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Ultrarush immunotherapy in patients with Hymenoptera venom allergy

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To the Editor:

We read the publication on ultrarush insect venom immunotherapy (VIT) by Brehler et al¹ with great interest. The authors are to be congratulated on their extensive collection of data. However, we cannot share their view that the "incidence and severity of adverse reactions decline if the VIT dose increase protocol is shortened to 2 days." First, in the 3 cohorts treated with conventional rush, intermediate rush, or ultrarush bee VIT, the number of patients with adverse reactions from VIT was not significantly different. We do not think, as suggested by the authors, that the "reason for this was the smaller number of patients." The three groups comprised 33, 32, and 57 patients, respectively, and thus should have been large enough to disclose clinically relevant differences. Second, among the 3 cohorts treated with wasp VIT, there was no significant difference with regard to the development of generalized skin reactions; however, the frequency of those obtaining intravenous treatment for generalized skin reactions was significantly different, with a higher percentage in the cohort treated according to the ultrarush protocol. Only the percentage of "systemic reactions," which, according to the authors, were mostly "attributed to emotional factors," was significantly different among the 3 groups receiving wasp VIT and more than twice as high with conventional rush than with ultrarush VIT. Thus only the occurrence of subjective symptoms was reduced in the ultrarush group, and we presume that this indeed is related to

the duration of treatment; the longer the procedure, the higher the chance of such reactions.

As Brehler et al¹ point out, the results of this retrospective data need confirmation from a prospective study. In our hands the ultrarush protocol used by Brehler et al caused significant adverse reactions when 15 patients were treated who had experienced systemic anaphylactic reactions to a bee sting (2 had mild reactions, with only generalized skin symptom; 9 had moderate reactions, with cardiovascular, gastrointestinal, and/or respiratory involvement; and 4 had severe reactions, with loss of consciousness). All had large local reactions (up to 30 cm in diameter), and in 6 (40.0%) patients 10 (7 mild and 3 moderate) systemic anaphylactic reactions occurred at venom doses of less than 100 µg. After repeated mild reactions, one moderate systemic reaction, or both, treatment was continued according to a conventional rush protocol, which was tolerated without further systemic adverse reactions by 4 of 6 patients. These 40% of patients with repeated or moderate adverse reactions during ultrarush VIT are considerably more relevant to the management of Hymenoptera venom allergy than the occurrence of only mild systemic anaphylactic reactions in 5 (17.9%) of the 28 patients allergic to bee venom who were treated previously by means of conventional rush VIT.²

Also, assessing the therapeutic efficacy of the ultrarush protocol by means of sting challenge tests would have added to the practical relevance of the article.³ At present, the data presented suggest a new possibility of treating Hymenoptera venom allergy. However, more work has to be done before the ultrarush protocol can be recommended for routine clinical use.

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