

All physicians must examine the Food and Drug Administration guidelines and the Academy's "Position statement" and determine for themselves which guidelines they feel comfortable with for their own patients. Dr. Falliers and Dr. Wells appear to be doing just that, and in so doing have given "very careful consideration to the potential benefits and risks of at-home administration of allergenic extracts . . .".

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Better drug trials

To the Editor:

I believe two articles that appeared in the October 1994 issue of the *JOURNAL* illustrate serious, but all too common, flaws in the current approach to clinical pharmaceutical trials. In a fluticasone trial, Chervinsky et al. (*J ALLERGY CLIN IMMUNOL* 1994;94:676-83) conclude that this new agent is safe and effective for the treatment of adults with mild to moderate asthma. It should come as no surprise that an inhaled steroid is effective in the treatment of asthma. The question we should really be seeking to answer is: is this new agent better than currently available drugs in terms of efficacy, safety, or cost? Without comparing old and new agents head to head, we are left with little clinically useful information.

Schweitzer et al. (*J ALLERGY CLIN IMMUNOL* 1994; 94:716-24) demonstrate another common methodological flaw. A new nonsedating antihistamine is compared with a classical antihistamine; chosen for comparison to the new drug is the notoriously soporific diphenhydramine. A more appropriate method would have been to compare cetirizine with a relatively nonsedating, widely used, and inexpensive drug such as chlorpheniramine.

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I appreciate the fact that pharmaceutical companies want to study their new drugs in clinical trials that give them the greatest chance of appearing superior, but we must ask, superior to what? Placebo-controlled trials are an essential element of such studies, but in addition to showing a drug to be superior to placebo, the drug must be compared with currently available agents so that we can ask ourselves, "Is this better than what we have now?" When drugs are compared head to head, the new agent should be compared with the best available drug in terms of efficacy, side effect profile, and cost.

I urge physicians and others who conduct clinical research to work with the drug companies to design fair and clinically relevant studies. Further, I urge clinicians who read the results of clinical trials to be skeptical of work that does not allow them to answer relevant clinical questions.

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And what about feces?

To the Editor:

In reference to the article "Direct exposure of carpets to sunlight can kill all mites" (Tovey et al. *J ALLERGY CLIN IMMUNOL* 1994;93:1072-4), we fully agree with the authors that sunlight treatment of carpets is safe, free, and highly effective in killing mites and eggs; however, the fact that there was no effect on mite allergen Der p I concentration (which constitutes 90% of mite feces particles) and the fact that mite allergens responsible for respiratory and eczematous allergic symptoms are often clearly associated with mite feces suggest that exposure of carpets to sunlight alone will not be useful as a form of prevention of symptoms unless Der p I concentration is effectively reduced.

Further, because these particles (normally 10 to 40 μ m mean diameter) may be pulverized by heat and thus become much smaller, the process of eliminating them might now be much more difficult, calling into question the final effectiveness of sunlight treatment in terms of benefit for patients.

We believe it is preferable to use commercially available products that have the dual effect of killing mites and eggs and of aggregating the above mite feces particles into pellets of greater dimensions, which can then be vacuum-cleaned.¹⁻³

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Reply

To the Editor:

In response to the letter by Dr. Monti and colleagues, we differ in our interpretation of data and the literature. The important components of any long-term strategy to control exposure to mite allergens are suppression of mite proliferation and removal of accumulated allergens from reservoirs. We found that several hours of direct exposure to sunlight can be 100% effective in killing mites. This is more effective than any acaricide. If performed regularly (e.g., monthly), such exposure could be expected to massively reduce the source of the accumulating allergen. Sunlight does not destroy existing mite allergen in carpet dust. We would suggest that this allergen was most effectively removed by wet vacuuming (about 80% effective) or by directly washing the carpet (>95% effective).

Mite feces are dense particles surrounded by peritrophic membranes, and we are not aware of any data that they are pulverized by exposure to sunlight, although this is an interesting speculation and suggests a source for smaller-sized mite aeroallergens.

In view of the diversity of the reported effectiveness of the acaricidal treatments recommended by the quoted references in the broader literature, I remain unconvinced that treatment with acaricides alone provides complete control of mites or facilitates the removal of accumulated allergen. Although such acaricidal treatments may be all that can be used for fitted carpets in some climates, in others, where loose carpets are used and the conditions and compliance are appropriate, a combination of direct exposure to sunlight and occasional washing or wet cleaning is probably the most effective method, as well as being simple, safe, and cheap.

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Yellow fever vaccine and egg allergy

To the Editor:

There is some concern surrounding the use of vaccines, grown on chick or duck embryos, in egg-sensitive patients. Guidelines have been proposed for use of measles vaccine in such patients.¹

We describe the case of a 40-year-old woman who requested a yellow fever vaccine before traveling to Ivory Coast. Since childhood she had experienced angioedema and generalized urticaria after egg ingestion. Results of skin testing with commercial egg extracts were negative, but a prick test with crude fresh egg white induced a typical wheal and flare, larger than the histamine control. According to the guidelines of the American Academy of Allergy and Immunology for measles vaccine,² we performed a skin prick test with the yellow fever vaccine diluted 1:10 and an intradermal test with the vaccine diluted 1:100 (Stamaril Pasteur, Merieux, France). No skin reaction was observed after 15 minutes. The patient then received the whole vaccine (0.5 ml, administered subcutaneously) without any adverse reaction. This suggests that crude food allergens might be of greater help than commercial extracts for skin testing in patients with food allergy.³ Furthermore, the guidelines proposed for measles vaccine in patients allergic to egg might also apply for yellow fever vaccine.

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