

Semen contact urticaria

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J R Soc Med 1995;88:108P-109P

CASE PRESENTED TO SECTION OF DERMATOLOGY, 16 DECEMBER 1993

Keywords: semen; urticaria; hypersensitivity

An allergic reaction to human seminal fluid was first reported by Halpern *et al.* 1967¹. Since then there have been more than 30 cases recorded in the literature but it remains a rare cause of dyspareunia.

CASE REPORT

In October 1993 a 25-year-old marketing assistant was referred to the dermatology outpatients department with a 4 year history of vaginal burning and stinging. This arose within 5 min of her husband's ejaculation and could last for up to 1 h. It happened following her first sexual encounter and subsequently. Symptomatology was identical with two different sexual partners. Sex without ejaculation or when using a condom averted the symptoms. Semen coming in contact with other body sites did not produce the same reaction. She had a past history of mild eczema, asthma, hayfever and cosmetic intolerance. The oral contraceptive pill, Femodene (ethinylloestradiol 30 mcg, gestodene 75 mcg) was her only regular medication. She was first referred to a gynaecologist and, secondly, to a genitourinary physician, but no physical or microbiological abnormality could be found. Periods of abstinence from sexual intercourse did not reduce the symptoms on renewed exposure nor did therapeutic trials of antifungal preparations.

Twenty minutes following an occlusive scratch patch test with her husband's fresh semen, an urticarial response was seen with 3 mm induration. This is the first positive reaction we have seen in our patch test clinic over a 10 year period. Patch testing to her husband's fresh semen was negative at 48 h and 96 h. Positive prick test reactions to house dust mite, grass, Beech, and fungi were consistent with her atopic diathesis: ++ positive patch test reactions to parabens and balsam of Peru were relevant to her history of cosmetic intolerance. A diagnosis of contact urticaria to semen was therefore confirmed. Sexual abstinence or use of a condom

have not been well tolerated by the patient and her husband. Therapeutic trials of different antihistamines are currently being undertaken.

DISCUSSION

Our patient represents a classical example within the spectrum of hypersensitivity reactions to human semen. The reaction is of a type 1 hypersensitivity and the majority of patients have an atopic diathesis^{2,3}. Symptoms may arise following the first episode of intercourse or after exposure to several sexual partners. It is not known how patients become sensitized prior to their first sexual exposure but in one case the patient was known to have a twin brother¹. Antigen exposure may therefore have arisen *in utero*. It is conceivable that in other cases early interuterine death and absorption of a twin brother may have been missed. Itching, burning or swelling may be localized to the site of contact with semen, result in regional discomfort, e.g. uterine contractions, or evolve into more widespread urticaria or anaphylaxis. Fortunately, there have been no reports of death resulting from this.

The antigen has been identified as a prostatic protein with a molecular weight ranging between 14 000 and 40 000 Da^{4,5} and is species specific. The only exception to this is a report by Holden *et al.* of a pregnant woman developing hypersensitivity to canine semen after her third experience of canine bestiality, who was reactive to canine semen but nonreactive to human semen⁶. No clear mechanism has been found to explain either why this disorder arises nor why it is so rare. Glycoproteins from human seminal plasma are known to suppress lymphocyte blastogenesis. Prostaglandin E, also found in semen has local immunosuppressive effects². Reduced local immunosuppression may therefore be relevant. A rare genetic polymorphic predisposition to recognize and respond to a specific prostatic protein when in contact with vaginal mucosa with or without altered semen factors may account for its aetiology.

Avoiding contact with semen for prolonged intervals, by sexual abstinence or condom usage, has lessened the degree of symptoms in some patients but allowed progression to anaphylaxis in others. The same patient may respond differently over time^{7,8}. Artificial insemination of sperm washed free of seminal plasma and placed high in the uterine cavity has resulted in symptomless conception. Antihistamines have been variably successful²⁻⁴. Precoital intravaginal cromoglycate may also be helpful⁹. Desensitization procedures followed by frequent regular intercourse has cured some patients but induced progressive symptoms in others^{4,9,10}. This rare condition poses diagnostic and therapeutic difficulties, but recognition and proof of its occurrence prevents unnecessary multiple referrals.

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(Accepted 16 February 1994)

Tuberculous pancreatic abscess: an unusual manifestation of HIV infection

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J R Soc Med 1995;88:109P-110P

CASE PRESENTED TO CLINICAL SECTION, 12 NOVEMBER 1993

Keywords: tuberculosis; pancreatic abscess; human immunodeficiency virus

SUMMARY

Pancreatic tuberculosis is unusual occurring in only 2.7% of autopsy studies of persons with miliary disease¹.

Reports of focal pancreatic tuberculosis are rare, even in patients with the acquired immunodeficiency syndrome (AIDS) in whom abdominal tuberculosis is a frequent feature². We describe two patients infected with the human immunodeficiency virus (HIV) who developed tuberculous pancreatic abscesses. In both this was their AIDS-defining illness.

CASE REPORTS

Case 1

A 48-year-old homosexual man presented to casualty complaining of a 2 month history of anorexia, upper

abdominal pain, 4 kg weight loss and night sweats. There was no past history of, or exposure to, tuberculosis. On examination he was anicteric, pyrexial (38 °C) and had a tender palpable mass in the epigastrium.

Investigations showed a lymphocyte count of 0.410⁹/l, CD4 count 120 per mm³, alkaline phosphatase 270 µ/l (normal up to 130 µ/l) and serum amylase of 490 IU (normal 100-340 IU). An HIV antibody test was positive. Abdominal ultrasound showed a dilated biliary tree and a 3.54 cm mass of mixed echogenicity in the head of the pancreas, subsequently confirmed by endoscopic retrograde cholangiopancreatography (Figure 1). A fine needle aspirate of the lesion was Ziehl-Neelsen (ZN) positive for acid-fast bacilli (AFB) and at 2 weeks cultured *Mycobacterium tuberculosis* (MTB). Quadruple antituberculous therapy (rifampicin, ethambutol, isoniazid and pyrazinamide) was instituted and the patient was asymptomatic and afebrile within days after the initiation of treatment. A repeat ultrasound scan at 10 days showed partial resolution of the mass with calcification. Nine months later he remains well and asymptomatic.

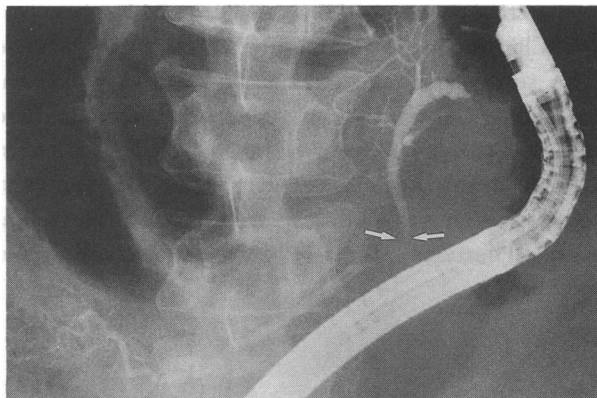


Figure 1 Endoscopic retrograde cholangiopancreatography showing extrinsic compression of the pancreatic duct in the region of the head of the pancreas (arrowed)

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