Aspirin Desensitization Treatment: A Case Report
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Background: Aspirin (ASA) is one of the best known and most widely used drugs in the world. Patients with coronary artery disease require prolonged treatments with this drug, which is denied to those patients with histories of adverse reactions to it.

Methods: In a rapid desensitization protocol a patient with a history of ASA-induced urticaria-angioedema was treated with escalating doses of aspirin administered orally every 25 minutes.

Results: The patient completed the desensitization protocol in few hours without complications, and currently is able to take 125 mg of ASA per day without adverse reactions.

Conclusions: This report describes the first desensitization treatment with aspirin carried out in our hospital. No other case was found in the national bibliography.

Adverse Drug Reactions to Anti-asthmatics in Patients with Bronchial Asthma
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Background: The number of self-reported adverse drug reactions (ADRs) has been rapidly increased with the active pharmacovigilance activities in Korea. However, there has been few data on ADRs to anti-asthmatics in Korea. This study was conducted to investigate the clinical characteristics of ADRs to anti-asthmatics in adult patients with bronchial asthma.

Methods: ADRs to anti-asthmatics reported to Regional Pharmacovigilance Center of Inha University Hospital by 2 physicians were collected from January 2011 to April 2011. Causality assessment of adverse events was performed by using WHO-UMC criteria and Naranjo’s probability scale. Clinical information was additionally collected from electronic medical records.

Results: Twenty five ADRs to anti-asthmatics were reported in 19 (male 5, female 14) out of 228 patients with asthma. The most common offending anti-asthmatics were inhaled glucocorticoids combined with inhaled long-acting beta agonist (LABA) (12 of 19 subjects, 63.2%), theophanol (10.5%), oral LABA (10.5%), doxofylline (5.3%), acetylcysteine (5.3%), and montelukast (5.3%). Severity of ADRs was mild in most patients (13 of 19, 68.5%), and no severe ADR was detected. By frequency, oral LABA was the commonest drug associated with ADRs (2 in 17 prescription, 11.8%). ADR frequency was not different according to asthma control status. But ADRs to simultaneously prescribed drugs were more frequently detected in patients with combined upper airway diseases (ADRs to antihistamines) or patients with combined infection (ADRs to anti-infective drugs, mucolytics, oral LABA, or to SABA), or older patients with asthma.

Conclusions: Although the severity is usually mild, ADRs are relatively common in patients with bronchial asthma. Physician should monitor ADRs to anti-asthmatics or related drugs in patients with asthma, especially in older patients or in patients with multiple drug treatment for combined conditions.

Presentation of Three Cases of Allergic Reactions to Triptorelin
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Background: Triptorelin is a drug that is frequently used in pediatrics to treat precocious puberty -an often condition in childhood endocrinology services. Despite its widespread use, there is not much research on hypersensitivity reactions to this drug. We found 3 patients that have suffered allergic reaction during the treatment with Triptorelin.

Methods: We treated three 8 years old girls diagnosed with precocious puberty that have suffered allergic reaction during the treatment with Triptorelin. Patient 1: An hour after the first dose the patient broke out in a rash over her face, trunk and upper limbs. She also showed general paleness, conjunctival erythema, arthralgia and joint swelling in both knees with functional impotence of the lower limbs. Patient 2: Five minutes after the second dose the patient showed anaphylactic reaction. Patient 3: Two hours after the second dose the patient showed generalized urticaria and tachycardia.

Results: Once overcome those events. We started to provoke the reaction by doing the progressive-controlled triptorelin test. Finally we could confirm the hypersensitivity reaction to this drug.

Conclusions: The triptorelin is a drug that may cause hypersensitivity reaction. So, after the first application, we recommend to monitor the patient and also plan some actions to avoid a possible anaphylactic shock event.

Adverse Drug Reactions in Hospitalized Patients
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Background: To describe adverse drug reactions (ADRs) in hospitalized patients.

Methods: A cross-sectional study with a questionnaire for adverse drug reactions based on European Network for Drug Allergy (ENDA) was performed. Hospitalized patients older than 12 years of age were included.

Results: A total of 150 patients were studied, 84 being female. Their ages ranged from 14 to 94 years, with an average of 55 years. The average number of medications per patient was 7.5. Fifteen ADRs were reported during hospitalization (10%). Five ADRs were classified as hypersensitivity, including 2 IgE-mediated reactions that were observed in 2 patients hospitalized for desensitization (anti-rabies vaccine and insulin). The procedure had to be suspended in these patients. Three non-IgE-mediated hypersensitivity reactions occurred: rash after non-steroidal anti-inflammatory drug (NSAID) intake, coughing and itching with angiotensin converting enzyme inhibitor (ACEI) and rash with iodinated contrast. The remaining patients (10) had common side effect reactions to several drugs. Twenty-eight patients had had prior hypersensitivity reaction, being five IgE-mediated (two with beta-lactam antibiotics, one with non beta-lactam antibiotic, one with insulin and the last one with rabies vaccine) and 23 non-IgE-mediated (8 with NSAIDs, 5 with ACEI, 3 with beta-lactam antibiotics, 3 with non beta-lactam antibiotics, 2 with iodinated contrast and 2 with other drugs). Most hypersensitivity reactions were cutaneous. In 3 patients, previous hypersensitivity reactions were not mentioned at the time of hospitalization.

Conclusions: The average number of medications administered per patient during hospitalization is high. Adverse drug reactions are very common and have great clinical relevance. Ten percent of patients presented ADRs during hospitalization and one third of them had hypersensitivity reactions, what is in accordance with literature.

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An Unusual Reaction to Intravenous Iron Sucrose
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Background: Intravenous (IV) iron dextran, the original parenteral iron formulation, is associated with a high incidence of non-IgE mediated hypersensitivity. Newer formulations of IV iron therapies include low molecular weight iron sucrose (IS) and sodium ferric gluconate complex (SFGLC) without dextran, reducing severe adverse reactions by 93%. A case of a rare reaction to IV IS associated with generalized skin pruritus and difficulty in breathing is reported.

Methods: A 62-year-old Caucasian male with multiple gastric surgeries, secondary to recurrent gastric ulcers and gastric outlet obstruction, presented with severe iron deficiency anemia (IDA) requiring IV iron therapy.

Results: Chronic malnutrition and malabsorption, associated with difficulty in tolerating oral and jejunostomy tube (J-tube) feedings, resulted in a two month 30 pound weight loss. Oral iron supplementation via a J-tube did not improve the IDA. Prior administrations of IV iron dextran resulted in flushing, generalized urticaria and angioedema associated with pruritus of the face and extremities within ten minutes of infusion. The allergy/immunology service was consulted. Premedication with IV diphenhydramine, 50 mg, prednisone via J-tube, 32 mg, and IV ranitidine, 50 mg, was followed with slow administration of a test dose of IS, 25 mg, at 1.6 mg/min. Within 30 minutes of the IV IS infusion, symptoms of nausea, flushing, and generalized pruritus, and difficulty in breathing were noted. The infusion was stopped and treatment with IV methylprednisolone, 125 mg, resulted in resolution of the reaction over several hours. No eosinophilia or elevated liver transaminases occurred. Subsequently, the infusion was reattempted: pre-medications consisted of IV methylprednisolone, 60 mg, IV diphenhydramine, 50 mg, and IV ranitidine, 50 mg, 75 minutes prior to the infusion of IS, 275 mg, 1.5 mg/min. Treatment was tolerated without adverse effects.

Conclusions: A rare systemic reaction to IV IS is reported. Treatment with methylprednisolone, diphenhydramine and ranitidine 75 minutes before IS infusion was successful.

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Urticaria and Arthralgias in a Nine-Year-Old with Recurrent Urinary Tract Infections
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Background: Serum sickness is a type III immune complex hypersensitivity reaction occurring after exposure to foreign antigens, most commonly medications. Symptoms typically begin 1 to 3 weeks after initial exposure to the offending agent and include fever, malaise, urticarial or morbilliform rashes and arthralgias which may progress to arthritis, nephritis, neuropathy or vasculitis. We report a case of drug-induced serum sickness in a patient who had previously tolerated trimethoprim/sulfamethoxasole (TMP/SMX) for treatment of recurrent urinary tract infections.

Methods: A 9 year-old female presented with a pruritic, erythematous rash that began 2 days after completing a 10 day course of TMP/SMX for a urinary tract infection. TMP/SMX had previously been prescribed to treat recurrent urinary tract infections without adverse side effects.

Results: Initially she developed a fever and a blotchy rash with patches of erythema which started on the torso and progressed to generalized urticaria over a 24 hour period. Associated symptoms included fatigue, lethargy, generalized myalgias and arthralgias with swelling limited to the left knee, ankles and fingers. No mucosal lesions, nausea, vomiting or diarrhea were present. Pertinent findings on physical examination included mild edema of the left knee without associated erythema or warmth and proximal and distal interphalangeal joints of the hands, wrists, knees and ankles absent of an effusion, but tender to palpation with full range-of-motion. Urticarial lesions with serpiginous borders and central clearing were noted on the trunk and extremities including the palms but not soles. Hyperpigmented areas at sites of previous urticarial lesions were present. Prednisone, 10 mg 3 times daily, and cetirizine, 10 mg daily, was prescribed and within 24 to 48 hours, all symptoms improved. No further laboratory studies were obtained. Prednisone was tapered over a 2 week period and cetirizine was discontinued simultaneously without recurrence of symptoms. The patient was advised to avoid TMP/SMX indefinitely.

Conclusions: Medications are the most common cause of serum sickness with TMP/SMX being frequently implicated. Immune complex reactions generally occur a few weeks after initial exposure to a medication; however, drug-induced serum sickness should still be considered in cases to which an agent may have been previously tolerated.

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Jessner-konaff Lymphocytic Infiltrate as a Side Effect of Immunotherapy
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Background: Allergen immunotherapy has been used in the management of allergic diseases for nearly 100 years. It is the only specific treatment for hymenoptera venom anaphylaxis. Various venom immunotherapy schedules have been designed to treat anaphylaxis. Although the effect of venom