

Correspondence

Coping with air-filtering devices

To the Editor:

It is not surprising that Reisman et al. (*J ALLERGY CLIN IMMUNOL* 1990;85:1050-7) had difficulty in finding benefit from the use of air-filtering devices in the treatment of patients with allergic rhinitis and asthma. Pitfalls are inherent in the evaluation of room air size, usage and activity, number of windows and doors, connecting and adjoining areas and their usage, air tightness of the rooms, and patient compliance. These factors impact on the efficiency of the devices and could prove significant, even in a double-blinded, cross-over design. In Table II, we find that nine of the 40 subjects used the devices improperly. However, other patients may have temporarily disconnected the units between investigator visits. Since motors are required to move air through the filters, their noise can interfere with sleep and thus patient compliance. Dropping noncompliant patients from the data analysis is tantamount to ignoring side effects of drugs.

The bottom line is that filtering devices are available that approach 100% efficiency in removing particles $>1.0\ \mu\text{m}$ in diameter from the air that reaches them. However, in a natural setting, they cannot filter the air free of allergens before the patient inhales that air. A study reported 34 years ago with this conclusion¹ continues as true today. These devices can be helpful when they are used by a very select group of highly motivated patients.

Harold S. Novey, MD
University of California-Irvine
Department of Medicine
PO Box 14091
Orange, CA 92613-4091

REFERENCE

1. Novey HS, Irwin JW, Welts J, Burrage WS, Roach A, Gilchrist M. Removal of ragweed pollen from environmental atmosphere of patients. *J Allergy* 1956;27:398-408.

Delayed food reactions in atopic dermatitis

To the Editor:

The article by Kondo et al.¹ described enhanced proliferative responses of peripheral blood mononuclear cells (PBMC) to ovalbumin (OA) and bovine serum albumin (BSA) in patients with atopic dermatitis (AD) who demonstrated delayed sensitivity to those food antigens by double-blind, placebo-controlled food challenge (DBPCFC). The control groups were healthy children and those with immediate hypersensitivity reactions to the same foods. The authors imply a cause-and-effect relationship between the enhanced PBMC response and the delayed reactions by DBPCFC. However, numerous immunologic ab-

normalities have been described in patients with AD, and perhaps the same enhanced PBMC responses would be observed in patients with AD and negative DBPCFC. It would appear that this would be a more appropriate control group. This same question could be addressed by describing the PBMC responses to OA in milk-sensitive patients with AD and BSA responses in egg-sensitive patients. It would also be of interest to know how the patients with isolated delayed reactions to DBPCFC described in this article that "did not appear sooner than 2 hours" differ from patients of Sampson et al.² and Burks et al.³ who describe no such isolated late responses.

John M. Kelso, MD
Naval Hospital
San Diego, CA 92134

REFERENCES

1. Kondo N, Agata H, Fukutomi O, Notoyoshi F, Arai T. Lymphocyte responses to food antigens in patients with atopic dermatitis who are sensitive to foods. *J ALLERGY CLIN IMMUNOL* 1990;86:253-60.
2. Sampson HA, McCaskill CC. Food hypersensitivity and atopic dermatitis: evaluation of 113 patients. *J Pediatr* 1985;107:669-75.
3. Burks AW, Mallory SB, Williams LW, Shirrell MA. Atopic dermatitis: clinical relevance of food hypersensitivity reactions. *J Pediatr* 1988;113:447-51.

In re: Moscicki et al. (*JACI* 1990;86:325-32)

To the Editor:

The report of Moscicki et al. in their article, "Anaphylaxis during induction of general anesthesia: Subsequent evaluation and management" (*J ALLERGY CLIN IMMUNOL* 1990;86:325-32) carefully reviews anaphylaxis due to medications administered at the time of induction of general anesthesia. I have recently observed a case in which sensitization to latex in the anesthesia masks and gloves induced an anaphylactic reaction at the time of induction to anesthesia. An evaluation needs to include a skin test or specific IgE measurement of response to antigens from the rubber tree.

Richard W. Honsinger, Jr. MD
Los Alamos Medical Center
Los Alamos, NM 87544

REFERENCES

1. Slater J. Rubber anaphylaxis. *N Engl J Med* 1989;320:1126-30.
2. Spaner D, Dolowich J, Tarlo S, Sussman G, Butto K. Hypersensitivity to natural latex. *J ALLERGY CLIN IMMUNOL* 1989;83:1135-7.