Table 1—*Comparison of internal malignancies between patients with multiple basal cell carcinomas and controls*

Malignancy	Cases	Controls
Haematological*	5	0†
Breast	3	1
Gastrointestinal tract	1	2
Genitourinary tract	4	4
Total	13	7

*Four patients had non-Hodgkin's lymphoma and one had chronic myeloid leukaemia.
†P = 0.0625, McNemar's test (StatXact Turbo statistical package).

observation of a link between non-Hodgkin's lymphoma, malignant melanoma, and squamous cell skin cancer.[2] He did not, however, assess any association with basal cell carcinoma, the commonest malignancy in white people.

Exposure to ultraviolet radiation is recognised as a critical factor in the pathogenesis of basal cell carcinoma, presumably partly because of resulting immune suppression.[3] It could therefore be hypothesised that an association would exist between basal cell carcinoma and malignancies associated with immune suppression, such as haematological neoplasms.[4] Importantly, many patients with basal cell carcinoma develop multiple lesions, and it might be presumed that these subjects represent a group with high susceptibility —that is, one at greatest risk of internal malignancy. We report findings from a case-control study to identify an association between multiple basal cell carcinoma and haematological malignancy.

Altogether 141 white patients from northern Europe (mean age 71; 62 women) with histologically proved primary basal cell carcinoma (range 2-35 tumours per patient) were recruited over 18 months from dermatological outpatient clinics and followed up for roughly three years. Patients with other types of skin cancer or Gorlin's syndrome were excluded. Controls matched for age and sex (one case to one control) who had benign skin conditions (benign naevi, 67; eczema, 47; leg ulcers, 10; rosacea, 7; others, 10) were recruited in the same clinics. The presence of any histologically proved internal or haematological malignancy in cases or controls was noted. Thirteen cases, compared with seven controls, had an internal malignancy (table 1). This difference was not significant, though the difference between the number of cases (5) and controls (0) with a haematological malignancy approached significance. Four of the five cases developed the haematological malignancy after developing their first basal cell carcinoma.

Our pilot study suggests a link between basal cell carcinoma and haematological malignancy. Such a link would have implications for follow up and understanding of the pathogenesis of this malignancy.

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Peanut and nut allergy

Creams and ointments containing peanut oil may lead to sensitisation

EDITOR,—Pamela W Ewan suggests that peanut allergy in children is due to the ingestion of peanut butter before the age of 1 year but acknowledges that some children react after their first known exposure.[1] She supposes that minute amounts of allergen might be present in breast milk or hidden in foods, but it is not widely appreciated that arachis oil (peanut oil) is present in many preparations that are applied topically. Breast feeding mothers often treat sore nipples with chamomile ointment, the main ingredient of which is arachis oil. Presumably some of this is ingested by the infant, which could lead to sensitisation.

Children might also become sensitised to peanut allergen through skin contact. Despite the name, zinc and castor oil ointment, which is often used to treat napkin dermatitis, is 30% peanut oil. Napkin eruptions are common in children with atopic dermatitis, and absorption of allergens is increased across broken or inflamed skin, so sensitisation to peanuts could occur in this way. Certainly, skin contact leading to sensitisation occurs with other allergens, and although no evidence exists of specific induction of peanut allergy by this route, I prefer not to recommend the use of creams or ointments that contain arachis oil.

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Baby massage oils could be a hazard

EDITOR,—The recent articles on peanut allergy do not mention the fact that baby massage is becoming popular and that the oils used in this might pose a hazard.[1 2] If tiny babies suck their hands after a hand massage with arachis (peanut) oil they may ingest large quantities of nut products. Special care baby units such as that at Queen Charlotte's and Chelsea Hospital recommend arachis oil for massages of premature babies. Perhaps the potential risk should be indicated on the labels of massage oils and in baby massage books and at classes. Alternative products could be used.

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Serious adverse reactions to adrenaline are becoming more likely

EDITOR,—Pamela W Ewan's findings with regard to peanut and nut allergy[1] agree with my personal experience of the problem: such allergy occurs in otherwise atopic subjects, it is acquired early (possibly in utero in some cases), and after the first adverse reaction sufferers are almost invariably aware of the problem—although in some this is at a subconscious level, and they become averse to all nuts without remembering the reason.

I doubt, however, Ewan's implication that the problem is becoming much more common. It is difficult to obtain meaningful figures of prevalence in the past, but I have estimated a probable prevalence of hypersensitivity to any nut of between 1% and 5% in the population from which my patients have been drawn over some 30 years, and without much variation. Previously, those affected knew that they could not eat nuts, avoided them assiduously, were generally free of symptoms, and did not consult a doctor, which explains the medical profession's lack of awareness of the problem in the past. Those affected were detected, if at all, when they attended allergy clinics for investigation of other manifestations of atopy. Now, on the other hand, as a consequence of publicity generated by such organisations as the Anaphylaxis Campaign and British Allergy Foundation,[2] many people who managed very well by themselves over many years have been informed that they must seek medical advice and be referred to clinics, where investigation confirms only what they know already.

A consequence of this is that we are seeing a true increase in serious adverse reactions to adrenaline injections, which are now being offered routinely to such patients and used for any symptoms, whether trivial or even unrelated to hypersensitivity. Parenteral adrenaline certainly plays a major part in the management of dangerous anaphylaxis and angio-oedema, but these are exceedingly rare (especially when one considers the high prevalence of sensitivity to nuts), and they probably usually involve additional, non-atopic factors. Avoidance remains the golden rule and is usually practised successfully because the patient's tongue and lips are aware of traces of the allergen in prepared foods to which the patient has been blinded. Better labelling of foods would help, but I fear that we may see more frequent dangerous episodes, including deaths, due to adrenaline than to anaphylaxis unless a more measured response to the problem is developed.

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Study was not designed to measure prevalence

EDITOR,—Media coverage of Pamela W Ewan's study of peanut and nut allergy[1]—for example, in BBC Radio 4's *PM* programme—highlighted the conclusion in the abstract that "peanut and nut allergy is becoming common"; we note that in the key message this statement has become "peanut and nut allergy are becoming more common." The study, however, was not designed to measure the prevalence of such allergies and, indeed, was restricted to patients seen during one year at a particular allergy clinic; the only evidence given in support of the supposed