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RESEARCH LETTER

Case report: specific immunotherapy with dust mite allergens in a child with severe atopic dermatitis

To the Editor,

Atopic dermatitis is a chronic inflammatory skin condition that appears to involve a genetic defect in the proteins supporting the epidermal barrier. The goals of treatment are to reduce symptoms, prevent exacerbations, and to minimise therapeutic risks. This includes general measures, antihistamines, topical or systemic corticosteroids, topical calcineurin inhibitors and management of infections. In severe cases, systemic immunosuppressive agents like cyclosporine may be useful, but are not exempt of important adverse effects. Although there has been some controversy regarding the role of allergy in atopic dermatitis, the bulk of the data indicate that allergy plays a role in selected patients. Dust mites are consistently the most common positive aeroallergen, and also appear to be the most clinically relevant. However, specific immunotherapy is not generally taken into account as a therapeutic tool for atopic dermatitis.

A 10-year-old male patient with a history of persistent rhinitis and mild asthma was referred to our unit with severe atopic dermatitis, presenting intense pruritus, lichenified plaques, scaly and excoriated papules with huge affectation of quality of life (bad sleep, impossibility to practice sports). SCORAD at first visit was 106.6. Laboratory tests showed IgE levels of 12457 UI/ml with dust mite specific levels >100 kU/ml (*Dermatophagoides pteronyssinus*, *Blomia tropicalis*). He was not sensitised to other environmental or food allergens. Unfortunately, the severity of eczema did not allow the performing of skin prick test or atopy patch test. Treatment with antihistamines, topical and systemic corticosteroids showed only partial response.

We started specific subcutaneous immunotherapy (ALK-ABELLO, *Dermatophagoides pteronyssinus* 60%, *Blomia*

tropicalis 40%) in addition to sustained treatment with antihistamines (hydroxyzine 50mg/D and levocetirizine 5 mg/D), and a short course of oral corticosteroids (prednisone 1 mg/kg/D). We recorded mild clinical improvement of dermatitis at first month of therapy (SCORAD 71.9). After three months, our patient showed spectacular improvement of symptoms score and quality of life (SCORAD 30.2). Now, he continues with monthly immunotherapy with excellent tolerance. He practices judo without affectation of the skin or exacerbations of eczema. Rhinitis and asthma have shown improvement on symptoms scores and functional tests, too.

In conclusion, we present a case of severe atopic dermatitis in a dust-mite sensitisation patient with excellent response to specific immunotherapy. Although immunotherapy is not considered a first-line treatment for atopic eczema (indeed, in severe cases it is considered a contraindication), we thought that it may be a good alternative^{1,2} in patients with demonstrated allergy to environmental agents before the introduction of more aggressive therapies such as cyclosporine.

References

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