ABSTRACT BOOK

2003 Annual Meeting
American College of Allergy, Asthma & Immunology
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Section 1 contains all abstracts accepted for presentation at Concurrent Sessions, Sunday & Monday, November 9-10, 2003

Section 2 contains all abstracts accepted for presentation at Poster Sessions, Saturday & Sunday, November 8-9, 2003

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1% dilution in NS	Wheal(mm)	Erythema(mm)
Solu-medrol®	9	27
Solu-cortef®	0	0
Saline	0	0
Histamine	15	45

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DESENSITIZATION OF A PATIENT WITH GROWTH HORMONE HYPERSENSITIVITY.

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Introduction Hypersensitivity to growth hormone is extremely rare. There are unfortunately no standardizations available for skin testing or for densensitization to growth hormone. We report of a patient with an urticarial reaction to growth hormone that underwent skin testing and subsequent desensitization. Methods A 13 y.o. female w hormone deficiency was started on growth hormone replacement with Nutropin (somatropin, Genentech, Inc.) at a dose of 1.2mg SQ daily. Within 2 weeks she noticed hives around the injection site which became diffuse, only resolving after discontinuing the growth hormone. Skin testing was performed (both prick and intradermal) to the diluent alone, 1:100 dilution of the Nutropin, and concentrate Nutropin. Since no standardized extracts are available for skin testing, 3 control subjects were also tested and were negative. Prick test to latex was also done to rule out any reaction to the vial or syringe used to deliver the nutropin and was negative. Results The patient was negative to both prick and ID testing to Nutropin. She was then challenged with a test dose of 1/10 of the full dose given SQ in the ICU. Within minutes, she developed diffuse urticaria. Because of her nee Nutropin and history of developing urticaria, she was admitted for desensitization. She was desensitized by using successively increasing amounts of Nutropin until our top dose of 1.2mg was reached. We started with 1:1000000 dilution of 1.2mg Nutropin, diluted in 20cc of saline and given as an IV infusion over 20 minutes. This was followed by 1:100000, 1:10000, 1:1000, 1:100, 1:10 dilutions, and the full 1.2mg of Nutropin given IV. The patient was then given 1.2mg SQ 24 hours later, and was discharged uneventfully. Since then, she has remained on daily Nutropin injections for 7 months without any further reactions. Conclusions Although extremely rare, a hypersensitivity reaction to growth hormone may occur. Because of the lack of standardized reagents for skin testing, a negative skin test does not necessarily rule out a hypersensitivity reaction. Our protocol for intravenous desensitization to growth hormone seems to be safe and effective.

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SUCCESSFUL DESENSITIZATION TO GLATIRAMER ACETATE (COPAXONE) IN TWO PATIENTS WITH MULTIPLE SCLEROSIS.

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Introduction: Copaxone (Cpxn) is a polymer consisting of four amino acids, mannitol and sterile water. It is indicated for the reduction of relapses in relapsing-remitting multiple sclerosis (MS). We report two cases of successful desensitization to Cpxn. Case 1: A 31 year-old female with MS developed urticaria on both arms five hours after her first dose of Cpxn. She denied associated respiratory, cardiovascular, or gastrointestinal symptoms. Despite her skin lesions, she continued daily Cpxn use. These lesions did not improve with antihistamine therapy (diphenhydramine and cetirizine) and became more extensive, involving her legs and trunk. She decided to discontinue Cpxn after 10 days because of persistent urticaria, which resolved within 2 days. She was evaluated one week after discontinuing Cpxn. Examination revealed no skin lesions. Skin testing was not performed due to dermatographism. She underwent subcutaneous desensitization, which was tolerated without adverse reaction as shown in table I. She has tolerated daily Cpxn for more than 10 months. Case 2: A 43 year-old male with MS developed generalized pruritis followed by urticaria within 30 minutes of Cpxn administration. The patient had tolerated daily Cpxn for 2-3 months without untoward reaction. He sought emergency department management for this reaction, where he received epinephrine, diphenhydramine, and nebulized bronchodilator. He responded well to this treatment, was discharged home, and suspended Cpxn. He was evaluated approximately 2 months later. Skin testing was carried out. He had no wheal/flare reaction to full strength Cpxn at percutaneous level. There was a 1-2+ reaction to Cpxn (1/100 dilution) at intradermal level. Although this may have reflected an "irritant" response, IgE-mediated potential could not be excluded. He underwent subcutaneous desensitization as shown in Table I without adverse reaction and has tolerated daily Cpxn for more than 6 months. Conclusion: Copaxone is a polymer that has offered significant benefit to patients with MS. Our experience suggests that patients who have suspended Cpxn because of urticaria can be successfully and safely desensitized, and resume Cpxn use. To our knowledge, this is the first report of successful desensitization to Cpxn in patients with MS.

Protocol for Copaxone Desensitization *dosing every 30 mins by subcutaneous injection	
Dose Number	Dose
1	0.00002mg
2	0.0002mg
3	0.002mg
4	0.02mg
5	0.2mg
6	2mg
7	4mg
8	14mg

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SAFETY AND EFFICACY OF MONTHLY CARBOPLATIN DESENSITIZATION.

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Introduction: Hypersensitivity reactions to carboplatin (CBDCA) have been well documented in children and adults and may be increasing in frequency as use of this important antineoplastic drug increases. Protocols for desensitization have been described; most reported cases have been successfully rechallenged, but rare failures and even fatalities have also been reported. **Methods:** We report a case of hypersensitivity to carboplatin in a 4 year-old female with low-grade medullary pilocytic astrocytoma, which had been responding to monthly scheduled carboplatin and vincristine. After 25 minutes of her eighth carboplatin infusion, she mounted a reaction consisting of diffuse flushing, facial edema, urticaria, and chest tightness. A desensitization protocol with escalating doses of carboplatin was designed for all subsequent infusions. **Results:** The patient tolerated the desensitization procedure well. A premedication regimen consisted of H_1 and H_2 antihistamines, steroids, and a leukotriene antagonist. She subsequently completed an additional 7 monthly courses of carboplatin along with vincristine. Minor symptoms of facial flushing and eyelid erythema were treated with H_1 antihistamines and steroids; these were not judged severe enough to warrant discontinuation, in contrast to the initial reaction. For these minor breakthroughs, the preceding dose in the protocol was repeated and subsequently added to the following month's course. Frequency and severity of breakthrough reactions decreased as these repeat doses were interpolated into the protocol. The final desensitization protocol is shown in the table. Follow-up MRI revealed further decrease in tumor size after several carboplatin courses facilitated by desensitization. **Conclusion:** The desensitization protocol described successfully delivered carboplatin despite a prior serious reaction to this agent. Adaptation of the protocol for breakthrough symptoms was also successfully demonstrated. Although the mechanisms of carboplatin hypersensitivity and desensitization remain unclear, overall safety and efficacy for carboplatin desensitization can be applied to repeated monthly courses.