

by oral route. Regarding patient's follow-up, 93.8% of respondents referred to an allergist.

The seniority doesn't seem to influence the ignorance of the main classifications and the recognition of the clinical signs, as well as the fact of having done the internship at the general practitioner office (realised by 80% of the interns who answered).

The severity of grade 2 symptoms is underestimated and treatment is not consistent with international recommendations, underscoring the underutilisation of adrenaline. In terminological difficulties found in the Ring and Messmer classification, such as the terms of Quincke's oedema, bronchospasm, mild hypotension, etc., may contribute to these diagnostic difficulties.

Conclusions: Our work suggests that training on recognition and management of anaphylaxis should be improved. Creation of a degree of Allergy, in France, and development of postgraduate education would participate in strengthening knowledge about this disease.

0849 | Exercise induced anaphylaxis: does it occur only with food?

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Introduction: Exercise plays an important role in IgE mediated allergy against omega-5-gliadin (w-5G) wheat protein. Thus, wheat-dependent- exercise-induced- anaphylaxis is a good model for "co-factor-mediated" anaphylaxis.

Objectives: We present a 38-year-old-male patient with recurrent anaphylaxis for the last 3 years. After three different food intake—chicken, ravioli, and toast—he experienced sudden onset of itching, generalized urticaria, dyspnea, dizziness, and hypotension in the same manner within 10-30 minutes of exercise. The patient did not have any history of atopy, allergy, and/or food intolerance. No other cofactor was identified as the externally applied exercise. Similar complaints developed more mildly after exercise followed by myorelaxant and fast food intake.

Results: Skin prick tests (SPT) were negative with aeroallergens, whereas positive reactions were observed with wheat and barley, among six different flours (wheat, barley, rye, rice, corn, oat), and positive ID tests with all, except rice. SpelgE measured by ImmunoCAP was found to be negative for gluten and wheat mix, but w-5G was positive (1.87 kUA/L). Antigliadin IgA-IgG, and tissue transglutaminase IgG-A screened to exclude Celiac disease were negative. As the patient refused to have provocation test with myorelaxants, we were unable to perform it.

Conclusions: Although no reaction was mentioned after the exercise without food intake, as well as myorelaxant use, adrenalin auto injector was prescribed as the patient observed wheat-dependent-

exercise-induced anaphylaxis. This case was presented as myorelaxant can be a rare cofactor in addition to w-5G(+)/gluten(-) spelgE.

0850 | Rhabdomyolysis in the context of food-dependent exercise induced anaphylaxis

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Case Report: Background: Food-dependent exercise induced anaphylaxis is a severe generalized allergic reaction, which is more frequent in young people, with an estimated prevalence of 0.048% among teenagers.

On the other hand, rhabdomyolysis is the breakdown of muscle fibers that causes release of the contents of said fibers (myoglobin) into the bloodstream. It is extremely unusual in the context of anaphylaxis.

Methods: A 27-year-old patient was referred to our department for study. Approximately three months before he had presented an episode of pruritic wheals distributed throughout the integument, facial flushing with facial oedema sensation, occipital headache, nausea and a feverish feeling, few minutes after starting to run. He had had dinner (chicken, salad, and wholemeal bread) ninety minutes before exercising.

At the emergency room, high levels of muscle damage parameters (CK 55.000 U/L, AST 800 UI/L, ALT 450 UI/L) were revealed, with decreased renal function. Intense fluid therapy was established to re-hydrate the patient and he showed rapid clinical improvement.

Results: Complementary tests were performed at emergency department (chest x-ray, brain CT and electroencephalogram) without pathological findings. Three months after the episode, skin prick tests (SPT) with common aeroallergens were all negative. SPT with common trophallergens and *Anisakis simplex*, were also negative. Total IgE (106 kU/L), basal tryptase (1.56 µg/L) and complement (C3: 110 mg/dL, C4: 33.40 mg/dL, C1 inhibitor: 31.80 mg/dL and CH 100: 401.38 U) were into normal range. Specific IgE to gliadin (rTri a 19) (ImmunoCAP) was positive (3.02 kUA/L).

Conclusion: This patient had an episode compatible with Wheat-Dependent Exercise-Induced Anaphylaxis. It was possibly not identified at emergency room because of the simultaneous episode of rhabdomyolysis. It has been mainly associated with multiple Hymenoptera stings, and it is very rarely in an anaphylaxis. In our case, rhabdomyolysis seems to have been associated to physical exercise, although it is tempting to speculate that the undiagnosed anaphylactic episode could have contributed to an increase in the intensity of rhabdomyolysis.