

including an emergency drug chart, are available on the ward. On arrival, the child's weight and vital signs (blood pressure, pulse, and respiratory rate) are recorded, the emergency drug chart is completed, and an intravenous cannula is inserted. The child is examined for any evidence of allergy by the day-care nurse before progressing to the challenge. Any abnormal respiratory findings such as wheeze or breathlessness preclude the test from being performed until the child is well. Evidence of and distribution of eczema are clearly marked out, as this is a common coexisting condition in food allergy which may also be the only sign of a reaction. Throughout the challenge procedure, vital signs are recorded, and the child is examined for any reaction before each subsequent dose is ingested. The nut challenge involves the child's ingesting visually measured doses of nut at 15–30-min intervals. It starts with a nut touching the oral mucosa and progresses to the ingestion of a portion the size of a pinhead, which is then doubled until a minimum of 5 g of nut has been ingested. The challenge procedure is specific to each individual, using the principle of starting with a quantity smaller than that which caused the presenting reaction, and given at time intervals longer than the time to the reaction. The challenge also considers the child's age, as children over 7 years are given whole nuts while younger children receive peanut butter or ground tree nuts. In those children where difficulties in ingesting the nut are encountered, the measured dose is given in or with a familiar food that the child has eaten before (e.g., peanut butter on chocolate buttons). Children complete a 60–120-min (no reaction) or 4-h (mild reaction) observation period after the end of the challenge before discharge home. Fifteen of the 17 children showed no symptoms after open challenge (Table 1). All these children continued to ingest foods containing nut without incident. Two children reacted, one with hives on the left cheek and abdomen after 45 min, and the other with mild urticaria under the left eye 2 h after the start of the challenge. Neither

experienced a major or life-threatening reaction.

With the increase in public awareness of nut allergy, coincidental allergy-like symptoms may be attributed to nuts, labelling children as having a lifelong, potentially fatal allergic condition and subjecting them to many lifestyle restrictions. As the skin and blood tests are highly predictive of the absence of IgE-mediated allergy (2, 4), we have found that the parents of our patients welcome our supervised challenge procedure in an informal but safe setting where a negative test places the diagnosis of nut allergy in doubt.

Hourihane et al. (5) recently suggested that some children may show resolution of their nut allergy. The 15 children in our study with negative nut challenges may fall into this category or may coincidentally have reacted to another food or other factor which we have not identified. The two patients who reacted when challenged are important, as they demonstrate the possibility of persistence of symptoms despite a negative test, a phenomenon not described by Hourihane et al. (5), and the need to conduct all nut challenges in a setting where any allergic reaction can be safely managed. These children may need a repeat blinded, placebo-controlled nut challenge in future to avoid any bias.

In conclusion, we propose an easy, economical, yet effective and safe dietary challenge for nuts. Our study also confirms that history alone, that is, in the absence of confirmatory allergy tests, is not adequate to make the diagnosis of nut allergy. We recommend that all hospital-based allergy clinics should offer these challenges as an integral part of the treatment and management of food allergy.

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Prevalence of latex-specific IgE in blood donors: an Italian survey

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Key words: blood donors; IgE antibodies; latex.

● ALLERGY TO latex has been recognized as a relevant medical problem since the mid-1980s, and its prevalence seems to be

increasing. Some subsets of subjects with higher risk have been identified; they include health workers (1), children with spina bifida (2), and rubber-plant workers (3). However, only sparse data are available on the prevalence of latex allergy in the general population (4). Therefore, we evaluated the prevalence of allergy to latex in 1025 healthy adults (blood donors) by measuring their serum latex-specific IgE levels.

All donors were informed of the aim of the study and gave their written permission for

Of 1025 donors, 3.5% were positive, most of them also to grass pollen, but very few were clinically allergic to latex.

the collection of blood samples. They were also required to fill in a simple questionnaire on their personal allergic history (previous or concomitant asthma and/or rhinitis), the existence of potential occupational risk factors, and the possible symptoms (itching, cough, wheezing, angioedema) due to latex exposure; for instance, in the case of latex gloves, manipulation or diagnostic/surgical procedures. Health-care workers were excluded from the study, since they represent a high-risk category. The concentration of latex-specific IgE in serum was measured by an automated system (CAP Pharmacia, Uppsala, Sweden). The ranges for the CAP class scoring were as follows: class 0: <0.35; class I: 0.35–0.70; class II: 0.7–3.5; class III: 3.5–17.5; class IV: 17.5–50; class V: 50–100; class VI: >100 kU/l. Samples in class III or higher were considered strongly positive. All positive samples were reassayed for consistency of results.

We evaluated 1025 subjects, 84% male and 16% female, with a mean age of 39.1 years (range: 19–65). Latex-specific IgE were found in 36 out of 1025 (3.5%) subjects; six out of these 36 had strong positivities; and 17 subjects were classified in class I and 13 in class II. The prevalence of latex-specific IgE was significantly higher in women (31 out of 156) than in men (five out of 869): chi square, $P=0.001$. The prevalence was also higher in subjects with a positive allergy history (19 out of 142 vs 17 out of 893; $P=0.001$), while no relationship with age was detectable. None of the subjects with classes I and II positivity reported a significant history of latex-induced reactions. The six subjects

with class III or higher CAP positivity underwent the skin prick test for latex (Stallergènes, France), grass, *Parietaria*, mugwort, cat, dog, *Aspergillus fumigatus*, *Alternaria*, birch, hazelnut, alder, *Olea*, *Dermatophagoides pteronyssinus*, and *D. farinae* (Bayer DHS, Italy). Only one out of these six subjects reported contact urticaria using latex gloves for gardening (Table 1), but the remaining patients had skin positivity to several pollens.

The prevalence of serum IgE positivity to latex was overall low (3.5%), compared to that reported by other authors (4). Moreover, strong positivity was very rare (0.6%) and of clinical relevance in only one subject (0.09% of the population). It can be hypothesized that the observed latex-IgE positivities in five cases were due to cross-reactivity with grass allergens, as recently demonstrated (5). Finally, this study could provide a relatively realistic estimation of the prevalence of latex sensitization in the general population, since it was assessed in a large unselected sample by an objective method.

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Angioedema due to losartan

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Key words: angioedema; losartan; transient ischemic attack.

● ANGIOEDEMA is a rare adverse drug reaction to angiotensin II receptor antagonists. We report on a patient with angioedema of the face and generalized urticaria associated with a transient ischemic attack with unilateral neural and motor

deficiencies. For 4 months, a 49-year-old woman had been on antihypertensive medication with the angiotensin II receptor antagonist losartan (Lorzaar[®], Merck) 50 mg/day. Furthermore, she had taken simvastatin (Zocor[®], Merck) 10 mg/day because of hyperlipoproteinemia for 4 months. There were no previous episodes of angioedema, urticaria, or transient ischemic attacks. Cerebral magnetic resonance imaging showed no signs of cerebral bleeding or infarction.

From complete health, she developed angioedema of the face and generalized urticaria. In addition, she showed typical signs of hemisyndrome with unilateral neural and motor deficiencies on the right side of the face as well as on the right arm and leg.

After discontinuing medication with

A unique case of angioedema associated with transient ischemic attack due to an angiotensin II receptor antagonist.

Table 1. Clinical features of subjects with CAP positivity of >2

Patient no.	Age (years)	Sex	Prick latex	Symptoms due to latex	Previous surgery	Other sensitization
1	35	M	Positive	No	Yes	Grass, <i>Parietaria</i>
2	42	M	Positive	No	No	Grass, mugwort
3	27	F	Positive	No	No	Grass
4	36	M	Positive	No	No	Grass, mugwort
5	38	F	Positive	No	Yes	Grass, birch
6	63	M	Positive	Yes	No	None