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Reply

To the Editor:

Retterer et al[1] note that their patient reacted to zoster vaccine, and then was primarily found to be sensitized to gelatin 3 years later, without alpha-gal–specific IgE. In their assessment, the best explanation is that the gelatin-specific IgE is more likely the culprit in the previous reaction to zoster vaccine than alpha-gal–specific IgE. They suggest for this specific patient that tick bites inoculate other antigens such as gelatin that could potentially sensitize the patient.[2] Alternatively, we suggest that before the availability of alpha-gal–specific IgE testing the patient may have had positive specific IgE to alpha-gal (and gelatin and beef), but the circulating alpha-gal–specific IgE antibody concentrations diminished over time, as is frequently observed in our clinics when patients successfully avoid further tick bites and red meat.[3]

Although the quantitative alpha-gal content of various meats clearly varies and contributes to reactions,[4] an important clinical observation suggested by the report of Mullins et al[5] is that

patients who have alpha-gal allergy can often have reactions that are context specific. Some patients report reactions only to beef, whereas others react only to pork.[5] We have performed a 2-step challenge/administration of zoster vaccine in an alpha-gal–allergic patient avoidant of mammalian meat with declining alpha-gal–specific IgE (sIgE alpha-gal of 23.10 kU/mL, negative gelatin sIgE) and observed no symptoms, similar to what was done by Pinson and Waibel.[6] In addition, we are aware of 4 more patients among our alpha-gal patients who have received zoster vaccine uneventfully despite an existing diagnosis of alpha-gal allergy demonstrated by positive sIgE to alpha-gal and appropriate clinical history. This provides additional support that not all alpha-gal–allergic patients will react to zoster vaccine.

There are a large number of clinical questions that challenge the management of alpha-gal allergy. What are the incidence and prevalence of alpha-gal in the US population? Why do some patients react to alpha-gal in one context but not another? How long does alpha-gal allergy typically last? Should patients who can tolerate alpha-gal in some contexts continue to consume it? Can we *a priori* identify individuals who are unsafe to receive certain vaccinations? We would suggest that researchers and clinicians would benefit from a multisite, collaborative, cohort study of alpha-gal allergy, with the multifold goal of determining how antigenic specificity varies between patients at the time of diagnosis and following how reactivity, specific IgE antibody concentrations, and antibody specificity change within patients naturally over time, as well as with ongoing exposure versus avoidance and with unexpected antigenic challenges.

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