ABSTRACT

Background: Sensitivity to Salsola kali is a frequent cause of allergic respiratory disease in various regions of Spain. However, there are very few articles in which this allergen has been studied.

Methods and Results: In order to evaluate the tolerance of this extract, a prospective study has been performed. This study was observational, multi-centred and open, involving 88 patients with allergic respiratory disease due to sensitivity to Salsola, aged between 5 and 52 years. The administration of the extract was performed subcutaneously, through one of two treatment schedules: cluster (8 doses in 4 visits) or conventional (13 doses in 12 visits). A total of 42 adverse reactions were registered, in 26 patients (35 local reactions in 21 patients and 7 systemic reactions in 6 patients). Among the 7 systemic reactions, 4 were registered with the cluster protocol and 2 with the conventional protocol (p = 0.329). In no patients were serious adverse reactions registered.

Conclusion: The subcutaneous administration of a Salsola extract is safe and well tolerated, both when administered using a conventional schedule and when using a cluster schedule.


Tolerance of a Salsola kali extract standardized in biological units administered by subcutaneous route.
Multicenter study


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RESUMEN

Antecedentes: La sensibilización a Salsola kali es una causa frecuente de enfermedad alérgica respiratoria en varias zonas de España. Sin embargo, apenas existen publicaciones en las que se estudie este alergeno.

Métodos y resultados: Para valorar la tolerancia de este extracto, se ha realizado un estudio prospec-tivo, observacional, multicéntrico y abierto, en el que se han incluido 88 pacientes, de edad entre 5 y 52 años, con enfermedad alérgica respiratoria por sensibilización a Salsola. La administración del extracto se ha realizado por vía subcutánea, mediante dos esquemas de tratamiento: agrupado (8 dosis en 4 visitas) o convencional (13 dosis en 12 visitas). Se han registrado un total de 42 reacciones adversas en 26 pacientes (35 reacciones locales en 21 pacientes y 7 sistémicas en 6 pacientes). De las 7 reacciones sistémicas, 4 se registraron con la pauta agrupada y 2 con la convencional (p = 0,329). No se registró ninguna reacción adversa grave.

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Conclusión: La administración subcutánea de un extracto de Salsola es segura y bien tolerada, tanto cuando se administra con una pauta convencional como con una pauta agrupada.


INTRODUCCIÓN

La Chenopodiaceae, la familia a la que pertenece la Salsola pertinere, son una importante causa de polinosis en diferentes zonas geográficas de España (Levante, Aragón, Andalucía). En un estudio epidemiológico publicado en 1995 sobre más de 4000 pacientes con alergia a pólen de Salsola, la presencia de alergia a este polen osciló entre 5.9% y 34.5%, dependiendo de la área geográfica.

A pesar de estos datos, no se ha estudiado la posible aplicación de la terapia alérgica con extractos de Salsola en personas alérgicas. Como se ha revisado la literatura entre los años 1989 y 2002, sólo se ha encontrado un estudio presentado en la Reunión Europea de Allergología y Clínica Inmunológica en 1997, en la que se evaluó la tolerancia a dos extractos: Salsola y Alternaria.

Por esta razón, se realizó este estudio multicéntrico con el objetivo de evaluar la tolerancia a un extracto de Salsola administrado subcutáneamente en pacientes que presentan una enfermedad respiratoria alérgica que son únicamente alérgicos a esta planta. Para poder adecuadamente evaluar la tolerancia, el tratamiento se administró en el periodo inicial bajo la supervisión de un especialista, ya que se utilizó un protocolo claramente definido en el periodo inicial. El primero de estos protocolos está compuesto por 13 dosis, administrando una dose cada semana. En contraste, el segundo consiste en un protocolo agrupado, que se ha descrito en otros estudios. En este estudio, el mantenimiento se alcanzó en cuatro sesiones administrando dosis en cada uno de los visitados durante el periodo inicial.

MATERIALS AND METHODS

Patients

A total of 88 patients have been included in this study, aged between 5 and 55 years. The criteria for inclusion in the study were: clinical history of rhinitis and/or asthma due to sensitivity to Salsola, a positive result in skin tests (prick test BU Salsola ≥ 100 μg/ml, ALK-Abelló, S.A.) and/or a positive IgE to said allergen (CAP class 2, Pharmacia, Uppsala, Sweden or > 0.7 KU/litre). The patients with relevant clinical sensitivity to other allergens, to whom it was impossible to administer the treatment under the supervision of a specialist, in those to whom immunotherapy had been administered with allergens in the 3 years prior to their inclusion in the study, or with a contraindication to the administration of the immunotherapy in agreement with the criteria of the WHO, were all excluded from the study.

Ethical Aspects

All the patients that were included in the study gave their informed consent to participate, which was approved by the ethical committees of the centres implicated and by the relevant Health Authorities.

Design

This was a prospective, multi-centre, observational and open pharmacovigilance study.

Immunotherapy

A standardised extract of Salsola kali (25 BU/ml, Pangramin® Depot BU, ALK-Abelló, S.A.) was administered subcutaneously adsorbed in an aluminium hydroxide gel. The extract was administered, during the initiation phase, according to two possible treatment schemes as specified in table I: conventional and cluster. In this phase, the administration was performed on a weekly basis with an interval between doses, in the case of the cluster protocol of 30 minutes. In the maintenance phase, the administration of each dose was monthly. Since we are dealing with an observational study and in accordance with the legal requirements currently in force in Spain, each patient chose under which protocol that he/she wished the extract to be administered having previously been adequately informed.

All the doses were administered under the direct supervision of the specialist in the centres involved, in accordance with the recommendations of the European Academy of Allergology and Clinical Immunology (EAACI)².

No patient received premedication before any of the doses given in the study were administered.
Adverse effects were recorded in accordance with the guidelines of the EAACI, both during the initiation phase as well as during the maintenance phase. The criteria used to adjust the doses were in the case of the conventional protocol in agreement with the recommendations of the EAACI, whilst in the case of the cluster protocol action was taken in accordance to the experiences of previous studies.

Statistical Analysis

Statistical analysis was performed using the statistical software package SPSS. The association between variables was determined using the chi-squared test or Fisher’s Exact Test, establishing the level of significance at the probability of error < 0.5.

RESULTS

Characteristics of the sample

The principal characteristics of the sample are resumed in table II. The mean age of the patients was 28.1 ± 11.6 years and in 46.6 % of the subjects there was a family history of atopy. Over the whole duration of the study, a total of 4 patients dropped out: two due to causes unrelated to the treatment; one patient for having presented two systemic reactions at the same dose, which in accordance to the experimental protocol meant the patient had to be retired from the study; finally a patient suffered an attack of eczema that led to the decision that the patient should no longer continue with the treatment.

Characteristics of the treatment

The administration of the treatment was carried out following the conventional protocol in 22 patients (25 %) and the cluster protocol in 66 (75 %). During the initiation phase, a total of 814 doses were administered, of which 528 corresponded to the cluster protocol and 286 to the conventional.

Tolerance

Local reactions: a total of 35 reactions were registered (4.3 % of the doses administered), of which 18 occurred during the administration of the cluster protocol (3.4 % of the doses) and 17 with the conventional protocol (5.9 %). The reactions were registered in 21 patients (23.9 % of the total number of subjects). Of the total number of reactions, 27 were registered in patients older than 15 years of age and 8 in younger subjects.

Systemic reactions: there were a total of 7 systemic reactions (0.86 % of the total number of doses administered), that occurred in 6 patients (6.8 %). These reactions are described in more detail in table III. No statistically significant differences were detected when the percentage of systemic reactions in each of the protocols used was assessed (0.7 % with the conventional and 0.76 % with the cluster protocol p = 0.273).
Although the systemic reactions appeared more often in patients that had suffered from asthma and rhinitis (10.5 %) than in those that were diagnosed exclusively with rhinitis (5.8 %), these differences were not statistically significant (p = 0.273).

Finally, when the appearance of adverse reactions was analysed in terms of age group, it is noteworthy that of the 7 systemic reactions registered, 2 appeared in 2 patients older than 15 years of age, and 5 occurred in paediatric patients (< 14 years), this difference being statistically significant (p = 0.002).

**DISCUSSION**

In general, immunotherapy studies have been centred on those allergens that have an elevated prevalence in any population, as is the case for mites or grasses. However, there are other allergens to which an important number of patients are sensitive, although this sensitivity may be restricted to particular geographic areas. For this reason, it is at times complicated to find reference in the literature to the behaviour of this type of allergen. This is indeed the case of *Salsola*, which in zones such as Aragón, Levante or Andalucía (south and eastern Spain) is frequently the cause of allergic sensitivity, yet no references to this allergen exist in the literature.

In this study, we have focused our efforts on understanding the tolerance to this allergen. The allergen was administered under one of two distinct protocols, both frequently used by specialists: the conventional protocol or the cluster protocol. Given the characteristics of the study, each patient was allowed to choose under which of the two protocols he/she wished to have the treatment and administered. As such, it is notable and of interest that a significant percentage of the patients decided to administer the allergen following the cluster protocol. This protocol, involves an important reduction in the number of visits with respect to the conventional protocol, and in the doses necessary in order to reach the maintenance treatment. Several recent studies have justified the use of this type of protocol in clinical practice.

When we centred our attention on the systemic reactions, we could compare the results obtained with the cluster protocol to those obtained in other studies in which a similar or identical cluster protocol has been applied to administer pollen extract. Thus, in our study we find a similar relationship between the induction of a systemic reaction and the doses, or the numbers of patients, (0.76 % and 6.1 %) as that obtained in other studies. Indeed, Moreno et al determined percentages figures of 1.2 % of the doses and 9.5 % of the patients, whilst in the study of Guardia et al these percentages were 0.9 % and 6.3 %, respectively.

Furthermore, it is important to underline that we did not observe any significant difference in the tolerance between those patients treated with the cluster protocol or those treated with the conventional protocol. Nevertheless, the cluster protocol must still continue to be administered under the strict control of a specialist, given that the administration of various doses on the same day could represent a risk to the patient. However, using the cluster protocol represents an important saving with respect to the conventional protocol, which can be coupled to the fact that in none of the studies performed to date has a difference been detected in terms of the severity of the reactions when these two treatment regimes are used.

Immunotherapy is clearly more efficient when acting in the early stages of an allergic illness. In this sense, its use in paediatric patients is clearly appro-

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**Table III**

<table>
<thead>
<tr>
<th>Type</th>
<th>Severity (EAACI)</th>
<th>Time of onset</th>
<th>Treatment phase</th>
<th>Treatment schedule</th>
<th>Val</th>
<th>Dose (ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Grade 1</td>
<td>Delayed</td>
<td>Initial</td>
<td>Conventional</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>Urticaria*</td>
<td>Grade 3</td>
<td>Delayed</td>
<td>Initial</td>
<td>Cluster</td>
<td>3</td>
<td>0.1 + 0.2</td>
</tr>
<tr>
<td>Eczema</td>
<td>Grade 1</td>
<td>Delayed</td>
<td>Initial</td>
<td>Conventional</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Allergic reaction (AR)</td>
<td>Grade 2</td>
<td>Delayed</td>
<td>Initial</td>
<td>Cluster</td>
<td>3</td>
<td>0.1 + 0.2</td>
</tr>
<tr>
<td>Urticaria and angioedema</td>
<td>Grade 3</td>
<td>Delayed</td>
<td>Initial</td>
<td>Cluster</td>
<td>2</td>
<td>0.4 + 0.6</td>
</tr>
<tr>
<td>Cough</td>
<td>Grade 2</td>
<td>Delayed</td>
<td>Maintenance</td>
<td></td>
<td>3</td>
<td>0.8</td>
</tr>
</tbody>
</table>

*In this patient, according to the protocol, the dose was reduced twice. When the dose that provoked the reaction was again administered, the patient suffered an identical reaction and he was excluded of the protocol.
appropriate, not only from the curative point of view but also from the preventive point of view, as clearly demonstrated in other studies. Whilst in this study we did not set out to establish the levels of tolerance with respect to age, they did appear to be significantly more reactions in children than in adolescents or adults. For this reason, the administration of immunotherapy to infants should be very carefully supervised by specialists. However, it is important to underline that of the reactions that appeared in children, two were non-specific reactions: in one case fever and in the other case the reaction consisted of a non-pruriginous cutaneous eruption. In both cases, immunotherapy was administered under the conventional protocol and the patients continued with the treatment administration. The same occurred in a third subject that reacted with grade 2 asthma. In accordance with the protocol, once the doses had been lowered and subsequently returned to the original higher doses, the patient did not suffer any further reaction.

In conclusion, immunotherapy with an extract of Salsola kali is well tolerated in patients with allergic respiratory illness, either when administered in a conventional manner or when using the cluster protocol.

ACKNOWLEDGEMENTS

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REFERENCES