

consequently, no hyperpigmentation were present at the site. However, our histologic findings do not support such a theory. Interestingly, we have found spongiosis with intraepidermal vesiculation and focal hydropic degeneration of the basal cell layer; these findings have not been previously reported in nonpigmenting fixed drug eruptions.

Although the radiologic contrast media are widely used, only iohalamate has been reported as the cause of a nonpigmenting fixed drug eruption (3).

In summary, we report a new case of nonpigmenting fixed drug eruption due to an iodinated contrast medium (ioxaglic acid) with good tolerance of a noniodinated contrast medium (iopamidol). To our knowledge, no case of a similar reaction has been described in relation to this drug.

Key words: contrast media; drug eruptions; ioxaglic acid.

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Honey allergy and rhinitis in Ankara, Turkey

ALTHOUGH the prevalence of honey allergy in the general population is not known, it is quite rare among pollen-allergic patients (1). The patients referred to our adult allergy clinic with seasonal rhinoconjunctivitis (SR) were evaluated for their food allergy/intolerance from 1991 to 1996. Of the 275 SR patients admitted (170 females, 105 males, mean age 30.4 ± 1.9 years, range 15-61), 45 (16.4%) reported allergy to various foods and two (0.7%) had anaphylaxis to honey. The skin prick test (SPT) findings of the patients are outlined in Table 1.

Honey allergy was severe in only one of the cases. The first patient was a 40-year-old woman, born in

Table 1. Positive skin prick test reactions to pollens in 275 seasonal rhinoconjunctivitis patients

Allergen	n	%
Timothy	243	88.4
Timothy alone	65	23.6
Mugwort	118	42.9
Mugwort alone	2	0.7
Birch	77	28
Birch alone	1	0.4
<i>Parietaria officinalis</i>	38	13.8
<i>P. officinalis</i> alone	1	0.4
<i>Olea europaea</i>	126	45.8
Hazelnut	74	26.9

central Anatolia who had been settled in the Mediterranean region, in Antalya, for the last 10 years. She had complained of rhinoconjunctivitis in spring and summer for the last 9 years. She had experienced three severe anaphylactic episodes with honey (the third occurred after she ate a honey cake) in the last 2 years. The SPT of that patient revealed sensitivity

to *Artemisia* and *Olea* pollens. The second patient was a 47-year-old male doctor from Ankara who had worked in northern Germany

for 22 years and had returned to Ankara 2 years before. He reported SR in Germany in spring which had improved in the last 5 years. He had had itching and edema in his throat and lips along with gastrointestinal complaints after eating honey. After four such occasions, he had stopped eating honey. During that time, he had also experienced oral allergy symptoms with hazelnut and apple. SPT was positive only for birch.

The common points in the two patients were the emergence of honey allergy in middle age after a period of SR and residence in two different geographic and climatic regions. In addition, the second patient had food sensitivity.

Honey allergy is a very rare, but serious health condition. Further investigations will give us more detailed information on this disorder.

Key words: anaphylaxis; honey allergy; pollen rhinoconjunctivitis.

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Anaphylaxis to dexamethasone

CORTICOSTEROIDS are used in the treatment of several diseases, including allergic disorders. Therefore, it is ironic that they may themselves cause allergic reactions (1, 2). We report a case of anaphylaxis after intramuscular injection of dexamethasone.

A 48-year-old woman was referred to our clinic because she had had an anaphylactic reaction to Dalamon (ALTER, Madrid, Spain). The patient

The first case of anaphylaxis to dexamethasone.

had developed flushing, intense generalized pruritus, facial angioedema, hypotension, and loss of consciousness 5 min after intramuscular administration of Dalamon. She was rapidly admitted to the intensive care unit and treated with dexchlorpheniramine, epinephrine, methylprednisolone, hydrocortisone, and colloid plasma expander; after observation of 24 h, she was discharged.

The patient gave her informed written consent before we began the study.

Dalamon is made up of several substances: cocarboxylase 250 mg, pyridoxal 5'-phosphate 250 mg, cobamamide 2000 µg, cyanocobalamin (vitamin B₁₂) 500 µg, hydroxocobalamin (vitamin B_{12b}) 500 µg, dexamethasone 1.5 mg, and lidocaine 50 mg.

Skin tests (prick and intradermal) were negative to the several individual drugs which make up Dalamon and to Dalamon itself. Both positive (histamine) and negative (saline solution 0.9%) control skin tests were also carried out. Controlled challenge tests of up to therapeutic doses were negative to cocarboxylase, pyridoxal 5'-phosphate, cobamamide, cyanocobalamin, hydroxocobalamin, and lidocaine. The challenge was positive with sodium phosphate dexamethasone after subcutaneous administration of 0.4 mg. The patient had intense generalized pruritus, flushing, dizziness, hypotension, and dysphonia, as well as laryngeal edema demonstrated by indirect laryngoscopy. The patient required dexchlorpheniramine and epinephrine to control the reaction. The diagnosis was dexamethasone hypersensitivity.

We decided to determine whether any other corticosteroids could not be tolerated. Accordingly,

Table 1. Skin test with corticosteroids

	Prick	Intradermal
6-Methylprednisolone	10 mg/ml	10 mg/ml
Prednisolone	10 mg/ml	10 mg/ml
Hydrocortisone	100 mg/ml	100 mg/ml
Betamethasone	4 mg/ml	4 mg/ml
Dexamethasone	4 mg/ml	4 mg/ml

we carried out skin tests (skin prick and intradermal) to 6-methylprednisolone, prednisolone, hydrocortisone, and betamethasone; all were negative (Table 1). The patient tolerated 40 mg of 6-methylprednisolone, but had another anaphylactic reaction after 20 mg (subcutaneous) of hydrocortisone; she then refused to continue the study.

There are several points to emphasize in this case. It is the first report of anaphylaxis due to dexamethasone, based on the dexamethasone controlled challenge test. Skin tests to dexamethasone were negative, but positive skin tests in systemic adverse reactions to corticosteroids have been reported in only a few cases (3-5). The patient also had a severe reaction to the hydrocortisone administered by us, although she had previously received the same drug for treatment of her anaphylactic reaction with no adverse reaction. In view of this last fact, we believe that the patient may have been in a refractory period, or sensitized to this drug.

In summary, we report the first case of anaphylaxis caused by dexamethasone.

Key words: anaphylaxis; dexamethasone; hydrocortisone; steroids.

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