

work is needed to confirm or refute the hypothesis that "cockroaches and mites share the same beds."

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Cross-sensitization between latex and fruits

To the Editor:

I read with interest the recent article, "Work-related late asthmatic response induced by latex allergy" by Brugnami et al. (*J Allergy Clin Immunol* 1995;96:457-64). They are correct when they discuss cross-reactivity between latex and fruits, but it seems important for the comprehension of clinical findings to demonstrate the reality of an immunologic cross-reactivity. In this way, only evidence of common epitopes (e.g., obtained by inhibition techniques) can support this hypothesis. Without such laboratory data, case reports of cross-reactions may be too subjective or only coincidences. In subject 5, Brugnami et al. described mild episodes of asthma and rhinoconjunctivitis after drinking tropical fruit juice. Did this juice contain banana? This was not precise. It might also contain kiwi or passion fruit, which are frequently associated with latex allergy, but to my knowledge, a cross-antigenicity with these fruits has not yet been established. It must also be stressed that many fruit juices may contain preservatives, such as sulfites, which are known to cause respiratory symptoms in patients with asthma.

Many fruits are clinically involved in association with latex allergy. In addition to banana, avocado pear, and chestnut, several reports have implicated passion fruit, kiwi, papaya, pineapple, orange and other citrus fruit, apple, peach, grapefruit, raspberry, fig, walnut, hazelnut and almond, peanut, watermelon, tomato, celery, and rye flour.

Do these fruits of phylogenetically different families really share common epitopes with latex? This is not clear, and the demonstration of immunologic cross-reactions has only been established for some species, such as banana, avocado, and chestnut.

Our friends from Marseille¹ first described a cross-reactivity with banana, and our Spanish colleagues²

described the association with chestnuts. For avocado pear, we have demonstrated a cross-reactivity by RAST inhibition³ and by immunoblotting inhibition.⁴ These works have been recently confirmed by Ahlroth's publication in this Journal.⁵ For kiwi, a communication by Françoise Andre was presented in the last congress of the European Academy of Allergy and Clinical Immunology in Madrid.⁶ For the other fruits, similar studies must be performed.

On the other hand, we must focus on a better discrimination between cross-antigenicity (immunologic mechanism), cross-sensitization (perhaps demonstrated by skin-testing?), and cross-allergy (clinical data).

In conclusion, until an immunologically confirmed cross-antigenicity is demonstrated, care must be taken in the interpretation of clinical findings. This seems necessary for our medical experience and for the credibility of our discipline. In Europe, Allergology has to find its place among medical specialties. It is the duty of all allergists to contribute to this aim.

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Reply

To the Editor:

This is in response to Dr. Lavaud's letter (Cross-sensitization between latex and fruits) regarding our article published in the October 1995 issue of the Journal. We thank Dr. Lavaud for his comments.

Regarding subject 5, unfortunately we cannot be more

precise because the patient in question was not able to furnish other information (such as the brand of tropical fruit juice, etc.). She remembers only one episode associated with drinking tropical fruit juice and having an asthma attack together with rhinoconjunctivitis, while she was not at home.

The main concern of our study was late asthmatic reactions and follow-up of patients with asthma. We agree that our reporting of cross-reactivity between latex and fruits was more anecdotal than scientific, but it is also true that it was not the principal aim of our study. We also agree that when medical history suggests a

cross-reactivity between latex and fruits, it is necessary to demonstrate an immunologically confirmed cross-antigenicity.

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Correction

The following correction applies to the letter (reply) by E. R. McFadden, Jr., which was published in volume 96, p. 1016, 1995, of The Journal of Allergy and Clinical Immunology.

The allergen PC₂₀ after salbutamol administration should be 16,091. The *p* value of 0.10 associated with comparisons between salbutamol and no treatment is not changed.