

Reactions of 2 Young Children With Milk Allergy After Cutaneous Exposure to Milk-Containing Cosmetic Products

Cow's milk allergy is the single most common food allergy in children; it manifests with eczema, urticaria, gastrointestinal symptoms, respiratory symptoms, or anaphylaxis.¹ Current management relies on avoidance and treatment of allergic reactions. Most reactions occur after milk ingestion; however, cutaneous exposure can also elicit symptoms. Pediatricians should be aware that children who are allergic to milk need protection not only from accidental ingestion of milk but also from topical exposures. Skin care and cosmetic products represent a clinically significant source of food allergens. We report 2 children with milk allergies who developed allergic reactions caused by cosmetic products containing milk proteins.

Case 1. A 2½-year-old boy with severe eczema and milk allergy (serum milk IgE level, 17.5 kIU/L, using ImmunoCAP [Pharmacia Diagnostics AB, Kalamazoo, Mich]; a level >15 kIU/L has a 95% positive predictive value for acute allergic reactions) developed a diffuse pruritic rash and emesis 2 to 3 hours after bathing in Baby Magic Calming Milk (Playtex Products Inc, Westport, Conn), which contains milk protein. There were no other known exposures to milk that day. The reaction has been attributed to skin contact, and symptoms resolved with diphenhydramine.

Case 2. A 3-year-old girl with a known non-IgE mediated allergy to milk developed an erythematous maculopapular rash and angioedema 24 hours following application of Burt's Bees Buttermilk Lotion (Durham, NC), which contains buttermilk powder, to her face (**Figure**). Milk allergy was previously diagnosed after recurrent episodes of emesis, abdominal pain, and distention within 2 hours after ingesting milk-containing products. No other exposures to milk during these same 24 hours were noted. She was treated in the emergency department with diphenhydramine and prednisone.

Comment. Patients with food allergies should be aware that cosmetic products may contain allergenic food proteins (**Table**). Recent interest in organic and natural products has led to false beliefs that these products are safer and better for children with allergies. However, foods in cosmetics may cause various allergic reactions, including contact urticaria or eczema. Inadvertent mucosal exposures via rubbing of the eyes and thumb sucking may also occur. Systemic reactions are possible if contaminated products are used over open skin sores, such as diaper rashes or eczema. Anaphylaxis to a diaper cream containing milk proteins was reported in 2 children with milk allergy.^{2,3}



Figure. A 3-year-old girl with milk allergy 24 hours following the application of buttermilk lotion to her face.

Table. Examples of Food-Containing Cosmetics and Bath Supplies Found in Local Stores*

Product	Allergenic Food Protein
Drugstore Brands	
Aveda conditioner (Minneapolis, Minn)	Almond, hydrolyzed wheat starch
Aveeno Daily Baby Lotion (Johnson & Johnson Consumer Products Co, Skillman, NJ)	Oat flour
Back to Basics shampoo (Graham Webb, Carlsbad, Calif)	Hydrolyzed soy protein
Gerber Teeny Bodies Moisturizing Cream (Gerber Products Co, Fremont, Mich)	Hydrolyzed wheat protein, mango, cocoa
Keri Original Moisture Therapy (Bristol-Myers Squibb, New York, NY)	Sunflower seed oil
Neutrogena Body Wash (Neutrogena Corp, Los Angeles, Calif)	Sesame oil
Nivea Visage cleansing cream (Beiersdorf, Hamburg, Germany)	Lactose
Softsoap Body Wash (Colgate-Palmolive, New York, NY)	Milk protein
Natural Health Store Brands	
Burt's Bees Baby Bee Diaper Ointment (Durham, NC)	Sweet almond oil
Burt's Bees Baby Bee Shampoo bar	Buttermilk powder, sweet almond oil
California Baby Diaper Rash Ointment (Los Angeles)	Coconut oil
Healthy Times Baby's Herbal Garden Sweet Violet Lotion (Poway, Calif)	Almond oil
Mustela Cleansing Lotion (Courbevoie, France)	Peanut, almond and corn oils
Weleda Calendula Baby Cream (Congers, NY)	Almond
Weleda Calendula Baby Soap	Brown rice, malt extract

*Only selected scents or lines.

This precaution extends beyond patients with milk allergy because cosmetic products may contain other food ingredients, including cold-pressed peanut, sesame, and almond oils, wheat, and soy. A recent study has drawn attention to the potential for development of allergic sensitization to peanut through skin contact with ointments containing peanut oil in children with eczema.⁴ Education regarding avoidance must include vigilance with reading ingredient labels for all products used for children with food hypersensitivities.

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Philanthropy and Medicaid

As a private pediatrician whose practice is 50% public aid, I was touched by the editorial by Dr Rivara "Sustaining Optimism,"¹ which highlighted the loss of philanthropy by physicians toward needy patients in our own country. In my community, as in his and many others, only a few providers accept Medicaid. I was, however, surprised that he advocated expanding our unsuccessful publicly funded health insurance to cover even more people. The failure of the system is not simply the failure of physicians to be generous. Perhaps young doctors like me are not more enthusiastic about universal health care because of the obvious failings of Medicaid, as evidenced by the small fraction of physicians who participate. Let's make the program work for doctors, patients, and government budgets alike before we talk about expanding its enrollment.

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The Message in the Silence

The editorial "Sustaining Optimism"¹ in the May issue of the ARCHIVES raises important questions, which I would like to answer from the perspective of a pediatrician in private practice. Like the resi-

dency applicants interviewed, I too spent time as a medical student and resident in clinics serving low-income patients. When I entered practice, we provided care to our share of Medicaid patients. Even though compensation failed to cover expenses, as pediatricians we held that children should not be denied first-class medical care because of parental financial circumstances.

Despite the increasing financial difficulties in maintaining a medical practice, and inadequate reimbursements, we continued to accept Medicaid until escalating bureaucratic regulations and procedures finally forced us to give up doing so. I believe that, as was the case with our practice, it is the insurmountable day-to-day hassles more than lack of top-dollar compensation that have pushed physicians in private practice to drop Medicaid participation.

As a medical student, I rotated through Veterans Administration hospitals. It was commonly acknowledged that those facilities were the epitome of mismanagement and poor resource use. To the Veterans Administration's credit, that is no longer so. However, most physicians today consider Medicaid and the Veterans Administration system of our training days as demonstrations of health care under any type of national health plan. We are also keenly aware that in countries such as Great Britain and Canada, exorbitant waits for services or total lack of them altogether are the norm. Our practice prides itself on providing office services 365 days a year (this year 366 days!) and 24/7 phone availability. Last winter, a bronchiolitis outbreak in France resulted in morbidity and mortality that would be appalling by American standards, in part because of lack of access to pediatric services on weekends. In a recent *Washington Post* article,² a German reporter on assignment here, writing about his wife's medical problems, expressed amazement at the quickness with which she received appointments with specialists and for necessary tests (in Germany, it takes 2 months to schedule a magnetic resonance imaging appointment, even in a major city) and by the personal care she received (in Germany, it is unheard of for a physician to call to check up on a patient seen in the office).

In the editorial, it is suggested that by using hospitals such as the one Dr Rivara is affiliated with for one's own personal care we would demonstrate an advocacy of a single standard of care. But I ask, is it ethical to do so if that standard is not the best possible care? Whether the differences between your county-owned hospital and one that serves an affluent population are clinically significant (better nurse-to-patient ratios, the latest computed tomography scanner that provides superior imaging with less radiation exposure, or sophisticated computer software in the pharmacy to eliminate medication errors) or merely patient comfort (private rooms with cable television), denying some patients any service on the grounds that offering the service to all patients is unaffordable is very problematic. While universal health coverage is not necessarily synonymous with a Canadian- or European-style system, neither established physicians nor recent medical school graduates realistically see any other model to provide coverage for all Americans. While they acknowledge 40 million Americans being without insur-