



NEUKIRCHEN SPECIALTY CLINIC

ACUTE CLINIC FOR THE TREATMENT OF ALLERGIES, SKIN AND ENVIRONMENTAL DISEASES
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Our reference:
LR/vo

Your correspondence from

Your reference

Date

04 August, 2003

Discharge Summary (please forward to the treating physician)

Patient: Bernadette Horvath, born January 10, 1996
Residence: Tegzes Street 39, H-1221 Budapest, Hungary
Insured: Andrea Kovacs
Member/insurance number: ----- (private)

Dear esteemed colleague,

We wish to report on your above mentioned patient, who was an inpatient at our institution from **June 16, 2003** to **July 9, 2003**.

Diagnoses:

- 1. Exacerbation of atopic dermatitis, complicated by a massive bacterial superinfection**
- 2. Sensitization to foods due to IgG4 antibodies**
- 3. Impairment of the intestinal flora from Candida hypercolonization**

Family history:

From the family history, we learned that the patient's father had an atopic diathesis present since childhood in the form of eczema in the folds of the skin at the joints. We also learned that two other siblings also suffer from eczema, but that they do not have the same characteristics as in our patient.

Patient history:

The first eczematous skin changes started at the age of 3 months. The skin changes began presumably with stomatitis, which was treated with an antimycotic. Initially the upper thigh and the upper arm were affected.

From the age of two the disease started spreading, during which the intensity and appearance of the efflorescence also increased. After living near the Dead Sea for four years, there were apparently no symptoms for two years. A brief course of steroids was unsuccessful. Since then, treatment with ointments and creams was continued.

We are assuming that the previous patient history is as known.

Findings on admission:

We examined a 6½-year-old well-nourished female child in somewhat compromised general condition, because of the severity of the eczema. The pediatric examination showed palpable, indolent, and mobile laterocervical, submandibular, and inguinal dermatopathic lymphadenopathies but was otherwise normal

Skin:

Upon admission, extensive eczema was found which involved the neck, parts of the shoulder, axillae, upper arms, elbows, lower extremities, especially the backs of the knees, the genital regions, the groins and the buttocks.

In these locations there were ill-defined patches with partially raised, weeping edematically infiltrated erythemas, partially forming crusts, inflamed, swollen and red from the bacterial infection. In the affected areas fine scaly patches were also noticeable.

Laboratory:

The admission laboratory results were as follows:

Hematology:

BSG, erythrocytes, hemoglobin, hematocrit, MCV, MCH, MCHC, leucocytes, thrombocytes, MTV, RDW within normal range.

Differential:

Granulocytes, lymphocytes, monocytes, erythrocyte morphology, basophils within normal range.

Eosinophils: 6% (RW: 2-4%)

Chemistry:

Blood sugar, GOT, GPT, gamma-GT, potassium, sodium, calcium, magnesium, iron, phosphorus, total bilirubin, triglycerides, cholesterol, urea, uric acid, creatinine, alkaline phosphatase within normal range.

Cortisol (serum), ACTH within normal range.

Total protein and serum electrophoresis:

Total protein, albumin, α -1 globulin, α -2 globulin, β -globulin, γ -globulin: normal.

Serology:

Rheumatoid factor: < 8.94 IU/mL (RW: < 14.0 IU/mL)

Waalser-Rose test: CRP (quantitative), anti-Streptoc. titer, anti-Staphyl. titer, anti-Streptoc. titer within normal range

Anti-Streptoc.-Dnase B: 299 E/mL (RW: < 75 IE/mL)

Gluten-IgE, antibodies for tissue transglutaminase –IgA within normal range.

Gluten-IgG (EIA): 27.4 U/mL (RW: < 11.0 U/mL negative, 11.0-17.0 U/mL, borderline, > 17.0 U/mL positive)

Total IgE: 62 U/mL (value within normal range)

Specific IgE antibodies:

RAST class 0:

Grasses (early), grasses (late), trees (early), trees (late), latex, animal epithelium, bird feathers, house dust, Candida albicans, baker's yeast, nut mixtures, alpha-lactalbumin, casein, pork, tomatoes, codfish, trout, beef, duck, bananas, carrots, potatoes, green apples, poultry, millet, wheat flour, rye flour, barley flour, corn, rice, buckwheat flour, formaldehyde, isocyanate MDI, pyrethrine, PCP pentachlorophenol

RAST class 1:

Mugwort, mildew, beta-lactalbumin, oat flour

RAST class 2:

Soybeans, egg whites (chicken), celery

IgG4 food allergies:

Class 0:

Celery, carrots, soybeans, tomatoes, apples, bananas, peaches, potatoes, rye flour, mustard seeds, garlic, vegetables (peas, green beans, parsley, spinach, fennel, onions), nuts (peanuts, hazelnuts, walnuts, Brazil nuts, almonds, sesame seeds), fruits (melons, oranges, grapes, cherries, strawberries, lemons), spices (paprika, caraway, pepper, dill, vanilla, cinnamon), fish (codfish, crabs, mussels, tuna fish, salmon), meat (beef, pork, poultry, lamb, turkey), grains 1 (gluten-free: corn, rice, millet, buckwheat flour, amaranth), eggs (egg white, egg yolk)

Class 1:

Wheat flour

Class 3:

Kiwi fruit, grains 2 (containing gluten: spelt, kamut, malted barley, oats, Triticale)

Class 4:

Casein, milks (alpha lactoglobulin (from cows), beta lactoglobulin, (from cows), milk from goats, sheep, or mares)

IgG grain screen (containing gluten)

Class 0:

Malted barley flour, oat flour

Class 1:

Spelt, kamut

Class 2:

Triticale

Urinalysis:

Normal.

Bacteriology:

Gluteal fold, genitals, groin, elbows, axillae, neck, backs of the knees: massive Candida albicans

Mycology:

Gluteal fold, genitals, groin, elbows, axillae, neck, backs of the knees: Candida albicans negative

Stool: massive Candida albicans

Stool:

The microbiological and mycological examination of the stool showed a slight decrease in the amount of Enterococcus sp. and Bifidobacterium sp. with a normal pH of 6.0. **Parasites:** undetectable. **Local immune status:** Fecal IgA: 0.51 mg/g (reference value: > 0.7 mg/g).

Impression/Treatment/Hospital Course:

Bernadette has been diagnosed with a chronic stationary form of atopic dermatitis, which at the time of admission was massively superinfected with bacteria. Reactive laterocervical, submandibular, and inguinal lymphadenopathy was observed in the massive bacterial hyperinfection of the skin.

Eosinophilia is detected in the differential hematology and chemistry values were normal.

Immunological studies show increased Streptococcus Dnase-B titer as a possible epiphenomenon of a previous streptococcal infection.

The total IgE value has risen discretely, and in testing of specific IgE antibodies only slight sensitizations of mugwort, mildew, beta-lactoglobulin, and oat flour were apparent. Slightly raised levels of sensitivity were noticed in RAST class 2 for soya, poultry egg whites, and celery. Type I sensitization conveyed by these IgE antibodies – according to Coombs and Gell – would be confirmed by immediate-type reactions produced by inhalation and foodstuff allergens.

Because of the small number of immediate-type sensitivity reactions, we decided to perform an IgG4 test for foodstuffs, which can be reproduced by delayed-type reactions. These tests can show slight sensitivities to Class 1 against wheat flour, spelt, and kamut as well as Class 2 Triticale. Unequivocal sensitivities (Class 3) are noticeable to kiwi and gluten-containing grains (spelt, kamut, barley, oat, Triticale), as well as casein, and milks (Class 4).

The high sensitivities against casein show that not only cow milk but other types of casein-containing milks are problematic.

The smear tests performed show a massive bacterial hyperinfection by *Staphylococcus aureus* and an increase in *Candida albicans* in the stool.

The stool examinations performed show – by decreased colonization resistance – that the intestinal flora have been impaired. This constellation of intestinal flora currently shows proof of a compromised immune system in the intestines (decrease in faecal IgA).

External therapy:

To alleviate skin inflammation, we treated the patient alternatively with soft zinc paste and preparations of ointments.

Later,, we continued the topical treatment with antibiotic externa.

Nitroxolin-containing externa was used for focal sanitation, from the results of repeated smear tests identifying the germs from all hyperinfected places and subsequent resistance analyses (an antibiotic sensitivity test in which 25 antibiotics in all are tested).

The necessity for sanitization is shown in the scientifically documented aggressive nature of *Staphylococcus aureus* and the danger that this organism, as a so-called superantigen, can play an important role in the maintenance and promotion of pathological and immunological events in the human system.

The intertriginosal regions were treated with Clotrimazol in various formulations.

After concluding sanitization, we started antiphlogistic local therapy with Ichthyol 5% in Pasta Zinci mollis. The regions around the eyes were treated with Bepanthen eye ointment.

After improvement in the eczema, purely remedial ointments were tested and used. Topical treatment was characterized by its intensity, and was carried out in a 6 to 8-hour cycle day and night under the constant supervision of a physician.

The ointment that was applied was covered with protective bandages.

Medical partial and complete baths were ordered as part of her care.

Internal therapy:

We treated the patient with Zinkorotat 40 and Glandol, which are metabolism-compensative and antioxidative.

For sanitization of the intestinal flora, we used Nystaderm suspension in the usual dosage.

To support the physiological flora by the biological production of healthy strains of lactic acid-producing bacteria, we introduced Symbioflor 1 and Ceve-Lacto active. We also introduced Synerga for immunomodulation.

To relieve the immune system, the patient was put on a special hypoallergenic and additive-free diet containing various grains, vegetables, fruits, meats, and oils. Open provocation tests were performed in order to discover intolerances to foodstuffs and allergies.

Progress and final results:

Due to the diet offered, treatment, and care given, the eczematic skin changes had markedly improved by the time the patient was discharged.

It is very important that, the prescribed diet, treatment, and care measures are also to be strictly complied with in the period following hospital treatment

We are happy to perform monitoring and all necessary therapeutic modifications to stabilize the patient's condition in our clinic and also on an in-patient basis. Follow up visits can be scheduled at our clinic by calling us at tel.09947/28107.

Should the condition of the skin markedly worsen, against our expectations and should clinical services be too distant for further medical care, then in-patient treatment is preferable.

Plans for further treatment and monitoring in the period after hospitalization will be arranged with the mother on the day of discharge.

Discharge medication (external):

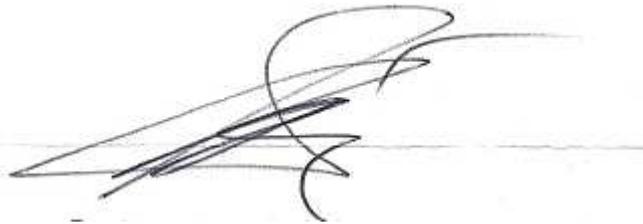
- Efflorescence: Ichthyol 5% in Pasta Zinci Mollis (ca. 10-14 days)
- Genital and axillary regions: Clotrimazol 1% in Unguentum emulsificans aquosum (ca. 2-3 weeks)
- Treatment of the ocular regions: Bepanthen eye ointment
- Skin care: Glycerin 5% in Unguentum emulsificans aquosum

Discharge medication (internal):

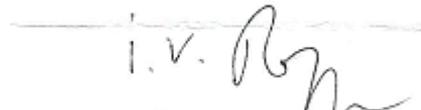
- Nystaderm: 4x ½ tablet or Nystaderm suspension 4x1 mL (ca. 10 days)
- Ceve-Lacto active: 1x1 capsule (2 months)
- Synerga: 1x1 tablet (2 - 3 months)

After two months a stool flora test should be done. Because of the high Streptococcus Dnase-B titer, we recommend that monitoring be done in 3 months.

Yours truly,



Dr. Med./Inst. for Medicine and
Pharmacy Klausenberg,
L. Ressler-Antal,
Medical Director, Specialty Clinic



Dr. med. S. Hauelsen
Specialist in Dermatology,
Chief Physician,
Neukirchen

We ask for your understanding that in the prescribing of pharmaceutical agents we are mainly limited to the formulary used in our clinic. We have informed the mother of your patient that the future treating physician can prescribe another medication using his or her own discretion which has the same effect without breaching the mutual trust between the treating physicians.