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Reply

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Doña and co-workers' comments on our editorial (1) underline two aspects of NSAIDs hypersensitivity. The first one is paracetamol tolerance in NSAIDs-hypersensitive patients, particularly in those reacting to different NSAIDs, including selective COX-2 inhibitors (coxibs). As reported in the editorial, Doña and co-workers found that intolerance to paracetamol could represent a "marker" of reactivity to etoricoxib and to other coxibs (2). This was not the case in our two patients. On the other hand, reviewing the outcome of paracetamol tolerance in coxibs-reactive patients was out of scope of our article, dealing with challenge tests with coxibs in patients with cutaneous hypersensitivity to multiple NSAID. The two cases we presented underlined the need of checking tolerability of alternative NSAIDs (including selective COX2-inhibitors) in a proper setting. The same holds obviously true also for paracetamol, as highlighted by Doña et al. (2).

The second aspect is the prevalence of hypersensitivity reactions to NSAIDs: definitely this class of drugs is one of the most common causes of adverse reactions (3), and in some populations is the most frequent one, as recently reported by Doña et al. (4). Differences in the prevalence rate of drug hypersensitivity may depend on study populations (ethnicities, inpatients or outpatients, adults or children), differences in methods for assessing offending drug, and different methods of data analyses (5). However, we believe that an exact ranking of prevalence doesn't appear very relevant in the evaluation of coxibs as alternative drug in cutaneous hypersensitivity to multiple NSAIDs.

References

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