



Question dubious allergies



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During a doctor's consultation, patients will usually be asked if they have any allergies to drugs. This is important, as giving a patient a drug they are allergic to can lead to a serious adverse reaction.

How do patients know they have allergies? Often, the appearance of a rash or other side effects while taking a drug, leads to the impression that the drug caused it. Doctors may reinforce this impression when the patient returns to inform them.

Though the diagnosis of a drug allergy is obvious when there is a severe reaction, most symptoms that patients experience are not severe.

In such cases, it is impossible for the doctor to determine whether the symptoms were truly caused by the drug.

It is often prudent to ask the patient to stop the medication first and see if the symptoms continue.

A classic scenario is one where a two-year-old gets a rash for the first time when he takes an antibiotic; he is then assumed to have an allergy and the drug is avoided, often for life.

I confess that if I encounter a child who has been



ST ILLUSTRATION: ADAM LEE

labelled as having a drug allergy, I will often inquire in detail.

A teenage girl who was recently hospitalised for an operation is an example of incorrect labelling.

Her penicillin allergy was causing some difficulties with the choice of antibiotics she required. However, the description of her previous reaction – an itchy rash that lasted more than two days after stopping the suspected drug – did not suggest a true allergy.

It is very common for children to have rashes during an infection.

After discussing it with her and her mother, we arranged for a skin test followed by her taking penicillin under close supervision.

She tolerated both without any reaction, and the allergy label that she had been living with for years was removed.

It took only a few minutes of my time, but it could make all the difference to the child, should she require penicillin in the future.

WRONG IMPRESSIONS

Drug allergies in children are often over-reported. Let us take rashes as an example.

If I were to see 100 children in the community with a new onset of rash, more than 90 would have contracted the rash due to unknown reasons, such as a reaction to heat or from an ongoing viral infection.

Only 5 per cent of the rash cases would be caused by a drug. Studies bear this out: At least 80 per cent to 90 per cent of assumptions that a child is allergic to penicillin – the most commonly prescribed type of antibiotics – turn out to be wrong upon testing.

But I must add a word of caution.

Though it may embolden parents to question whether their young child truly has a drug allergy, they should not make conclusions themselves. It is best to consult an expert on drug allergy.

BETTER TO KNOW FOR SURE

Why bother with this question of drug allergy, one may ask. There are other drugs out there. Surely there is no need to see a specialist to find out if my child has an allergy?

I hear these statements from parents who are surprised that I ask so much about their child's drug allergy.

The main reason for verifying suspected drug allergies lies with the use of alternative drugs if there is no true allergy.

Alternative options not only cost more, but they may not be as effective. This is because each drug has a specific action. For example, in

the case of antibiotics, they each work on specific bacteria. You could say antibiotic A has a 90 per cent chance of curing the infection caused by bacteria X.

If you use antibiotic B, the chance of curing the infection might be only 75 per cent, and it might also take longer. The most commonly used drugs are the most common because they are the most effective and, often, the safest as well.

Studies published last year in the Journal Of Allergy And Clinical Immunology found that hospitalised patients labelled with a penicillin allergy used stronger antibiotics, stayed longer in the hospital and spent more money.

If they had sought a specialist to check if they were truly allergic to penicillin and paid for the tests, at least 80 per cent to 90 per cent of them would not only have saved money, they could have avoided unnecessary side effects and a longer stay in hospital.

AN ALLERGY THAT WASN'T

A few weeks ago, an 11-year-old girl came to the emergency department to get treated for an uncontrolled eczema flare-up.

She had been scratching and had bleeding, inflamed skin for over a month.

As she had been labelled with a penicillin allergy since she was an infant, her general practitioner prescribed her another antibiotic. But it did not work.

Her allergy label came about after she took penicillin for the very first time without ever receiving antibiotics before, and got a rash after the very first dose. The rash lasted longer than a typical allergic reaction would, but did not result in other problems.

Based on this description, I was certain that she did not have a penicillin allergy. After a discussion with her parents, we arranged for her to undergo a drug challenge the very next morning.

The timing was fortuitous because she had developed a fever overnight from an infection and needed an effective antibiotic to treat it.

She underwent the drug challenge the following morning and, as expected, had no reaction to the drug at all. As she was able to continue taking penicillin, her fever subsided rapidly and there was a dramatic improvement in her skin condition within two days.

Most importantly, she was able to finally get a good night's sleep.

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