

Correspondence

Is immigration a prognostic factor for oral allergy syndrome in patients with birch pollen hypersensitivity?

To the Editor:

We have read the article titled, "Detection of prognostic factors for oral allergy syndrome in patients with birch pollen hypersensitivity" (Asero et al. *J Allergy Clin Immunol* 1996;97:611-6) with great interest. Birch pollen-related food hypersensitivity is not only a medical problem for the native population of middle and northern Europe but also an interesting health problem for foreigners who go there to work or settle.^{1,2} We have previously named this condition, seen among the immigrants from the Mediterranean, Middle East, African and South American regions, who do not usually have allergic problems related to birch pollen, *para-occupational syndrome*.³

Actually, immigrants can be considered as an appropriate, and although not fully determined yet, a "low or high risk" group for the investigation of this type of allergic diseases. The allergic survey performed among the immigrants living in Sweden showed that the prick test and/or RAST positivity to birch was 16% in the persons who had been there approximately 2.5 years and increased to 53% in those who had been living there for more than 10.5 years.¹ Twenty-one (40.4%) of the 52 birch-sensitive immigrants who had asthma, rhinoconjunctivitis, eczema, and urticaria were allergic to only birch pollen; and 19 (36.5%) had oral allergy syndrome. Among these 52 patients, 23 were female and 29 were male. The mean age was 34.2 ± 8.8 years (minimum, 16 years; maximum, 53 years), and the mean residence time in Sweden was 10.2 ± 6 years (minimum, 1 year; maximum 29 years) (unpublished data). I think that immigration is also an important issue, which should be surveyed, among the prognostic factors for birch pollen allergy and related food hypersensitivity.

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Concurrent sensitization to natural rubber latex and human seminal fluid

To the Editor:

In recent years IgE sensitivity to latex has been reported.¹ A less frequent problem is IgE sensitivity to human semen.^{2,3} We are unaware that both of these sensitivities have been reported in a single individual. We wish to report a woman who demonstrated IgE antibody to both latex antigens and human semen.

A 29-year-old health care worker was referred to us for treatment of recurrent urticaria and angioedema in 1992. She had experienced episodic generalized hives since age 12. At age 26, she had hives after taking penicillin by mouth. During her episodes of hives she would experience angioedema of the eyelids and lips on occasion, but no intraoral angioedema. Since 1990, she thought that she was allergic to latex. She had to use powdered gloves and would have urticaria over the hands and face and angioedema of the hands. When her husband used latex condoms, she would experience vulvar angioedema. For at least 5 years, she had noted that semen caused contact urticaria and vulvar angioedema. She described episodes of a pinprick sensation in her larynx and development of a high, squeaky voice (as if she had inhaled helium), stridor, dyspnea, and cough. The length of these episodes was 15 minutes. She suspected apples, walnuts, and kiwi fruit as causes. However, she stated that she tolerated bananas, avocados, melons, celery, and tomato. The patient was instructed in the use of an Epi-Pen (Center Lab, Port Washington, N.Y.) and told to wear a Medic-Alert bracelet stating "allergy to latex." She was advised to avoid the suspected foods and latex condoms and to use only vinyl gloves for her health care work.

A solid-phase latex allergen prepared from latex gloves was used to test serum from the patient and pooled sera from seven latex-sensitive subjects for latex-specific IgE antibodies. The patient's serum and the pooled sera of four women sensitive to human semen were tested for IgE antibodies to a semi-purified fraction of pooled human semen (fraction IV).^{2,3} The patient's total IgE was 25 IU/ml. The C1 esterase inhibitor level was normal. Results of skin prick tests with celery, apple, melon, potato, and filbert nut were negative. Results of specific allergen tests with hazelnut, black walnut, wheat, English walnut, peanut, pecan, Brazil nut, banana, kiwi, and penicillin were negative, as determined by RAST. Serum IgE antibodies to seminal fluid fraction IV were demonstrated at 269% of normal control. Serum IgE antibodies to latex rubber glove extract were positive at

519% of negative control. Normal for both of these values is less than 250% of negative control.

Four months later, after careful avoidance of semen and latex, the patient's IgE antibodies to seminal fluid fraction IV had decreased to 217%, and her IgE antibodies to latex extract had decreased to 296% of negative control. At this time she still experienced vaginal erythema and pruritus from her husband's semen, but these symptoms were less severe.

We report here a case of a woman who produced IgE antibodies to both latex and seminal fluid. We did not find IgE antibodies to suspected food allergens, and we believe the patient's episodes of dysphonia may have been due to inhalation of latex antigen. The patient's careful avoidance of exposure to latex and semen produced a measurable decrease in allergen-specific antibodies after 4 months. The episodes of possible laryngeal edema ceased.

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