

CORRESPONDENCE**Response to Hulshof et al by Antonio Martorell and Belen de la Hoz, on behalf of the authors****A. Martorell¹ and B. de la Hoz², on behalf of the authors**¹Hospital General Universitario. Unidad de Alergología. Valencia and ²Hospital Ramón y Cajal. S. Alergología. Madrid. Spain.

We read Dr Hulshof's comments on our paper 'Oral desensitization as a useful treatment in 2-year-old children with cow's milk allergy' with great interest.

This study demonstrated that 90% of the patients in the active group reached the tolerance dose of 200 mL of cow's milk and remained tolerant after 12 months in comparison to 23% of the patients in the control group (and not the 76.6% as L. Hulshof and colleagues suggested) [1].

The ultimate goal of food allergy therapy is permanent oral tolerance which in most cases occurs spontaneously over time, but the most important objective is that patients can consume the food without restrictions to improve the quality of life of children and their families and this is the main goal of oral desensitization treatment.

In the study of Staden et al. 12/25 children (48%), after completing SOTI treatment, tolerated the planned full maintenance dosage and were able to integrate the allergenic food in the diet (pattern I and II), nine (75%) with permanent oral tolerance after a median of 21 months of maintenance treatment [2]. Casein specific IgE levels decreased progressively and may not be detectable at 3 years of treatment [3]. In the active group, 27 patients (90%) reached the tolerance dose of 200 mL, and all remained tolerant after 12 months of follow-up. The double-blind placebo-controlled food challenge (DBPCFC) was not done at the end of the study in these patients since they were taking doses of 200 mL of cow's milk once a day, every day, and cow's milk and dairy products without restrictions with good tolerance. Staden et al. [2] express threshold dose in protein dose, but further controlled studies as published by Longo et al. in

the *Journal of Allergy and Clinical Immunology* are expressed in milliliters of cow's milk [4].

The type of milk used for the oral desensitization and DBPCFC protocols is fresh pasteurized milk (33 mg/mL, as it is known) as used in other studies (Staden et al. [2] Longo et al. [4] Meglio et al. [5]) and is therefore comparable with other studies.

The Muller's classification of anaphylaxis is not adequate for assessing the severity of adverse food reactions since not all reactions are anaphylactic. Acute generalized urticaria or cutaneous facial angioedema are features of anaphylactic reactions to cow's milk, but urticaria/facial angioedema isolated are not anaphylaxis. Longo used Clark's classification [6]. We use Clark's classification modified. Clark and Ewan considered acute generalized urticaria or cutaneous facial angioedema as mild grade reaction. We included acute generalized urticaria and cutaneous facial angioedema as moderate grade reactions. Oral desensitization protocol includes follow up in the hospital under strict medical control.

The results of this study together with our experience of 10 years of oral desensitization with cow's milk in children indicate that it is reasonably safe. Adverse reactions are effectively managed by parents and pediatricians as when they have to deal with the reactions that occur in patients who are on elimination diet to accidental exposures.

In our opinion oral desensitization in 2-year-old children with cow's milk allergy is a reasonably safe and effective therapeutic procedure, and even if it means maintaining the administration of cow's milk for an indefinite period, is a great improvement in quality of life which is valued by both children and their parents.

References

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