

symptoms were controlled with antihistamines.

The abnormal laboratory values in HAE are normal in variant and new-variant angioedema, namely C4, C2, C1 INH level and functional activity. Our patients with new-variant HAE are unlikely to have AAE because of the lack of a typical underlying disorder and normal laboratory findings, including C1q.

Four forms of angioedema have been discussed and the clinical presentation is similar in all forms but the underlying cause, laboratory findings, and treatment varies. This report describes a unique familial type of angioedema that we term new-variant angioedema.

*VA Greater LA Healthcare System
11301 Wilshire Blvd
111R Los Angeles
CA 90073, USA
Tel: (310) 268-3011
E-mail: william.klaustermeyer@med.va.gov

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Occupational protein contact dermatitis due to melon

S. García, M. Lombardero*, E. Serra-Baldrich, P. Amat, M. Lluch-Pérez, A. Malet

Key words: melon; occupational; protein contact dermatitis.

Melon or *Cucumis melon* (1) belongs to the Cucurbitaceae family. The fruit grows on a trailing ground vine with shrubby branches with a growth cycle of between 3 and 5 months in warm climates with dry summers.

Colour of the fruit varies broadly depending on the type of melon: Spanish melons are more of a darker green, Charentais melons are lighter green or greyish, Galia melons have yellow skins whilst the brown ones are heavily lined, and the Cantaloupe is basically yellow.

Cases of allergy to melon have been described as oral allergy syndrome and even with respiratory disorders and hypotension (2). There has also been a report of a case of protein contact dermatitis in relation to different types of fruit (apples, oranges, pears and peaches), potatoes, garlic and onions in addition to melon and accompanied with symptoms of oral allergy and not only with dermatitis (3).

We describe the case of a 29-year-old woman complaining of dermatitis on her hands. She had suffered for 3 months on coming into contact with some varieties of melon. Apart from dermatitis, no other clinical symptoms were evident and the patient was able to tolerate ingestion.

Skin prick tests of the skin and pulp of the five varieties of melon were positive: Galia melon: skin 10 × 5 mm, pulp 4 × 3 mm; Cantaloupe melon: skin 23 × 20 mm, pulp 3 × 4 mm; Blood red melon: skin 17 × 11 mm, pulp 9 × 5 mm; Spanish melon: skin 11 × 7 mm, pulp 10 × 6 mm; Comelo melon: skin 16 × 17 mm, pulp 4 × 3 mm (histamine 3 × 3 mm).

No allergies to pollen or to other types of fruit were detected.

Positive tests were also reported for skin tests to curry and to cynodon (4, 5). Tests were negative to vegetables, fruit, legumes, nuts and other spices (all performed using commercially produced extracts). Tests carried out for pneumoallergens (dust mites, fungi, dog and cat dander as well as pollen including grasses and birch) were also negative, as were tests for latex allergy.

Total IgE serum was reported as 250 kU/l and specific IgE was detected in the patient's blood for all the varieties of melon with a class 2 (CAP-system) result.

In the immunoblot test performed, two bands were detected one with a molecular weight of approximately 14 kDa and the other 32 kDa.

Epicutaneous testing was also performed. The standard series were positive to nickel sulphate (of no clinical relevance) and the series for plants included lactone and primula, which were negative.

Occupational contact hypersensitivity to melon is therefore evident, with a skin disorder being the only clinical symptoms. No allergies to pollen or to other types of fruit were detected.

The authors found no previous reports of any patient suffering from the same selective symptoms on contact with melon on skin in the bibliography.

*ALERGO CENTRE
Barcelona
Spain
ALK ABELLO
Madrid
Spain
E-mail: amalet1@hotmail.com

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Olive allergy

J. Azofra*

Key words: allergy; olive.

Rhinitis, in conjunction with conjunctivitis and asthma, all caused by olive pollen allergy, is a well-known disease in the Mediterranean area. Adverse cuta-

neous reactions to topically applied olive oil or olive wood – contact dermatitis – have seldom been reported (1, 2). However, and in spite of its extensive consumption, I am not aware of any description of food allergy to olive or olive oil. I report a case of immunoglobulin E (IgE)-mediated food allergy to olive ingestion.

The patient was a 19-year-old woman, who had a 4 years long history of episodes of facial, neck, and hands angioedema, and intense palms itch. In one of the episodes the angioedema affected the tongue too, and the itch was generalized. The symptoms abated in 24 h. On each occasion the patient had ingested olives 15–30 min beforehand. There was no relation with exercise. She tolerated olive oil, and had not rhinitis/asthma during the pollen season.

Prick-by-prick tests with three different olive brands, gave a positive result (9 × 7 mm.). Five control subjects showed a negative skin test. A prick test with *Olea europaea* was negative. The IgE antibody levels specific to olive was 1.7 kU/l, and 0.73 kU/l to *O. europaea* (CAP System; Pharmacia, Barcelona, Spain).

A case report of an IgE-mediated olive allergy.

The number of foods who have been described as etiologic agents in allergy, is very high, and evergrowing. However, and to the best of my knowledge this is the first report of olive allergy. It is noteworthy the absence of published cases, given the high consumption, at least in the Mediterranean area.

Clinical symptoms, as well as the positive skin test, and the detection of specific IgE, all point towards an IgE-mediated food allergy.

*Unidad de Alergia
Hospital Central de Asturias
Dr Bellmunt s/n. 33006 Oviedo
Spain
E-mail: alergis@hca.es

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