFC could be delabelled as having peanut allergy, potentially avoiding unnecessary treatment.

Among infants with positive challenges, the median eliciting dose was 240 mg of peanut protein. Skin prick test (SPT) results and Ara h 2-specific IgE levels were higher in infants with positive challenges (median SPT: 7 mm) than those with negative challenges (median SPT: 5 mm). However, neither measure predicted the reaction threshold or severity during the challenge.

Anaphylaxis occurred in 8.3% of infants undergoing TOFC. Among infants with a positive challenge, 12.7% experienced anaphylaxis. Two infants required adrenaline infusion for persistent hypotension, with both recovering without lasting effects. Researchers noted that serious reactions were managed safely in appropriately equipped hospitals.

At the time of presentation, 376 infants had started OIT, with 97.1% successfully starting treatment at a dose below their individual reaction threshold identified during TOFC.

The researchers concluded that oral food challenges should be routinely considered when evaluating infant peanut allergy, regardless of whether management plans involve immunotherapy or avoidance. Future studies could help clarify the longer-term implications of challenge-based assessment for peanut allergy diagnosis and treatment pathways.

> **More than one-third of infants who underwent TOFC could be delabelled as having peanut allergy**

Clinical Algorithm Reduces Unnecessary Nut Elimination Diets

TREE NUT and peanut allergies are among the most common food allergies in young children and can be difficult to diagnose and manage because spontaneous resolution is uncommon and concerns about severe allergic reactions often lead to prolonged dietary avoidance. Although oral food challenge (OFC) remains the diagnostic gold standard, clinicians may be reluctant to perform challenges because of the perceived risk of anaphylaxis. Consequently, many children continue unnecessary elimination diets that may adversely affect nutrition and quality of life.[7]

A study presented at EAACI 2026 aimed to develop a practical clinical algorithm incorporating clinical history, skin prick testing (SPT), specific IgE (sIgE) levels, recognised cross-reactivity patterns, and predictive thresholds to guide safer dietary reintroduction. Using this approach, unnecessary elimination was discontinued in 54.9% of avoided nut exposures.

This prospective, cross-sectional study enrolled children attending a paediatric allergy and immunology clinic between November 2024–December 2025. Participants were classified according to 2023 EAACI guidance as having allergy, or likely, probable, or possible allergy. All patients underwent fresh food SPT and sIgE testing. OFCs were undertaken when indicated using a four-step incremental protocol. Receiver operating characteristic analyses were performed using confirmed allergic reactions, based on clinical history or OFC, to establish clinically useful cut-off values. Logistic regression modelling was used to estimate probability curves for clinical reactivity.

Overall, 786 potential tree nut and peanut exposures from 131 children were assessed, with 466 foods initially eliminated from the diet. Elimination was safely discontinued in 256 of 466 cases (54.9%), including 187 following a negative OFC and 69 after negative allergy testing. Complete dietary liberalisation was achieved in 40 children, while 91 continued avoiding at least one nut. Median age at presentation was 34 months, symptom onset occurred at a median of 13 months, and 35.2% presented with anaphylaxis. Among 193 OFCs performed according to the algorithm, only six (3.1%) were positive, comprising two episodes of anaphylaxis and four cases of generalised urticaria. Estimated 50% probability sIgE thresholds ranged from 1.44–10.90 kU/L and corresponding SPT thresholds from 4–6 mm, while 95% probability thresholds ranged from 15.1–63.0 kU/L for sIgE and 7–17 mm for SPT, depending on the specific nut.

These findings suggest that integrating clinical history, SPT, sIgE thresholds and selective OFC into a structured clinical algorithm can safely reduce unnecessary elimination diets while maintaining a low OFC positivity rate. This pragmatic approach could support more confident decision-making in routine paediatric allergy practice, reduce unnecessary dietary restrictions, and improve patient quality of life. However, the findings are limited by the single-centre design, relatively small sample size, and the need for external validation before widespread implementation.

Socioeconomic Deprivation Linked to Missed Paediatric Food Allergy Challenges

A RETROSPECTIVE audit presented at EAACI 2026 has highlighted a significant socioeconomic disparity in attendance at paediatric oral food challenge appointments, with children from more deprived areas showing higher rates of non-attendance. The study examined whether deprivation and ethnicity influence engagement with specialist food allergy services.[8]

Oral food challenges are a key component of paediatric food allergy diagnosis and management, allowing clinicians to confirm or exclude allergy and guide dietary decisions. However, missed appointments, including parent cancellations and "Was Not Brought" (WNB) outcomes, reduce clinic efficiency, delay diagnosis, and may contribute to inequalities in care. The Midland Metropolitan University Hospital (MMUH), Smethwick, UK, serves communities including Sandwell and Birmingham, two of the most deprived local authority areas in England, making the evaluation of healthcare access particularly relevant.

The audit reviewed 189 scheduled paediatric food challenge appointments between September 2024–September 2025, with 184 cases included after exclusions. Patients were categorised according to deprivation index, with scores grouped into lower (1–3), middle (4–5), and higher (6–10) socioeconomic categories. Attendance outcomes were recorded as completed challenges, parent cancellations, medical cancellations, or WNB episodes.

Overall, 34 children (18.5%) did not attend their appointment, and 24 (13.0%) had appointments cancelled by parents, resulting in a combined parent-driven non-attendance rate of 31.5%.

A clear socioeconomic gradient was observed. Children from the most deprived group accounted for 19 of the 34 WNB cases (55.9%). Within deprivation indices 1–3, WNB occurred in 26% of appointments and parent cancellations in 14%. In contrast, WNB rates were lower among children from higher socioeconomic groups, occurring in 18.5% of cases.

Ethnic patterns reflected the deprivation distribution. Among children in the most deprived group, 78% were from ethnic minority backgrounds, compared with around half of those in the least deprived group being White British or from a Mixed ethnic background. Asthma and eczema were the most frequently reported atopic comorbidities across the cohort.

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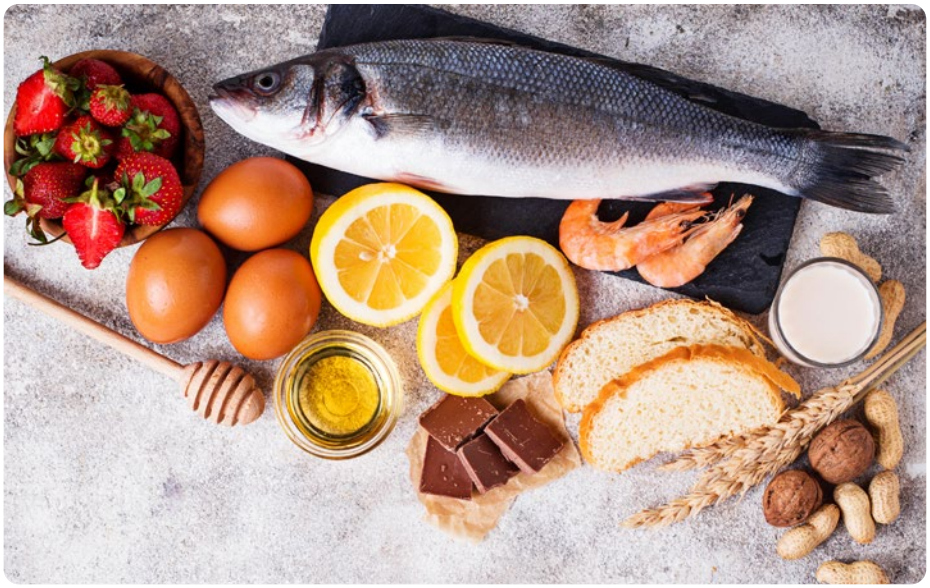
The authors concluded that socioeconomic deprivation is strongly associated with reduced engagement with paediatric food challenge services. The findings suggest that standard appointment systems may not adequately address barriers faced by families experiencing deprivation, and that targeted approaches, including improved communication, additional support, and deprivation-sensitive service design, may help reduce missed appointments and improve equity in allergy care.



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