

Correspondence

Angio-oedema without hives, IgE and omalizumab

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We read with much interest in *Clinical and Experimental Dermatology* the report of Pedraz Muñoz *et al.* on two patients with idiopathic angio-oedema treated with omalizumab.¹ We congratulate them on this very interesting paper, both in the cases and the review, but the report also raised some questions that we would like to address.

First, the authors state that to their knowledge, there are only eight published case reports of idiopathic angio-oedema treated with omalizumab in the literature to date.¹ However, and obviously because of the delay between the acceptance and the publication of their paper, they did not mention our recent report on another eight patients with isolated angio-oedema refractory to other treatments, for which only omalizumab was successful.²

Second, we would like to draw attention to the high doses used by Pedraz Muñoz *et al.*,¹ as all the patients in our study responded without delay at monthly doses of 300 mg, and maintenance could be carried out at doses as low as 75 mg, with a wide time range, from 3 to 16 weeks.² Likewise, in the previously conducted randomized studies on chronic urticaria and angio-oedema, monthly doses of 300 mg were sufficient to control angio-oedema (and in some cases superior to placebo or other lower doses).^{3,4}

Finally, a major analytical finding by Pedraz Muñoz *et al.* was the level of total IgE, which ranged between 150 and 875 kU/L in their patients.¹ This might suggest an atopic condition and/or a causal allergy, which was not further investigated by the authors. In our opinion, an accurate allergological study could help exclude other underlying conditions, such as allergenic agents (foods, drugs other than angiotensin-converting enzyme inhibitors, latex, *Anisakis simplex*), or nonallergenic agents

(nonsteroidal anti-inflammatory drugs, opioids, infections) able to cause recurrent angio-oedema in our environment.⁵ Perhaps the subsequent elimination of avoidable triggers might make unnecessary the continuous (and expensive) use of omalizumab in these patients.

I. Jáuregui,¹ J. Azofra,² C. Díaz² and M. Ferrer³

¹Allergy Department, Hospital Universitario Basurto, 18 Avenida de Montevideo, 48013, Bilbao, Spain; ²Allergy Department, Hospital Central de Asturias, Oviedo, Spain; and ³Allergy Department, Clínica Universidad de Navarra, Pamplona, Spain

E-mail: ignacio.jaureguipresa@osakidetza.net

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