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Latex contact urticaria presenting as facial swelling in a motor mechanic

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Type I allergic reactions to latex usually present as anaphylactic reactions (1, 2) or contact urticaria (3). The prevalence of Type I allergy to latex is rising due to increased use of cheaper, poorer quality latex products such as gloves and condoms (4). Certain professionals, such as surgeons, dentists and nurses, laboratory technicians and patients with urological defects and spina bifida are more prone to latex allergy (5–9).

Case Report

An 18-year-old trainee vehicle mechanic presented with a 4-month history of recurrent swelling occurring exclusively on his face. He had to attend our Accident and Emergency Department on 2 occasions because of the severity of the facial oedema. Each episode lasted no more than 24 h and was not associated with any specific sequelae or symptoms. Antihistamines were moderately effective. The patient suffered from mild asthma and had a family history of atopy. The rash was related to his work environment, requiring him to lose time. A work place visit was undertaken but no obvious allergens were identified. It was concluded instead that he was suffering from cold urticaria, as his symptoms appeared to be related to working on vehicles adjacent to the garage doors and had occurred through the winter months. Prick tests to brake dust and fluid from the workplace were negative.

He returned later in the summer with a recurrence of the facial urticaria, which had spread to his hands and forearms. He linked this episode directly with the wearing of disposal natural latex gloves provided at his work-

place. RAST to latex showed a grade 2 reaction and skin prick tests to raw ammoniated latex, latex solution (Diagenics, Newark, UK), and the culprit glove gave strong positive reactions. He had no reaction to the negative diluent. Avoidance of all latex products has completely relieved his problem.

Discussion

Occupational contact urticaria was responsible for 29.5% of all reported occupational dermatoses in Finland 1990–1994 (10). In this series, natural rubber latex was the 2nd most common cause, accounting for 23.7% of all patients with contact urticaria. Engine mechanics ranked 28th (3.9 per 100,00 workers) as an occupation at risk of developing contact urticaria. Motor engineering is an unusual vocation to develop latex allergy. Also of interest is the localized nature of the contact urticaria. For many months, the swelling occurred exclusively on the face. The patient's hands, which were in much closer contact with latex, were unaffected.

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Contact dermatitis due to levobunolol in eyedrops

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Case Report

A 32-year-old woman had had bilateral eczema of the eyelids for 1 month. She had been operated on for congenital glaucoma 1 year before and since then had been using Betagan (levobunolol hydrochloride 0.5%) eyedrops. On discontinuing them, the eyelid dermatitis disappeared.

She was patch tested with the European standard series, levobunolol HCl (0.5% aq.) and the vehicle ingredients, benzalkonium chloride and disodium edetate. A +++ reaction was observed to levobunolol HCl (0.5% aq.) on D2 and D4, the rest being negative. Patch testing with other β -blockers in eyedrops was then performed: timolol maleate (0.5% aq.), betaxolol HCl (0.5% aq.) and carteolol HCl (2% aq.), showing no reaction. Finally, systemic β -blockers were tested at 20% pet.: propranolol, atenolol, nadolol, metoprolol and celiprolol. No reactions were obtained.

Discussion

Side-effects of any kind from levobunolol are rare (1),

and allergic contact dermatitis extremely so (2, 3). As far as we know, this is the 1st report of sensitization to levobunolol in which other topical and systemic β -blockers were tested. We found no cross-reaction between these β -blockers. Kanzaki et al. (4) reported 6 cases of sensitization to another topical β -blocker, befunolol, also testing timolol (0.5% aq.) and carteolol (2% aq.). There was no cross-reaction. Levobunolol was not tested.

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