

Correspondence

Fatal asthma attack associated with inhalation of nebulized distilled water

To the Editor:

I am writing about the article by Sietta et al. (*J Allergy Clin Immunol* 1995;95:1285-7) concerning fatal asthma attacks associated with inhalation of nebulized distilled water. It was certainly a frightening article.

However, before the distilled water can be implicated as the cause, there are two obvious questions. It was noted that the water was administered through a rubber face mask. Although the patient appears to have no risk factors, this raises the question of latex sensitivity. Was a RAST for latex performed post mortem on the patient's serum? The second issue is whether the water contained preservatives. Sulfite sensitivity has been known to cause severe bronchospasm when sulfites are administered in a therapeutic β -adrenergic agent. It would be helpful if the authors could comment on this.

Joseph T. Marino, MD
Allergy and Pulmonary Medicine
6555 Coyle Ave.
Suite 393
Carmichael, CA 95608
1/8/69888

Fatal asthma during inhalation challenge

To the Editor:

In the article "Fatal asthma attack during an inhalation challenge with ultrasonically nebulized distilled water" (Sietta et al. *J Allergy Clin Immunology* 1995; 95:1285-7), it is mentioned that a 22-year-old with well controlled asthma had a fatal asthma attack after inhaling ultrasonically nebulized distilled water through a rubber face mask during an inhalation challenge. Histologic examination at autopsy confirmed mucus plugging, airway wall edema, and mast cell and eosinophil infiltration of the airways. The triggering event was believed to be a decrease in osmolarity of the airways caused by inhalation of the hypotonic solution. Unfortunately, there is no mention of whether the patient had a history suggestive of latex sensitivity, although the procedure was performed with a "rubber face mask." Immediate hypersensitivity reactions to latex products have been reviewed and may include urticaria, rhinitis, conjunctivitis, bronchospasm, and anaphylaxis.^{1,2} Although mucosal and parenteral routes of exposure pose the greatest hazards, respiratory exposure may also cause reactions.

I would be interested to know whether the patient had a history suggestive of latex sensitivity or whether any serum remains to be tested for IgE antibodies to latex. Latex hypersensitivity should be considered in the dif-

ferential of allergic reactions when rubber products are involved.

Carol G. Baum, MD
Director
Department of Allergy and Clinical Immunology
Northeast Permanente Medical Group
210 Westchester Ave.
White Plains, NY 10604

REFERENCES

1. Slater JE. Latex allergy. *J Allergy Clin Immunol* 1994;94: 139-49.
2. Slater JE. Rubber anaphylaxis. *N Engl J Med* 1989;320: 1126-30.

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Pollen-food allergy syndrome

To the Editor:

Dr. Kelso (*J Allergy Clin Immunol* 1995;96:275) believes that the diagnosis of the oral allergy syndrome (OAS) should be reserved for patients who have "itching of the mouth and throat, and rarely other symptoms, after the ingestion of fruits and vegetables (usually fresh) and sometimes nuts, and who also have pollinosis." It is surely the case, however, that the OAS, like any other syndrome, simply indicates a set of symptoms that occur together. Whatever the most common allergens involved or the rarity of associated symptoms, they can hardly be used to define the syndrome itself.

The description of the OAS consisted of oral irritation, throat tightness, lip swelling, and oral mucosal blebs, which occurred in a group of highly atopic patients who, for the most part (50 of 80 cases), had atopic eczema.¹ Patients seldom described the symptoms unless prompted, but they rapidly learned to avoid the offending foods. In this group of atopic patients, other allergic symptoms were common, but as others have confirmed,² they always occurred later. OAS and vomiting were the most frequent symptoms provoked by shellfish, fish, nuts, and eggs (accounting for 72.5% of reported symptoms with these foods); whereas wheat, milk, fruit, and vegetables were mainly associated with other symptoms and less frequently with OAS and/or vomiting (16% of reported symptoms). There was no evidence to support the view that OAS was an isolated allergic response to foods in the mouth, as Dr. Kelso implies. Indeed, it has been shown that in patients with an OAS response to eggs or milk, these foods are also capable of producing a nasal response, just like pollens or other airborne allergens.³ In brief, OAS describes the oral manifestations of systemic IgE-mediated hypersensitivity.

Although the recognition of oral allergic reactions can be useful for diagnostic purposes, it would surely be confusing to use different names for the same combination of symptoms, depending on the allergen involved or