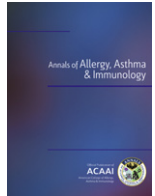




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Correspondence

Anaphylaxis in the community setting: determining risk factors for admission—the role of asthma

To the Editor: We read with interest the recent article by Steele et al on anaphylaxis in a community setting.¹ The authors identified predictors of hospitalization in patients with anaphylaxis who presented to the emergency department of their community hospital. Steele and colleagues are to be commended for addressing the paucity of literature on predictors of anaphylaxis hospital admissions.

The authors cited our study of hospitalizations for anaphylaxis in Florida.² They state in their discussion that our study, "...found a history of asthma to be predictive of hospitalization for anaphylaxis."¹ We thank the authors for acknowledging our work. However, our study was not designed to identify predictors of hospitalization. In our paper we studied only inpatients ($n = 464$ adults and children) who were discharged in 2001. We did not access data from emergency departments throughout Florida.

Asthma is mentioned briefly in the results section of our paper.² We reported a prevalence of asthma of 6.5% (30/464) among the adult and pediatric patients hospitalized with an anaphylaxis code. Nine of those 30 patients with asthma had a principal discharge diagnosis of anaphylaxis triggered by food. According to federal surveillance data for Florida (obtained by telephone interviews) for the year 2001, the prevalence of adults who have ever been told they have asthma was 9.9%, whereas the prevalence of adults who have been told they currently have asthma was 5.8%.³ Equivalent data for children are not readily available to us. For this letter we re-analyzed our Florida anaphylaxis hospital inpatient discharge database and excluded the records of patients under the age of 18 years to compare the prevalence of asthma in our adult patients hospitalized for anaphylaxis with the general population estimates from the federal surveillance system. Of the 415 adults in our study, 23 had *International Classification of Diseases, 9th Revision-Clinical Modification* codes for asthma (prevalence = 5.5%). Given these

prevalence estimates, it appears that a diagnosis of asthma is not predictive of hospitalization for anaphylaxis in adults. A comparison group of patients with anaphylaxis who were not hospitalized would be needed to allow the calculation of a confounder-adjusted measure of association (eg, an odds ratio for the relationship between asthma and anaphylaxis hospitalization after controlling for age, race, sex, and comorbidities).

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Disclosures: Authors have nothing to disclose.