

reaction was seen. Funk & Maibach (8) have proposed to classify skin reactions to PG into four types: irritant contact dermatitis (most frequent), allergic contact dermatitis, nonimmunologic contact urticaria, and subjective irritation. They concluded that exploration of PG dermatitis should include repeated patch tests with serial dose dilutions (1:10% in water), repeated open application tests, oral challenge tests, and biopsies.

In our patient, we tested three preparations of PG: PG 10% in water prepared by our institution was negative, PG 10% in water supplied (by Prof. Oleffe, Erasme Hospital, Belgium) was positive, and PG (concentration unknown) supplied by Wellcome Laboratory was positive. The clinical history and the results of patch tests to PG (erythema plus edema) are consistent with an allergic reaction. However, an oral provocative challenge to PG may be useful to confirm allergic reaction to PG, as suggested by Hannuksela & Forstrom (9), who found a correlation between patch tests and oral provocative tests with PG. Our study rejects the hypothesis that acyclovir is a sensitizing agent and allows its future use in the systemic form if required. Moreover, the use of other drugs or topical medications containing PG should be considered with caution in such patients. Indeed, observations of cutaneous reactions (10) have been reported after oral ingestion of PG or intravenous injection of drugs with PG as vehicle (diazepam).

Key words: acyclovir, contact dermatitis, propylene glycol, Zovirax[®] cream.

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Anaphylactic reaction caused by cherry ingestion

FRUITS AND vegetables are commonly implicated in food allergy. In Spain, fresh fruits are the most frequent cause of food allergy (30% global frequency) (1), and fruits belonging to the Rosaceae family are the most frequently implicated (2). Nevertheless, clinical manifestations due to sensitization to cherry (*Prunus avium*, Rosaceae) are rarely described, and most cases fit the so-called oral allergy syndrome. In their survey, Garcia-Ortiz et al. (3) reported that only 1.5% of patients with pollinosis had symptoms related to the intake of cherry.

In this paper, we report on an anaphylactic reaction caused by cherry ingestion.

■ A 36-year-old man was referred to our department for allergologic investigation because, after eating cherries, he

had immediately presented vomiting, dyspnea, itching, and generalized edema, mainly of his lips, eyelids, and scrotum. Those symptoms were off a few hours

after urgent treatment. He had a clinical history of hay fever (pollinosis), but he had never had symptoms related to the ingestion of fruits or vegetables.

Skin prick tests with commercial extracts (Laboratorios Leti[®], Spain) of common pollens (grass pool, *Cynodon*, *Phragmites*, *Olea*, and *Artemisia*) and fruits (apple, plum, peach, cherry, pear, and strawberry) were performed; all of them, exclusive of apple, peach, pear, and strawberry, were positive. In the same way, skin tests (by the *prick-prick* method) with fresh fruits (apple, plum, peach, cherry, pear, and strawberry) were also carried out, and elicited positive reactions, exclusive of apple, pear, peach, and strawberry. Both a positive (histamine 10 mg/ml) and a negative (saline solution) control were included. Skin prick tests with the same commercial extracts and the same fresh fruits (*prick-prick*) were performed on five control healthy subjects. All of them were negative.

Serum specific IgE to the same fruits was determined (CAP System[®], Pharmacia, Sweden) in our patient. High levels of serum specific IgE to all of the fruits tested were detected: peach, 15.0 kU/l; plum, 13.20 kU/l; strawberry, 9.81 kU/l; pear, 8.22 kU/l; cherry, 8.0 kU/l; and apple, 6.90 kU/l.

■ These data suggest that our patient suffered an IgE-mediated anaphylactic reaction to the ingestion of cherry. He had previously tolerated the intake of apple, plum, and peach. As far as he remembered, he had never before eaten cherry.

Subiza et al. (4) reported another case of anaphylactic reaction related to the ingestion of cherry, and suggest cross-reactivity among Rosaceae species; nevertheless, they could not detect serum specific IgE either to cherry or to other fruits belonging to the Rosaceae family. In our patient, serum specific IgE to cherry was detected; this result suggests the existence of an IgE-mediated mechanism.

Positive results in skin tests and RAST are often seen to fruit that patients tolerate, and are probably the expression of cross-allergenicity among fruits or with pollens (2). Oral allergy syndrome in response to fruits and vegetables often occurs as clusters of hypersensitivity to members of the same botanic family. Thus, clinical cross-reactivity to Prunoidae is essentially due to a common 13-kDa IgE-binding component (5). In our patient, *in vivo* and *in vitro* tests led us to suggest the existence of cross-reactivity only between cherry and plum, among Rosaceae fruits. However, as he mentioned, he tolerated the intake of plum without eliciting symptoms. The presence of high levels of serum specific IgE to fruits which do not elicit clinical manifestations or positive skin prick tests led us to suspect *in vitro* cross-reactivity among Rosaceae fruits, which was not clinically shown in our patient. In agreement with Pastorello et al. (5), who found other major 30-kDa allergens in cherry, our patient's clinical history led us to suspect the existence of other allergens not shared among Rosaceae species. However, we took a conservative approach, and recommended avoidance of fruits included in the Rosaceae family for our patient.

In summary, our patient presented an IgE-mediated anaphylactic reaction, presumably due to sensitization to an allergen of cherry not shared among Rosaceae species.

Key words: allergenic cross-reactivity; anaphylaxis; cherry; fruit allergy; Rosaceae.

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Rhinitis in Singapore

RHINITIS is a common problem in Singapore. The results of our first local, community-based questionnaire survey (1) on chronic rhinitis showed an overall prevalence of 32.5%. However, the diagnosis and treatment of rhinitis locally has always been empirical. This is partly due to the difficulty in classifying the types of rhinitis. The International Consensus Report on the Diagnosis and Management of Rhinitis (2) published in *Allergy* was therefore of great interest to us. We wanted to look at the types of rhinitis that present to us on the basis of this new classification.

Rhinitis was defined as inflammation of the nasal lining characterized by nasal congestion, rhinorrhoea, sneezing, or itching and classified as allergic rhinitis, infectious rhinitis, and other (Table 1). Consecutive cases of rhinitis seen in the clinic were entered into the study upon informed consent. A clinical protocol was completed by the attending doctor. All patients had a nasal smear, skin prick test (Greer Laboratories), and total IgE (3M FAST test). For nasal smears, a significant eosinophil count was defined as more than 10 cells per high-powered field. Positive skin prick test was defined

Table 1. Classification of rhinitis: International Rhinitis Management Working Group Classification

Classification	No. of patients (%)
Allergic rhinitis	95 (81.2)
infectious rhinitis	
Acute	3 (2.6)
Chronic	6 (5.1)
Other	
Idiopathic	103 (88.0)
NARES	12 (10.3)
Occupational	1 (0.9)
Hormonal	0
Drug-induced	10 (8.5)
Irritants	0
Food	52 (44.4)
Emotional	27 (23.1)
Atrophic	0

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