Hypersensitivity reaction with intravenous GnRH after pulsatile subcutaneous GnRH treatment in male hypogonadotrophic hypogonadism

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Summary: Chronic pulsatile subcutaneous administration of low doses of gonadotrophin releasing hormone (GnRH) is an effective therapy for men with hypogonadotrophic hypogonadism. Hypersensitivity reactions to GnRH are rare.

We wish to report hypersensitivity reactions with intravenous GnRH after low dose pulsatile GnRH treatment in two men with hypogonadotrophic hypogonadism due to suprasellar disease.

Introduction

Hoffman & Crowley found that low dose pulsatile gonadotrophin releasing hormone (GnRH) administered at a frequency similar to the frequency of luteinizing hormone (LH) pulsations in normal men could normalize both pituitary and gonadal function and initiate early pubertal changes in men with idiopathic hypogonadotrophic hypogonadism over a 3 month period. Since that time numerous studies have confirmed these results.

Another subgroup of the hypogonadotrophic category, acquired GnRH deficiency due to suprasellar disease, can also benefit from pulsatile GnRH therapy. A hypersensitivity reaction to GnRH is rare and requires discontinuation of therapy. It is reported as a wheal and flare reaction resembling an urticarial allergic reaction at multiple old injection sites.

We wish to report two reactions with GnRH, one being life-threatening.

Case reports

Case 1

At the age of 13 this male patient was treated with cranial surgery for craniopharyngioma. After surgery the patient was hypopituitary and was treated with deamino arginine vasopressin (DDAVP), hydrocortisone and thyroxine. At the age of 16 our patient still had hypogonadotrophic hypogonadism and there was no increase in circulating levels of either LH or follicle stimulating hormone (FSH) in response to releasing hormone (RH) (Relefact LHRH Hoechst, 100 µg intravenous bolus). At that time on examination we found that one testis had descended while the other was retractile and both were of prepubertal size. Since our patient primarily had suprasellar disease and did not have surgery within the fossa, we put him on a trial with pulsatile subcutaneous (s.c.) GnRH treatment with 5.0 10.0 and 2.5 µg/pulse/90 min. He initially responded with a rise in gonadotrophins, i.e. LH rose from mean 2.8 IU/l to 14.0 IU/l and FSH from 2.2 IU/l to 6.6 IU/l (normal values for LH = 4.9-8.9 IU/l; FSH = 3.1-6.2 IU/l), although testicular function could not be stimulated. Soon a progressive decline in LH and FSH levels occurred. The further lack of response was due either to the development of gonadotrophin deficiency or formation of antibodies. It persisted when the dose of LHRR was lowered and so the desensitization phenomenon was excluded as the cause of failure. Treatment with pulsatile GnRH was discontinued and then an acute 100 µg intravenous (i.v.) GnRH test was performed. Within minutes after administration he suffered bronchospasm and vascular collapse. He recovered upon repeated doses of 0.3 ml 1:1000 adrenaline

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s.c., antihistamines, corticosteroids and amino-
phyline. There were no signs of hypersensitivity
to GnRH at the site of needle puncture on the
abdominal wall during pulsatile s.c. treatment.
The only complaint was that during the last 20
days of pulsatile GnRH treatment he had
generalized pruritus on his arms and legs without
urticaria or erythema.

Skin prick testing with 1:1000 dilution of GnRH
gave no reaction. Testing with 1:100 and 1:10
dilutions of GnRH gave a positive local reaction
(papule, erythema, pruritus) and at this stage
testing was stopped. Negative control was
performed with saline. The same testing procedure
was performed on another patient who was treated by
pulsatile GnRH and none of the dilutions yielded
a positive result, even when given intradermally.

It was concluded that the reaction was most
likely anaphylactic since minute doses gave a
positive result.

Case 2

A 20 year old man was found to have a suprasellar
disease and to be hypopituitary. Acute 100 µg i.v.
bolus GnRH test (Relrefact LHRH Hoechst) was
performed and a low gonadotrophin response was
noted. A trial with pulsatile s.c. GnRH was started
(5 µg/pulse/90 min) during which he did not
complain of any hypersensitivity reaction. He had a
good gonadotrophin response (LH rise from mean
1.41 IU/l to 15.01 IU/l and FSH from mean 1.41 IU/l
to 4.71 IU/l), but testosterone levels remained low.

Treatment with pulsatile GnRH was discontinued
and an acute GnRH 100 µg i.v. test was performed.
During the GnRH i.v. bolus the patient complained of
malaise and pruritus localized to the abdomen
where GnRH had been previously applied subcutaneously. He also noted a swelling and
redness of the skin around the needle marks, which
resembled urticaria.

Skin testing to GnRH was done in a similar
fashion as stated above. Skin prick testing with
1:100, 1:100 and 1:10 dilutions of GnRH gave no
reaction nor did intradermal testing with a 1:1000
dilution. Intradermal testing with 1:100 and 1:10
dilutions of GnRH gave positive local reactions.
Undiluted GnRH applied intradermally also gave
positive local reaction. As it was not certain whether
these reactions were due to irritation of the skin,
0.5 ml of undiluted GnRH was given intravenously.

Shortly after, the patient complained of malaise
and a sensation of warmth in the head. There was
no drop in blood pressure or change in pulse rate.

It was concluded that the patient was allergic to
GnRH. We have reason to believe that this adverse
reaction is dose-dependent as he had previously
tolerated small doses when applied s.c.

Discussion

These serious reactions raise the problem of
hypersensitivity to GnRH when minor or even no
complaints exist during low dose s.c. GnRH
administration, and of the safety of further
standard i.v. GnRH testing. We suggest that prior
to bolus i.v. application of GnRH after long term
treatment with GnRH immunological testing is
always necessary.

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