

Correspondence

Reply

To the Editor:

Gamboa et al¹ provide a possible explanation as to the clinical phenomenon we reported previously, where some wheat-allergic children tolerate whole-grain wheat cereal biscuit (WWCB) but continue to clinically exhibit allergy to other forms of wheat.² Since publication, we have recorded more patients from our own service and received reports from others who have also observed this pattern in some wheat-allergic children. Tolerance to WWCB therefore appears to be more common than previously assumed.

The current hypothesis proposed by Gamboa et al, that these WWCB-tolerant but otherwise wheat-allergic individuals may be sensitized to Tri a 14, is worthy of further investigation. Unfortunately, there are few details as to the extraction method performed by Gamboa et al. We provided evidence that the proteins responsible for wheat allergy but tolerance to WWCB in our cases were likely to be within the alcohol-soluble but water-insoluble gliadin fraction, with the candidate proteins being of a larger size than Tri a 14 at 9kDa. Unfortunately, Gamboa et al do not comment on whether they were able to successfully extract Tri a 14 from wheat flour; thus, the absence of this protein on the extract obtained from WWCB in their study

may be due to a failure of extraction rather than an absence of the protein in WWCB. Without IgE-immunoblot data, Gamboa et al have not convincingly demonstrated that their 4 cases are due to IgE binding to Tri a 14, which may be subject to destruction during the manufacture of WWCB.

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