In three T-cell clones of the double-negative phenotype, we measured the *in vitro* production of chemokines of the C–C type, and we found high amounts secreted (12–28 ng/ml for RANTES, 21–48 ng/ml for MIP-1α, and 10–64 ng/ml for MIP-1β), independently of the Th type of the clones. The stable presence of this double-negative Th2 type subset has not been assessed by other studies. The patient survived after 3 years' observation, and spontaneously recovered from the hypereosinophilia and the symptoms described, after reintroduction of antiretroviral treatment. Studies of his T-cell function are in progress, but the CD4+ cell number further decreased, thus pointing to the possible role of this cell in the hypereosinophilic syndrome observed. The high production of C–C chemokines in an AIDS patient with hypereosinophilia may be due to various causes, but it is very unlikely to have been due to antiviral defense mechanisms (8). C–C chemokines act as potent activators of eosinophils, and may be implicated in allergic manifestations (9).

Our observation highlights two main points:

1) CD4–CD8– T cells may be important sources of IL-5 and other type 2 cytokines, as well as chemokines involved in eosinophil recruitment and activation
2) hypereosinophilic (hyper-IgE) syndrome in HIV disease may be reversible as a result of subpopulation dynamics and viral infection.

Of course, these points are relevant to other observations on the primary hypereosinophilic syndrome without HIV infection.

Key words: CD8; CD4; cytokines; eosinophilia; HIV disease; hyper-IgE; Th2 cells.

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## Adverse reaction to potassium iodide from a cough syrup

IODIDE-containing drugs are effective and are widely used in enhancing sputum clearance when given orally to patients with mucus hypersecretion. Iodides appear to stimulate secretion of airway fluid directly, and these agents can also probably stimulate a vagal reflex that causes a mucokinetic effect (1).

Toxicity resulting from ingestion of excess iodine has not been commonly reported. Nevertheless, some patients are known to have allergic-type reactions to iodine (2, 3).

Iodides have been implicated in the pathogenesis of many dermatologic diseases (4–6), usually after application of an antiseptic solution, and rarely after systemic administration of iodine.

■ A 66-year-old man was referred to our department for allergologic study because of adverse drug reactions. His medical history included chronic obstructive lung disease, blood hypertension, and penicillin allergy. Our patient had presented an episode of angioedema, itching, and erythema involving the face and neck, together with dyspnea, a few hours after taking the second dose of a cough syrup (Elixifilin®) containing theophylline (80 mg/15 ml) and potassium iodide (130 mg/15 ml). Its additives include saccharose (2.25 g/15 ml) and ethanol (10%).

Those symptoms disappeared 24 h after treatment with parenteral corticosteroids, and avoidance of such cough syrups.

An oral challenge test with Elixifilin, as is, was performed (single-blind and placebo-controlled). Increasing doses were taken hourly by our pati-

ent, up to 35 ml (cumulative dose), and immediate adverse reactions did not appear. Nevertheless, approximately 5 h after the challenge test, our patient developed edema of his face and neck, together with itching in the pharynx and eyes, conjunctival hyperemia, dysphagia, and a feeling of being hot. Symptoms subsided spontaneously and wore off completely after treatment with methylprednisolone.

One month later, in order to determine which of the constituents of the cough syrup caused the adverse reaction, we challenged our patient again (single-blind and placebo controlled) with increasing doses of theophylline up to 350 mg cumulative dose. This time, neither immediate nor nonimmediate reactions were observed.

■ Iodine has been widely implicated in many dermatologic reactions, commonly after local application, by virtue of a delayed-hypersensitivity mechanism; therefore, iodine is considered a hapten which can elicit contact reactions. On the other hand, some patients present allergic-like reactions after the administration of radiographic iodine contrast agents, but the mechanism of such reactions is not completely explained.

The effects of exposure to levels of dietary iodine higher than those required to support thyroid function have not been well defined; 1000 μg iodine or less per day is probably safe for most patients, but may be toxic for a small proportion of the population. In their study, Garber et al. (4) did not find side-effects after daily ingestion of iodine-enriched eggs (711 μg iodine/egg) for 8–16 weeks. In thyrotoxicosis, recommended oral doses of inorganic iodine range from 0.2 to 2 g/day (7).

*A case of late (>5 h) reaction with edema and itching in the face region.*

The normal dose of Elixifilin for adults is 30 ml every 8 h; that is to say, approximately a 260-mg dose of potassium iodide every 8 h. In the challenge test, our patient took a cumulative dose of approximately 300 mg potassium iodide. It was difficult to suspect a toxic mechanism when the first reaction appeared after the second dose of cough syrup. Nevertheless, an IgE-mediated mechanism is difficult to prove because iodine operates as a hapten, and *in vitro* tests are not available.

On the basis of clinical history and the results of challenge tests, our diagnosis in this case was nonimmediate adverse reaction to potassium iodide because the oral challenge test with the other suspected constituent (theophylline) did not elicit an adverse response. We excluded both saccharose and ethanol because these additives are found in many foods and drinks, and clinical history did not lead us to suspect them.

Key words: edema; iodide.

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## Thirteen cases of allergy to human seminal plasma

THE FIRST case of human seminal plasma allergy (HSPA) was reported in 1958 by Specken (1). In 1967, Halpern et al. (2) provided evidence of a reaginic pathogenesis in a second case. In 1979, in our department, Sabbah et al. (3) reported the first French case and the first successful desensitization. Since 1979, numerous other patients have been investigated in our department, and we have diagnosed 12 new cases. We present briefly our 13 observed cases with clinical characteristics and immunotherapy results.

■ Table 1 summarizes the 13 cases. Our experience confirmed what is described in the literature. Our patients were all female. Six patients presented local reactions (LR) with vulvovaginal reactions, and seven had systemic anaphylactic reactions (SAR) of various degrees. Diagnosis was based on a clinical history of postcoital reactions. These reactions were

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