

admissions to the emergency department, even after exposure to minute quantities of allergen by skin contact or inhalation.

At the age of 18 she inadvertently entered a dairy shop and inhaled milk proteins experiencing a fatal reaction (asthma, horticaria, angioedema).

We believe that an inappropriate exclusion diet had caused a loss of tolerance. Some reasons do not support the possibility that this case could simply reflect the natural course of severe food hypersensitivity. The occurrence of immediate-type symptoms to previously tolerated food has been reported in adults, but usually in these patients there is no overt evidence of previous asymptomatic sensitization. In the usual pattern of allergy children might experience symptoms after few exposures. In our case the temporal link between the diet and the development of symptoms is suggestive for a causal relationship between the two. The immunologic risk of elimination diets has been reported in the literature.

We found three papers involving 13 children with documented IgE hypersensitivity who could all previously tolerate the offending food before the elimination diet induced the subsequent development of immediate type symptoms (1–3). Evidence suggests that exposure to large doses of antigen might produce a suppression of the specific IgE response, a model likely to explain oral desensitization to food (4). Therefore, the induction of a loss of tolerance by interruption of exposure to large doses of antigen is conceivable in children with preexisting subclinical sensitization. This is the first report of fatal loss of tolerance after an exclusion diet and the presence of asthma, a risk factor for severe food allergic reactions, probably played a role. Incidence and hospital admissions for acute anaphylaxis seem to increase (5). Our hypothesis is that this increase might be due, at least partially, to the widespread and uncontrolled recommendation of elimination diets.

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Euro coins and contact dermatitis

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Key words: contact dermatitis, Euro, nickel.

Starting from January 2002, the Euro has become the official monetary unit of the European Union and has replaced the various national currencies. It has been recently demon-

Sensitization to nickel did not increase after the introduction of Euro coins.

strated that the 1 and 2 euro coins release very high amounts of nickel, at variance with the 50 and 10 cent coins. This has been attributed to the peculiar bimetallic structure of the 1 and 2 euro coins (that are composed by a ring and a central plate of different cupro-nickel alloys): the bimetallic structure generates a galvanic potential that is responsible for corrosion and nickel release in contact with human sweat (1). The release of nickel has been found to exceed by about 300-fold the limits recommended by the European Union. Thus, it has been claimed that handling Euro coins can lead to an increase of the prevalence and severity of contact dermatitis caused by nickel.

We attempted to test the hypothesis that the current handling of Euro coins has increased the rate of nickel sensitization. This was performed by studying two large groups of patients referring for suspected contact dermatitis. The first group was studied before the introduction of the Euro (i.e. before January 2002), and the second group from January 2002, when the new currency was introduced.

More than 1000 consecutive outpatients suspected of contact dermatitis underwent a patch test with the European Standard Series (2). All the patients had an eczema strictly confined to both hands. Patients pierced at any body site were excluded from this analysis in order to avoid a heavy confounding factor, as it has been shown that the presence and number of piercing increases the rate of contact allergy (3). Demographic data, working habits and the history of allergic diseases were carefully recorded in all patients. In particular, the patients were screened by clinical history for the presence of one or more of the following: hayfever, allergic asthma, atopic

Table 1. Characteristics of the patients patch-tested before and after the introduction of euros

	Before Euro	After Euro	P (χ^2)
Patients	753	292	
Sex (M/F)	273/480	76/216	NS
Mean age	43	42.5	NS
Age range	15–81	14–82	NS
History of allergic diseases	122 (16.2%)	50 (17.1%)	NS
Patch-test nickel positivity	202 (27%)	78 (26%)	NS
Age range	15–76	14–72	NS
History of allergic diseases	39 (19.2%)	15 (19.6%)	NS

dermatitis, food or drug allergy, hymenoptera venom hypersensitivity.

A total of 753 patients were patch-tested before January 2002, and 252 after that month. The characteristics of the two groups of patients are summarized in Table 1.

It is worthy of note that there was no difference at all in the rate of positivities to nickel sulphate between the two groups (27% vs. 26%, chi-square test, $P = \text{NS}$), although the two groups were well matched for their general characteristics. As expected, according to the existing literature, the positivities to nickel were largely more frequent in women than in men, and the prevalence of atopic diseases was around 20%.

Based on the data from the literature, indicating that some euro coins release high amounts of nickel, an increased occurrence of nickel sensitization and contact dermatitis should be expected after the new currency has been introduced (4). Nevertheless, our data collected in a large population that can be considered a representative sample of what seen in the current clinical practice do not confirm the hypothesis. So far, after about 2 years of use of Euro, no increase in nickel sensitizations could be detected in the general population referring for hand dermatitis. This reassuring datum is probably because of the fact that in everyday life, the direct contact with the metal of coins is not prolonged enough to make the increased nickel release clinically significant. In this regard, it has to be taken into account that nickel release experiments were made under artificial conditions (artificial sweat) (1), whereas short-term handling does not increase the release of metals (5). Indeed, in our population there was no subject that could be considered 'at high risk' for prolonged and continuous handling of coins and metals, such as cashiers or jewellers (6), therefore we cannot exclude that in very selected patients, with specific working habits, the use of the new coins can lead to increased occurrence or worsening of contact dermatitis.

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Predominant aeroallergen pollen grains in the atmosphere of Ankara, Turkey

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Key words: Ankara; pollen allergy; pollen calendar; Turkey.

Determinations of types and falls of pollen grains are helpful for patients suffering from allergic diseases (1, 2). For this reason, pollen calendars are made. The aims of the study are to improve seasonal pollen calendar and to determine concentrations of allergenic pollens in the air of Ankara.

Atmospheric pollen was collected by use of a Burkard 7-day recording volumetric trap in three consecutive years (1994–1996). Counts were made at 1 h

interval, and total daily counts were converted to numbers per cubic meter of air (3).

During the 3-year observation period, 52 pollen types were identified (Fig. 1). Tree pollens were dominant comprising 85.9% of total airborne pollen, consisted of the main following arboreal plants: Pinaceae, *Populus*, Cupressaceae, *Robinia pseudoacacia*, *Acer*, *Morus*, *Platanus*, *Quercus*, *Salix* and *Betula*. Grasses and weeds pollen comprising 14.1% of the total, consisted of Gramineae, Chenopodiaceae, *Plantago*, Urticaceae and *Artemisia*.

The earliest pollen grains were noted in January (Fig. 1). Pollen concentrations began to increase in February and March, reached their maximum level in April (Fig. 1).

According to the main pollination period of the various types recorded, three groups could be distinguished:

- Pollen with a short principal period, < 10 weeks: *Aesculus*, *Ailanthus*, *Fagus*, *Juglans*, *Maclura*, *Tilia*, *Ulmus*, *Castanea sativa*, *Sambucus* and *Typha*.
- Pollen with a medium principal period, between 10 and 15 weeks: *Acer*, *Platanus*, *Quercus* and *Salix*.
- Pollen with along principal period, > 15 weeks: Pinaceae, *Populus*, Cupressaceae, Moraceae, Gramineae, Chenopodiaceae, *Betula*, *Artemisia*, *Robinia pseudoacacia*, Oleaceae, Urticaceae, *Plantago*, Rubiaceae and Boraginaceae.

Many pollen types in Ankara atmosphere do not reflect the typical steppe vegetation. The vegetation is in the region typical urban because of the introduction of ornamental plants and trees. The 3-year study in Ankara region shows tree pollens are abundant.

Some important allergenic pollen grains such as Pinaceae, *Populus*, *Acer*, *Platanus*, *Quercus*, Gramineae, Chenopodiaceae, *Betula* and *Plantago* were also found in high concentrations. These pollen types are responsible for many cases of pollinosis (4, 5).

The 3-year pollen calendar of the region presented in this paper may be useful for allergologists to establish an exact diagnosis.