

Anaphylactic shock after game of squash in atopic woman with latex allergy

SIR,—Delayed hypersensitivity to natural rubber products is well known. Urticaria as an immediate hypersensitive reaction to latex was first recorded ten years ago,¹ and since then about 100 cases of immediate-type allergic reaction to latex have been described.^{2,3} Most reactions manifested as urticaria but asthma or even severe anaphylaxis during medical examination or surgery were also noted in some patients.³ More than 70% of patients had a proven history of atopy.² We report a 25-year-old woman who was admitted to our emergency unit after a severe anaphylactic shock reaction which occurred after a game of squash.

10 minutes after the end of a squash match this fit woman had increasing swelling of hands and feet, perioral tingling, and dizziness. She had lost consciousness for a short time, during which peripheral pulses were not palpable. Generalised urticaria was noted. Immediate parenteral administration of histamine antagonists, plasma expanders, and high-dose corticosteroids led to rapid stabilisation of the systemic circulation. Urticaria slowly diminished an hour later in our emergency unit. She had no further abnormalities and routine laboratory investigations were normal. She recovered rapidly and was well the next morning. She had had allergic rhinitis for 13 years and neurodermatitis for 18 months. Furthermore she had had five minor operations, the last being appendectomy 8 months previously. At this operation she had had a severe anaphylactic reaction with generalised urticaria and shock which was treated successfully. None of the drugs used during the operation provoked any allergic reactions in skin tests and the cause of anaphylaxis at that time remained unclear. 2 months before this latest episode she had had intense contact dermatitis after wearing latex gloves.

After exclusion (as far as possible) of other allergens, skin scratch tests showed urticaria to several extracts of latex and latex gloves as well as to the latex-containing handle cover of the patient's squash racket. Accidental touching of the eyelid with a latex-contaminated finger led to an acute angio-oedema, sneezing, rhinitis, and a symptomless fall in systemic blood pressure from 105/70 to 85/70 mm Hg. Exposure to a squash ball and rubber-containing dust from the squash court elicited no allergic reactions. Serum IgE against latex was strongly positive (grade 3+).

In view of the patient's history of atopy, recurrent episodes of anaphylactic shock after contact with latex products, a provokable immediate-type hypersensitivity to latex products, the presence of serum IgE against latex, and the exclusion of other allergens, we assume that rubber allergy caused both episodes of anaphylactic shock in our patient. We are not aware of other reports of anaphylactic shock due to latex allergy occurring during normal life activities.

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Unusual cause of acute urinary tract infection in Muslim youths

SIR,—A year ago an 18-year-old male consulted me for haematuria, high-grade fever with chills, burning sensation on micturition, and severe headache. Urine analysis revealed tiny blood clots and culture yielded *Escherichia coli*. The infection was promptly controlled with co-trimoxazole and urine cultures became negative on 3 consecutive weekly examinations. 2 months after stopping the treatment the patient presented again with the same complaints. A 2 h postprandial blood sugar was 125 mg/dl and a cystourethrogram was normal. This time he was put on nalidixic acid for 4 weeks. When cultures were again negative co-trimoxazole one tablet daily at bedtime for 2 weeks was given for prophylaxis.

The patient was closely questioned about his sexual practices. He disclosed that when masturbating he would, just before ejaculation, press the urethra very tightly at the level of the glans so that no drop of semen was discharged. 1 or 2 minutes later the ejaculate was reversed by back-milking movements applied to the penile urethra. He did this because Muslims have to be *pak* (pure) when offering *Namaz* (prayers). This purity is broken by ejaculation and re-validated by taking a bath. In winter, to avoid baths while maintaining purity he adopted this unusual form of masturbation.

Interviews with eight of the young man's friends revealed the practice to be used quite often by seven of them, all for the same reason. They did not masturbate in this way very often because they prayed only rarely. My patient prayed regularly and masturbated daily. Another boy reported a burning sensation on micturition but nothing else.

The patient was advised to abandon the habit and over the 7 months after stopping antibiotics he has had no recurrence of urinary infection.

The high pressure generated during ejaculation with the outlet closed off could damage urethral epithelium, allowing bacteria to flourish. Furthermore semen collecting in the glans could become contaminated before it is milked back.

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von Willebrand factor activity in primary and in scleroderma-associated Raynaud's phenomenon

SIR,—Dr Rose and colleagues (March 3, p 500) describe the use of von Willebrand factor (vWF) as a marker of endothelial damage in haemolytic uraemic syndrome and systemic vasculitides. We have measured plasma vWF activity in 20 patients with primary Raynaud's phenomenon¹ and in 20 with scleroderma-associated Raynaud's.² Activity was 108 (SD 31)% in primary Raynaud's and 199 (79)% in the scleroderma-associated condition. This confirms the existence of endothelial damage in patients with scleroderma-associated Raynaud's phenomenon. vWF activity may be useful, together with capillaroscopy, in distinguishing primary from scleroderma-associated Raynaud's phenomenon.

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Mupirocin-resistant *Staphylococcus aureus*

SIR,—Mupirocin became commercially available in the UK in April, 1985, and is used widely for the topical treatment of bacterial skin infections. Since May, 1988, it has also been available for the elimination of nasal carriage of staphylococci, including methicillin-resistant *Staphylococcus aureus* (MRSA).

There have been some reports of mupirocin-resistant *S aureus*¹⁻⁵ so we did a large survey to estimate the level of mupirocin resistance among staphylococci. Clinical isolates from hospital inpatients and outpatients and from general practice were examined by microbiology laboratories in Birmingham, Bristol, Leeds, and London. Organisms were cultured and were tested for susceptibility by the disk method, with agar incorporating 5% lysed