distinct plateau formation of the inspiratory curve. This
typical 'cut-off' shape of the tracing is not evident in the
figures of Smith and Cooper. Consequently, effort-
dependent artefacts could have contributed to the results
of this investigation.

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Reproducibility of skin prick reactivity
in cystic fibrosis

Sir,

Holzer et al. reported considerable variation in responses
to allergen skin testing over a few months in a small group
of children with cystic fibrosis (CF). However, we found
only minor fluctuations in the skin test reactions of
62 patients with CF. These children and adolescents
attended our laboratory on at least two occasions for
allergen skin prick tests. The average time between
the first and last study was 19 months (range 3-26), while
the mean age of the group when last tested was 10.7 years
(range 4.1 to 18.8). We defined atopy as a weal of 3 mm
diameter greater than a negative control to one of 5
allergens.

Thirty-seven children remained non-atopic, and 15
remained atopic, thus, 52 (84%) out of 62 CF patients had
reproducible results. Furthermore, 8 of the 10 subjects
who showed varying responses became atopic, which is in
keeping with the increase in prevalence of skin test
reactivity during childhood. It is important to note that

half of the children who converted to atopic by our
criteria had at least one allergen weal of 2 mm or greater
when first tested and one of those who reverted to
non-atopic still had 2 allergen weals of 2.5 mm.

Our data do not support Holzer et al. since we found
that atopy, as defined by skin prick reactivity, was
reproducible in the majority of our patients.

References

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Mr Holzer and co-workers comment:

From the data it is obvious that there is little difference
between our figures and those of Henry et al. Fifty-two
(84%) out of 62 of their subjects had reproducible results
(consistently positive or consistently negative) while 10
(16%) were variable. Our figures of 19 (76%) out of 25
patients with reproducible results and 6 (24%) with
variable results were not significantly different from theirs
($\chi^2 = 0.30$).

It is interesting that 48% of our patients were consistent-
ly positive while only 24% of their patients were
always positive. Part of this difference may be explained
by the consistently positive reactions to Aspergillus
fumigatus in children with more severe lung disease in our
group. Henry et al. do not comment on the clinical
spectrum of their patients. The important message from
both studies is that there is a group of children with
cystic fibrosis who show variable results to allergen skin
testing and that to define atopy on the basis of tests done
on one occasion can be misleading.