and a prospective survey of fatal and severe reactions from March 1998–February 2000 were performed.

**Methods.** Details of death certificates from the offices of national statistics were reviewed for fatal allergic food reactions via codes from the International Classification of Diseases, Ninth Revision (ICD-9), and inquiries were sent to pediatricians asking them to report on patients under 16 who died or were admitted to the hospital for an allergic reaction to food.

**Results.** Eight children died in a population of 13 million children, yielding an incidence of 0.006 deaths per 100 000 children. Milk caused 4 of the deaths, peanut, 2; egg white, 1; and mixed food, 1. Two children died despite receiving early epinephrine before admission, and 1 child with a mixed food reaction died from an epinephrine overdose. Over the 2-year prospective period, there were 6 near-fatal reactions, none caused by peanut, and 49 severe ones, 10 caused by peanut, yielding incidences of 0.02 and 0.19 per 100 000 children per year, respectively. All fatal cases and 5 of 6 near-fatal cases had a clear history of asthma. Those suffering the most severe reactions tended to have had severe previous reactions, but it was notable that in 2 of 3 fatal reactions and 5 of 6 near-fatal reactions, the previous event had not required urgent hospital treatment.

**Conclusions.** The finding of so few deaths in such a large population should reassure parents and doctors that the risk of death is small. The child with food allergy and asthma may be at particular risk. Although a previous mild reaction may not be as reassuring as had been thought, the absence of asthma may be. Early administration of epinephrine may not prevent death, and concomitant treatment for the asthmatic component of an allergic reaction may be very important.

**Reviewer’s Comments.** Although the risk of death from food allergies may be small, parents and physicians should not be lulled into a false sense of security regarding the potential severity of adverse reactions to foods. Concomitant asthma places patients with food allergy at particular risk of a severe reaction. Although some foods more commonly cause severe reactions, it is important to note that any food theoretically can cause a severe life-threatening reaction, and the fact that milk caused more food-related deaths than peanut in this study emphasizes this point. The authors also mention that early epinephrine use may not prevent death, but it is still the general consensus that early and proper use of epinephrine in severe food reactions is associated with a better prognosis.

**Study Population.** Placentas from 44 normal term pregnancies and from 4 preterm pregnancies (26, 28, 32, and 34 weeks of gestation) were investigated.

**Methods.** Placentas were obtained immediately after delivery to recover functionally active maternal and fetal circulation. A fetal artery and a fetal vein were cannulated and perfused with pure medium, whereas the intervillous space of placenta was flushed with allergen containing medium (materno-placental circulation). Samples were collected throughout the perfusion experiment from fetal venous outflow and tested for the presence of β-lactoglobulin (BLG), ovalbumin (OVA) and the inhalant birch pollen allergen Bet v 1.

**Results.** Transplacental transfer of BLG, OVA, and Bet v 1 was detected in both term and premature placentas. The allergens were readily detectable in fetal effluent at the beginning of the perfusion experiment and allergen levels reached plateau after about 2 hours. The steady state transfer rate of BLG and OVA in term placenta was 0.012% ± 0.001 and 0.013% ± 0.001 of total dose. The observed transfer rate of Bet v 1 after 2 hours of perfusion was 0.155% ± 0.034 of total dose. Transplacentally transferred concentration of BLG and OVA in preterm placentas increased continuously throughout perfusion time.

**Conclusions.** Allergen-specific cord blood reactivity may be attributed to low levels of allergens crossing the human placenta and providing the fetus with the necessary stimulus for T cell priming.

**Reviewer’s Comments.** An accumulating body of evidence supports the transplacental transfer of food and environmental allergens. Specific immunoglobulin (IgE) antibodies are present in the cord blood and furthermore, peripheral blood mononuclear cells from fetuses as early as 20 weeks of gestation proliferate on stimulation with specific allergens indicating previous exposure. Transplacental transfer of food allergens such as peanut may be partially responsible for early sensitization and development of food allergy.

**ANAPHYLAXIS**

**EPIPEN JR VERSUS EPIPEN IN YOUNG CHILDREN WEIGHING 15 TO 30 kg AT RISK FOR ANAPHYLAXIS**


**Purpose of the Study.** Epinephrine autoinjectors are widely prescribed for out-of-hospital treatment of children at risk for anaphylaxis. Prescribing physicians face the dilemma of choosing either the 0.15-mg EpiPen Jr or the 0.30-mg EpiPen when neither dose is deemed optimal. These investigators studied the rate and extent of epinephrine absorption after administration of either EpiPen Jr or EpiPen in children weighing 15 to 30 kg.

**Study Population.** Ten children were recruited from pediatric allergy practices with the following entry criteria: age, 4 to 8 years; weight, 15 to 30 kg; history of severe acute allergic reaction(s); and current EpiPen Jr or EpiPen carried. Eight patients had peanut anaphylaxis, while 1 each had anaphylaxis to egg and fish.

**Methods.** Study patients were randomly assigned in double-blind manner to self-administer either EpiPen Jr or EpiPen in the lateral thigh after formal review of proper administration technique. Plasma epinephrine concentrations, blood glucose, blood pressure, heart rate, and ad-
MATERNO-FETAL PASSAGE OF NUTRITIVE AND INHALANT ALLERGENS ACROSS PLACENTAS OF TERM AND PRETERM DELIVERIES PERFUSED IN VITRO

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