before surgery (not two to three days as pointed out by Loffroy et al). In our department, pain control after PRAE is standardised with oral/intravenous medication of non-steroidal anti-inflammatory agents and level 1/2 analgesics.

Issue 7: Controlled trials should be undertaken to compare the treatment of selected locally advanced RCC with or without PRAE

Despite the comments of our colleagues, we conclude that PRAE does not improve the survival of patients with renal cell carcinoma after surgery. Our current knowledge regarding possible benefits of PRAE is based on retrospective studies with only small cohorts of patients with heterogeneous characteristics. Nevertheless, we would like to quote the last sentence of our article [2]: "Further research, in particular prospective randomised clinical trials, is necessary to provide evidence for the pros and cons of this procedure reliably."

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New tools for allergy diagnosis and clinical advice after immediate reactions to ICM

The Editor — Sir,

Immediate adverse reactions to iodinated contrast media (ICM) are common in clinical practice, being classified as toxic (owing to osmolality, viscosity or ionising ability), non-immune hypersensitive (non-specific histamine release) or allergic (Type I or Type IV hypersensitivity) [1]. Traditionally, it has been considered that most immediate ICM reactions are caused by non-immune mechanisms (mainly non-specific histamine release); thus, preventive drug treatment and no further studies are advised. Nevertheless, at least in severe reactions, an allergy work-up could prove useful for the radiologist [2].

A 59-year-old man, an ex-smoker with thrombocytopenia who had never been exposed to ICM, suffered an ischaemic heart attack requiring coronary angiography. At the time of the procedure, he was on acetylsalicylic acid, clopidogrel, atorvastatin, atenolol, enalapril and nitrates. Fifteen minutes after the start of intravenous iodixanol (Visipaque® 320 I mL⁻¹; GE Healthcare Biosciences, Little Chalfont, UK) he complained of feeling hot, chills, faintness, dizziness and generalised rash; angioedema of trunk and limbs and hypotension developed. The procedure was then stopped and the patient fully recovered after volume reposition and administration of antihistamines and corticosteroids. A new coronary angiogram was scheduled 4 days later after a 24 h preventive antihistamine plus corticosteroid treatment, but the reaction happened again. An allergy work-up was therefore decided upon.

Skin-prick tests with all available non-ionic ICM (iobitridol, iodixanol, iohexol, iomeprol, iopamidol, iopromide, ioversol and ioxaglate) at full-strength concentration proved negative. Sequential intradermoreactions with 1:100 and 1:10 dilutions, at a 20 min reading, were strongly positive only for iodixanol 1:100 (*i.e.* 1:10 not performed). With the aim of seeking the theoretically best alternative, and according to Dewachter et al [4], ICM intradermoreactions with full-strength concentration were performed; these tests proved positive for iobitridol, iohexol, iopromide and ioversol. A basophil activation test (BAT) was strongly positive for iodixanol, iohexol and ioversol. As a result, iomeprol and ioxaglate, both with all negative allergy tests, were recommended for future administrations.

In the span of only 1 year, new facts and techniques have challenged our traditional concept of immediate adverse reactions to ICM. Brockow et al [2], in a multicentre European study, performed skin tests at concentrations up to 1:10 in 122 patients with a clinical history of immediate ICM reactions. These tests obtained a sensitivity of 26% (which reached 50% if the tests were performed between 2 and 6 months after the reaction) and a specificity of 96%. Moreover, they observed that almost half the patients (49%) and 43% of those with positive skin tests had never been exposed to ICM. Recently, Dewachter et al [4] performed ICM intradermoreactions at full-strength concentration (1:1) in 38 patients with immediate ICM reaction and obtained even higher sensitivity (73%). The argument that these positive intradermoreactions could correspond to irritating responses was counterbalanced by the fact that

only 9 out of the 188 full-strength intradermoreactions performed with alternative ICM proved positive. These authors confirmed that 30% of the reactions occurred in the first exposure to an ICM and suggested that cross-reactivity among ICM could be less than expected (approximately 7%), as measured by positive skin tests. Finally, the first positive BAT to an ICM has recently been published [5].

Radiologists should be aware that allergic immediate reactions to ICM can be more common than previously thought and can occur in the first administration. Skin tests up to 1:10 dilution are useful to establish the diagnosis, whereas skin tests at full-strength concentrations can aid the radiologist in the choice of an alternative ICM. BAT also appears to be a valuable tool in the diagnosis of immediate ICM allergy.

Yours etc.,

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Erratum

Re. Corbett RH. Correspondence, Inaccuracy in geographic terms. *Br J Radiol* 2010;83:541.

“The letter from RH Corbett in the June edition of *BJR* (*Br J Radiol* 2010;83:541) should have been accompanied by the following Editorial response, which was unfortunately omitted: *Dr Corbett’s point is well made. This was primarily an Editorial (rather than a refereeing) oversight and we will heed his comments - Ed*”.