

consecutive series of 316 patients who received stents. The New Approaches to Coronary Intervention Palmaz-Schatz Stent Registry study⁵ reported 1-year cardiac mortality and major event rates of 6% and 29%, respectively.

Our findings of coronary-stent placement were substantially less favourable than in Benestent I,¹ and were similar to other non-trial experiences. With the current technology, and as practised by most angioplasty operators on an increasingly complex coronary population, stents do not seem to be the panacea for coronary heart disease. Randomised controlled trials comparing balloon angioplasty and stent placement on larger less selected patients and lesions are needed.

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Morbidity from hepatitis B after introduction of nationwide immunisation in Italy

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The National Communicable Disease Reporting System in Italy has included hepatitis B since 1986. Although from that year on, hepatitis B has been notified from Health Units all over Italy, more reliable data have been available since 1988. The average morbidity rates for hepatitis B in the period 1988-91 was 6.7 cases per 100 000 population.¹ In 1991, a law for the mandatory immunisation of newborn children and adolescents against hepatitis B was approved by Parliament. In 1995, 4 years after the introduction of the universal hepatitis B vaccination, morbidity was 5.3 cases per 100 000.¹

In the period after introduction of mandatory hepatitis B immunisation, the reduction of morbidity from viral hepatitis B has been 20.9%, more evident in the age group 0-14 years (-37.7%) than in the age group 15-24 years (-28.2%).² Vaccination coverage, monitored by the means of quarterly reports by the Regions, is satisfactory for children aged 1 year (more than 95%), but less satisfactory (80%) among adolescents. In the period 1991-95, the Surveillance System for Adverse Events after immunisations registered 408 reactions to hepatitis B vaccination. In the same period, 12 million doses of hepatitis B were distributed. 28 out of the 408 reactions, mainly neurological, were classified as severe adverse reactions. Reports of adverse events after immunisation against hepatitis B represent the 16% of all notifications sent to the surveillance system, whereas the adverse reactions to diphtheria/tetanus and diphtheria/tetanus/pertussis account for about 50% of the total.³

The combination of nationwide vaccination of newborns and adolescents and prevention programs targeted at high-risk groups have contributed to the control of a disease which was once one of the major public health concerns in Italy.

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Atopic dermatitis in a child due to cow dander

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A 10-month-old boy presented to us with his first attack of obstructive bronchitis. He had also severe, generalised atopic dermatitis which had begun when he was 7 months old. His mother had allergic rhinitis, his father's brother and his own two brothers had bronchial asthma, and one had atopic dermatitis. His parents and grandparents were cattle farmers, and they used to enter the house in their working clothes. The patient had never been in the cow sheds, nor had he ever touched the cows. He had been breastfed for his first 7 months and thereafter had received a soy-based formula.

Skin testing with cow dander (Bencard Co) induced a pronounced urticaria; RAST against dander was strongly positive (stage 3). Cow's milk skin test was positive; RAST and challenge with 200 mL of whole milk were negative. Skin tests with egg, soy, and wheat were negative. Hospital admission led—without much therapeutic effort—to a quick improvement. A few days after discharge from hospital, the boy's grandfather, wearing his working clothes, took the boy in his arms. This led instantly to a rash, coughing, and breathlessness, cyanosis, and signs of circulatory shock which made emergency admission to hospital necessary. After this, whenever there was direct contact with working clothes or with furniture contaminated with cow dander, the

	Patients				
	1	2	3	4	5
History					
Age at manifestation/age at diagnosis that cow dander was the reason (months)	7/10	3/11	3/28	9/34	4/39
Parents' occupation (cb=cattle breeder, v=veterinarian)	cb	cb	v	v	cb
Direct contact with cattle	No	No	No	?	No
Ever touched cattle	No	No	Once	Often	?
Allergy tests					
Cow dander					
Skin test (compared with histamine=+++)	++++	+++	ND	++++	++++
RAST	3	3	3	4	ND
Cow's milk					
Skin test (compared with histamine=+++)	+++	++++	+++	+++	+++
Oral provocation (double blind, 200 mL whole cow's milk (-=negative, +=positive))	-	+	ND	-	-

Patient 1 is the index patient described in this letter. ND=not done.

History and allergy tests in five children with atopic dermatitis due to cow dander

boy responded with acute exacerbations of his dermatitis. He is now 25 months old. After meticulous avoidance of cow dander, he has only mild atopic dermatitis and no asthma. His diet includes cow's milk.

Cow dander is a well known antigen in occupational asthma.^{1,2} To our knowledge this is the first report of childhood atopic dermatitis caused by cow-dander. There are no routine tests for measurement of the major allergen BosD2; thus diagnosis relies on RAST and on cutaneous testing.³ We have since looked for cow dander sensitisation whenever the history suggested this possibility, and within the past 12 months we have found four more children whose atopic dermatitis might be due to cow dander, and who have improved after elimination of the antigen (table). Three of them never had direct contact with cattle, but were contaminated by their parents.

A previous publication has reported about 150 children who have never been in contact with cattle who had positive skin tests with cow dander.⁴ In another investigation, four of six patients with milk allergy had IgE antibodies to cow dander, but none of five patients with cow-dander allergy had IgE antibodies against milk.³ In our series, skin tests against cow's milk were positive in all five patients, oral challenge with whole cow's milk was positive in one. Whether this indicates a cross reactivity against common antigenic determinants or multiple allergies in atopic people is unclear.

It is important to consider cow dander as a possible cause of atopic dermatitis in children; the elimination of this allergen can be helpful.

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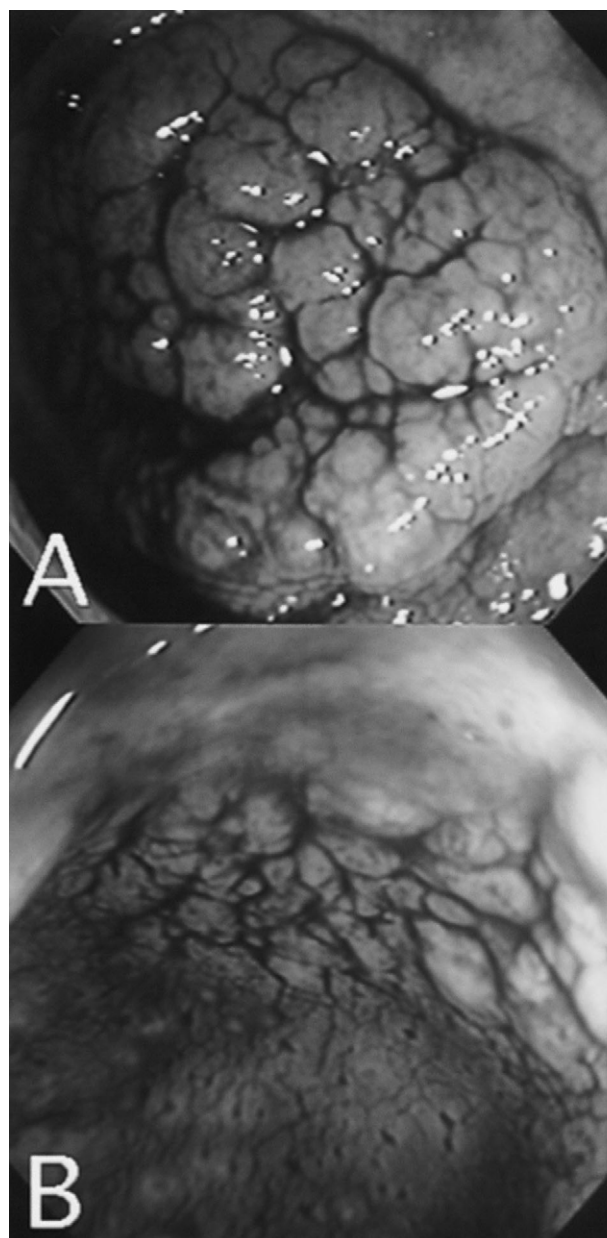
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Regression of mucosa-associated lymphoid-tissue lymphoma of rectum after eradication of *Helicobacter pylori*

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Although the gastrointestinal tract is one of the main sites of extranodal malignant lymphoma, the tumour rarely occurs in the colorectum.¹ Some malignant lymphomas originate from mucosa-associated lymphoid tissue (MALT). Treatment of *Helicobacter pylori* infection may cause regression of gastric MALT lymphoma.² We report a 72-year-old Japanese woman with rectal MALT lymphoma which regressed after eradication of *H pylori*.

The patient had rectal bleeding in January, 1997. Proctosigmoidoscopy showed a broad-based protrusion in the rectum (figure A). A biopsy specimen showed diffuse infiltration of centrocyte-like cells within the lamina propria and lymphoepithelial lesions. Southern blot analysis of the specimen did not detect gene rearrangement of immunoglobulins. Computed tomography and ultrasound



Endoscopic findings in the rectum before (A) and after (B) eradication of *Helicobacter pylori*

examination showed no lymphadenopathy (stage Ie). Upper endoscopy showed chronic gastritis with lymphoid follicles but without any infiltration of lymphoma cells. *H pylori* infection was confirmed by histology and culture.

We attempted to eradicate *H pylori* with a 14-day course of omeprazole, amoxycillin, and clarithromycin. Eradication was proved successful by endoscopy 14 days after the end of treatment. Repeated proctoscopy 21 days after the end of treatment showed that the rectal tumour had regressed (figure B). Biopsy specimens showed lymphoid follicles with germinal centres, but no lymphoma cells. Regression was further confirmed by proctoscopies at 7 and 12 weeks after the end of treatment.

Wotherspoon et al² reported that eradication of *H pylori* can induce regression of low-grade MALT lymphoma of the stomach. Regression of this type of lymphoma had also been reported in salivary glands,³ duodenum,⁴ and small intestine,⁵ after eradication of *H pylori*. These reports and our case suggest that the association of *H pylori* and MALT lymphoma