Desensitization Units. A Current Need in Intermediate Care

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EDITORIAL

The prevalence of allergic diseases increases worldwide, in both developed and developing countries. Since the Industrial Revolution its increase is progressive, with hypotheses suggesting a connection between hygienic patterns and reduced exposure to microbial substances during childhood. Nowadays, a global level 30-40% of the population is affected by one or more allergic diseases, being young subjects a high percentage of this increase; so, when this young population reaches adulthood, it is expected to further burden the allergic diseases. Allergic problems are therefore expected to continue increasing as air pollution and global warming. Despite the epidemiological data shown, services for patients with allergic diseases are scattered and far from ideal [1].

Desensitization is defined as the procedure by which an allergic patient is given doses created from said allergen for the purpose of temporarily allowing its administration and good tolerance. Desensitization makes it possible to induce the patient a provisional state of tolerance to what causes the allergic reaction. The diluted amounts of the allergen are increased to obtain the target. Desensitization does not mean that the patient stops being allergic, but that it “deceives” the immune system so that a reaction is not triggered.

If we refer to the hypersensitivity of a drug, the user has a private treatment and there is no effective alternative treatment. The most frequent cases are related to antibiotics and chemotherapy drugs [on all platines and taxanes]. Desensitization is performed when there is no adequate alternative to the initial pharmacological treatment, allowing the maintenance of first-line treatment, being the most appropriate for its pathology besides the most effective and not having to appeal to other alternatives. Talking about food hyper sensitization, avoidance and use of antihistamines or epinephrine has been the standard of care for patients with food allergies. Together with the recent advances in epicutaneous, sublingual and oral immunotherapy, generating desensitization units can be a key point in changing therapeutic management. Undoubtedly, these alternatives have significant socioeconomic effects on patients and their families.

Performing desensitization is complex, requires the coordination of many people and services. The increase in allergenic prevalence in recent years and the scarcity of resources - human and material - should lead to the creation and organization of intermediate care units. The therapeutic approach should be interdisciplinary with all the professionals involved: oncologists, allergists, pharmacists, schedule management and nursing staff as key point.

Desensitization is a procedure that involves some risk. Therefore, it is usually performed in Intensive Care Units, in order to reduce the risk of anaphylaxis and the severity of the reaction, if it happens. Nowadays, the Intermediate Care Units establish forms of care assistance to potentially critical patients that allow increasing the capacity of care of the center without affecting the overall mortality of care. Medical care improves efficacy and efficiency, thus reducing conventional hospitalization rooms need, costs and overall mortality [2,3].

Intermediate Care Units are designed for patients who are at risk of needing life-sustaining therapeutic measures, but require more vigilance and nursing care than can be received in conventional hospitalization [2]. That is just what desensitization needs.

Highlighting the results of the study by Sloane et al. [4], where is demonstrated that desensitization was clearly cost-effective and safe for patients allergic to chemotherapy and monoclonal antibodies; And so it is cost effective and safe for patients with cancer and chronic disease for first line therapy. It should be noted that slower protocols tend to be more effective than urgent protocols. Oral desensitization represents a promising goal for reducing the burden of disease caused by food allergy [1].

Finally, we cannot forget the safety of the user. Therefore, intermediate care units led by nursing should be the point of reference for desensitization. All this opens new lines of research, as published success rates change depending on the clinical manifestations, the drugs and the protocols applied, having as limitation the high probability of non-publication in the unsuccessful procedures.

REFERENCES


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