A child with atopic features, raised serum IgE, and recurrent infection treated with levamisole

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SUMMARY. A 6-year-old girl had a long history of severe eczema, asthma, recurrent otitis media, and staphylococcal infections with disseminated chronic skin abscesses. Immunological studies showed a neutrophil chemotaxis defect, hyperimmunoglobulinaemia E, IgE antibodies against cows' milk proteins, absence of IgM, and absence of staphylococcal haemolysins. Neutrophil phagocytic and bactericidal functions and complement system were normal. In the course of treatment with levamisole (2-5 mg/kg, 3 times a week for one year) a striking clinical improvement occurred: the skin lesions and the staphylococcal abscesses gradually cleared and the girl gained weight. There was also a partial correction of the immune deficiency.

In 1966 Davis et al. reported two children aged 9 and 6 years with long histories of chronic staphylococcal abscesses and chronic dermatitis, which they termed Job's syndrome. Several clinically similar disorders with hyperimmunoglobulinaemia E, and abnormal leucocyte mobility have since been described. Treatment with levamisole has improved the clinical and immunological conditions of a few such patients.

We report a 6-year-old girl who, from age 2 months, has suffered from severe eczema, recurrent staphylococcal infections, and widespread chronic abscesses. Laboratory findings included defect of cellular neutrophil chemotaxis, high plasma IgE level, pronounced eosinophilia, a T-lymphocyte dysfunction, and an IgM deficiency. Treatment with levamisole for one year (2.5 mg/kg three times a week) resulted in clinical improvement, with a partial correction of the immunological defects.

Case report

A 6-year-old girl, the second child of related parents, was admitted to hospital in May 1977. Her mother suffers from allergic rhinitis and bronchial asthma with strikingly positive skin tests and specific IgE to Dermatophagoides pteronyssinus and to house dust; no history of recurrent infection was reported by the rest of the family. The patient began to suffer from severe eczema and bronchial asthma when she was 2 months old. At 12 months she developed recurrent upper and lower respiratory infections, staphylococcal sepsis, middle-ear infections, and 'cold' skin abscesses. She was repeatedly admitted to hospitals; cultures obtained from ear discharge and from subcutaneous abscesses grew Staphylococcus aureus on several occasions.

At age 5 she developed chronic herpetic keratitis, and mucosal and cutaneous candidiasis. H1 receptors, antihistamines, steroids, and antifungal treatments had no effect. A milk-free and egg-free diet given over a long period proved unsuccessful.

In May 1977 she was referred to our unit. On admission she appeared very ill: her temperature was up to 39°C, weight and height were on the 3rd centile. The skin was reddened with diffuse lichenification and pruritus; the nails were dystrophic and thickened. Large cold abscesses were present on the back, in the axillae and on the legs, with enlarged lymph nodes in the cervical, axillary, and inguinal regions. There was a corneal ulcer in the left eye, and purulent conjunctivitis in both eyes. Chest x-ray films showed a large infiltration of the left lower lobe.

Repeated blood counts including platelets were normal except for a persistent eosinophilia, of between 30 and 50% (4.2-6.0 x 10^9/l). The blood group was AB. Blood cultures grew a penicillin-resistant S. aureus and intravenous gentamicin 7 mg/kg was given. The staphylococcal sepsis and pneumonia resolved within 2 weeks.

Cellular immunity. Skin tests for delayed hypersensitivity were performed with the following:
Inflammatory response. Total haemolytic complement, C3, C4, C3PA, serum opsonic activity, phagocytic, and bactericidal ability of the patient’s neutrophils against S. aureus, myeloperoxidase content, and NBT test were all normal.

In vitro studies of chemotaxis showed a severe defect in the migration of the patient’s granulocytes. In several tests performed before treatment, the cellular chemotactic response was only 5% that of the age control group, while the humoral generation of chemotactic factors was normal (80%).

Clinical and immunological findings after treatment. The high levels of specific IgE antibodies to cows’ milk prompted us to continue a milk-free diet for 3 months. During this period the immunological tests and the clinical conditions remained unchanged.

After this observation period, levamisole was started at a dose of 2.5 mg/kg orally 3 times a week for one year. No side effects were observed during this time. The cows’ milk-free diet was continued. After 2 months there was a pronounced clinical improvement; the dermatitis gradually cleared up, and the recurrent infections and skin abscesses became less and less frequent and eventually disappeared. A partial correction of the immunological defect could also be observed (Table).

T-lymphocyte count increased; the blastogenic response to PHA became normal; and delayed skin test to candida became positive; the motile response of neutrophils became normal. Total and specific IgE decreased, while serum IgM and staphylococcal haemolysin remained undetectable.

After one year of treatment with levamisole, this medication was stopped while maintaining the egg-free and milk-free diet. Now, after two years without levamisole, the clinical and immunological improvements continue, the girl’s clinical condition is good and she attends school regularly.
Discussion

The clinical findings in this patient were similar to those of the children with cellular chemotaxis defect associated with hyperimmunoglobulinaemia E reported by a number of authors. Recurrent severe staphylococcal infections and eczematous dermatitis are signs that are typical of this disease. In our patient however, the immunological abnormalities differed from those of the cases reported. In addition to the accepted abnormalities (high IgE levels, neutrophil chemotaxis defect, T-lymphocyte dysfunction) there was consistent IgM deficiency, not described before. Furthermore, despite repeated infections with S. aureus the child lacked staphylococcal haemolysins.

A primary specific response defect to S. aureus would explain the high susceptibility to such infections. Schopfer et al. found IgE antistaphylococcal antibodies in 7 affected patients and they suggested that 'the recurrent, atypical staphylococcal infections are not due to a primary defect of polymorphonuclear function, as measured by chemotaxis, but may be a consequence of an abnormal immunologic response to S. aureus'. They did not refer to the presence of specific agglutinins. It is likely that in our patient the lack of IgM might have been the primary defect predisposing to recurrent infections and to atopic symptoms, as in other immunoglobulin deficiencies. The allergic conditions could have induced the neutrophils and T-lymphocyte dysfunctions.

The mechanism underlying the neutrophil and T-lymphocyte dysfunction in this syndrome is still a matter for discussion. Hill and Quie showed that neutrophil chemotaxis can be inhibited in vitro by histamine, probably through the increase of the intracellular concentration of cyclic-AMP, and that the IgE-mediated histamine release in their patients might be one aetiology for the decreased chemotactic responsiveness. In patients suffering from allergic rhinitis the migration defect was present only during periods of active rhinitis; it was also possible to induce it in vitro by incubating the patient's leucocytes with the appropriate allergen. Further support for this suggestion is provided by the in vitro improvement of chemotaxis by H2-receptor antagonist.

There is strong evidence that histamine could lower the number and the function of circulating T-lymphocytes as shown also in allergic patients. A persuasive hypothesis put forward by Busse and Sosman is that the 'coldness' of abscesses might be related to high histamine levels. They showed that histamine inhibits the release of β-glycuronidase in a dose-dependent manner; this inhibition was paralleled by an increase in neutrophil cyclic-AMP level.

Levamisole has been reported to decrease cyclic-AMP and to increase cyclic-GMP level in human and animal lymphocytes and, by maintaining intracellular cyclic-GMP concentration, to enhance microtubular assembly and polymorphonuclear motility. Levamisole treatment in our patient brought the chemotactic responsiveness back to normal, and increased the number and function of peripheral T-lymphocytes. The disappearance of recurrent infections and skin abscesses after treatment with levamisole may have been attributable to the partial correction of the immunological defect.

The striking improvement of the dermatitis suggests that the abnormal function of the immune system may be crucial for the pathogenesis of the eczema. In support of such a hypothesis is the observation that the eczema in 2 patients with the Wiskott-Aldrich syndrome receiving a bone-marrow transplant disappeared after the engraftment of T-lymphocytes, suggesting that the recipient's abnormal T-lymphocyte function was the cause of the eczema.

In conclusion, we consider that levamisole may be useful in patients suffering from severe recurrent infections associated with defective neutrophil chemotaxis and hyperimmunoglobulinaemia E, although allergen-avoidance may also be required.

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Table Immunological data before, during, and after levamisole treatment

<table>
<thead>
<tr>
<th></th>
<th>Normal values</th>
<th>Before</th>
<th>During*</th>
<th>After</th>
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<tbody>
<tr>
<td>Cellular chemotaxis</td>
<td>100±18</td>
<td>5</td>
<td>85</td>
<td>90</td>
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<tr>
<td>Random motility</td>
<td>100±15</td>
<td>5</td>
<td>85</td>
<td>110</td>
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<tr>
<td>Total IgE (U/ml)</td>
<td>18±3</td>
<td>16000</td>
<td>8000</td>
<td>1570</td>
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<tr>
<td>Specific IgE cows' milk (PRU/ml)</td>
<td>--</td>
<td>49</td>
<td>20</td>
<td>10</td>
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<tr>
<td>IgM (mg/100 ml)</td>
<td>65±25</td>
<td>Undetectable</td>
<td>Undetectable</td>
<td>Undetectable</td>
</tr>
<tr>
<td>Staphylococcal haemolitic titre (U/ml)</td>
<td>--</td>
<td>Undetectable</td>
<td>Undetectable</td>
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<tr>
<td>T-lymphocytes (%)</td>
<td>61±5</td>
<td>12</td>
<td>43</td>
<td>50</td>
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<tr>
<td>T-lymphocytes (×10^9/l)</td>
<td>&gt;1.5</td>
<td>0.204</td>
<td>0.86</td>
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<tr>
<td>In vitro lymphocyte response to PHA SI</td>
<td>&gt;10</td>
<td>6</td>
<td>14</td>
<td>30</td>
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References


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