Many patients report allergic reactions to this antibiotic, but amoxicillin allergy range between 1-10%. However, clinicians hesitate to prescribe it when a suspected, but unproven, allergy exists. Our aim is to confirm amoxicillin allergy in children with clinical suspicion.

This study was done between January 2018 and December 2020, in children younger than 18 years, admitted to the emergency room with suspicion of clinical allergic reaction to amoxicillin. According to the protocol of our hospital, they were referred for pediatric allergology appointment to perform prick tests and afterwards oral provocation test. A total of 57 cases were referred for evaluation. The average age was 8.4

(1-17) years old, and 53% were female. The suspicion was based on late rash reaction presented in 68.4%, urticarial exanthema in 19.3%, edema in 8.8%, vomit in 8.8%, cutaneous rash in 7% and dyspnea in 2.1%. In 18 patients, specific IgE screening for amoxicillin was performed, but all results were negative. All children did a prick test for amoxicillin and oral provocation test. There were no positive results for prick tests, but two positive results in the oral provocation test (3.5%).

Confirmation of amoxicillin allergy, before deciding to use it or not, is an important tool for antimicrobial stewardship and, consequently, to decrease the rate of antibiotic resistance. So far, in our hospital, there were only two positive results.
with recent asthma symptoms (Kendall’s Tau-B = 0.236, p = 0.016).

Serum periostin levels significantly correlated with asthma symptoms during the last 12 months in 10-year-old children who were infected with RSV during their first two years of life. Our preliminary results suggest that serum periostin level may be useful in diagnosing asthma in children, especially those with recent asthma symptoms and history of RSV infection in infancy.

165 ORAL BETA-LACTAM CHALLENGE TEST WITHOUT ANTECEDENT SKIN TESTING IN CHILDREN WITH HISTORY OF ALLERGY TO ETA-LACTAM

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Beta-lactam (BL) antibiotics are among the most prescribed drugs globally but can provoke hypersensitivity reactions which can lead to incorrectly labelling as ‘allergy’. Data on prevalence and incidence of drug hypersensitivity reactions (DHRs) are limited, especially in the pediatric age. It is important to assess subjects with history of hypersensitivity reactions to BL as up to 70% are not allergic based on diagnostic test results. Laboratory tests for identifying children who are allergic to drugs have low diagnostic accuracy and predictive value. The gold standard to diagnose DHR is drug provocation test (DPT). DHRs are classified as immediate or nonmediate/delayed reactions. Mild delayed cutaneous reactions including maculopapular rashes and urticaria/angioedema are common reactions in children and often occur in the setting of viral infections. In mild cutaneous delayed reactions, some clinicians suggest performing only DPT because of its high negative predictive value, without skin testing and serum IgE measurement while other suggest SPT and/or specific IgE to culprit drug if patient/caregiver cannot provide a detailed description of the previous reaction.

Aim: to investigate the proportion of positive oral provocation tests in children labeled as BL antibiotic allergy.

Direct oral challenge was performed in patients with history of benign rash associated with beta-lactam antibiotic. Because detailed description of suspected allergic reaction could not be provided from all caregivers, all patients went specific IgE to amoxicillin and/or basophil degranulation test to culprit drug which was negative. 19 patients were included, average age 6 years and 1 month. In 17 patients suspected allergic reaction was caused by amoxicillin (AMX); 8 of which in combination with clavulanic acid, one with phenoxymethylpenicillin and one with cephalaxin. A DPT involved open 3-step graded oral provocation test with AMX, time interval between the doses was 2h. The patients were monitored for 24h after challenge and were discharged with instructions to call in the event of a delayed reaction.

After DPT there was no reaction in 89% of patients, one patient developed benign rash and one drug-induced enterocolitis syndrome.

BL antibiotics can be safely readministered to children with history of benign rash to beta-lactams using graded oral challenge in medically supervised settings if sIgE is negative even if uncertain history. It is important to establish a correct diagnosis of BL antibiotic allergy since using alternative non-β-lactam antibiotics in these patients leads to higher healthcare costs and adverse events.

The allergic phenotype is an important subset of asthma patients with type 2 inflammation. Dupilumab, a fully human monoclonal antibody, blocks the shared receptor component for IL-4/IL-13, key and central drivers of type 2 inflammation in multiple diseases. In phase 3 VOYAGE, add-on dupilumab 100mg/200mg (body weight ≤30kg/>30kg, respectively) every 2 weeks vs placebo, reduced severe asthma exacerbations by 59.3% (P<0.0001) and improved lung function in children aged 6 to <12 years with uncontrolled moderate-to-severe type 2 asthma (baseline blood eosinophils ≥150cells/μL or FENO ≥20ppb). This analysis evaluated the efficacy of dupilumab in pediatric patients with type 2 asthma with/without evidence of allergic asthma (total serum IgE ≥30IU/mL and ≥1 perennial allergens-specific IgE ≥0.35kU/L at baseline).

Annualized severe exacerbation rate during the 52-week treatment period was assessed using a negative binomial model.

350 pediatric patients with type 2 asthma were enrolled: of which, 261 had evidence of allergic asthma and 89 did not. Baseline characteristics were similar between subgroups, except for prevalence of ongoing atopic comorbidities (99.6% vs 77.5%) and median levels of type 2 biomarkers (blood eosinophils: 540.00cells/μL vs 310.00cells/μL; FeNO: 28ppb vs 13ppb; total serum IgE: 657.00IU/mL vs 107.00IU/mL) which were all higher in patients with vs without evidence of allergic asthma. Dupilumab vs placebo significantly reduced annualized severe exacerbation rate by 62% (P<0.0001) in patients with, and 51% (P<0.05) in patients without evidence of allergic asthma. No significant interaction was observed between the treatment effect and evidence of allergic asthma. In the overall safety population, the incidence of treatment-emergent adverse events (TEAEs) was similar across treatment groups; the most common TEAE occurring more frequently in the dupilumab group was injection site erythema (12.9% dupilumab vs 9.7% placebo).

The majority of pediatric type 2 asthma patients enrolled in VOYAGE had evidence of allergic asthma; these patients had very high levels of type 2 biomarkers. Dupilumab demonstrated efficacy in reducing severe asthma exacerbations in children aged 6 to <12 years with uncontrolled, moderate-to-severe type 2 asthma, with or without evidence of allergic asthma.