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Allergic reaction to phorate : an organophosphorus compound

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To the Editor

Phorate ($C_7H_{17}O_2PS_3$) is a non-biocumulative organophosphorus compound marketed as 90% pure emulsifiable liquid or granules for the killing of mites, ophids, corn root worms, nematodes and other pests inhabiting crops, vegetables, ornamental or fruit plants. It is extremely toxic to mammals. Improper handling of the chemical or its container without adequate safety measures, may contaminate, drinking water, edibles, clothing, utensils and the human body.[1] It can be absorbed by lungs, skin and gastrointestinal tract. It is metabolized to phorate sulphoxide, phoratesulphone and oxygenated analogues in the liver and excreted as diethyl phosphoric acid, o-o diethyl phosphorothioic and o-o diethyl phosphorodithioic acids in urine (35%) and faces (3-5%).[2] It is seen that although the third world accounts for only 15% of the world's pesticide consumption, half of the estimated annual half to one million pesticide associated poisonings and over half of the ensuing 19000 deaths occur in developing countries mainly because of lack of protective devices while handling these pesticides.[3]

Toxic fatal reactions in humans with phorate are unknown, but few cases have developed coma, convulsions, frothy sputum and neurological deficit with it.[2] While there are no reports of allergic cutaneous reaction with phorate, recently 3 members (father and 2 sons) of a peasant family presented to us with complaints of generalized itching, urticarial skin rash and cough for 2 days. A day earlier to the appearance of cutaneous lesions, all of them had sparkled phorate in their agriculture farm without protective measures. A thorough personal and family history and systemic examination excluded mastocytosis, atopic diathesis, worm infestation, allergic drug reactions or other systemic illness. Cutaneous examination revealed several generalized urticarial lesions in all the three members. Laboratory investigations revealed moderate lymphocytosis with significantly high eosinophil count (5500, 3200, 3100/mm^3 respectively in the 3 members) with vacuolization in 20-30% cells. Serum IgE levels were extremely high (2518 IU/ml and 2316 IU/ml) respectively in the two boys examined at a fortnight interval.

All the 3 members were advised to avoid phorate and treated with oral dexchlorphinaramine maleate and cyproheptidine with no therapeutic response. Prednisolone was then added with which they responded within a fortnight with clinical cure. All the members of the family are disease free today for 2 years. It appears that the peasant family got sensitized to phorate previously and when exposed unprotected they developed severe allergic symptoms.

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