

Letter to the Editor

Authors reply to beta-lactam allergy in children

Editor,

We thank you for the opportunity to answer to the interesting remarks made by colleagues Perez-Rodrigues et al. (1) on our recent paper published in *Pediatric Allergy and Immunology* on betalactam allergies in children. We found the comments very useful to clarify a few issues that a critical reading of our paper could actually raise.

In our study, a group of 1170 children with already suspected immediate allergic reactions to penicillins and/or cephalosporins was evaluated. There were no self-reported allergies in the studied population.

We agree that the percentage of betalactam (BL) allergic children found in our study is very high, particularly if compared with literature data. However, such percentage can be explained by the fact that penicillins, including benzyl penicillin, are the most frequently prescribed drugs for children in our country and by the characteristics of the sample assessed, which might be unique for genetic reasons.

We used PPL and MDM produced by the Institute of Immunology and Virology of Torlak (Serbia). The highest concentrations for all tested drugs were given in the Methods section, and were the same proposed by Torres et al. (2) in the position paper of the European Network for Drug Allergy (ENDA). The testing was done in accordance with the ENDA position paper on diagnosis of immediate allergic reactions to BLs.

As far as re-evaluation is concerned, we are aware of its importance in patients who suffered immediate reactions to BLs and display negative results in the first allergologic exam, including challenges. However, at the time we started this study, we did not include re-evaluations in our diagnostic protocol, as we have been doing since 2003.

The skin testing results presented in the paper were obtained by both skin prick and intrader-

mal testing (mentioned as skin tests at the beginning of Methods section). We did not show separately the results obtained by each of the two *in vivo* methods, as it was not the scope of the paper. We showed the separate data only for the challenge test, to emphasize the low percentage of positive responses to it, in case the skin test was negative. In parts of the Results section and in the Table 1, the *in vivo* tests were marked as skin prick tests, but they should have been marked as skin tests, as we did not show any separate data on the percentages of the results obtained by skin prick testing.

We also want to underline that the Ethical Committee of the University Children's Hospital in Belgrade approved the study. For the control group of 100 children without drug allergies the informed consent was obtained, and the testing was carried out according to a request on the part of parents because of a family history of drug hypersensitivity. Only those children constituted the control group. We do agree that performing the testing without an informed consent would be unethical.

With regard to the diagnosis of selective sensitizations, we performed provocation tests only with suspect BLs; therefore, such diagnosis actually was based only on responses to skin tests. However, in patients with immediate reactions to penicillins, the negative predictive value of skin tests with compounds other than the culprit ones is very high (3, 4).

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