

accurate and meaningful in the evaluation of the allergic patient. Critical evaluation of such tests over the past 3 decades has repeatedly shown the need for rigorous clinical validation of any test method. It would benefit the readers if Drs Eberlein-König and Ring would provide a more balanced review of the literature, including those studies showing limited or questionable clinical relevance for these methods.³⁻⁵

There are many publications comparing venom skin tests and RASTs, with some also comparing the results with leukocyte histamine release. Few of these studies compared the test results in individual patients with the outcome of a concurrent insect sting challenge. Even among patients with a clear history of systemic reaction to a sting and positive venom skin tests, only 30% to 60% will have a systemic reaction to the next sting.⁶⁻⁹ To compare a new method with existing, clinically validated methods serves to establish an *in vitro* correlation, but does not quite prove a reliable clinical correlation. Drs Eberlein-König and Ring do not provide data linking positive and negative results in these various tests to clinical outcomes such as sting challenges.

There have been conflicting reports of the correlation and validity of some new diagnostic methods, so it would be premature to advise patient care specialists that such tests should be routinely used in the field. The availability of such research methods would be potentially useful in problem patients but should be limited to specialized laboratories involved in the clinical investigation and validation of these techniques.

The Committee has fulfilled its mission to educate and guide the membership of the AAAAI in the limitations and significance of the diagnostic tests for insect sting allergy available in this country. We leave it to others to provide a comprehensive review of the field.

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Response to life-threatening anaphylaxis to venom immunotherapy in a patient taking an angiotensin-converting enzyme inhibitor

To the Editor:

The letter to the editor by Ober et al entitled "Life-threatening anaphylaxis to venom immunotherapy in a patient taking an angiotensin-converting enzyme inhibitor"¹ raises several important questions.

The authors imply that patients with venom allergy who are receiving venom immunotherapy (VIT) while taking and angiotensin-converting enzyme inhibitor (ACEI) are at increased risk of severe anaphylaxis compared with those receiving specific immunotherapy (SIT) for environmental allergens while taking an ACEI. Although patients receiving VIT are selected on the basis of their history of prior anaphylaxis compared with patients receiving SIT, there does not appear to be much evidence that patients receiving VIT in total are at increased risk of anaphylaxis compared with those receiving SIT. It would seem to be prudent that if there is a concern of ACEI potentiating anaphylaxis, these measures should be extended to both patients receiving SIT and patients receiving VIT.

The authors recommend the withholding of ACEIs for at least 24 hours before VIT. Although lisinopril and enalapril have half-lives of 12 hours, other ACEIs, such as quinapril, are highly protein bound and have terminal half-lives of up to 22 hours.²

Ideally, other drugs, such as calcium-channel blockers, should be substituted for ACEIs. If ACEIs are used, their use should be limited to nonprotein-bound ACEIs. In addition, the withholding of these drugs for 24 hours (or 2 half-lives) might not be sufficient to prevent ACEI effects.

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