

Letter to the editor

To the editor,

The recent article on 'Mastocytosis and insect venom allergy: diagnosis, safety and efficacy of venom immunotherapy' by Niedoszytko et al. (1) represents a useful contribution to the topic and the authors should be congratulated for the in depth review on the subject.

Nevertheless, the statement 'However, failures of pretreatment with omalizumab in prevention of recurrent anaphylaxis have also been reported (57), so the efficacy of omalizumab needs further evaluation' in the section under the heading *Pretreatment and means of precautions*, which refers to the findings of Carter et al. (2), appears somewhat misleading.

Specifically, the 1st Carter case presenting with '...4 to 6 episodes (of unprovoked anaphylaxis) per year.... has had no episodes of anaphylaxis, and the omalizumab has been well tolerated with only local swelling at the site of injection. Since starting omalizumab, he is no longer taking

doxepin and has reduced his dose of Advair 250/ 50 mg to 100/50 mg.'

In reference to the second case from the same report, 'The patient has not experienced any episodes of anaphylaxis requiring epinephrine in 5 months since starting therapy (fig. 1). The patient has had 1 episode of diarrhea lasting 2 h that did not necessitate a visit to the emergency department or activation of the emergency medical system. The drug (omalizumab) has been well tolerated with the exception of local swelling and erythema at the injection site. He has discontinued cromolyn sodium and montelukast since starting omalizumab.'

The above quotations along with fig. 1, which shows control of unprovoked anaphylaxis episodes in these systemic mastocytosis patients (during the 24 and 5 month omalizumab treatment for case 1 and 2, respectively), the reported severity of anaphylaxis episodes prior to omalizumab therapy and lastly the

authors' (Carter et al.) conclusion ('This is the first observation of the potential efficacy of omalizumab in the treatment of patients with mastocytosis and unprovoked anaphylaxis') do not support the first part of the concluding sentence of the Niedoszytko et al. review ['However, failures of pretreatment with omalizumab in prevention of recurrent anaphylaxis have also been reported']. Obviously, one has to agree with the second part of the statement, '... the efficacy of omalizumab needs further evaluation', as evidence, drawn solely from case reports, may not be confirmed by controlled trials involving a sufficient number and probably different subvariants of mastocytosis patients.

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References

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2. Carter MC, Robyn JA, Bressler PB, Walker JC, Shapiro GG, Metcalf DD. Omalizumab for the treatment of unprovoked anaphylaxis in patients with systemic mastocytosis. *J Allergy Clin Immunol* 2007;**119**:1550–1551.