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ABSTRACTS: POSTER SESSIONS

P93  MALIGNANT IDIOPATHIC ANAPHYLAXIS COMPLICATED BY SIGNIFICANT CARDIOMYOPATHY IN A 35 YEAR OLD MAN. A.T. Tovar-Tejada, M.D.*, S. Guttman, M.D.* P. Avila, M.D. C. Choy, M.D. J. Kishiyama, M.D. San Francisco, California.

Background: Patients with the malignant classification of idiopathic anaphylaxis (IA) and accelerated coronary artery disease (CAD) complicated by sudden death is an increasingly common presentation.

Purpose: To report a case of refractory malignant idiopathic anaphylaxis (IA) and accelerated coronary artery disease (CAD) complicated by sudden death.

Case Report: In 1996, a 35 year-old man suffered a myocardial infarction (MI) requiring a 2 vessel CABG. His lipid profile, blood glucose, and hormone levels were within normal limits. The following year he developed multiple episodes of anaphylaxis characterized by hives and anaphylactic shock. One episode of anaphylaxis led to another MI. In 1998 he developed anaphylaxis during an exercise treadmill test. We referred to our local and respiratory unit for further evaluation and management. Workup revealed no evidence of vasoconstriction, mastocytosis, or hypersensitivity to medications. He was treated with anakinra and prednisone (50 mg qid), which was slowly tapered. However, over the following 13 months he suffered 8 anaphylactic episodes of varying degrees of severity, mostly triggered by cold temperature exposure or exercise, although some occurred at rest. His IA was eventually controlled on prednisone (25 mg qid) in conjunction with doxepin, hydroxyzine, H2 blockers, albuterol tablets, and ketotifen. At this point, however, the patient developed complications including weight gain, depression, proximal myopathy, and arthralgia of the femoral head. Against medical advice, NP stopped his metoprolol and prednisone and was symptom free for three months.

Conclusion: This case is notable for the refractory nature of the IA complicated by several comorbid conditions, including CAD requiring beta-blocker therapy and devastative complications of corticosteroid therapy.


A 39 year old male with seasonal allergic rhinitis and asthma developed progressive shortness of breath that did not respond to inhaled beta agonists. Physical examination was significant only for intermittent bibasilar crackles. Pulmonary function testing revealed a moderate restrictive pattern and a severely reduced diffusing capacity (DLO). A chest x-ray revealed bibasilar lung fibrosis. Fiberoptic bronchoscopy was non-diagnostic. There were multiple allergic problems in the home including a feather quilt and pillows, three cats, and a dog that went into the patients bedroom. Milder in the bathroom, and a significant number of water leaks with mold growth detectable by odor. Skin testing revealed allergic reactivity to multiple pollens, feathers, and cats. A home mold analysis revealed increase numbers of several types of molds, especially Penicillium species. His sputum contained high levels of mite and cat-specific IgE and very high levels of mite and feather specific IgE. There were no detectable levels of penicillium-specific IgE and a commercial hypersensitivity screen was negative. However, his lymphocytes exhibited a strong in vitro proliferative response to Penicillium extract. Serial environmental control measures in the home were instituted which included moving to a new home, because of the hopeless diagnostic in other extrinsic asthma due to mold and feather allergens. As a result, he improved rapidly and dramatically, and has remained stable for over a year. This case demonstrates the importance of a detailed environmental history in patients with interstitial lung disease and that strict environmental control is an essential therapeutic approach in these patients. Furthermore, commercial hypersensitivity pneumonitis screens may be negative in the presence of significant disease and special immunological investigations may be required.

P95  PARENTAL KNOWLEDGE ABOUT PREVENTIVE MEASURES OF ALLERGY IN THE PEDIATRIC POPULATION.

C.J. Almendares, M.D.*, S. Orozco, M.D. J.A. Ortega. Mexico City

BACKGROUND: Avoidance of the early sensitization to environmental and food allergens is the preventive measure that physicians can teach to the family. To accomplish this objective the allergist should promote to pediatricians to start these preventive measures in the early life.

OBJECTIVE: To determine if the level of information received for the parents in the pediatric clinic is effective to acquire knowledge about the prevention of allergic illness and change their attitudes to improve their environmental and feeding practices.

METHODS: A prospective, descriptive study was made since February 13 to April 30 1999. The instrument of the study was an open questionnaire of 23 easy language questions applied to every parent at the pediatric clinic in the National Institute of Pediatrics in Mexico City. Each question had a correct score. The level of knowledge in preventive measures was classified in: Very low (0-20%), Low (21-50%), Good (51-75%), Very good (80-100%). The statistical data were analyzed in Excel 97.

RESULTS: We received 87 complete questionnaires. The average of education of the parents was high school. The average in the score was 75.4% the main source of information about measures to prevent allergy was the physician. 46.5% of the parents received information about the role of breastfeeding in prevention of allergic illness, 75% of the parents are aware about the importance of avoiding dairy products in the home, and 75% of the parents have the knowledge about the importance to avoid house dust and pets in their homes.

CONCLUSIONS: With the information received in the pediatric clinic the parents can identify the risk factors to develop allergy but they didn't put in practice measures to avoid them. To have success in the parental education programs for the prevention of allergic illness, we have to increase the communication skills to change the attitudes in the family for improve their environmental conditions and feeding practices.

P96  USE OF MONTELUKAST IN THE TREATMENT OF ATOPIC DERMATITIS. A CASE REPORT.

G. Galindo MD*, L. Zuniga MD, S. Gonzalez-Diaz MD. Universidad Hospital Montereay, N.L. MEXICO.

Atopic dermatitis is a chronic inflammatory disease that frequently is difficult to control. It affects up to 15% of the general population, it is characterized by eczematous plaques, lichenification, and pruritus. It is usually recurrent and refractory to treatment, and associated to other allergic diseases as asthma, allergic rhinitis and conjunctivitis.

We report the case of G.S., a 15 year female with a history of severe atopic dermatitis since 1 year, refractory to conventional therapy as moisturizing creams, topical corticosteroids, oral antihistamines, and immunotherapy. She has also symptoms in upper and lower airways, perennial allergic rhinitis, conjunctivitis, and bronchial asthma, since 6 mos., with crises during cold weather. Physical examination revealed generalized dermatitis consisting of erythematous and desquamative plaques, marked lichenification and evidence of secondary skin infection. Her serum IgE level was 52.320 IU, nasal cytology showed metachromatic cells 4-10 per field, PFT reversible obstruction, skin tests positive to dermatoglyphs. We indicated the conventional therapy, with poor response after 3 weeks of treatment, and decided to add montelukast 10 mg per day to control her asthma. 2 weeks later she showed significant clinical improvement, with clearing of her cutaneous symptoms. She continued for 6 weeks and then discontinued the montelukast and switched to another antihistamine, with recurrence of in her atopic lesions, then received Zafirlukast, 30 mg Bid. After 2 weeks of therapy without improvement we switched back to montelukast with remarkable improvement after 1 week of therapy. This case illustrates the clinical benefits of the antileukotriene therapy as a new option to treat patients with refractory atopic dermatitis.