Dell Children's **Allergy, Asthma, and Immunology Clinic**

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Ascension

Contents

Dell Children's Allergy, Asthma, and Immunology Clinic

Office hours: Monday-Friday, 8 a.m.-4 p.m.
Main office number: 512-628-1870
Fax number: 512-628-1871
Back line number for PCPs: 512-628-1879 (daytime)
After-hours contact: Call the clinic number to reach the answering service

Please use the main office number to reach our staff regardless of office location.

Our clinic locations

Dell Children's – Allergy, Asthma and Immunology Mueller

1301 Barbara Jordan Blvd., #200D
Austin, TX 78723
512-628-1870

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Lina Z. Mahmood, MD

Pooja Varshney, MD

Dell Children's – Allergy, Asthma and Immunology Cedar Park

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512-537-9130

Samuel Vazquez Agosto, MD
Soo Hee Kim-Delio, MD

Dell Children's – Westlake

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Austin, TX 78746
254-537-9130

Jackee D. Kayser, MD

Updated March 2026
For the most up-to-date information, please view the Dell Children's Allergy, Asthma, and Immunology Clinic website.

Our providers

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Lina Mahmood, MD

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Common indications for referral

Indication	Allergic rhinitis
Findings	• Common symptoms can include sneezing, rhinorrhea, nasal congestion, pruritus of the naso- and oropharynx, postnasal drip, fatigue, and itchy or watery eyes • Can be associated with comorbid asthma • Symptoms can be present year-round, seasonally, or episodically • Allergic rhinitis is uncommon in children < 2 years of age
Evaluation	None; diagnostic testing will be offered to patients referred to the DCMC Allergy, Asthma, and Immunology Clinic
Treatment	• Allergen avoidance when possible • Nasal saline • Glucocorticoid nasal spray* • Antihistamine nasal spray* • Oral (systemic) minimally sedating antihistamines (preferred agents include cetirizine) • Ophthalmic antihistamines, when indicated *Families should be informed to administer nasal sprays away from the nasal septum to decrease the risk of septal perforation
Red flags	N/A
Referral details	When to refer: • Children with moderate to severe or refractory AR or those with comorbidities should be referred to an allergist for diagnostic testing and expanded management options, including immunotherapy • Children with prolonged or severe manifestations of rhinitis, co-morbid conditions (e.g. asthma, recurrent sinusitis), symptoms interfering with quality of life and/or ability to function, or who have found medications to be ineffective or have had adverse reactions to medications • Consider referral of any child with allergic rhinitis because of the potential preventive role of allergen immunotherapy in progression of allergic disease
Referral timeline	• Routine referrals: Varies according to practice location • Urgent referrals: Call 324-KIDS (512-324-5437) or physician line if you need to speak with a physician or expedite a patient referral.
Additional information	Additional information • When possible, patients should discontinue systemic antihistamines for 1 week prior to their appointment as antihistamines can interfere with the results of skin allergy testing

Indication	Anaphylaxis
Findings	Acute onset of a severe, potentially life-threatening systemic reaction, often involving **2 or more** organ systems, including: • Respiratory (shortness of breath, repetitive coughing, throat tightness) • Cardiovascular (weak/fast pulse, low blood pressure, dizziness) • Cutaneous (generalized hives, flushing) • Gastrointestinal (vomiting, diarrhea, abdominal pain)
Evaluation	Detailed history to ascertain potential triggers (e.g., food, drug, insect venom) and the timeline of symptom onset. Diagnostic testing may be offered to patients referred to the DCMC Allergy, Asthma, and Immunology Clinic if a specific trigger is identified.
Treatment	For active symptoms consistent with anaphylaxis, provide immediate IM epinephrine, supportive measures as indicated, and refer to the nearest emergency department. For patients with a history of anaphylaxis, provide a prescription for IM epinephrine, instructions for use, and an anaphylaxis home management plan (see example plans here). • If indicated for suspected food allergy, provide safe restaurant eating, food label reading plans and tips. • If patient has co-morbid asthma, ensure bronchodilator prescription in case of wheezing during anaphylaxis
Red flags	N/A
Referral details	When to refer: • If the etiology of the anaphylaxis is unknown • Recurrent anaphylaxis with multiple or unknown triggers • Persons with food-, drug-, exercise-, or venom-induced anaphylaxis
Referral timeline	• Routine referrals: Varies according to practice location. • Urgent referrals: Call 324-KIDS (512-324-5437) or physician line if you need to speak with a physician or expedite a patient referral.
Additional information	Please coach the patient or caregiver to provide: • Detailed event narrative, including: – Suspected trigger, with amount and preparation – Time from exposure to symptoms – List of symptoms – Interventions (including timing/number of epinephrine doses) – ED or hospital course – Labs (e.g., tryptase) • List comorbid asthma or atopy • Current medications • Provide a copy of any ED discharge instructions/action plans (Fax to 512-628-1871)

Indication	Asthma
Findings	Recurrent episodes of wheezing, chest tightness, shortness of breath, and coughing.

Evaluation	• Clinical diagnosis
	• Detailed history:
	  – Symptom patterns, triggers, nocturnal symptoms, SABA use, and interference with activity
	  – Frequency of systemic corticosteroid use and number of emergency department visits
	  – School absences related to asthma
	  – Medical adherence and medication usage technique
	  – Screen for comorbidities (allergic rhinitis, GERD, obesity)
	• Spirometry or pulmonary function testing, if able
	• Diagnostic testing will be offered to patients referred to the DCMC Allergy, Asthma, and Immunology Clinic

Treatment	• Prescribe a short-acting beta agonist (SABA) with a spacer • Provide an "Asthma Action Plan" • Educate on reducing environmental triggers (tobacco smoke, indoor allergens). • Consider: Systemic corticosteroids may be indicated for patients experiencing an exacerbation of their symptoms (eg, requiring multiple beta-agonist treatments within 24 hours) • Consider: Inhaled corticosteroids (ICS) or long-acting beta-agonist [LABA] + ICS combination) may be needed based on the patient's symptoms and risk assessment
Red flags	• Prior intubation/ICU for asthma • ≥2 systemic steroid bursts in past year • Frequent ED visits • Nocturnal symptoms most nights • Exercise limitation
Referral details	When to refer to clinic: • Patients with red flag-associated symptoms • Patients on medium-dose inhaled corticosteroids + long-acting beta agonist OR on high-dose inhaled corticosteroids • Infants, toddlers, and preschool-age children who are on a daily controller medication • Coughing or other asthma symptoms that are interfering with physical activity • Excessive school absences due to asthma • Poor adherence with medications and instructions • Evaluation of contribution of environmental allergies to asthma
Referral timeline	• Routine referrals: Varies according to practice location. • Urgent referrals: Call 324-KIDS (512-324-5437) or physician line if you need to speak with a physician or expedite a patient referral.

Indication	Atopic dermatitis
Findings	• Erythematous, scaly, and (often) excoriated lesions • Lichenification can be seen from chronic scratching • Sleep disturbance is common • May coexist with other forms of atopy
Evaluation	• Eczema is a clinical diagnosis • Note: eczema is rarely caused food allergies; as such, food panel testing or elimination diets are generally not recommended • Diagnostic testing may be offered to patients referred to the DCMC Allergy, Asthma, and Immunology Clinic
Treatment	• Patient education • Skin barrier care: daily lukewarm baths followed by liberal application of thick, fragrance-free moisturizers/emollients • Topical corticosteroids for flares: – Mild: Low-potency topical corticosteroid once or twice daily (eg, hydrocortisone cream 2.5%) x 1-2 weeks – Moderate: Mid-potency topical corticosteroid twice daily for the body (eg, triamcinolone ointment 0.1%) and low-potency topical corticosteroid twice daily to face, neck, and skin folds (eg, hydrocortisone cream 2.5%) x 2 weeks – Severe: Same as moderate with the addition of wet wraps (limit to 3 days because of increased steroid absorption). Send an urgent referral to an allergist or dermatologist – Provide a break in steroid treatment after 14 days of use. • Topical calcineurin inhibitors or topical PDE4 inhibitors are options as steroid-sparing agents • Consider antihistamines for refractory pruritis • Patients with eczema are predisposed to secondary viral and bacterial infections. Infection should be considered during flares as systemic antivirals or antibiotics may be needed.
Red flags	Refer to the emergency department for signs of severe secondary bacterial or viral infection (eg, extensive crusting, purulence, ulcers, or vesicles suggestive of eczema herpeticum).
Referral details	When to refer: • To confirm the diagnosis of atopic dermatitis in a patient with dermatitis • To evaluate for possible comorbid conditions such as food allergy, allergic rhinitis, and asthma • Patients whose atopic dermatitis responds poorly to treatment • Patients with associated recurrent infections • Of note, food panels are not recommended prior to evaluation
Referral timeline	• Routine referrals: Varies according to practice location. • Urgent referrals: Call 324-KIDS (512-324-5437) or physician line if you need to speak with a physician or expedite a patient referral.

Indication	Drug allergy
Findings	Immediate reactions • Hives, pruritus, angioedema, wheeze, hypotension shortly after dosing Delayed reactions • Morbilliform exanthem days into course • Serum sickness–like illness • SJS/TEN (target lesions, mucosal erosions, systemic toxicity) • DRESS (rash, fever, eosinophilia, organ involvement) • Many rashes during viral infections while on antibiotics are non-allergic in nature
Evaluation	The suspected drug must be stopped immediately. Comprehensive documentation is essential, recording the drug name (generic and proprietary), strength, formulation, route of administration, indication for use, and a precise description of the signs, symptoms, and severity of the reaction.
Treatment	• Acute IgE-mediated reactions: Stop the culprit drug immediately. – For urticaria, can use non-sedating antihistamines such as cetirizine – Treat as anaphylaxis when systemic symptoms are present. • For benign, delayed exanthems, stop the culprit drug and provide symptomatic therapy (eg, antihistamines or topical steroids). • Long-term: accurate documentation of the reaction and, when appropriate, specialist evaluation to confirm or remove the allergy label. Desensitization with allergy consult is an option when the culprit drug is strongly indicated and no good alternative exists (e.g., β-lactams, certain chemotherapeutics)
Red flags	These features may require emergency department evaluation: • Anaphylaxis, respiratory compromise, hypotension • Blistering or mucosal erosions (SJS/TEN) • Fever and systemic symptoms with rash (DRESS, serum sickness) • Organ dysfunction (hepatitis, nephritis).
Referral details	When to refer: • Patients with a history of suspected immediate or delayed medication reactions.
Referral timeline	• Routine referrals: Varies according to practice location. • Urgent referrals: Call 324-KIDS (512-324-5437) or physician line if you need to speak with a physician or expedite a patient referral.

Indication	Eosinophilic esophagitis (EoE) and other eosinophilic gastrointestinal disease (EGID), including eosinophilic gastritis (EoG), eosinophilic enteritis (EoN), eosinophilic colitis (EoC)
Findings	• Variable presentation across childhood – reflux, vomiting, failure to thrive, dysphagia, feeding dysfunction, abdominal pain, weight loss, choking, food impaction, disordered eating.
Evaluation	• Initial evaluation is usually done by pediatric GI: upper endoscopy with esophageal biopsies. Guidelines require symptoms of esophageal dysfunction plus eosinophilic infiltration and exclusion of other causes. • Once diagnosed, an allergy evaluation (skin/sIgE ± atopy patch testing, detailed food history) helps guide dietary therapy and manage comorbid atopy.
Treatment	Treatment will be managed by a pediatric allergist or pediatric gastroenterologist. Treatment may include: • Pharmacologic therapy: swallowed topical corticosteroids and proton pump inhibitors (PPIs) • Diet therapy: elemental formulas or an elimination diet (eg, removing major allergens like dairy, wheat, egg, soy). • Biologics: dupilumab • Esophageal dilation may be used to treat symptomatic narrowing.
Red flags	• Inability to tolerate PO and/or food impaction warrants immediate medical attention.
Referral details	When to initiate referral: • All patients with confirmed EGID should be seen by Pediatric Allergy and Pediatric Gastroenterology • Patients may be offered visits in Dell Children's multidisciplinary Eosinophilic Esophagitis Clinic (Pediatric Allergy, Pediatric GI, Nutrition, Psychology) on a case-by-case basis. If you/your patient is interested in referral into this clinic, please indicate and/or call the clinic. To be seen in the EoE clinic, patient must have biopsy-proven EGID.
Referral timeline	• Routine referrals: Varies according to practice location. • EoE clinic referrals: Triaged by nurse coordinator at 512-628-1810, select option 3, then option 2. • Urgent referrals: Please call 324-KIDS (512-324-5437) or physician line if you need to speak with a physician or expedite a patient referral.
Additional information	Fax the following information to 512-628-1871: • Growth charts • Pertinent office visits • Prior allergy testing, if applicable • Endoscopy reports, if available

Indication	Food allergy

Findings	• IgE-mediated food allergy suspected based on culprit food, timing, characteristic symptoms, and reproducibility
	  • Food IgE panels (i.e. "Childhood Food Allergy Panel," "Comprehensive Food Allergy Panel") are not recommended due to high rate of false positives
	• Non-IgE mediated food allergy
	  • Food protein induced enterocolitis syndrome (FPIES) – delayed-onset vomiting, lethargy, pallor, can be severe
	  • Food protein induced allergic proctocolitis (FPIAP) - if atypical or concerned about other allergic comorbidities
	  • Food protein enteropathy – vomiting, diarrhea, FTT
	  • Eosinophilic GI disease – biopsy-proven disease

Evaluation	• Allergy-focused history – culprit food, amount, timing, symptoms, reproducibility, co-factors • Assess IgE sensitization with skin prick tests or serum specific IgE to suspect foods • Oral food challenge in the allergy office when the diagnosis is uncertain and/or to assess tolerance • For non-IgE entities (FPIES, EoE), routine IgE tests may be negative
Treatment	• Strict avoidance of culprit foods with label education is the cornerstone • For IgE-mediated allergy with anaphylaxis risk, prescribe epinephrine autoinjector(s) and provide written anaphylaxis plan for home/school
Red flags	• Time-sensitive referrals: multiple food allergies, FTT, early-onset food allergy, interest in early-life immunotherapy, FPIES • Anaphylaxis, poor PO intake, dehydration due to FPIES reactions
Referral details	When to initiate referral: • IgE-medicated allergic symptoms (anaphylaxis, urticaria, angioedema, itch, wheezing, gastrointestinal symptoms) with food exposure • Eosinophilic esophagitis (EoE) or other eosinophilic gastrointestinal disease (EGID) • Food protein induced enterocolitis syndrome (FPIES) • Other non IgE food allergies [ie, food protein induced allergic proctocolitis (FPIAP); food protein enteropathy; infants with gastrointestinal symptoms including vomiting, diarrhea, blood stools, poor growth, and/or malabsorption (usually after consultation with GI)] • Atopic families with strong history of food allergy interesting in evaluating risk and preventing allergy • Facilitating early food introduction in at-risk infants • Itchy mouth/throat with raw fruits and vegetables • Food allergy testing — skin testing, laboratory testing • Food allergy treatments — oral immunotherapy, biologic therapies • Food challenge to confirm allergy status, determine if allergy outgrown, or clarify diagnosis • Anaphylaxis diagnosis and education • Food allergy nutrition guidance — embedded registered dietitian • Mental health impact of food allergy — embedded pediatric psychologist • Food allergy clinical trial and research participation opportunities
Referral timeline	• Routine referrals: Varies according to practice location. • Urgent referrals: Call 324-KIDS (512-324-5437) or physician line if you need to speak with a physician or expedite a patient referral.
Additional information	Food IgE panels are not recommended due to high rate of false positive results. Testing in the Allergy clinic will be coordinated based on clinical presentation. Fax the following information to 512-628-1871: • Growth charts, pertinent office visits, prior allergy testing

Indication	Immunodeficiency/recurrent infections
Findings	• Increased frequency, severity and duration of infections • Unexpected complications or unusual manifestations of infection • Infection with opportunistic organisms • Noninfectious manifestations in GI, endocrine, hematologic organ systems, autoimmunity, immune dysregulation • Symptoms may include: recurrent otitis, sinusitis, pneumonia, sepsis, meningitis; unusual/opportunistic infections; chronic diarrhea; poor wound healing; deep skin/organ abscesses • Physical clues: absent tonsils/lymph nodes (agammaglobulinemia), chronic candidiasis, splenomegaly/lymphadenopathy, dysmorphic features (e.g., DiGeorge) • Failure to thrive or weight loss may be prominent
Evaluation	• Complete blood count with differential (absolute neutrophil and lymphocyte counts, with close attention to normal ranges for age) • Consider further work up if indicated: Immunoglobulins (IgG, IgA, IgM, IgE), complement studies (CH50 preferable to individual complement components), vaccine titers (diphtheria, tetanus, pneumococcal IgG) • Cultures can also be helpful

Treatment	• If Immunology referral deemed unnecessary:
	  • Set up expectations for the family regarding frequency of viral infections and/or anatomical issues that predispose patient to infections (i.e. OM)
	  • Focus on conditions that increase risk of infection and then re-evaluate (Rhinitis, asthma, dysphagia, etc)
	• Treatment options (prophylactic antibiotics, IVIG or subcutaneous IgG replacement, JAK-inhibitors/immunomodulators) will usually be started by the immunologist. However, may consider starting prophylactic antibiotics pending specialist evaluation if patient having recurrent severe sinopulmonary infections
	• If seeing a patient with abnormal newborn screening for SCID:
	  • Patient should be immediately placed in an isolated clinic room available. Staff should mask, gown and glove
	  • Discuss newborn precautions – avoid sick contacts, large crowds, seek care for fever >100.4 F, masking with baby in the home, avoid new live vaccine in baby or contacts

Red flags	Known SCID history in a sibling or parent, or early childhood death due to fulminant infection/sepsis. Multiple abnormal newborn screenings for SCID.

Immunodeficiency/recurrent infections - continued

Referral details	When to initiate referral:
	• Patients with a family history of known immunodeficiency disorder (such as X-linked agammaglobulinemia, SCID, Chronic Granulomatous Disease, etc.)
	• Patients with multiple autoimmune conditions with/without lymphoproliferative features (lymphadenopathy, hepatosplenomegaly, B-symptoms)
	• Patients with recurrent sinopulmonary infections – more than 4 new ear infections within 1 year, more than 2 serious sinus infections within 1 year, more than 2 pneumonias within 1 year
	• Extensive antibiotic usage:
	  • ≥ 2 months on antibiotics with little effect
	  • Need for IV antibiotics to clear infections
	  • Infections that do not respond to adequate courses of appropriate antibiotics
	• Patients with recurrent deep seated abscesses (or more than 2 deep-seated infections including septicemia) and poor wound healing after surgeries
	• Patients with recurrent or difficult to treat mucocutaneous candidiasis or other fungal infections
	• Desire for additional expertise managing recurrent infections
	• Failure of an infant to gain weight or grow normally
	• Infections with unusual organisms: Serratia, recurrent or refractory C. diff., Nocardia, MTB, etc.
	• Unexplained chronic or refractory diarrhea

Referral timeline	• Routine referrals: Varies according to practice location. • Urgent referrals: Please call 324-KIDS (512-324-5437) or physician line if you need to speak with a physician or expedite a patient referral.
Additional information	Fax any medical records, list of medications, and relevant labs (CBC, ESR/CRP, C4/C1-INH if done) to 512-628-1871

Indication	Insect hypersensitivity
Findings	• Large local reaction (swelling contiguous with sting site, peaking at 24–48 h) • Systemic allergic reaction (urticaria, angioedema, respiratory or cardiovascular symptoms remote from sting). Toxic reactions from many stings cause systemic symptoms without true allergy.
Evaluation	None
Treatment	• Acute systemic reaction: treat as anaphylaxis as above. • Definitive therapy: venom immunotherapy (VIT) greatly reduces risk of future systemic reactions (to <5%). • Large local reactions: cold compresses, oral antihistamines, oral antihistamines, topical steroids, occasionally short oral steroid course if extensive
Red flags	History of sting-induced anaphylaxis (especially with respiratory or cardiovascular compromise), multiple simultaneous stings, or underlying mastocytosis/high tryptase.

Referral details	When to initiate referral:
	• Patients who have had an anaphylactic reaction to a sting should be prescribed an EpiPen, educated on its use, and referred to an allergist for further evaluation.
	• Testing can be helpful for identification of the insect responsible for the reaction and establishing a diagnosis of allergy as this can guide medication prescriptions, facilitate education on avoidance, and dictates treatment options such as immunotherapy.
	• Venom immunotherapy (VIT) is extremely effective at reducing the risk of subsequent systemic allergic reactions from a sting to less than 5% (from 30-60%), and systemic reactions when they occur are generally milder.
	  • VIT is generally not necessary in children younger than 17 years who have experienced isolated cutaneous systemic reactions without other systemic manifestations.
	  • VIT is also generally not indicated for patients who have had only a large local reaction because the risk of systemic reaction is relatively low. There may be special circumstances that would favor testing and treatment to include frequent exposure, impaired quality of life, or underlying medical conditions.

Referral timeline	• Routine referrals: Varies according to practice location. • Urgent referrals: Please call 324-KIDS (512-324-5437) or physician line if you need to speak with a physician or expedite a patient referral.
Additional information	Fax medical records (including ED records when indicated) to 512-628-1871

Indication	Urticaria/angioedema
Findings	• Urticaria: transient, pruritic, erythematous wheals with central pallor; the duration of individual lesions is <24 hours. • Angioedema: deeper, non-pitting swelling (lips, eyelids, tongue, extremities, genitalia). Airway involvement (tongue, larynx) may cause stridor/voice change. • Of note: In chronic spontaneous urticaria (CSU), lesions recur without an obvious trigger; physical urticaria is triggered by cold, pressure, cholinergic stimuli, etc.
Evaluation	• Acute urticaria, minimal work-up — look for triggers (infection, new foods/drugs, insect stings) and assess for anaphylaxis. • CSU, limited screening labs (CBC, ESR/CRP, thyroid-stimulating hormone) often sufficient; extensive "allergy panels" rarely helpful. • Consider C4 and C1-INH levels if angioedema occurs without hives, is recurrent, or there is family history (hereditary angioedema).
Treatment	• First-line: second-generation non-sedating H1 antihistamines at standard dose; can increase up to fourfold in CSU per guidelines if needed. • Short course of oral corticosteroids for severe acute episodes. Avoid known triggers (NSAIDs, heat, tight clothing). • Epinephrine is indicated when urticaria/angioedema is part of anaphylaxis or involves tongue/laryngeal swelling with airway compromise
Red flags	Angioedema with airway/voice change, wheeze, hypotension (treat as anaphylaxis/send to ED)
Referral details	When to initiate referral: • Patients with acute urticaria or angioedema without an obvious or previously defined trigger and who fail adequate trial of H1 nonsedating antihistamines for 4 weeks • Patients with acute urticaria or angioedema due to presumed food or drug with need for diagnostic confirmation or assistance with avoidance procedures • Patients with chronic urticaria or angioedema (those with symptoms for 6 weeks or longer), that have required one course of systemic steroids • Patients with recurrent angioedema without urticaria • Patients with suspected or proven cutaneous or systemic mastocytosis • Urticaria with concern for urticarial vasculitis: referral to dermatologist for skin biopsy • Suspicion for an IgE- mediated allergic cause • Symptoms difficult to control, have required systemic steroids, persist beyond 6 weeks. • Recurrent non itchy swelling with abdominal pain • Desire for additional expertise managing recurrent urticaria or angioedema
Referral timeline	• Routine referrals: Varies according to practice location. • Urgent referrals: Please call 324-KIDS (512-324-5437) or physician line if you need to speak with a physician or expedite a patient referral.
Additional information	Fax any medical records, list of medications, and relevant labs (CBC, ESR/CRP, C4/C1-INH, if done) to 512-628-1871.

Patients not seen by the Dell Children's Allergy, Asthma, and Immunology Clinic

- Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)
- Periodic fever with aphthous stomatitis, pharyngitis, and adenitis (PFAPA)
- Fever of unknown origin (FUO)
- Periodic fever syndromes

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Contact us

512-628-1870
DellChildrens.org