

ent, up to 35 ml (cumulative dose), and immediate adverse reactions did not appear. Nevertheless, approximately 5 h after the challenge test, our patient developed edema of his face and neck, together with itching in the pharynx and eyes, conjunctival hyperemia, dysphagia, and a feeling of being hot. Symptoms subsided spontaneously and wore off completely after treatment with methylprednisolone.

One month later, in order to determine which of the constituents of the cough syrup caused the adverse reaction, we challenged our patient again (single-blind and placebo controlled) with increasing doses of theophylline up to 350 mg cumulative dose. This time, neither immediate nor nonimmediate reactions were observed.

■ Iodine has been widely implicated in many dermatologic reactions, commonly after local application, by virtue of a delayed-hypersensitivity mechanism; therefore, iodine is considered a hapten which can elicit contact reactions. On the other hand, some patients present allergic-like reactions after the administration of radiographic iodine contrast agents, but the mechanism of such reactions is not completely explained.

The effects of exposure to levels of dietary iodine higher than those required to support thyroid function have not been

A case of late (> 5 h) reaction with edema and itching in the face region.

well defined; 1000 µg iodine or less per day is probably safe for most patients, but may be toxic for a small proportion of the population. In their study, Garber

et al. (4) did not find side-effects after daily ingestion of iodine-enriched eggs (711 µg iodine/egg) for 8–16 weeks. In thyrotoxicosis, recommended oral doses of inorganic iodine range from 0.2 to 2 g/day (7).

The normal dose of Elixiflin for adults is 30 ml every 8 h; that is to say, approximately a 260-mg dose of potassium iodide every 8 h. In the challenge test, our patient took a cumulative dose of approximately 300 mg potassium iodide. It was difficult to suspect a toxic mechanism when the first reaction appeared after the second dose of cough syrup. Nevertheless, an IgE-mediated mechanism is difficult to prove because iodine operates as a hapten, and *in vitro* tests are not available.

On the basis of clinical history and the results of challenge tests, our diagnosis in this case was non-immediate adverse reaction to potassium iodide because the oral challenge test with the other suspected constituent (theophylline) did not elicit an adverse response. We excluded both saccharose and

ethanol because these additives are found in many foods and drinks, and clinical history did not lead us to suspect them.

Key words: edema; iodide.

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Thirteen cases of allergy to human seminal plasma

THE FIRST case of human seminal plasma allergy (HSPA) was reported in 1958 by Specken (1). In 1967, Halpern et al. (2) provided evidence of a reaginic pathogenesis in a second case. In 1979, in our department, Sabbah et al. (3) reported the first French case and the first successful desensitization. Since 1979, numerous other patients have been investigated in our department, and we have diagnosed 12 new cases. We present briefly our 13 observed cases with clinical characteristics and immunotherapy results.

■ Table 1 summarizes the 13 cases. Our experience confirmed what is described in the literature. Our patients were all female. Six patients presented local reactions (LR) with vulvovaginal reactions, and seven had systemic anaphylactic reactions (SAR) of various degrees. Diagnosis was based on a clinical history of postcoital reactions. These reactions were

Table 1. Summary of 13 cases of human seminal plasma allergy

Patient no.	CL.Sy	Age (years)	Period	SP skin tests			SP sIgE	Total IgE (kU/l)	Immunotherapy +/—	Results
				PT	IDT					
					1/1000	1/100				
1	LR	30	10 years	<0	<0	7/10	<0	24	+	0
2	LR	19	6 months	—/13	4/10	ND	<0	43	+	0
3	LR	16	2nd/3rd act of intercourse	2/70	ND	ND	0.32 PRU/ml	7	+	0
4	LR	20	?	9/15	ND	ND	<0	733	—	
5	LR	26	3 years	5/10	ND	7/15	<0	110	—	
6	LR	30	10 years	<0	ND	ND	1.1 kU/l	5044	—	
7	Urt., Oed.	35	?	ND	ND	ND	4.2 kU/l	260	—	
8	Ast.	36	> 10 years	5/30	10/45	ND	2.2 PRU/ml	245	+	+
9	Rh., Urt.	59	> 30 years	5/30	6/25	ND	0.5 kU/l	15	+	0
10	Ast.	25	4 years	ND	10/45	ND	Class 1	310	+	+
11	Ast., Oed.	51	30 years	6/30	6/25	ND	<0	310	+	+
12	Urt., Oed., Ast.	18	1st act of intercourse	5/40	6/35	ND	2.6 kU/l	260	+	+
13	Ast.	26	?	12/70	10/50	ND	Class 3	315	+	+

CL.Sy: clinical symptoms; Age: age of first symptoms; Period: period between beginning of sexual activity and first symptoms; SP: seminal plasma; PT: prick test*; IDT: intradermal test*; immunotherapy +/—: done/not done; Result: 0/+ : no benefit/good result; LR: local reactions; Urt.: urticaria; Oed.: angioedema; Ast.: asthma; Rh.: rhinitis; ND: not done.

* Skin tests are expressed in wheal/flare (in mm).

prevented by coitus interruptus or by using condoms. The diagnosis was confirmed by investigations including skin tests and specific IgE (sIgE) measurements with seminal plasma (SP). The sperm was obtained from the regular partner and prepared (proteic extraction and sterilization) in our laboratory. It was used for the skin tests and possibly for immunotherapy.

Skin tests. First, prick tests were carried out and then, in some cases, intradermal tests (dilution 1/1000 and 1/100 of proteic extract) were done.

Specific IgE. The units varied because the techniques changed between 1979 and now (RAST and CAP RAST Pharmacia), and, moreover, some results did not come from our laboratory (no. 10).

Immunotherapy. When indicated, rush immunotherapy, with the above-mentioned prepared sperm extract, was performed during hospital admission (24–72 h). More often, the maximum dose was 0.1 ml of dilution 1/100, except in case no. 12 in which it was necessary to reach the dilution 1/10 to obtain a good result.

■ **Local reactions.** Cases 1–6 represent the patients with LR. Clinically, these LR had been preceded by repeated gynecologic infections, and very often the women were treated for that. The link with SP has never been established at an early stage. All these women were young (16–30 years old), and the period between the beginning of sexual activity and clinical symptoms could be very brief (as soon as the second or third act of intercourse) or longer (10 years). In this group, prick tests were positive in four cases and intradermal tests in two cases,

sIgE was positive in only one case, and total IgE was normal in four cases and high in two cases.

Systemic anaphylactic reactions. Cases 7–13 represent the patients with SAR. Three patients presented asthma (nos.

8, 10, and 13), one patient presented urticaria with angioedema (no. 7), and three had associated cutaneous symptoms (either urticaria or angioedema) and respiratory symptoms (rhinitis or asthma) (nos. 9, 11, and 12). The average age was higher in this group: two women were under 30 (nos. 10 and 12), and the others were over 30 – two were even over 50 (nos. 9 and 10). The time between the beginning of sexual intercourse and clinical symptoms was extremely variable, ranging to more than 30 years after the first sexual intercourse.

In this group, prick tests and intradermal reactions were always clearly positive; sIgE was highly positive in four cases (nos. 7, 9, 12, and 13), weakly positive in two cases (nos. 9 and 10), and negative in one case (no. 11); and total IgE demonstrated that this group was more often atopic than the LR group with a high dosage.

■ Specific immunotherapy was indicated three times in the LR group, and in those three cases, we failed to induce clinical improvement (neither decrease of nor disappearance of symptoms). It was indicated six times in the SAR group with successful results in five cases (no symptoms) and one failure.

A report of clinical characteristics and immunotherapy results.

■ We report 13 cases of HSPA. Seven women had systemic allergic reactions. In this group, nearly all had an atopic background (6/7), diagnosis (skin tests and sIgE) posed no difficulties, and immunotherapy often produced clinical benefit (5/6). Six women had local reactions, always complicated by repeated gynecologic infections. Atopic background was not frequent. Diagnosis by skin tests and sIgE was much more complex, because skin tests were weakly positive and sIgE was not found in most cases. Immunotherapy offered no benefit in this group.

Key words: allergy; human seminal plasma; immunotherapy.

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Indoor allergy to spathe flower (*Spathiphyllum floribundum*)

OCCUPATIONAL allergy to plants is well known in those heavily exposed such as gardeners or florists (1). Less common are reports of allergies to indoor ornamental plants in homes. Allergy to weeping fig (*Ficus benjamina*) is the best documented. It was first described as a cause of occupational allergy. Later, patients with indoor allergy were reported (2, 3). We now describe another indoor plant allergen, that of the widely grown ornamental spathe flower (*Spathiphyllum floribundum*).

■ A 40-year-old woman, a medical secretary, presented at our outpatient clinic. Her personal history revealed that she had experienced an episode of

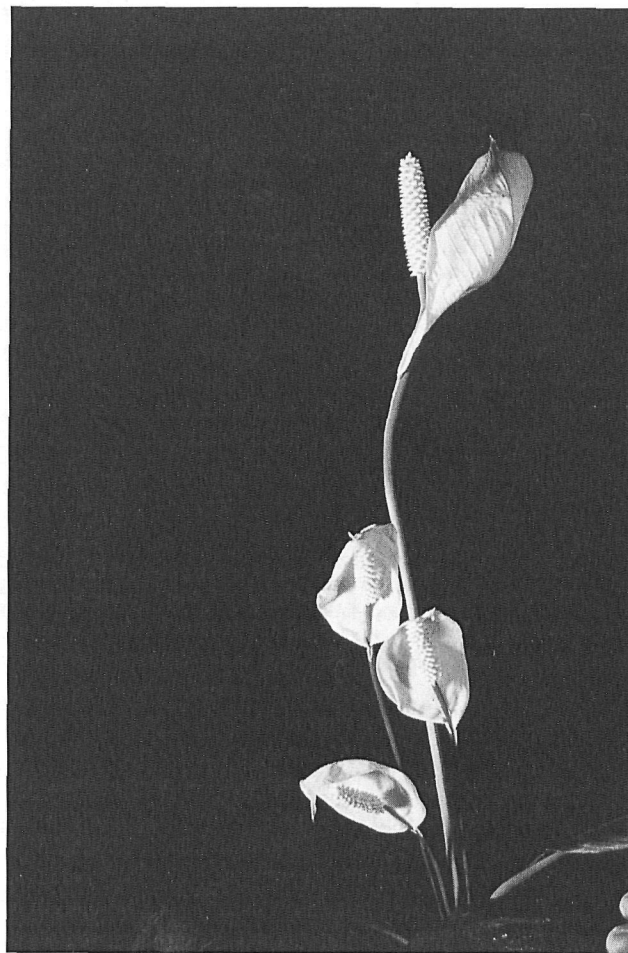


FIGURE 1 *Spathe flower* (*Spathiphyllum floribundum*).

severe rhinoconjunctivitis and asthma 15 years before after exposure to a bedcover filled with wild silk. Seasonal rhinoconjunctivitis due to pollinosis had affected her since childhood, but the symptoms had lately been easing.

For 2 years, the patient had suffered from newly acquired, perennial rhinitis of unknown cause. The symptoms affected her at home exclusively. She had acquired a dog and a cat only very recently and direct contact with them did not trigger any reactions. Her symptoms worsened when a large indoor plant in her living room and bedroom had to be trimmed. Severe conjunctivitis and mild rhinitis promptly affected her. Upon removal of the plant, the symptoms stopped immediately and had not recurred since.

A case of perennial allergy to an ornamental plant.

■ Skin prick tests (SPT) were performed with commercial extracts in glycerol (Alyostal from

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