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.

Franziska Ruëff, MD[a]
M. Beatrice Bilo, MD[c]
Marek Jutel, MD[d]
Holger Mosbech, MD, DMSc[e]
Ulrich Müller, MD[f]
Helmut Küchenhoff, PhD[b]
Bernhard Przybilla, MD[a]

From [a]AllergieZentrum, Klinik und Poliklinik für Dermatologie und Allergologie, and [b]the Statistical Consulting Unit, Department of Statistics, Ludwig-Maximilians-Universität, Munich, Germany; [c]the Allergy Unit, Department of Internal Medicine, Allergy, Immunology and Respiratory Diseases, Ospedali Riuniti di Ancona, Azienda Ospedaliero-Universitaria, Ancona, Italy; [d]the Department of Clinical Immunology, Silesian Piasts University of Medicine in Wroclaw, Poland; [e]the Allergy Unit, National University Hospital, Rigshospitalet, Copenhagen, Denmark; and [f]Allergiestation Medizinische Klinik, Zieglerspital, Spitalnetz Bern, Switzerland. E-mail: Franziska.Rueff@med.uni-muenchen.de.

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REFERENCES

1. Patriarca G, Nucera E, Roncallo C, Aruanno A, Lombardo C, Decinti M, et al. Sublingual immunotherapy with venom for patients with Hymenoptera venom allergy. J Allergy Clin Immunol 2009;124:385.
2. Patriarca G, Nucera E, Roncallo C, Aruanno A, Lombardo C, Decinti M, et al. Sublingual desensitization in patients with wasp venom allergy: preliminary results. Int J Immunopathol Pharmacol 2008;21:669-77.
3. Severino MG, Cortellini G, Bonadonna P, Francescato E, Panzini I, Macchia D, et al. Sublingual immunotherapy for large local reactions caused by honeybee sting: a double-blind, placebo-controlled trial. J Allergy Clin Immunol 2008;122:44-8.
4. Ruëff F, Przybilla B, Müller U, Mosbech H. The sting challenge test in Hymenoptera venom allergy. Allergy 1996;51:216-25.
5. Haeberli G, Brönnimann M, Hunziker T, Müller U. Elevated basal serum tryptase and hymenoptera venom allergy: relation to severity of sting reactions and to safety and efficacy of venom immunotherapy. Clin Exp Allergy 2003;33:1216-20.
6. Dugas-Breit S, Przybilla B, Schöpf P, Ruëff F. Possible circadian variation of serum mast cell tryptase concentration. Allergy 2005;60:689-92.

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Magician's asthma

To the Editor:

The "Clinical pearls" review entitled "Exotic pet allergy" by Phillips and Lockey[1] 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 Lockey[1] 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."

Jeffrey D. Miller, MD

From Mission: Allergy, Inc, Hawleyville, Conn. E-mail: JeffreyMillerMD@comcast.net.

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REFERENCE

1. Phillips JF, Lockey RF. Exotic pet allergy. J Allergy Clin Immunol 2009;123:513-5.

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Reply

To the Editor:

We thank Dr Miller[1] 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,[4,5] 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.

Joshua F. Phillips, MD
Richard F. Lockey, MD

From the Department of Internal Medicine, University of South Florida, Tampa, Fla. E-mail: jfphillips76@gmail.com.

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REFERENCES

1. Miller JD. Magician's asthma. J Allergy Clin Immunol 2009;124:386.
2. Phillips JF, Lockey RF. Exotic pet allergy. J Allergy Clin Immunol 2009;123:513-5.
3. Folletti I, Forcina A, Marabini A, Bussetti A, Siracusa A. Have the prevalence and incidence of occupational asthma and rhinitis because of laboratory animals declined in the last 25 years? Allergy 2008;63:834-41.