

Negative venom skin test results and mastocytosis*To the Editor:*

The recent rostrum article by the Insect Committee of the American Academy of Allergy, Asthma and Immunology in the September issue of the Journal presents important new recommendations for managing patients with negative venom skin test results despite histories of systemic reaction to an insect sting.¹ In our view, the guidelines have to be supplemented by one very important issue.

As the authors mention, a negative in vivo (skin) test result in a patient with a history of systemic sting reaction may be indicative for a non-IgE-mediated reaction (eg, mastocytosis). Patients with this entity have a particularly increased risk for anaphylaxis, especially after insect stings.² Despite this, in the new working guidelines, the advice for performing a simple and reliable screening test for mastocytosis in just these patients is missing.³

Every year we perform intradermal skin tests with *Hymenoptera* venoms in approximately 150 patients in our allergy unit before initiating venom immunotherapy. In the past year, we found 3 patients with negative skin test results to yellow jacket venom (ALK-Abello, up to

1.0 µg/mL concentration), 2 of them without detectable venom-specific IgE (CAP-FEIA, Pharmacia, Sweden) but a history of anaphylactoid reactions III and IV, respectively. Determining serum tryptase levels (Pharmacia, Sweden), we could identify these 2 patients as having a systemic mastocytosis without cutaneous involvement. The clinical importance of such a finding for the patients' management is already profoundly discussed in the *Journal*.² As members of the EAACI Interest Group on Insect Venom Allergy, we are engaged in a prospective study regarding this topic ("Increased baseline serum mast cell tryptase levels in insect venom-allergic patients: a risk factor for severe sting reactions, for side effects during venom immunotherapy, or for treatment failure?"), which will end in April 2006. The preliminary data gained up to now in our center are convincing in that early diagnosis of mastocytosis and proper treatment greatly contribute to the outcome in patients with a history of systemic sting reactions. Fifty-nine percent of our patients with raised serum tryptase concentrations had a history of anaphylactoid reaction grade III/IV versus only 36% of our patients with normal concentrations.

Because an elevated baseline serum tryptase level is highly indicative for mastocytosis, we want to advise our colleagues to engage this inexpensive, reliable, and simple to perform test in the diagnostic evaluation of patients

with a positive history of systemic reaction to a sting, especially when the in vivo findings are negative.²⁻⁴

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