and swollen lips. Following parenteral administration of epi-
nephrine and glucocorticoid together with intravenous bolus
of fluids the boy recovered. Two hours earlier he had eaten
tuna steak. His mother tasted a piece of it and reported mild
tongue pruritus.

Therefore the boy was diagnosed of having scombroid poi-
soning. Two days later he performed some experiments at
home. He realized that his hand in a container with cold
water, as opposed to a hand in warm water, has swollen and
blushed. When he drank a small amount of an ice tea he felt
throat tightness. Barefoot walking on the cold floor caused to
him itching of the soles of the feet. The ice cube test was
performed at hospital. The test resulted positive and diagnosis
of cold urticaria and anaphylaxis was made.

For the whole next year the boy suffered from hypersensi-
tivity reactions to cold. Continuous oral antihistamine therapy
made symptoms less severe.

However, it is interesting that the boy got over an acute
enteral infection caused by Campylobacter jejuni just a week
before the reported episode of anaphylaxis to cold occurred.
Moreover, two days before the symptoms of the enteral infec-
tion started the boy swam in a pool with very cold water
colder than sea water and had no reactions. Conclusion: The
exact mechanisms of hypersensitivity reaction and histamine
release to cold are not completely elucidated. There are many
infected agents that have already been associated with cold
urticaria but Campylobacter jejuni was not one of them.
Future investigations are needed to reveal the pathophysiologic
pathways that connect these two conditions.

Patients with FPIES usually have undetectable specific IgE
to triggering food, except in rare cases of atypical FPIES. In
addition to classic acute FPIES symptoms, children with atypi-
cal FPIES can also have symptoms consistent with an acute
IgE-mediated hypersensitivity such as urticaria, angioedema,
flushing, and wheezing, and are likely to have a more pro-
tracted course. Rarely, patients with IgE-mediated food aller-
gies develop non-IgE-mediated food allergies and vice versa.
Our patient is a child who had been avoiding cow’s milk due
to immediate cutaneous reaction on ingestion, with positive
specific IgE and skin prick-to-prick test. After ten months of
avoidance, and negative new specific IgE, she was challenged
for resolution. She tolerated cow’s milk during the 2 hour
observation period, but then developed delayed profuse vomit-
ing. FPIES was confirmed with another, FPIES designed oral
food challenge, and she has been advised to continue using an
extensive hydrolysate formula. Due to the known possibility
of developing FPIES to other proteins, their cautious introd-
uction is advised. Further follow-up will be taken, considering
OFC every 18-24 months.

Food-protein induced enterocolitis syndrome (FPIES) is a
non-IgE mediated gastrointestinal hypersensitivity, categorised
into two major phenotypes: acute and chronic. Acute FPIES
manifests as profuse, repetitive vomiting, 1-4 hours after expo-
sure to a triggering food, sometimes with diarrhea 5-10
hours later, leading to dehydration and lethargy. In chronic
FPIES symptoms develop over days or weeks with intermittent
emesis, progressive diarrhea, abdominal distension and failure
to thrive. The pathophysiology of FPIES remains obscure, but
there is evidence of profound activation of innate cells, eosi-
nophils, and pan-T-cell activation. Most FPIES cases are
induced by cow’s milk proteins and soy in infants, although
other single or multiple foods can be triggers, including solid
foods, where there are significant geographical differences.
The incidence ranges from 0.015 to 0.5% There is a signifi-
cant lack of awareness among professionals about FPIES and
significant delay of diagnosis. There are some adult patients,
too. Diagnosis is purely clinical, and there are diagnostic crite-
reria for patients presenting with possible PFI and diagnostic
criteria for the interpretation of oral food challenges (OFC ),
as shown here. The most important aspect of management in
patients with FPIES is the avoidance of triggering food. The
natural course is favourable, and there are no reports of long-
term complications in children with FPIES and it is largely a
self-limiting, generally benign disorder of childhood.