recruited from the same consecutive patient series as the patients in the control group. It must be excluded that patients in the SL-VIT group had been diagnosed much earlier than patients in the control group and were now reinvited for SL-VIT. Such a time delay in the SL-VIT group may be an important confounding variable because clinical and also immunologic reactivity may change spontaneously over time in patients who had had sustained their last systemic reaction to a sting years or decades before. There is a strong suspicion for such a time delay in the SL-VIT patients of the study by Patriarca et al.2 Thus, venom-specific IgE appeared to be much lower in patients in the SL-VIT group (3.66 ± 7.4 kU/L) than in those in the SC-VIT group (14.27 ± 23.65 kU/L). Unfortunately, no statistical comparison was made. Furthermore, patients in the SC-VIT group had severe reactions (grade III and IV) after a field sting more often than patients in the SL-VIT group (50% vs. 34%). Although the difference was not significant, one would prefer a much better match of potentially important risk factors in a small case-control study. The observation that SL-VIT was associated with few side effects is irrelevant in that context.

In summary, SL-VIT should not be offered to patients with a potentially life-threatening disease before sound experimental data on the pharmacokinetics of sublingually administered venom (influence of saliva on the venom, data on absorption, change of immunologic parameters) are available. Patients who refuse regular treatment may qualify for alternative therapies. Nevertheless, this refusal cannot be taken as a justification to use therapies such as SL-VIT, which still lacks sufficient experimental evidence regarding its efficacy.

Magician’s asthma

To the Editor:

The “Clinical pearls” review entitled “Exotic pet allergy” by Phillips and Lockey1 brought to mind a case I saw many years ago of a 35-year-old male engineer without prior allergy but with a 6-month history of rhinoconjunctivitis and asthma, the latter requiring daily medication for control. Further history revealed that the patient also worked as a professional magician and that he had obtained a rabbit to pull out of a hat 2 months before the onset of symptoms.

Initial skin test results were negative to the commonly tested allergens, including mites, pollens, molds, and dog and cat dander, but the result of a subsequent test with rabbit extract was positive. The rabbit was removed from the act, and the patient became free of symptoms off medication.

Phillips and Lockey1 are indeed correct when they state that “allergists/immunologists should query patients regarding contact with any and all indoor house pets, in addition to exposure to dogs and cats. Asking whether or not an animal exists in the home is not adequate.”

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REFERENCE
Available online May 28, 2009.
doi:10.1016/j.jaci.2009.03.043

Reply

To the Editor:

We thank Dr Miller1 for adding this case to the discussion after review of our recent article.2 A report found that the prevalence of allergy to laboratory animals, including rats, mice, and rabbits, has decreased from 8.2% in 1976 to 4.2% in 2001,3 primarily because of efforts to limit work exposure. However, these animals are found in many different environments, from the household to nonlaboratory workplaces, such as the magician’s stage. As new cases of rhinitis and asthma exacerbation from rabbit exposure continue to appear in the literature,4–6 the allergist must be vigilant. Rabbit and rodent extracts for skin testing and immunotherapy are commercially available for the diagnosis and treatment of resultant allergy.

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Disclosure of potential conflict of interest: The authors have declared that they have no conflict of interest.

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