operating notes, and also consideration of isosulfan blue as a potential culprit.

John M. Kelso, MD

Division of Allergy, Asthma and Immunology, Scripps Clinic, San Diego, Calif.

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Corresponding author: John M. Kelso, MD, Scripps Clinic, 3811 Valley Centre Drive, San Diego, CA 92130. E-mail: kelso.john@scrippshealth.org.

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Reply to “Isosulfan blue-induced perioperative systemic allergic reactions”

To the Editor:

We thank Dr Kelso for his correspondence1 to our article “Perioperative allergic reactions: allergy assessment and subsequent anesthesia” in the Journal of Allergy and Clinical Immunology: In Practice.2

Blue dyes including methylene blue, patent blue, and isosulfan blue are used clinically to identify sentinel lymph nodes in patients undergoing oncologic evaluations. A recent meta-analysis describes a 0.06% anaphylaxis rate to blue dyes, whereas another single-center study describes hypotension on 0.5% of cases using isosulfan blue dye. Overall, blue dyes are indeed being increasingly identified as “hidden” causative agents of perioperative allergic reactions,3,4 and allergists should include them in the list of possible causative agents when evaluating patients with perioperative allergic reactions. Allergists can also perform dye skin testing using the published nonirritating skin testing concentrations as part of the comprehensive evaluation in cases where dyes were used.5,6

We agree that a thorough review of the electronic medical records including the anesthesia record and operative report is needed as part of the allergy consultation and assessment. At our academic medical center, we also review the operating room nursing record, which may document irrigations such as heparin and saline mixture, bacitracin and saline mixture, and Visipaque dye given intra-arterially. Lastly, a comprehensive approach to perioperative allergic reactions should include review of the medication administration report where all agents given during a procedure should be thoroughly documented.

Alenea Banerji, MDa,b
Kimberly G. Blumenthal, MD, MSa,b,c

aDivision of Rheumatology Allergy and Immunology, Department of Medicine, Massachusetts General Hospital, Boston, Mass
bHarvard Medical School, Boston, Mass
cEdward P. Lawrence Center for Quality and Safety, Massachusetts General Hospital, Boston, Mass

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Corresponding author: Alenea Banerji, MD, Massachusetts General Hospital, 219, 100 Blossom Street Boston MA 02114. E-mail: abanerji@mgh.harvard.edu.

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The allergic effector unit: From basic science to drug-targetable mast cell–eosinophil interactions in patients

To the Editor:

We read with great interest Guillet et al’s Clinical Communication1 presenting the effect of mepolizumab administration in an eosinophil bronchial asthma patient with concomitant idiopathic mast cell (MC) activation syndrome. The authors found that mepolizumab administration resulted in a reduction of blood eosinophilia, eosinophilic cationic protein (ECP), and serum tryptase levels, with amelioration of asthma, gut, and skin symptoms. Interestingly, although both omalizumab and mepolizumab reduced serum tryptase, only the latter decreased asthma symptoms. This is possibly due to omalizumab binding to circulating free IgE, thus not affecting already bound IgE.2

The reduction in tryptase and ECP serum levels might be due to a direct effect of mepolizumab on MCs. It was published that administration of mepolizumab in pediatric eosinophilic esophagitis significantly reduced MC numbers and occurrence of MC-eosinophils (Eos) couples due to inhibition of IL-9 production from Eos, thus influencing MC survival in the gut.3 Mepolizumab can affect the Eos, which, when not inhibited, engage MCs in a physical and soluble crosstalk we named allergic effector unit (AEU). Indeed, in previous works, we showed that the activating receptor CD48 on human cord blood-derived MCs engages CD244/2B4 on peripheral blood Eos, resulting in activation of both cells.4 Importantly, MCs and Eos produce several mediators