Letters to the editor

Readers respond

Something as simple as this
I read with interest Dr. Choo-Kang’s article (“Specific IgE testing: Objective laboratory evidence supports allergy diagnosis and treatment,” p. 10) in the March 2006 issue of MLO. The first paragraph got my attention, as I had gone through over a year of identical symptoms with my young daughter. She would have continuous nasal discharge and coughing that would not let her nap or sleep well overnight.

We brought her to the doctor almost every month. Frequently, antibiotics were given, along with cough medicine and decongestants. We tried eliminating different foods from her diet. We eventually did have a RAST test performed on her and saw a pediatric allergist. The results of the test showed a slight sensitivity to dust mites. At the recommendation of the allergist, we removed all stuffed animals from her room as well as the carpet in her bedroom. We also purchased an air purifier. None of this made a difference.

Although my daughter was born 3-1/2 weeks early, she was healthy. She was also breast fed for a year. She was not exposed to certain food types too early and did have a prescription vitamin supplement. We thought we were doing everything that we could for her.

Then one day, her vitamins disappeared. She would sometimes take them off the table, if she could reach them, and carry them around. When they could not be found, we were not concerned, knowing that they would show up in a day or so like they had in the past. After doing a complete search of her toy box and every other place we could think of, I scheduled an appointment with her doctor to get a new prescription written. By the time of the visit, it had been about two weeks that she had been without the vitamins. Her coughing and nasal discharge had almost completely disappeared. We mentioned this to the doctor, who agreed that it was remarkable. She said that maybe a preservative in the vitamin drops might have been the cause of the symptoms. The doctor recommended over-the-counter vitamins. Now, except for the occasional cold, my daughter is fine.

I don’t know how many children are affected the same way, but it might be a relief for parents to know that the answer might be something as simple as this. I hope Dr. Choo-Kang finds this letter of interest and can address this particular issue if he feels it worthy of investigating.

—Toni Rathborne
Somerset Medical Center
Somerville, NJ

Dr. Choo-Kang’s reply: Thank you for your letter and interest in the article. Reactions to food and medication, preservatives, and additives such as food coloring are often non-specific and hard to document. These reactions are generally not typical IgE-mediated reactions, so allergy testing by in vitro (blood) or skin-prick techniques are not appropriate. To correctly establish the possibility of a reaction, a double-blind-placebo control oral challenge should be performed. In this test, your child would be given either the item in question or a benign placebo and then monitored for the development of adverse signs and/or symptoms. This sort of testing is technically difficult and challenging for most primary-care doctors and community specialists to perform.

Instead of the proposal put forward by your child’s doctor, it may be possible that her improvement was inevitable as she got older. Although approximately 30% of children will have frequent coughing and wheezing with respiratory infections during the first two years of life, the vast majority (70%) outgrow this tendency. Environment — such as day-care attendance, cigarette-smoke exposure, and the presence of older siblings — all play roles in whether or not a child will continue to have viral-induced wheezing. In addition, the time of year is important. So, a child who is between one and two years of age may often seemingly “outgrow” his/her respiratory problems during the summer when previously having a “horrendous” time just five or six months earlier. Your child’s own relatively negative allergy evaluation would have predicted a favorable outcome as you have observed.

Military med-lab “might”
I enjoyed reading Lt. Col. Elaine Perry’s Education feature, “A medical lab career in the U.S. Army: challenges with rewards,” in the March 2006 issue (p. 42). I wanted to point out that exciting laboratory careers are analogously available to Air Force and Navy personnel — both enlisted and officer. The Air Force also offers a resident Phase I course and an extended Phase II didactic and practical course for enlisted personnel in medical laboratory technology. Much like the Army’s program, this course can lead to an Associate of Science in Medical Laboratory Technology through the Community College of the Air Force and, coupled with work experience, eventually qualify one to sit for national certification examinations.

Advancement in the clinical laboratory field is also available to Air Force and Navy enlisted personnel. The caption-less photo on page 43 shows laboratory professionals from all branches of the service, but I noticed Capt. Ronni Leslie-Holt, USAF, centered in front. Having successfully completed the Air Force’s Phase I and II lab training programs (which totaled ~19 months then), she and I both served together as enlisted lab technicians back in the early 1990s; currently, we’re both commissioned officers, pursuing our master’s degrees in laboratory-related studies at

MLO welcomes letters to the editor. We ask that you include a phone number for verification. While we prefer to publish the writer’s name, we will publish a letter with “name withheld by request,” but our editorial staff must have the writer’s name confirmed for our files. MLO reserves the right to edit any letter for style and length.
Memorable Features of the Top 10 Instruments that Changed the Lab

10. The Klett colorimeter: Big, thick heavy filters, suitable for paper weights but a tad gaudy for cufflinks.

9. The Coleman Junior: If you lost the black rubber cup that covered the reaction well, you could use your empty coffee cup and not risk dropping heavy filters on your foot.

8. Ames Hematek Stainer: A classic still in many labs, and a marvel of smart engineering. But there’s a GRIND then SNAP! when you misload a slide.

7. Fibrometer: This electro-mechanical device for detecting clots has a familiar clickity-clack that tells you, your test is not done yet.

6. Dupont ACA: Mix a bicycle chain, a couple of vises, a color wheel, a needle, and a guillotine paper cutter, and what do you have?

5. AO Microscope: What do you get when you combine the sturdiness of a Fisher-Price toy with the interchangeability of a VW beetle? The DC-3 of microscopes.

4. The IL Flame Photometer Model 143: You press a button, you hear a series of clicks then a short “pop,” and PRESTO! You’re cookin’ with propane.

3. Autoanalyzer by Technicon: Colored fluid and bubbles in tubes rivalled lava lamps for entertainment.

2. IL 113 Blood Gas Analyzer: First to combine pCO2, pO2, and pH electrodes into one unit, and if you ran out of membrane for the pO2 electrode, you could use cigarette-package cellophane in a pinch (which was readily available in most labs in the 1970s).

1. The Coulter Counter Model S: This was the original spaghetti factory with six red lights, dueling oscilloscopes, expensive and slippery-when-wet glass reaction chambers, and 20 miles of tubing. With this machine, you developed a permanent wrist-rocking motion.

—Capt. G. Shane Hendricks
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AFIT Graduate Student
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Adapted from “Ten instruments that changed the lab” by Roy Midyett, MT(ASCP), MLO May 2005, p.30.