

# Common Food Allergens in Iranian Children

Z. Pourpak\*, A. Farhoudi, S. Arshi, M. Movahedi, M. Gharegozlou, F. Yazdani, M. Mesdaghi

## Abstract

**Background:** The prevalence of food allergy is different in different parts of the world. Identification of the most common food allergens is a priority in any population to provide effective preventive and curative measures.

**Objective:** The aim of this study was to determine the most common food allergens in Iranian children.

**Methods:** One hundred and ninety children with skin, respiratory or gastrointestinal symptoms, thought to be due to food allergy, were studied. The total serum IgE and eosinophil count tests were measured in all patients. Allergy to 25 food allergens was determined according to the patient's history, skin prick tests, RASTs (Radioallergosorbent Test) and open food challenge tests.

**Findings:** The most common food allergens were cow's milk, tomato, egg white, egg yolk, beef and almond, respectively.

**Conclusion:** The order of common food allergens in this study was different from other reports; this might be due to the different food habits and /or ethnic diversities.

**Iran J Med Sci 2003; 28(1):17-22.**

**Keywords •** Allergens • child • food • food hypersensitivity • radioallergosorbent test • skin tests

## Introduction

**F**ood allergy (FA) as it is called today, has been the concern of man for centuries and was noticed by many ancient physicians. Avicenna the eminent Iranian physician of the 10th century stated that legumes could cause severe headaches and also induce attacks in asthmatic patients.<sup>1</sup> Referring to the similar issue, Fletcher and Beaumont in early 17th century said "what is one man's poison, is another's meat and drink". Yet, it was not until the nineteenth century that physicians began to pay serious attention to what was called food idiosyncrasy.<sup>2</sup> One of the early reports on the role of foods in asthma appeared in 1840 by Roods and in 1855 there appeared a detailed account of a man whose asthma and constitutional symptoms were caused by ingestion of wheat.<sup>2</sup> This remarkable report is one of the pioneer observations of what is referred to now as FA.<sup>2</sup> It seems, however, that FA was infact noticed as a problem but the knowledge about the diseases linked with it, its diagnostic tests and hypoallergenic diets are all recent developments in this field.

Immunology, Asthma and Allergy Research Institute, Tehran Medical Sciences University, Tehran, Iran

**Correspondence:** Z. Pourpak, MD, PhD, Tehran Medical Sciences University, Tehran, Iran  
P.O.BOX: 19835-355  
Tel: +98-21-6935855  
E-mail: [zpourpak@yahoo.com](mailto:zpourpak@yahoo.com)

Z. Pourpak\*, A. Farhoudi, M. Movahedi, et al.

FA is usually mediated by IgE antibody directed against specific food proteins, but other immunologic mechanisms can also play a role. The primary target organs for food allergic reactions are skin, gastrointestinal tract and respiratory system.<sup>3</sup> Food allergic reactions are often confined to one target organ, but allergen-specific IgE is believed to bind similarly to mast cells in almost all tissue sites.<sup>3,4</sup> Failure in diagnosis or treatment of FA may be the cause of serious disturbance in thriving and development of children.<sup>5</sup> Although accurate data on the prevalence of food hypersensitivity are unavailable, it has been estimated that up to 8% of children of less than 3 years of age and 2% of adults experience food-induced allergic disorders.<sup>6</sup> In the USA, 6% of children and 1.5% of adults suffer from FA.<sup>7</sup> A cross-sectional epidemiological study of FA in 15 countries showed that 12% of respondents had food allergy/intolerance (range: from 4.6% in Spain to 19.1% in Australia). Self reported food allergy intolerance has been shown to differ significantly across several countries, probably due to cultural differences.<sup>8</sup> Population studies have shown that prevalence of food allergy in Netherlands, the UK, France and Japan are 0.8-2.4%<sup>9</sup>, 1.4-1.8%<sup>10</sup>, 3.2%<sup>11</sup> and 12.6%<sup>12</sup>, respectively. The order of common specific allergens varies in different countries, reflecting a possible interaction of genetic factors, cultural and dietary habits as well as exposure to new allergenic products early in life.<sup>13</sup> For example, peanut allergy is common in the UK,<sup>14</sup> France<sup>15</sup>, Switzerland<sup>16</sup> and North America<sup>17</sup>, but very in Italy<sup>18</sup>, Singapore<sup>19</sup> and Israel.<sup>13</sup> Identification of common food allergens in every country, therefore, is essential for proper diagnosis and treatment of patients with FA, as well as determination of a suitable hypoallergenic diet. The aim of this study was to identify the most common food allergens among allergic Iranian children.

## Materials and Methods

*Patients:* In a six-year period, all patients complaining of cutaneous, respiratory or gastrointestinal disorders (40%, 51.6% and 8.4% respectively), suspected to be due to FA, referring to Allergy and Immunology Department of Children Medical Center, with at least two of the following criteria, were studied.

1. A clear history of complaints related to food<sup>3</sup> (maximum one hour after ingestion of the offending food) and not being seasonal.<sup>20-22</sup>
2. Having elevated serum IgE, eosinophilia or positive familial history of allergy.
3. Onset of disease in the first year of life.<sup>2, 21-23</sup>

In all patients, total serum IgE level was measured using ELISA method. The kits were obtained

from IFCI Clone Systems Company, Bologna, Italy.

Hypersensitivity to food allergens was studied using skin prick tests, RASTs and open food challenge tests. Blood eosinophil counts were also determined.<sup>20</sup> All patients were controlled clinically 2-3 weeks before and during usage of hypoallergenic diet (for outbreak of rash, hives, vomiting, diarrhea, cough, asthma or any other complaints).

### *Skin prick test*

All patients (except those with severe eczema) underwent skin prick test<sup>24-26</sup> for twenty-five food allergen extracts (shown in Table 1) that were selected according to the following three criteria:

- Necessity in children's diet
- included in conventional Iranian diet
- included as common food allergens according to available reports.

The allergens were purchased from Dome Holister Stier (Miles, Canada).

A positive control test with histamine hydrochloride 1 mg/ml and a negative control test with negative control solution (glycerol 50%) were also included. Those with a wheal diameter of at least 5-7 mm in positive control and no response to negative control underwent skin prick test. Skin tests were done using prick method with disposable blood lancets. The resulting wheal and flare reactions of histamine were read at 10 minutes and of allergens at 20 minutes. The skin test considered positive if the diameter of the wheal was 3 mm or more.<sup>24</sup>

### *Radioallergosorbent Test (RAST)*

One milliliter of the patients' serum (100 cases) were kept in -70°C (especially from patients whose parents didn't permit doing prick test or from infants or patients with severe eczema).<sup>24,25</sup> Fourteen food allergens (containing milk, egg yolk, egg white, fish, melon, chicken, orange, beef, tomato, almond, soy, rice, corn and wheat) were chosen for RASTs. Allergen coated disks were purchased from Kabi Pharmacia Diagnostics, Uppsala, Sweden. Tests were done according to the instructions given in the kit and the intensity of results was categorized as 0-5+, while positive RAST was defined as the presence of specific IgE $\geq$ 2+.<sup>27,28</sup>

### *Hypoallergenic diet*

This was chosen on the basis of hypoallergenic foods, the essential foods in children's diet and Iranian conventional foods.<sup>29,30</sup> The hypoallergenic diet was given to all patients and they were controlled clinically 2 weeks before and during usage of the diet (for outbreak of rash, hives, vomiting, diarrhea, cough, asthma or any other complaints). Duration of taking the diet was 10-15 days except in patients with atopic dermatitis<sup>28</sup> or gastrointestinal disorders, which was 3-4 weeks.<sup>21,31</sup>

## Common Food Allergens in Iranian Children

**Table 1:** Common food allergens in different age groups

Allergens	Age (years)				Total (n=190)
	≤1 (n=24)	1-3 (n=63)	3-6 (n=39)	6-12 (n=64)	
Cow's milk	37.5%	28.5%	23%	23.4%	50
Egg white	37.5%	17.4%	15.3%	3.1%	28
Egg Yolk	33.3%	12.6%	7.6%	7.8%	24
Tuna	4.1%	11.1%	12.8%	9.3%	19
Tomato	16.6%	19%	5.1%	28.1%	36
Almond	16.6%	9.5%	5.1%	14%	21
Beef	12.5%	17.4%	2.5%	14%	24
Walnut	12.5%	7.9%	7.6%	10.9%	18
Corn	0	3.1%	0	4.6%	5
Potato	8.3%	3.1%	0	3.1%	6
Orange	4.1%	12.6%	5.1%	9.3%	17
Apple	0	3.1%	0	3.1%	4
Wheat	4.1%	3.1%	2.5%	4.6%	7
Melon	4.1%	3.1%	0	6.2%	7
Onion	0	0	0	7.8%	5
Pea	8.3%	7.9%	0	3.1%	9
Rice	0	0	0	1.5%	1
Hazelnut	0	3.1%	2.5%	6.2%	7
Soybean	16.6%	9.5%	5.1%	4.6%	15
Peanut	4.1%	0	2.5%	1.5%	3
Cabbage	4.1%	0	5.1%	4.6%	6
Shrimp	4.1%	0	2.5%	1.5%	3
Grape	4.1%	6.3%	5.1%	6.2%	11
Garlic	4.1%	4.7%	2.5%	6.2%	9
Mushroom	0	0	0	0	0

### Open food challenge test

The patients responding to hypoallergenic diet within 2-3 weeks and with collaborative parents (96% of patients) were chosen for open food challenge test.<sup>32-34</sup> Although Double Blind placebo Controlled Food Challenge (DBPCFC) test is the gold standard for diagnosis of FA<sup>33</sup>, in infants and young children whose allergic symptoms are predominantly objective (rash, hives, vomiting, diarrhea or decreased pulmonary function test)<sup>26,31,33</sup>, in whom the effect of suggestion is minimal<sup>31</sup> and for screening a large number of foods, open or single blind food challenge test may be utilized.<sup>31,32</sup> The 25 food items were given freshly and were challenged one by one and in various days. Amount of food given to each patient was determined according to his age, weight and clinical symptoms.<sup>35</sup> The offending food was brought by patients to the office and then challenged with incremental portions of it. Five dilutions of the food were put in contact with perioral skin, and while patients were fasting the five dilutions were given to them to be ingested one by one with 30 minutes intervals. After ingestion of undiluted food, patients were controlled clinically for 2-12 hours. Repetition of any previous complaints was determined as positive open food challenge test.<sup>21,31,33</sup> When the skin test and/or RAST was negative and the history of reaction to the offending food was doubtful, the suspected food was replaced in diet at home.<sup>33,36</sup>

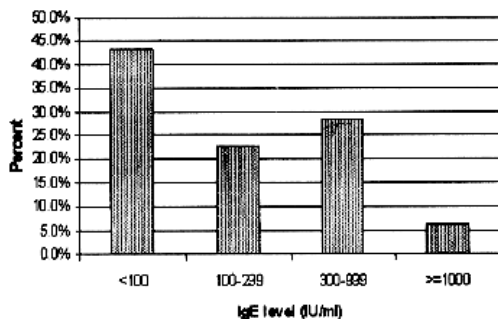
Open food challenge test (for 5-25 food subjects according to the patient's age) was done for 100 patients (50%). Those who had any history of anaphylaxis, generalized urticaria or severe asthma [19 patients (5.5%)] did not undergo the challenge test.<sup>36</sup> During the tests, intensive safety measures were taken.<sup>37</sup>

Those with a positive challenge test or with positive skin prick test and/or RAST that were exactly compatible with their history were considered food allergic. According to the patients' age, final results were categorized into four groups. (Age≤1, 1<age≤3, 3<age≤6, 6<age≤12)

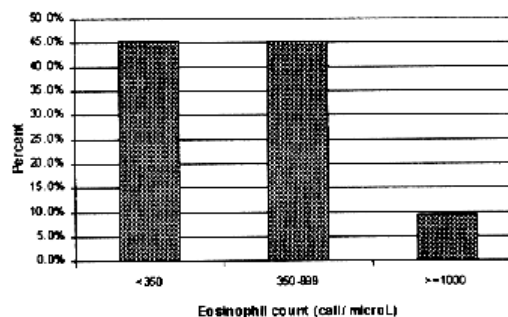
### Results

One hundred and ninety children (58.5% boys and 41.5% girls) were studied. They were 3 months to 12 years old (mean±SD: 4.8±3.3 years). Skin prick test was performed in 171 patients (all patients, except those with severe eczema, negative response to positive control or severe dermatographism). Skin prick test in 53.2%, RAST in 45.8% and challenge test in 88.5% were positive to at least one allergen, without any life-threatening reactions. 97.3% of the patients responded to hypoallergenic diet. Among them, 87.2% of the patients with respiratory disease and 66.2% with skin disease were improved.

The mean and standard error of serum total IgE



**Fig 1:** IgE level classification in children with food allergy



**Fig 2:** Eosinophil count classification in children with food allergy

was  $476.7 \pm 148.5$  IU/ml. Serum total IgE was less than 100 IU/ml in 43.3% of the patients, 100-299 IU/ml in 22.6%, 300-999 IU/ml in 28.3% and more than 1000 IU/ml in 6.2% (Fig 1). The mean and standard error of eosinophil count was  $585 \pm 72.2$  cell/ $\mu$ l. Eosinophil count was 350-999 cell/ $\mu$ l in 45.3% of the patients and more than 1000 cell/ $\mu$ l in 9.4% (Fig 2).

Common food allergens in different age groups are shown in Table 1. Cow's milk, egg, tomato and nuts were the most common food allergens at different ages. Totally, cow's milk and tomato were the most common food allergens in this study.

## Discussion

The incidence of FA in children is higher than adults. Up to 8% of children less than 3 years of age and 2% of adults suffer from FA.<sup>6</sup> The complications of FA can prevent child's growth and even can be life threatening<sup>5,23</sup>, so children with FA should follow a restricted diet, which may lead to parent-child conflict.<sup>38</sup> Therefore, it is very important to find out the best diagnostic and treatment means and identification of the most common allergens is a priority in every population.

According to the patients' age, common food allergens were categorized into four groups (Table 1). In all age groups the most common food allergens were cow's milk, egg, tomato and nuts. Cow's milk, egg, soy, wheat allergies decreased with increasing age, but tomato, nuts, tuna and orange allergies increased, and might be due to dietary changes. Although most food allergies gradually improve after three years of age, cow's milk allergy continues till adolescence in 20-25% of patients<sup>39</sup>, which is also observed in this study. In contrary to other studies<sup>40,41</sup>, tomato is a common allergen in Iran. Tomato is introduced to Iranian children's food very soon and it is commonly used

to make soup for infants that can explain the high prevalence of tomato allergy in Iranian children. In France<sup>9</sup>, Japan<sup>10</sup>, Israel<sup>13</sup>, Australia<sup>40</sup> and Spain<sup>41</sup> egg has been reported as the most common food allergen, but in this study egg was in the second rank or even lower in all age groups. According to many studies walnut is not a common food allergen<sup>33, 42</sup>, while in this study it is one of the common food allergens, which may be due to its high consumption in Iranian diet. In contrary, peanut, which has been reported as a common food allergen in different studies,<sup>35,43-45</sup> has low prevalence in Iran, which is possibly because of its low usage in Iranian common diet.

As discussed above, it is obvious that food habits can influence the type of FA and local experiences should be taken into consideration to diagnose and treat FA in any population.

## Acknowledgment

We acknowledge all of our colleagues in the Immunology, Asthma and Allergy Research Institute.

## References

1. Vecina A: Ghanoon of Medicine, Vol. 2. 5th ed. Tehran, Soroush Publication Co, **1991**
2. Speer F: History of Food allergy. In: Speer F, et al, eds: Food Allergy. London: John Wright PSG Inc, **1983:1-12**.
3. Sicherer SH: Manifestations of food allergy: evaluation and management. *Am Fam Physician* 1999; **59(2)**: 415-24, 429-30.
4. Sicherer SH: Determinants of systemic manifestations of food allergy. *J Allergy Clin Immunol* 2000; **106(5 Suppl)**: S251-7.
5. Bellanti JA: Developmental aspects of food allergy in infancy and childhood. *Immunol Allergy Clin North Am* 1991; **11**: 885-93.

### Common Food Allergens in Iranian Children

- 6 Sampson HA: Food allergy. Part 1: Immunopathogenesis and clinical disorders. *J Allergy Clin Immunol* 1999; **103(5 Pt 1)**: 717-28.
- 7 Vierk K, Falci K, Wolyniak C, Klontz KC: Recalls of foods containing undeclared allergens reported to the US Food and Drug Administration, fiscal year 1999. *J Allergy Clin Immunol* 2002; **109(6)**: 1022-6.
- 8 Woods RK, Abramson M, Bailey M, Walters EH. International prevalences of reported food allergies and intolerances. Comparisons arising from the European Community Respiratory Health Survey (ECRHS) 1991-1994. *Eur J Clin Nutr* 2001; **55(4)** : 298-304.
- 9 Jansen JJ, Kardinaal AF, Huijbers G, et al: Prevalence of food allergy and intolerance in the adult Dutch population. *J Allergy Clin Immunol* 1994; **93(2)**: 446-56.
- 10 Young E, Stoneham MD, Petruckevitch A, et al: A population study of food intolerance. *Lancet* 1994; **343 (8906)**: 1127-30.
- 11 Kanny G, Moneret-Vautrin DA, Flabbee J, et al: Population study of food allergy in France. *J Allergy Clin Immunol* 2001; **108(1)**: 133-40.
- 12 Iikura Y, Imai Y, Imai T, et al : Frequency of immediate-type food allergy in children in Japan. *Int Arch Allergy Immunol* 1999; **118(2-4)**: 251-2.
- 13 Dalal I, Binson I, Reifen R, et al: Food allergy is a matter of geography after all: sesame as a major cause of severe IgE-mediated food allergic reactions among infants and young children in Israel. *Allergy* 2002; **57(4)**: 362-5.
- 14 Emmett SE, Angus FJ, Fry JS, Lee PN : Perceived prevalence of peanut allergy in Great Britain and its association with other atopic conditions and with peanut allergy in other household members. *Allergy* 1999; **54(4)**: 380-5.
- 15 Rance F, Kanny G, Dutau G, Moneret-Vautrin DA: Food hypersensitivity in children: Clinical aspects and distribution of allergens. *Pediatr Allergy Immunol* 1999; **10(1)**: 33-8.
- 16 Eigenmann PA, Calza AM: Diagnosis of IgE-mediated food allergy among Swiss children with atopic dermatitis. *Pediatr Allergy Immunol* 2000; **11(2)**: 95-100.
- 17 Hourihane JO: Peanut allergy: Recent advances and unresolved issues. *J R Soc Med* 1997; **90 Suppl 30** : 40-4.
- 18 Sicherer SH, Munoz-Furlong A, Burks AW, Sampson HA: Prevalence of peanut and tree nut allergy in the US determined by a random digit dial telephone survey. *J Allergy Clin Immunol* 1999; **103(4)**: 559-62.
- 19 Goh DL, Lau YN, Chew FT, et al: Pattern of food-induced anaphylaxis in children of an Asian community. *Allergy* 1999; **54(1)**: 84-86.
- 20 Hamilton RG, Adkinson NF: Immunological tests for diagnosis and management of human allergic disease. In: Rose NR, Macario EC, Folds JD, et al, eds: *Manual of Clinical Laboratory*, 5th ed. Washington DC: ASM Press, **1997**: 881-92.
- 21 Sampson HA, Metcalfe DD: Food allergies. *JAMA* 1992; **268(20)**: 2840-4.
- 22 Speer F: Manifestations of Food allergy. In: Speer F, et al, eds: *Food Allergy*. London: John Wright PSG Inc, **1983**: 27-39.
- 23 Sampson HA: Immunologic mechanisms in adverse reaction to foods. *Immunol Allergy Clin North Am* 1991; **11**: 701-17.
- 24 Demoly P, Michel FB, Bousquet J, Michel FB : In vivo methods for study of allergy. In: Middleton E, Reed CE, Ellis EF, et al, eds: *Allergy, Principles and Practice*. St. Louis: Mosby, **1998**: 430-40.
- 25 Philip SN: Skin testing. In: Rose NR, Friedman HM, et al, eds: *Manual of Clinical Laboratory Immunology*. 4th ed. Washington DC: ASM Press, **1992**: 685-8.
- 26 Sporik R, Hill DJ, Hosking CS: Specificity of allergen skin testing in predicting positive open food challenges to milk, egg and peanut in children. *Clin Exp Allergy* 2000; **30(11)**: 1540-6.
- 27 Ortolani C, Ispano M, Pastorello EA, et al: Comparison of results of skin prick tests (with fresh foods and commercial food extracts) and RAST in 100 patients with oral allergy syndrome. *J Allergy Clin Immunol* 1989; **83(3)**: 683-90.
- 28 Ownby DR: Tests for IgE Antibody. In: Bierman CW, Pearlman DS, Shapiro GG, Busse WW, et al, eds: *Allergy, Asthma and Immunology from Infancy to Adulthood*. 3rd ed. Philadelphia: Saunders, **1996**: 144-56.
- 29 Speer F: Biological classifications of foods. In: Speer F, et al, eds: *Food Allergy*. 2nd ed. London: John Wright PSG Inc, **1983**: 39-67.
- 30 Speer F: A discussion of individual foods. In: Speer F, et al, eds: *Food Allergy*. 2nd ed. London: John Wright PSG Inc, **1983**: 69-152.
- 31 Bahna SL: Practical considerations in food challenge testing. *Immunol Allergy Clin North Am* 1991; **11**:843-51.
- 32 Hoffman KM, Sampson HA: Adverse reaction to foods. In: Bierman CW, Pearlman DS, Shapiro GG, Busse WW, et al, eds: *Allergy, Asthma and Immunology from Infancy to Adulthood*. 3rd ed. Philadelphia: Saunders; 1996: 665-87.
- 33 Bock SA, Sampson HA, Atkins FM, et al : Double blind, placebo-controlled food challenge (DBPCFC) as an office procedure: a manual. *J Allergy Clin Immunol* 1988; **82(6)**: 986-97.

Z. Pourpak\*, A. Farhoudi, M. Movahedi, et al.

- 34 Lin FL, Vaughan TR, Vandewalker ML, Weber RW: Hypereosinophilia, neurologic, and gastrointestinal symptoms after bee-pollen ingestion. *J Allergy Clin Immunol* 1989; **83(4)**: 793-6.
- 35 Leinhas JL, McCaskill CC, Sampson HA: Food allergy challenges: guidelines and implications. *J Am Diet Assoc* 1987; **87(5)**: 604-8.
- 36 Durham SR, Church MK: Principles of allergy diagnosis. In: Holgate ST, Church MK, Lichtenstein LM, et al, eds: Allergy. 2nd ed. ST Louis, Mosby; **2001**: 3-16.
- 37 Reibel S, Rohr C, Ziegert M, et al: What safety measures need to be taken in oral food challenges in children? *Allergy* **2000**; 55(10): 940-4.
- 38 Sampson HA, Scanlon SM: Natural history of food hypersensitivity in children with atopic dermatitis. *J Pediatr* 1989; **115(1)**: 23-7.
- 39 Bishop JM, Hill DJ, Hosking Cs: Natural history of cow milk allergy: clinical outcome. *J Pediatr* 1990; **116(6)**: 862-7.
- 40 Hill DJ, Hosking CS, Heine RG: Clinical spectrum of food allergy in children in Australia and South-East Asia: identification and targets for treatment. *Ann Med* 1999; **31(4)**: 272-81.
- 41 Crespo JF, Pascual C, Burks AW, et al: Frequency of food allergy in a pediatric population from Spain. *Pediatr Allergy Immunol* 1995; **6(1)**: 39-43.
- 42 Hill DJ, Firer MA, Shelton MJ, Hosking CS: Manifestations of milk allergy in infancy: clinical and immunologic findings. *J Pediatr* 1986; **109(2)**: 270-6.
- 43 Yunginger JW: Anaphylaxis. *Curr Probl Pediatr* 1992; **22(3)**: 130-46.
- 44 Broadbent JB, Sampson HA: Food hypersensitivity and atopic dermatitis. *Pediatr Clin North Am* 1988; **35(5)**: 1115-30.
- 45 Niggemann B, Beyer K, Wahn U: The role of eosinophils and eosinophil cationic protein in monitoring oral challenge tests in children with food-sensitive atopic dermatitis. *J Allergy Clin Immunol* 1994; **94(6 Pt 1)**: 963-71.