anaphylaxis. Mainstay treatment for food dependent exercise induced anaphylaxis is recommending exercising only on an empty stomach. The consideration of food dependent exercise induced anaphylaxis in cases of unexplained anaphylaxis is important as reactions can be life threatening and clinicians should be reminded of the importance of thorough history taking.

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First Report of Anaphylactic Shock Caused by the Ingestion of Mite-Infested Flour in Panama

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Background: To report the first case of an anaphylactic shock, almost lethal, in the Republic of Panama, produced by ingestion of pancakes contaminated by mites.

Methods: A 21 year-old male patient was evaluated due to an anaphylactic shock after the ingestion of pancakes, eggs and milk. The patient had a background of a moderate allergic rhinitis. Not asthma. Skin prick test was performed on the patient with standardized extract of mites and food items, including, flour, milk and egg. After twenty minutes the results were read and considered positive since the wheal was 2 mm larger than the control (histamine 1 mg/mL). The Total IgE was determined by the chemiluminescence method. The determination of the specific IgE for mites and food was performed by the enzyme immunosassay technique. The counting and identification of the mites in the pancake samples that were eaten by the patient were placed in a microscopic slide using a Hoyer medium and analyzed in a stereomicroscope.

Results: The skin prick test performed was considered positive for Blomia tropicalis, Dermatophagoides pteronyssinus and negative for flour, milk and egg. The total IgE was increased and the specific IgE resulted positive for Dermatophagoides pteronyssinus and Blomia tropicalis, but negative for flour, egg and milk. The microscopic examination of the pancake wheat showed 3 different species of mites: Blomia tropicalis, Blomia sp. and Dermatophagoides pteronyssinus, the first one in major proportion.

Conclusions: The anaphylactic shock of the patient was produced by the ingestion of a commercial pancake contaminated by mites to which the patient was sensitized. Flour kept in open containers becomes a fertile ground for the growth of mites in tropical climates. Allergic patients should be warned of the danger of anaphylaxis in such conditions.

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Recurrent Anaphylaxis in Cow Milk Allergy: What Is Wrong?

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Background: Food allergens are one of the most important triggers of anaphylaxis in pediatric population and all efforts must be done to avoid new episodes.

Objective: To determine some factors associated to recurrent anaphylaxis induced by cow’s milk (CM) in pediatric patients with a previous anaphylactic episodes.

Methods: This is a retrospective study based on medical records from all CM anaphylactic patients, from a Brazilian reference center for food allergy. The anaphylaxis criterion used was based on the Second symposium on the definition and management of anaphylaxis. Patients and parents had received orientation regarding prevention of new episodes, including information about hidden allergens, label reading, and synonymous terms.

Results: It was included 53 patients (33M: 20F), median age of the first episode of anaphylaxis was 6 months (range 1–87 month) and in 56. 6% the first episode occurred until the age of 6 months. Fifty episodes were observed in 22 patients during the follow up. Twelve patients presented 2 or more episodes and 2 patients presented 6 episodes. It was not possible to detect the trigger food in 17 episodes and these situations were related to ingestion of: appetizers (4), margarine (3), bread (2), pizza (2), juice with casein (1), pasta (1), cake (1), chips (1), Italian sausage (1). Two episodes were challenged by accidentally skin contact and 2 by inhalation. Among the settings of episodes, the majority occurred at home. Other places included: school, restaurants and bakery.

Conclusions: This study showed that it is very difficult to reach success only with the orientations regarding anaphylaxis prevention. It is necessary to betake of other strategies to improve the measure to avoid new episodes of anaphylaxis such as: folders, visual midia and interactive activities. Furthermore, the continuous education is essential to reinforce the knowledge.

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Epidemiology of Anaphylaxis in Adults Treated in the Emergency Department, of the University Hospital of Monterrey n.l Mexico. During 2005–2010

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Background: The risk of anaphylaxis ranges from 0.2 to 0.7%. The objective of this study was to describe the causes, clinical features and complications of patients with anaphylaxis treated in the emergency department of our hospital.

Materials and Methods: A prospective, observational and descriptive survey was conducted for assessing adult patients with a diagnosis of anaphylaxis from March 2005 to 2010. Information was obtained from the medical records and from a questionnaire was that completed for the patients and a relative. The information included, triggers, demographics, allergy history and clinical characteristics of the current episode. All the cases were followed to their outcome.

Results: We documented 45 cases of anaphylaxis. 26 patients (58%) were male. The most common causes of anaphylaxis were: drug (49%), food (20%) and poison hymenoptera venom (16%). The most common clinical signs and symptoms included: dyspnea (69%), nausea (58%) and hypotension (56%). 44% of patients came to emergency departments in the course of 30 minutes after onset of symptoms while the 29% took 30 minutes to 1 hour and 27% more than 1 hour. Among the associated diseases, hypertension was 13% and rhinitis (11%). In 85% of the cases, patients remained under observation for 3 to 12 hours were the most frequent discharged. 7 patients were hospitalized and 4 sent to intensive care later were discharged without complications.
Conclusions: Anaphylaxis is not uncommon in our environment. Drugs are the most common cause as reported in the literature. The most frequent clinical manifestations are respiratory and gastrointestinal.

ANTI-IGE

269 Refractory Chronic Urticaria Treated with Omalizumab
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Background: Chronic urticaria (CU) is a common disorder characterized by recurrent episodes of urticaria pruritic erythematous lesions, associated with angioedema. It affects 0.1% of the population, it is estimated that approximately 15 to 25% of the population will have hives at some point in their lives. About 80% of UC patients are diagnosed as idiopathic chronic urticaria and that no cause is identified, 3 experiencing deterioration in their quality of life affecting your work, social relationships, schemes requiring multiple medications and doses higher than usual. This study proposes Omalizumab (anti-IgE humanized antibody) as a treatment for Refractory Chronic Urticaria (RCU).

Object: Demonstrate Omalizumab’s effectiveness in the treatment of Refractory Chronic Urticaria.

Methods: A clinical study, was carried out to evaluate the effectiveness of the Omalizumab’s treatment on RCU diagnosed patient, including male and female patients ages 12 to 50 diagnosed with RCU, with Scordar higher than 30 points. We made a questionnaire to know about the patient’s family background, skin symptoms beginning, administration of drugs such systemic steroids, immunosupressors, calcineurine inhibitors, presence of immunotherapy and age of start. Omalizumab was administered on doses according patient’s weight and IgE levels, bimonthly or monthly according to treatment guides. Severeness level was calculated with scordar every 1 month, with IgE serie level measurement and life quality questionnaire.

Results: 5 patients diagnosed with RCU were included in the group of Omalizumab and 5 patients in the control group (placebo). All patients were female. A gradual decrease on the life quality score and in Score, with a significant P under 0.05 was observed on all patients treated with omalizumab compared with patient in the group with placebo.

Conclusions: Treatment with Omalizumab progressively decreases the severeness level on RCU, with a significant improvement on the patient’s life quality.

270 Clinical Experience in Allergic Asthma Patients: Omalizumab with Immunotherapy
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Background: To evaluate the therapeutic efficacy of omalizumab and specific subcutaneous immunotherapy (SCIT) as a treatment modality in patients with more than one allergic-type condition.

Methods: In the first group (Group A), 2 males and 7 females with severe persistent asthma and a mean age of 34.2 years received omalizumab and SCIT. In the second group (Group B), 4 males and 2 females with severe persistent asthma and a mean age of 52.7 years received omalizumab only. In the third group (Group C), 1 male and 3 females with severe persistent asthma and a mean age of 28.8 years received omalizumab followed by SCIT. All patients were followed for 2 years and comparisons were made using pulmonary function tests and asthma control tests.

Results: The patients studied had severe persistent asthma for periods ranging from 2 to 10 years, and in addition had been diagnosed as allergic asthmatics for 5 to 40 years. The mean IgE levels were as follows: Group A: 553.9 IU/mL; Group B: 422.3 IU/mL; and Group C: 383.5 IU/mL. In all 3 groups results in the asthma control test increased by 2.5 fold over the period of study.

Conclusions: After the addition of SCIT to omalizumab therapy at 48 week of our study, no change was detected in urticarial attack rates. In another 17 year old male patient with moderate allergic rhinconjunctivitis, asthma and atopic dermatitis, omalizumab administration with SCIT at the same time, increased the severity of atopic dermatitis. We stopped the immunotherapy than the skin lesions lost. Omalizumab therapy is continued.

Background: Anti IgE therapy is the ultimate therapeutic option for severe atopic conditions, not controlled by conventional treatment. Its efficacy and safety was described in several peer reviewed publications. Here we report on the events temporally related to the administration of almost 4 hundred doses of the only monoclonal Anti IgE antibody approved in our country for the treatment of severe asthma.

Methods: Descriptive retrospective analysis of clinical charts of patients receiving omalizumab because of Severe Uncontrolled Asthma, considering those events presented in the 72 hours after administration of it, which was not present before the procedure or as a concomitant condition of the patient. Vital signs, respiratory and cardiovascular evaluation, and dermatological inspection were performed in the hour after administration of corresponding doses. Patients having any kind of complaint were evaluated in unscheduled visits.

Results: 384 doses of 150 mg omalizumab were given to from April 2007 to June 2011, to nine severe asthmatic patients. One of them received treatment for over 4 years, and two for over 3 years.

Conclusions: Our records from patients receiving omalizumab have not registered severe adverse events in almost four hundred doses given. The moderate adverse events of nausea and tachycardia resulted in discontinuation

Events related to omalizumab administration

| YES | NO |
|-----------------------------------------------|
| Local erythema and edema: 0.78%-mild | Muscle pain: 1%-moderate |
| Nausea: 0.26%-moderate | Bruises: 0.52%-mild |
| Sinusal Tachycardia: 0.26%-moderate | Headache: 0.26%-mild |
| Ear pain: 0.26%-mild | |