

LETTERS TO THE EDITOR

Dear Editor,

PREVENTION OF OMALIZUMAB-INDUCED HEADACHE

Headache was one of the most frequently reported adverse reactions for omalizumab in allergic asthma clinical trials.¹ In children aged 6–12 years, it was reported as ‘very common’ ($\geq 1/10$),¹ and 0.2% of patients in this age range who reported headache required clinical intervention (e.g. treatment discontinuation or the need for concomitant medication).² In adult and adolescent patients 12 years of age and older, headache was reported as ‘common’ ($\geq 1/100$ to $< 1/10$),¹ and 15% of patients in this age range who reported headache required clinical intervention (e.g. treatment discontinuation or the need for concomitant medication).² There have also been 63 reports of headache and 8 reports of migraine to the Medicines and Healthcare Products Regulatory Agency since February 2006, through the ‘Yellow Card’ reporting scheme.³

Despite the frequent occurrence of omalizumab-induced headache, there are no published data detailing its clinical course and/or treatment.

We present the case of an 8-year-old female patient receiving omalizumab for severe allergic asthma. Fortnightly, 300 mg subcutaneous injections had been administered since July 2013, with no reports of post-administration headache. However, in May 2016, the patient began reporting headaches commencing 30–60 min after administration, and responding only partially to oral paracetamol and/or ibuprofen. The headaches became increasingly troublesome such that the patient’s family requested cessation of treatment. A literature search failed to identify any data relating to this particular clinical scenario and so a pragmatic approach was adopted and pre-treatment with simple analgesia attempted. Before the next omalizumab treatment, 10 mg/kg paracetamol was administered orally 1 hour prior to the injection resulting in complete abrogation of the headache. The same procedure has been repeated for subsequent omalizumab treatments, and to date the patient has not experienced any further headaches.

While this is only a single case report, it highlights the potential for late-onset omalizumab-induced headaches in young children, and provides a potential management strategy for patients who experience this troublesome adverse effect.

Mr Jonathan Hall¹

Dr Julian Legg²

¹Principal Clinical Advice Pharmacist, Southampton Medicines Advice Service and ²Head of Paediatric Respiratory Department, Southampton Children’s Hospital University Hospital Southampton NHS Foundation Trust Southampton United Kingdom

Conflict of interest: None declared.

References

- 1 eMC. Xolair 150mg Solution for Injection – Summary of Product Characteristics (SPC) Leatherhead: Datapharm, 2016. Available from: <https://www.medicines.org.uk/emc/medicine/24912> [accessed 11 October 2016].
- 2 Drugs.com. Xolair – FDA Prescribing Information, Side Effects and Uses. Available from: <https://www.drugs.com/pro/xolair.html> [updated July 2016; accessed 11 October 2016].
- 3 Medicines and Healthcare Products Regulatory Agency. Omalizumab – Medicines and Healthcare Products Regulatory Agency Drug Analysis Prints. London: The Agency, 2016. Available from: <http://www.mhra.gov.uk/drug-analysis-prints> [accessed 11 October 2016].

Dear Editor,

SURVEY OF UK ATTITUDES AND PROTOCOLS FOR THE INVESTIGATION OF EARLY DEVELOPMENTAL IMPAIRMENT

Early developmental impairment (EDI) is estimated to affect 1–3% of children.^{1,2} EDI is defined as occurring when a child’s development falls below 2 standard deviations from the population mean in two or more developmental domains.^{1,3,4} In practice, the diagnosis often relies on a clinician’s subjective opinion rather than formal assessment.

EDI has many aetiologies^{1–5} and some children exhibit additional clinical signs, such as macrocephaly or dysmorphism, that may point towards an aetiology; others may have ‘isolated’ EDI with no additional features. There is no consensus on what aetiological investigations to perform in children with EDI, although guidelines have been suggested.^{1,2,4}

We explored if opinion on the investigation of EDI differs between UK clinicians. We asked clinicians subscribing to the email lists of the British Paediatric Neurology Association and British Academy of Childhood Disability to complete an online questionnaire assessing the variation in attitude towards the investigative approach of children with EDI. The questionnaire can be viewed at: www.surveymonkey.com/s/disordereddevelopment.

A total of 107 clinicians replied: 93 consultants, 6 associate specialists, 3 staff grades, 2 speciality doctors, and one each of ST4–8 trainees, allied health professionals and nurse practitioners. A total of 65 said their department had a protocol for the investigation of EDI, 36 did not and 4 did not know.

Clinicians were more likely to investigate a child if the following features were present: increasing severity of EDI (92.1%), dysmorphism (92.1%), family history of EDI (89.9%), microcephaly (89.9%) and macrocephaly (79.8%), epileptic seizures (80.9%), movement disorder (80.9%), visual impairment (78.7%), hearing impairment (68.5%), a disparity between abilities in different developmental domains (48.3%) and scoliosis (41.6%). A total of 5.6% of responders indicated that they investigated all cases the same.