BÖLÜM 34

BESİN ALERJİLERİNDE DESENSİTİZASYON

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GİRİŞ

Besin alerjisi herhangi bir besine karşı IgE aracılı veya non-IgE aracılı immünolojik mekanizmalarla gelişen bir ters reaksiyon olarak tanımlanmaktadır. Önemli morbidite ve bazen de hayatı tehdit edici anafilaksi ile sonuçlanabilmektedir (1). Besin alerjisi, özellikle son 30 yılda artan sıklığı nedeniyle toplum sağlığını etkileyen önemli bir durum haline gelmiştir (2). Besin alerjisinin klinik yönetimi gelişen akut reaksiyonların tedavisi şeklinde kısa vadeli müdahalelerden ve yeni reaksiyonların önlenmesine yönelik risk azaltıcı yaklaşımlardan oluşmaktadır (1).

Besin alerjisinde temel ve en eski yaklaşım sorumlu besinle temastan kaçınmaktır. Hasta ve ailesine/bakım verenlere sorumlu besinin hangi formlarda bulunabileceği konusunda bilgilendirme yapılmalı; etiket okuma, dış ortamda yenecek besinlerin alerjen içeriğini sorgulama davranışları kazandırılmalıdır. Tüm önlemlere rağmen gelişebilecek sistemik alerjik reaksiyonlar sırasında yapılması gerekenler ve epinefrin oto-enjektör kullanımı da hasta ve yakınlarına öğretilmelidir (1, 2).

Erken çocuklukta sık görülen IgE aracılı besin alerjileri olan inek sütü, yumurta, buğday, soya alerjilerinde yaşla birlikte tolerans gelişimi beklenmektedir (3). İnek sütü alerjisi olan bebeklerin %85'i en geç üç yaşında tolerans geliştirmektedir. Yumurta alerjisi daha uzun süre devam etmekte, buna rağmen 6 yaşta vakaların %65'i yumurta tüketebilir hale gelmektedir. Son yıllarda inek sütü ve yumurta alerjilerinin daha uzun sürme eğiliminde olduğu ve vakaların yaklaşık 1/3'ünde 12-16 yaşlarında alerjinin devam ettiği öne sürülmektedir (4). Yer fıstığı, ağaç kabuklu yemişleri, kabuklu deniz ürünleri ve balık alerjileri genellikle geç çocuklukta başlamakta ve erişkinlikte de devam etmektedir (3, 5).

IgE-aracılı besin alerjileri ağır/ ölümcül reaksiyon riski ile ilişkili olduğu için besinden kaçınma hayati önem taşımaktadır. Fakat hem temel be-

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kullanıldığında yan etkilerin azaldığı ve daha kolay bir immünoterapi süreci geçirildiği bildirilmiştir. Omalizumab kesildikten sonra da süt alımı devam ettiğinde desensitizasyon devam etmiştir (24). Süt ile OİT'e randomize plasebo kontrollü omalizumab eklenmesi sonucunda ise omalizumab ile daha hızlı ve daha güvenli desensitizasyon sağlandığı fakat anlamlı bir etkinlik farkı olmadığı görülmüştür (25). Benzer şekilde yer fıstığı ile yapılan randomize kontrollü bir çalışmada omalizumab grubunda OİT ile çok daha hızlı bir desensitizasyon sağlanabilmiştir (58). Çoklu gıda alerjisi olan hastalarda da omalizumab çoklu gıda OİT etkinliğini artırmış ve güvenli ve hızlı bir desensitizasyon sağlamıştır (27). Fakat hala biyolojik ajanların ne kadar süre kullanılacağı ve etkinlik üzerine olan etkileri konusunda cevaplanması gereken pekçok soru bulunduğundan, bu konudaki çalışmalar devam etmektedir.

SONUÇ

Besin alerjileri, son otuz yılda artan sıklığı ile üzerinde daha çok durulan ve çözüm aranan bir konu haline gelmiştir. Alerjen immünoterapi besinden kaçınma dışında kalıcı bir çözüm sunduğu için hasta ve yakınlarına çok şey vaad etmektedir. Büyük olasılıkla alerjen immünoterapi ve yardımcı tedaviler olarak biyolojik ajanların kullanımı bundan sonra daha da yaygınlaşacak ve önümüzdeki yıllarda rutin uygulamada yerini alacaktır.

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