Dermatological powder as hidden cause of occupational allergy due to casein: a case report

P Bonadonna, G Senna, G Passalacqua

We report a case of occupational asthma due to hidden casein, contained in a dermatological powder. A 44 year old nurse reported the recent onset of rhinitis and asthma, clearly related to the work environment. Skin tests for food allergens revealed a positivity for milk proteins. The source of dispersed milk proteins in the work environment was found to be a dermatological formulation of an inert refreshing powder, used to treat excoriated areas in the elderly. Skin prick tests confirmed the positivity to casein and to the commercial product.

A llergic sensitisation to milk proteins is a frequent cause of food allergy symptoms in children, but is relatively rare in adults. The most common clinical pictures of food allergy are urticaria-angioedema and other skin diseases or gastrointestinal symptoms; the respiratory tract is less frequently involved,

The above mentioned skin test reagents gave a negative reaction in 10 non-atopic controls and 10 atopic subjects without food allergy. Due to the high risk of severe reactions, the Ethical Committee denied permission to perform a bronchial specific challenge with casein. After this diagnosis, the patient was allowed to move to another department (internal medicine) where Fissan Powder was not used. She was also instructed to avoid contact with Fissan Powder and to check the composition of similar products before using them. At present, about six months after moving, she is well and has reported no further asthma episodes.

D I S C U S S I O N

The overall occurrence of allergic reactions to food is less frequent in adults than in children. In particular, allergy to milk is common in children under 3 years, lactalbumin being the most frequently responsible allergen, whereas casein is responsible for cows’ milk allergy in adults. The reactions to cows’ milk proteins are mostly cutaneous or

Table 1 Diagnostic procedures

<table>
<thead>
<tr>
<th>Test</th>
<th>Wheat (mm)</th>
<th>Erythema (mm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin reactivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histamine</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Diluent</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Whole milk</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Casein</td>
<td>8 (pseudopodes)</td>
<td>20</td>
</tr>
<tr>
<td>Lactalbumin</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fissan Powder</td>
<td>10 (pseudopodes)</td>
<td>25</td>
</tr>
<tr>
<td>Specific IgE (Pharmacia CAP system)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casein</td>
<td>1.15 (class 2)</td>
<td></td>
</tr>
<tr>
<td>Lactalbumin</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
gastrointestinal and are usually the consequence of a previous gastrointestinal sensitisation. In our patient, the clinical manifestations were respiratory and appeared only after exposure to a powder containing casein had begun. This would suggest that sensitisation through the respiratory tract had occurred. However, a skin positivity to milk was present and one episode of milk intolerance was reported, despite the open feeding being negative. Therefore, as we had available no previous data or serum samples, it is not possible to establish whether the exposure to airborne casein caused both sensitisation and symptoms or only caused symptoms in a previously sensitised patient. Nevertheless, we can speculate, in the present case, that the inhalatory threshold for symptoms is much lower than the oral one. Casein is the only antigen contained in the dermatological powder that can evoke a specific IgE recognition (confirmed by skin test and RAST positivity); an IgE reaction against silica or zinc oxide or magnesium nitrate is difficult to hypothesise and has never been described.

At variance with other reported cases of occupational milk allergy, in this case the presence of milk proteins at the workplace was not known or suspected, and a widely used dermatological preparation was the hidden allergen source. This further highlights the fact that in medical environments, great attention must be paid even to “innocent” products.

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**Main messages**

- Respiratory allergy to milk proteins is not common in adults, and in only in few cases is it related to the work environment.
- Common pharmaceutical preparations may behave as hidden sources of airborne milk proteins and provoke severe respiratory symptoms.

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**Policy implications**

- Greater attention in general should be paid to the possible hidden sources of sensitising/triggering allergens in the work environment. A correct diagnosis and the subsequent allergen avoidance/removal are critical: they allow patients to keep working, with a favourable socioeconomic outcome.

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**REFERENCES**


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**Authors’ affiliations**

P Bonadonna, G Senna, Allergy Unit, Verona General Hospital, Verona, Italy.
G Passalacqua, Allergy & Respiratory Diseases, Dept of Internal Medicine, University of Genoa, Italy.

Correspondence to: Dr G Passalacqua, Allergy & Respiratory Diseases, Dept of Internal Medicine, Pad Maragliano, L.go R.Benzi 10, 16132 Genoa, Italy; giovanni.passalacqua@hsanmartino.liguria.it

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