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The association of food anaphylaxis in antiphospholipid syndrome and thrombosis cannot be considered a coincidence

To the Editor,

We have read with great interest the comments on our study "Food anaphylaxis in antiphospholipid syndrome and thrombosis."¹ We are very grateful to the authors for the opportunity that our colleagues bring us to clarify some details.

Severe anaphylaxis, fortunately, is an uncommon disease. The actual incidence of anaphylaxis is unknown but is estimated to be 10 to 20/100,000 patients/year. The biggest study on anaphylaxis among hospitalised patients in the previous decade was conducted as a retrospective study of adult patients between 1992 and 2001 at a tertiary care centre in Bangkok. Of 448,211 admissions, 80 events of anaphylaxis in 79 patients (0.017%) were found.² So, it was very difficult to find a big sample to anaphylaxis due to seed or fruit. We had to revise the records of 21,879 patients admitted to our Allergy Department in the last 22 years to find the number of patients necessary for a good statistical analysis. The sample size was calculated by simple random sampling in a control:case ratio of 1, with confidence limits of 98%, a power of 90% and an average of exposition among controls of 25%. A stratified analysis was performed in order to estimate the confounding and artefactual factors among the different independent variables, avoiding the selection bias. We finally selected 52 patients who suffered from severe anaphylaxis and 28% of them had anticardiolipin antibodies and 17.3% had thrombosis. This percentage can be considered not too big, but the fact that 75% of patients' diagnoses as having antiphospholipid primary syndrome with thrombosis had specific IgE against vegetal allergen, should not be considered a coincidence. Although it is true that given the heterogeneity of the clinical manifestations of APS it is likely that more than one pathophysiological process may play a role. Recent studies about vegetal food-induced anaphylaxis in Italy found that LTP is the most important allergen causing food-induced anaphylaxis, peach being the most frequently offending food. These data are very similar to our data but obviously geographic and environmental differences both between Italy and other countries and within Italy seem to play a relevant role in the pattern of sensitisation to foods.³

In the tables, we included as a medium level the patient number 33, who presented 18 GPL/ML in the first deter-

mination and 26 GPL/ML in the second analysis. We only presented in the table the first tests performed. None of our allergic patients were taking aspirin at the moment of anaphylaxis. The patients that suffered from thrombosis were treated with anticoagulants or aspirin after the diagnosis. We agree with our colleagues that antibodies should be reevaluated after three months. All patients with thrombosis were evaluated every three months. Those with anaphylaxis were tested again two months after discharge from the Hospital, in the third month of their process.

The rise in the incidence of anaphylaxis over the two decades of the study period is alarming. Raising the awareness of anaphylaxis management among healthcare providers and the public is warranted. Thank you very much again for the criticism that undoubtedly has improved our work.

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