Comorbidities during the syndrome such as type 1 diabetes, encephalitis, and long-term sequelae such as thyroid dysfunction, systemic lupus erythematosus, etc.  

**Methods:** We report a 39 year old female with history of traumatic brain injury (TBI) received proflaxis with phenytoin sodium 100 mg i.v every 8 hours, 4 weeks after starting with fever, malaise, sore throat, cervical lymphadenopathy, appeared itchy rash in face, neck. Admitted with malaise, generalized rash, edema midface, chelitis, jaundice, cervical lymphadenopathy, axillary and inguinal and hepatomegaly. We continued to study probable hypersensitivity syndrome asking paraclinical studies including blood count, liver function tests. We initiated 1 mg/kg/d prednisone for 6 weeks and subsequent dose reduction. Exit after 5 days of hospitalization for clinical improvement. Continuous current monitoring by the outpatient department of our hospital and late complications that can occur in this syndrome.

**Results:** Liver function tests as well as the count of the white series was abnormal, with the following report: AST (177 U/L), ALT (154 U/L), WBC (12.430 mm$^3$), eosinophil (1.310 mm$^3$). Biopsy report unavailable.

**Conclusions:** Aromatic anticonvulsants (phenytoin, carbamazepine and phenobarbital) are frequent causes of DIHS. Treatment involves discontinuation of the drug involved, admission to intensive care and systemic steroids at doses of 0.5 to 1 mg/kg/d and intravenous immunoglobulin $2 g/kg$.

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**388 Drug Hypersensitivity Reactions in Hospitalized Patients: What is the Role of the Allergist?**

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**Background:** Ten-to-twenty percent of hospitalized patients experience drug adverse reactions. There are few epidemiological data of drug hypersensitivity in inpatients in Brazilian population. Our aim was to analyze the main clinical and epidemiological data of drug hypersensitivity reactions in hospitalized patients and to assess the importance of the allergist’s evaluation.

**Methods:** A prospective study was developed in an Allergy Clinic of a Service in São Paulo, Brazil, from January 2010 to January 2011. We evaluated the cases in which the allergist was assessed. The patients were studied based on history of hypersensitivity reactions to drugs (HRD) using an adapted ENDA (European Network of Drug Allergy) questionnaire. We analyzed clinical and epidemiological data of drug hypersensitivity reactions and assessed differences of the allergist evaluation.

**Results:** Of all 80 cases in which the allergist was assessed, 65 (81%) were for HRD. The mean age was 57 years, 49 (75%) were women. Fifty (89%) experienced non-immediate reactions, 8 of them were severe adverse cutaneous reactions. Eight (12%) had just positive history of HRD, without reaction at the time of the evaluation. Neurosurgery (15), Infectious Diseases (11), Vascular surgery (8) were the main Clinics who assessed our specialty. Non-steroidal anti-inflammatory drugs (21), antiepileptics (16) and non-β-lactams antibiotics (15) were the most important pharmacological groups. Thirty (46%) patients were in use of more than 5 drugs at the time of the reaction, but in 46 (70%) evaluations there was 0 culprit drug suspected by the allergist. There was discordance between the allergist and the non-allergist opinion about the suspected drug in 13 (20%) cases. In 50% of cases other Clinics were assessed for the same reason. Eleven (17%) patients had history of HRD with the same pharmacological group before.

**Conclusions:** HRD is the main cause why the allergist is assessed. The pharmacological groups related to these HRD were different from the previously described. The history of HRD is still not appropriate asked from the non-allergists. The evaluation of the allergist can help to manage HRD properly.
histamine solution served as controls. A wheal with a diameter >3 mm in comparison with the negative control was scored as positive. Furthermore, in vitro allergy testing using the Phadia CAP system for specific IgE against shrimp, fish-mix, rainbow trout, rCyp p 1 and protamine sulfate was performed.

**Results:** Skin prick tests were positive to shrimp, fish-mix, mackerel, salmon and protamine sulfate. Intradermal testing with protamine showed a wheal diameter of 7 mm. Analysis of a blood sample showed elevated total IgE (2600 kU/L) and specific IgE to shrimp (2.94 kU/L), fish-mix (0.53 kU/L), rainbow trout (0.39 kU/L), rCyp p1 (0.53 kU/L) and protamine sulfate (0.77 kU/L).

**Conclusions:** Protamine sulfate is a polycationic peptide used to reverse the anticoagulant effects of heparin during cardiac surgery. It is commercially produced from the sperm of salmon and it is considered that persons who have an allergy to fish could be at risk of protamine reactions. The exact mechanisms by which it causes anaphylaxis are not fully understood. Due to a clear sensitization to fish proteins and protamine sulfate and a known allergy to shellfish we disapproved the standard anticoagulation protocol with heparin/protamine. Bivalirudin was used as an anticoagulant and the surgery proceeded without any untoward events.

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**Description of Drug Allergy Study Conducted in a Teaching Hospital between October 2007 and March 2011**

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**Background:** The World Allergy Organization (WAO) in 2003 defined ‘drug allergy’ as an immunologically mediated drug hypersensitivity reaction. The mechanism of drug allergy may be either IgE or non-IgE mediated. The true incidence of drug allergy is not known. There are only few studies/datasets using standardized clinical questionnaires and validated in vivo or in vitro tests to confirm the diagnosis of drug allergy. Here we have analyzed the obtained results of in vivo test in suspected drug allergy patients.

**Methods:** Data from the Centre of Allergies of the Clinical Hospital of the Universidad de Chile between the months of October 2007 and March 2011 was obtained. The information of the protocols of drug executed, by defining as Protocol the study of a probable allergy by 2 or more procedures, which can be: Prick Test, intradermal reaction, specific IgE and/or Test Patch.

**Results:** For a total of 126 drug protocols, 25% of them were trivirica vaccine, 24% β-lactams, 21% local anaesthetics and 10% to general anesthesia (inductors, muscle relaxants and Laxet). Of the total of patients undergoing protocols the most of them were women, there is no clear difference between the number of children and adults. The temporal distribution of protocols was stable between the months of October 2007 and March 2009 (15 protocols/semester), to then become variable, reaching values between 10 and 29 every 6 months. Of total protocols, 30.1% were positive; only one patient presented a mild adverse reaction (local welt). The β-lactams being most often the positive drugs. Protocols involving pethidine 100% was positive, diclofenac 33%, dipryne, ketoprofen and hydrocortisone each one 25%. The most accomplished protocol was trivirica vaccine, resulting in 100% negative. Of all negative protocols 58% went to provocation, resulting in a 8% positive, including one provocation to the trivirica vaccine.

**Conclusions:** Methodological study is very important for a possible drug allergy, because history is not enough to certify the diagnosis. To do a provocation test to a negative protocol is crucial.

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**Lung Toxicity Induced by Novel Antineoplastic Therapies in Cancer Patients**

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**Background:** Pulmonary toxicity and respiratory failure are major adverse events complicating the use of novel antineoplastic agents in the treatment of lung cancer. We aim to investigate the risk and characteristics of cytostatic-induced pulmonary toxicity caused by agents currently used to treat lung cancer.

**Methods:** A literature search was performed in PubMed to identify relative studies published until June 2011.

**Results:** Almost all categories of antineoplastic agents have been associated with some kind of pulmonary complications. Taxanes have been linked to acute pneumonitis, pleural effusion and reactions during infusion. Nucleoside analogs can cause diffuse alveolar damage, bronchospasm and acute respiratory distress syndrome (ARDS). Monoclonal antibodies are associated with pulmonary hemorrhage and hemoptysis. Acute pneumonitis and hypersensitivity reactions have been reported with podophyllotoxins, while diffuse interstitial pneumonia has been attributed to pemotrexed. Tyrosine kinase inhibitors of the epidermal growth factor receptor have been associated with acute pneumonitis, diffuse alveolar damage and pulmonary fibrosis. The exact incidence of lung toxicity caused by these agents remains unclear, although it seems relatively low. Clinical manifestation includes cough, fever, dyspnea and hypoxemia. Chest imaging reveals diffuse or patchy, unilateral or bilateral, ground-glass opacities or consolidations. It is important that other possible causes of respiratory failure be excluded when treating a lung cancer patient receiving chemotherapy.

**Conclusions:** Physicians should be aware of the potential of lung toxicities from antineoplastic agents, especially when they are combined with other cytotoxic drugs or radiation.

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**Redness of Skin: SSSS in a 10 Month Old Healthy Baby**

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**Background:** Infections are caused by staphylococcus bacteria commonly found on the skin or mucosal membranes of healthy patients. These bacteria can turn into blood stream and cause severe life-threatening conditions: severe erythema multiforme-like eruption of skin and lesions of the oral, genital and anal mucosa associated with fever, arthralgia and neurological symptoms. To find the correct diagnosis among mucocutaneous diseases sometimes difficult but is important for choosing the proper medication.

**Methods:** A 10 month old boy with symptoms starting 2 days before with upper airway tract infection, external otitis and some urticarial eruption on his body without fever. He was put on oral antibiotic and antibiotic treatment. He was referred to our Department because of high fever, conjunctivitis, stomatitis and redness of his skin all over his body with some blisters formation. He was unable to eat, he was in pain, but sleepy. After a few hours of his admission his fever became 39°C, severe exfoliation occurred, and some large flaccid bullae appeared and erupted, drained an amber-colored liquid and spreaded to cover extensive areas of his body revealing denuded skin. His history and symptoms suggested allergic reaction for his medication or auto-immun mucocutaneous disorder, but interestingly his laboratory tests were in the normal range. In spite of these to prevent a bacterial superinfection after bacterial culturing of throat, nose, skin, and blood, we introduced iv amoxicillin/clavulanic-acid therapy, cefoxitin eye drops, antiseptic local treatment of mouth (chlorhexidine bigluconate) and skin (unguentum antispticum). After 2 days his fever started and the top layer of his skin started to come off, partly powdery scales formed.

**Results:** The symptoms started to resolve slowly and the child became symptom free after 10 days. Bacterial culturing results confirmed the