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Maria de Filippo, Omar Ali Al Ali, Jean Luc Bourrain, Pascal Demoly, Anca Mirela Chiriac

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1 **Immediate flare-up-like reaction of skin tests to betalactams with lymphangitis during drug**
2 **provocation test**

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5 **DE FILIPPO Maria^{1,2*}M.D, AL ALI Omar^{1*} M.D, BOURRAIN Jean Luc¹ M.D, DEMOLY**
6 **Pascal^{1,3} MD-PhD, CHIRIAC Anca Mirela^{1,3} MD-PhD**

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8
9 ¹ Department of Pulmonology, Division of Allergy, Hôpital Arnaud de Villeneuve, University
10 Hospital of Montpellier, Montpellier, France;

11 ² Department of Pediatrics, Policlinico San Matteo Pavia, Istituto di Ricovero e Cura a Carattere
12 Scientifico, Italy;

13 ³ Equipe EPAR - IPLESP, UMR 1136 INSERM - Sorbonne Université, Paris, France
14

15 * The authors contributed ex aequo.

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20 * *Post publication corresponding author:*

21 Dr Anca Mirela CHIRIAC, a-chiriac@chu-montpellier.fr

22 Allergy Unit, Arnaud de Villeneuve Hospital, University Hospital of Montpellier

23 Address: 371, Avenue du Doyen Gaston Giraud, 34295 Montpellier Cedex 5, Montpellier, France

24 Phone: +33 467336107

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41 Beta-lactam (BL) antibiotics are the most common cause of drug-induced hypersensitivity reactions
42 (DHR).

43 Clinical Implications:

44 We present two clinical cases of patients with suspected immediate BL DHR who underwent drug
45 allergy work-up according to standardized diagnostic procedures, including skin tests (ST: prick,
46 SPT and intradermal tests, IDT) and drug provocation tests (DPT)¹. ST became positive after the
47 first DPT dose. The patients gave their consent to the diagnostic allergy work-up and use of their
48 de-identified data for research purposes.

49

50 A 68-year-old man placed on the liver transplantation waitlist for cirrhosis due to hepatitis C viral
51 infection in August 2017 was admitted to the hospital for cholangitis. The patient was empirically
52 treated with piperacilline/tazobactam (piperacillin 4g/t.i.d) intravenously. He had previously
53 tolerated this drug. About 45 minutes after the first dose, he developed pruritus and urticaria on the
54 neck and trunk without other associated symptoms. He rapidly recovered with cetirizine (10 mg) by
55 oral route. In December 2018 the patient reported a similar episode, treated with intravenous
56 dexchlorpheniramine. In June 2019, the patient underwent ST with several penicillin and
57 cephalosporin reagents. Histamine was used as a positive control. As SPT and IDT at the highest
58 recommended concentrations were negative when read after 15 minutes and 20 minutes respectively
59 (according to current recommendations), we proceeded to DPT (the first dose was given 60 minutes
60 after the IDT reading). Single-blind challenge with intravenous piperacilline/tazobactam was
61 performed, with 30 minutes increments, starting with 5%² (200 mg) of the therapeutic dose (4000
62 mg) that elicited his initial reaction. A few minutes before the administration of the second dose the
63 patient reported itching on the arms and scalp, in the absence of objective clinical signs. Therefore,
64 we decided to interrupt the test and monitor the patient for 15 minutes. A few minutes later the
65 patient presented a localized itchy erythema at the site of the ST corresponding to pure IDT to
66 piperacillin/ tazobactam and piperacillin, with ascending lymphangitic infiltration (Figure 1). No
67 wheal was observed. The ST was nonetheless considered positive, the DPT was interrupted and
68 cetirizine (10 mg) was administered.
69 Two hours after the administration of the first dose of the drug, the patient presented localized
70 urticaria on the arms and the abdomen, with resolution in 90 minutes (see Figure E1 in the Online
71 Repository).

72

73

74

75 A 62-year-old male patient, mentioned an episode of potential DHR in October 2012, with
76 generalized urticaria, preceded by pruritus of palms and soles. This reaction started five minutes
77 after the ingestion of 1000 mg amoxicillin for sinusitis, and during a meal containing shrimps. The
78 allergy work-up was performed six weeks after the initial reaction. Skin tests (read at 20 min for
79 IDT) were negative at the maximum recommended concentrations. As the patient had a history of
80 immediate reaction, DPT with amoxicillin was started immediately after reading the skin tests. The
81 began with 1 mg of amoxicillin (this was the first dose of the empirical DPT protocols that have
82 been used in our unit till 2016). Thirty minutes after the first dose of amoxicillin, the patient
83 presented a positive ST (> 3mm increase in the diameter compared to the injected wheal,
84 surrounded by erythema) in IDT only at the site of amoxicillin injection, with a linear shape form
85 and ascending lymphangitis 7.5 cm upward from the injection site (Figure 2). All the other ST
86 were negative. The DPT was stopped immediately, he was treated with cetirizine (10 mg) and
87 monitored for 90 minutes. No other symptoms appeared.

88
89 When negative immediate-reading ST occur in patients with a clinical history compatible with an
90 immediate reaction (i.e., potentially IgE-mediated), a DPT is usually performed, in absence of
91 contra-indications¹. In the two cases we present, the first dose of the oral DPT was followed by ST
92 positivity, associated in Case 1 with a systemic reaction (dose administered, 5% of initial eliciting
93 dose). The peculiarity of the second case is that the patient developed a positive ST at 60 minutes,
94 as opposed to 20 minutes following their performance and 30 minutes after the start of DPT without
95 systemic symptoms (dose administered 0.1% of the initial eliciting dose). The absence of any
96 systemic reaction in Case 2 may be due to the low initial dose.

97 ST reversal in these patients is likely due to a flare-up phenomenon. Flare-up reactions refer to the
98 reactivation of previous positive ST or the switch from negative to positive ST, usually after a
99 systemic challenge. This phenomenon is classically described in delayed-type allergy³. To the best
100 of our knowledge, such rapid flare-up reactions have not been described for BL (published cases
101 include delayed reactions)^{3,4}, but case reports suggestive of a flare-up-like reactivity suggesting
102 IgE-mediated allergy have been described for other drugs (e.g., ibuprofen⁵, paracetamol⁶).

103 In the two cases we present we observed localized superficial inflammation processes that
104 induced linear in superficial lymphangitis from the site of the IDT of piperacillin and
105 piperacillin/tazobactam (Case 1) and amoxicillin (Case 2), extending toward the arm. Lymphangitis
106 is an inflammation of one or more lymphatic channels mostly induced by infections (mostly
107 bacterial infections) occurring at the distal site of vessels. Many other causes could induce linear
108 supralymphatic eruptions with superficial lymphangitis and some of these are viral and fungal

109 infections, insect or spider bites, and iatrogenic etiologies like vaccinations, purified protein
110 derivative placement⁷. In a case series reported by Kano et al, three different cases which focus on
111 the theme of superficial lymphangitis were discussed and the idea of the effect of contact allergens
112 as a co-factor in this pathology was put forward. In their report, ST were negative for the alleged
113 contact allergens and this is why they were merely considered as co-factors⁸. In our cases, the drugs
114 are not contact allergens in the clinical history but injecting them by IDT may render them similar
115 to a contact allergen. Most described cases of allergic lymphangitis concern delayed
116 hypersensitivity reactions. Because dendritic cells are known to migrate from the sites of allergen
117 exposure to draining lymph nodes during the inflammatory response, this hypothesis could explain
118 why the linear lesions begin within the sites of IDTs and extend proximally to the draining lymph
119 nodes, in delayed DHR. The two cases we presented revealed acute superficial lymphangitis, which
120 raises the hypothesis of a local immunologic reaction to an allergen along lymphatic vessels,
121 establishing a linear lesion overlying the skin. The promptness in onset and resolution of the lesions
122 supports the assumption of this local reaction being elicited by mast cell mediator release, as
123 connective tissue mast cells are located by nerve endings and alongside the blood and lymphatic
124 vasculature⁹. Late-phase IgE-associated inflammatory responses to allergens cannot be excluded,
125 considering that the reaction occurred later than classically observed in ST for immediate type
126 reactions.

127 Although in Case 1, the reactive IDTs did not match the recommended positivity criteria (no wheal
128 was detected, only surrounding erythema), in Case 2, the IDT became positive according to
129 recommended reading criteria. In our experience, in more than 4000 patients tested for a suspicion
130 of DHR to BL, these are the only two cases of their kind.

131 As clinicians working in the drug allergy field and operating with iatrogenic procedures (especially
132 with BL antibiotics), we should be aware of rare cases. In these examples, monitoring the site of a
133 negative ST (despite clinical histories of immediate reactions) even after reading the ST result
134 within recommended lapses of time and when starting DPT prevented us from exposing our patients
135 to higher doses of allergens and potentially a more severe reaction.

136
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173 **Figure Legends**

174 **FIGURE 1:** The following reagents were tested at the maximal non-irritant concentrations
175 (“pure”): penicillin G (10 000 UI/ml, PG), amoxicillin/clavulanic acid (20 mg/ml for amoxicillin,
176 Ag), ampicillin (20 mg/ml, Ap), piperacillin (20 mg/ml), piperacillin/tazobactam (20 mg/ml for
177 piperacillin), cefuroxime (20 mg/ml, Z), ceftriaxone (20 mg/ml, C4).

178 **FIGURE 2:** Positive skin test to amoxicillin (20 mg/ml); the injected wheal is circled at the time of
179 the performance of IDT; the increased wheal, erythema and lymphangitis occurred after 1 mg
180 amoxicillin by oral route.

181

FIGURE 1

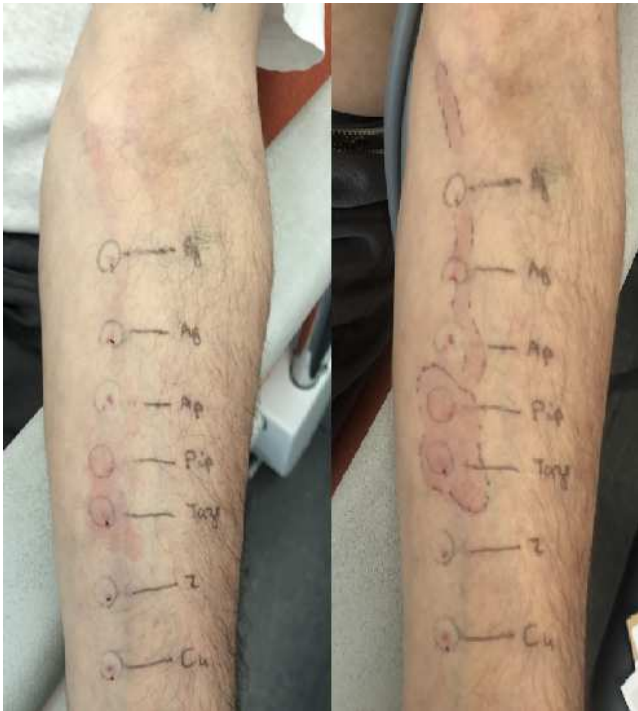


FIGURE 2

