

Correspondence

Reply

To the Editor:

We thank Drs Mattheij and de Vries¹ for their interesting communication on the diagnosis of β -lactam allergy in children. These results support our findings that β -lactam allergy is clearly overdiagnosed among children developing a benign maculopapular or urticarial rash during β -lactam treatment.² Indeed, these skin rashes are only rarely reproducible by a subsequent challenge, and most of them are probably of viral origin. In this situation, several studies including ours have shown that an oral challenge test without prior skin testing is a safe procedure and is currently the best diagnostic tool for confirming a causal relationship between drug administration and an adverse reaction.²⁻⁴ However, it is to be noted that the clinician should be certain that the initial reaction was a delayed benign rash. This degree of certainty is reached only if the clinician observed the reaction firsthand, or if there is clear documentation of the rash in the medical record. If there is any doubt about the nature of the previous reaction, intradermal skin tests should be performed, particularly to exclude an immediate allergy.

Different protocols for the drug provocations test have been proposed, with different dose and timing of delivery.²⁻⁵ Mattheij and de Vries used a 5-step oral challenge test and administered 50% of the daily dose. In our study, we found that a 1-dose oral challenge test (150% of the therapeutic dose) in patients with a history of a benign reaction is safe and might also help to identify

patients with a low reactivity to the antibiotic. We have challenged more than 300 children in our referral clinic with this protocol, followed by a 30-minute observation, without any significant reactions. More studies regarding standardization of the various protocols are needed in order to increase its acceptance and adoption as a standard practice in the diagnosis of β -lactam allergy.

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