

Letters to the editor

MITE AVOIDANCE

To the Editor:

The article by Denson-Lino, et al¹ well explains some of the reasons why poor children have excessive asthma due to dust mite exposure. There can, however, be good dust mite avoidance for most patients who need it at considerably less cost than stated. Pillows can be encased in strong trash can liners, available in grocery chain stores, and the plastic liner can then be sealed with very sticky tape, found at low cost in building supply stores. If the pillow is then wrapped in a bath towel before being placed in a pillow case, there is little noise or excessive heat.

Mattresses and box springs can also be encased in strong plastic sheeting, found in building supply stores, and these plastic sheets can be sealed with strong tape. A washable mattress pad or cotton blanket between the encasement and the sheet will make the bed comfortable. Total costs for these materials should be less than \$10, and three beds can be encased at this price. Many of my patients have used these methods successfully.

The above measures can significantly decrease the cost of care for asthma due to dust mites.

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Reference

1. Denson-Lino JM, Willies-Jacobo LJ, Rosas A, et al. Effect of economic status on the use of house dust mite avoidance measures in asthmatic children. *Ann Allergy* 1993;71:130-2.

Response:

I read with interest the comments of Dr. Werth concerning less expensive mite avoidance measures. I also have experimented with covering mattresses with plastic obtained from hardware stores and sealed with duct tape. While there seemed to be improvement in allergy symptoms, there appeared to be problems with durability, especially in keeping the mattress cover completely sealed and there were complaints about comfort. As there are no data yet available concerning "home-made" mattress covers and pillow covers, a controlled study would be of value and should be performed.

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ACETAMINOPHEN HYPERSENSITIVITY AND OTHER ANALGESICS

To the Editor:

We read the article about the patient suffering acetaminophen hypersensitivity with great interest.¹ Al-

though we do not have a large series, we think that, (at least in Turkey) acetaminophen hypersensitivity is seen more often than thought. During the first 9 months of 1993, 1,600,000 kilograms of acetaminophen and 572,000 kilograms of acetylsalicylic acid has been consumed in Turkey.² These two are the most commonly consumed analgesics in our country that are sold over the counter.

Although we do not have adequately documented data about analgesic allergy for our country, in the last two years 7 of the 38 patients who were admitted to our clinic and shown to have analgesic allergy also had various allergic reactions to acetaminophen. Notably 31 of the patients with analgesic hypersensitivity and 6 of the 7 patients with acetaminophen hypersensitivity were female. Symptoms of these patients with acetaminophen hypersensitivity began between the ages of 21 and 44 years (Geometric mean 26.9), and all of them also had hypersensitivity to aspirin and other nonsteroidal antiinflammatory drugs (NSAIDs). The age of onset for symptoms of those patients who were hypersensitive to NSAIDs other than acetaminophen was between 21 and 67 years (Geometric mean 35). Both of these groups had similar distributions of frequently associated conditions (bronchial asthma, mean of 40%; perennial rhinoconjunctivitis, 25%; and dermatographism, 20%). In all cases of patients who had acetaminophen hypersensitivity, allergic symptoms against another analgesic appeared first. Only one patient had life-threatening anaphylaxis after taking acetaminophen.

We have observed acetaminophen hypersensitivity to be starting at younger ages than for non-acetaminophen NSAID allergy, and the first reaction in all cases occurred with another NSAID or aspirin. In addition, there seems to be a female preponderance for analgesic allergy. For this reason, we want to point out the importance of these patients being informed by their physicians at the first reaction to NSAID of the possibility of developing acetaminophen hypersensitivity.

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References

1. Doan T, Greenberger PA. Nearly fatal episodes of hypotension, flushing, and dyspnea in a 47-year-old woman. *Ann Allergy* 1993;70:439-44.
2. Statistical data of Ministry of Health, 1993.

Response:

The letter by Dr. Kalyoncu and colleagues reports seven cases of acetaminophen hypersensitivity from a group of 38 patients with the diagnosis of analgesic allergy. Only one of the seven patients experienced life-threatening anaphylaxis with acetaminophen with other reactions being reported as less severe. The initial presentation of analgesic reaction occurred with NSAIDs. In contrast, the patient reported in *Annals of Allergy*¹ had tolerated aspirin uneventfully on previous occasions.

The recommendation presumably to test-challenge patients with acetaminophen after an immediate reaction to aspirin or an NSAID is not supported by literature in this area or clinical experi-

ence. While oral challenge with 1,000 mg of acetaminophen in 3 aspirin-sensitive patients² with asthma produced significant declines in FEV₁, symptoms of anaphylaxis did not occur. Other investigators have reported very few if any bronchospastic responses to therapeutic doses of acetaminophen in patients with aspirin-induced asthma.² Immediate generalized reactions (anaphylactic type) from acetaminophen fortunately are exceedingly rare.

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References

1. Doan T, Greenberger PA. Nearly fatal episodes of hypotension, flushing, and dyspnea in a 47-year-old woman. *Ann Allergy* 1993;70:439-44.
2. Settiple RA, Stevenson DD. Cross sensitivity with acetaminophen in aspirin-sensitive subjects with asthma. *J Allergy Clin Immunol* 1989;84:26-33.

SAFETY OF SPECIFIC IMMUNOTHERAPY

To the Editor:

Specific immunotherapy has been considered a suitable curative approach only when avoiding allergens is not possible or when appropriate medication fails to control asthma symptoms.¹ Researchers suggest that specific immunotherapy must be considered a second-level medication also because systemic reactions occur in from 5 to 20% of specific immunotherapy-treated patients. In order to assess the safety of specific immunotherapy we reviewed 25 yrs of clinical outpatient treatment with specific immunotherapy; we performed 287,000 injections in 6,319 patients suffering from allergic asthma and/or rhinitis; all subjects were treated with conventional schedules by means of aqueous or aluminum hydroxide adsorbed extracts, the percentage of which varied throughout years (Lofarma Allergeni and Bayropharm DHS, Milano, Italy).

Systemic reactions reported in the entire period were 182, divided as follows: mild acute asthma (24%); asthma and urticaria (10%); urticaria (59%); acute rhinitis (7%); no case of anaphylactic shock was ever observed; no admission to the hospital was necessary. Reactions occurred more frequently during the buildup phase (67%) than during the maintenance phase (33%) and were not significantly more common in females (58%). Systemic reactions occurred in our experience less frequently than reported in the literature² and none was life-threatening. This result confirms the safety of specific immunotherapy which if started early, can prevent chronic airway inflammation, the development of asthma after allergic rhinitis and new sensitizations.³ In this way it can modify the natural history of atopy unlike traditional pharmacological treatment. On the other hand antiallergic drugs, employed as first level treatment respectively in asthma and rhinitis, such as β_2 agonists and antihistamines have been reported potentially, although rarely, re-