Specific IgE Is Better Than Skin Testing for Detecting Aspergillus Sensitization and Allergic Bronchopulmonary Aspergillosis in Asthma

To the Editor:

We read with interest the review by Schulman et al1 in a recent issue of CHEST (January 2015) wherein the authors suggest the use of a skin test for screening sensitization to various allergens in preference to specific IgE antibody testing in patients with asthma. We agree with the authors that all patients with asthma should be screened for allergic sensitization against a particular allergen depending on its prevalence. However, we do not agree with the authors’ recommendation that skin testing is the preferred approach as this can potentially miss allergic sensitization against Aspergillus fumigatus. In a study comparing the performance of a skin test (intradermal) or specific IgE (against A. fumigatus) for the diagnosis of allergic bronchopulmonary aspergillosis (ABPA) in 372 subjects with asthma, the sensitivity of an A. fumigatus-specific IgE and Aspergillus skin test was 100% and 88% to 95%, respectively, in various models of latent class analysis.2 Thus, if a skin test is used as a screening modality, one can potentially miss 5% to 12% cases of ABPA.

It is extremely important that Aspergillus sensitization or ABPA is not missed. Aspergillus sensitization is associated with poorer lung function and worse symptoms,3 risk of death from asthma,4 and acute attacks of asthma requiring ICU admission; treatment with itraconazole can potentially improve the quality of life in these patients.5 Furthermore, the prevalence of ABPA in Aspergillus sensitization is about 40%,7 and delay in diagnosis and treatment of ABPA can cause irreversible lung damage in the form of bronchiectasis, lung fibrosis, and, finally, end-stage lung disease and respiratory failure.8

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