



## OLIVE POLLEN

Molecular Allergology



# Use components to identify patients for appropriate olive pollen SIT

Resolve multiple positivity to pollen tests

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## Use components to resolve multiple positivity to pollen tests

Most olive pollen allergic patients are poly-sensitized to several tree, weed or grass pollen allergens and the case history does not always clearly suggest which pollens are causing the symptoms.<sup>1,4,9</sup> Moreover, a positive olive pollen extract test may be a result of cross-reactivity and not by genuine olive pollen extract sensitization.<sup>1,4,6</sup>

### Complete natural extract detects sensitization to olive with high efficiency and sensitivity:

- Olive pollen t9

### Components can help explain multiple positive pollen extract tests and resolve:<sup>1,6,10</sup>

- True co-sensitization to various pollens
- Cross-reactivity caused by profilins, polcalcins or CCD

### Specific olive pollen components:<sup>1,2,7</sup>

- Ole e 1 – Trypsin inhibitor
- Ole e 7 – Lipid transfer protein
- Ole e 9 – 1,3 beta-glucanase

### Components explaining cross-reactivity between various pollens:<sup>6,8,10</sup>

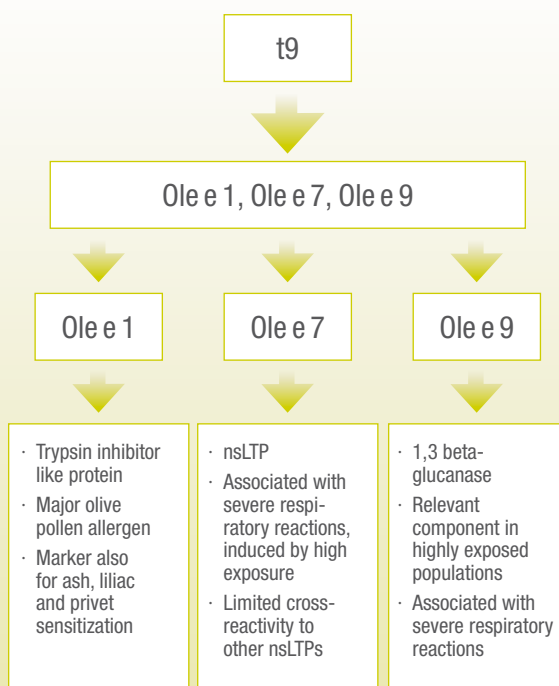
- Polcalcin
- Profilin
- MUXF3 (CCD)



## Suggested test profiles

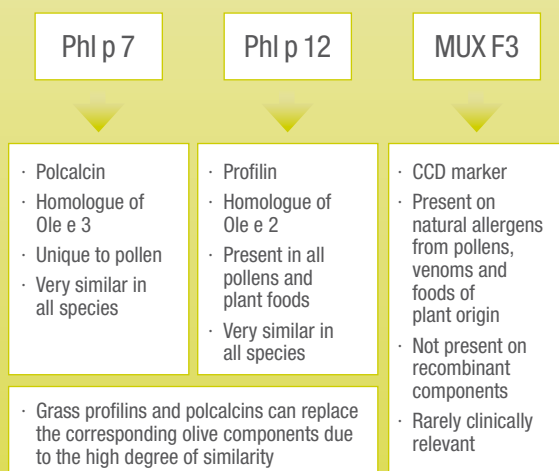
ImmunoCAP®  
COMPLETE EXTRACTS →

ImmunoCAP®  
Allergen COMPONENTS →



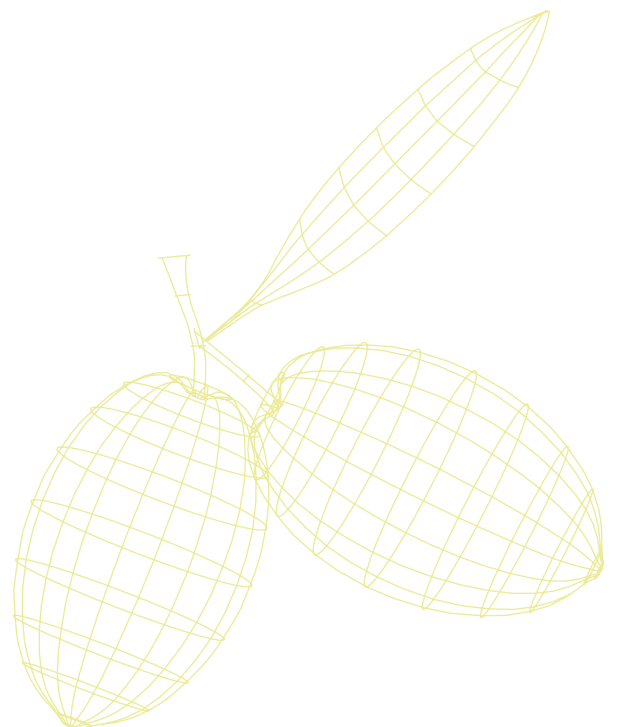
## MARKERS FOR CROSS-REACTIVITY

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## Did you know that?

- Pollen of olive tree (*Olea europaea*) is one of the most important causes of seasonal respiratory allergy in the Mediterranean area.<sup>1,7</sup>
- Sensitization to olive pollen normally varies between 5–40 % in olive pollen areas.
- More than 70 % of patients with sensitization to olive pollen have IgE antibodies to Ole e 1. The frequency of sensitization to Ole e 7 and Ole e 9 varies strongly between different areas (0–50 %).
- Sensitization to the cross-reactive allergens profilin, polcalcin and CCD is usually less frequent (< 20 %).<sup>1,7,8</sup>
- Ole e 7 is a non-specific lipid transfer protein (nsLTP) with limited homology and cross-reactivity to other nsLTPs.<sup>8,11</sup>
- The allergen composition of olive pollen extracts for SIT may vary significantly from producer to producer, especially with respect to Ole e 7 and Ole e 9.<sup>2,10</sup>
- Allergy diagnosis in patients exposed to multiple pollen species is complex and misdiagnosis is often a cause for unsuccessful specific immunotherapy treatment.<sup>4,10,12</sup>
- Up to 30 % of patients suffering from pollinosis simultaneously present allergy to vegetables.<sup>4,7</sup>
- Olive pollen allergy is common while olive fruit allergy is extremely rare.
- Ole e 1 is also a marker for sensitization to ash pollens, as well as privet, and lilac pollens since they are closely botanically related.<sup>3,5,8,9</sup>
- The ash pollen season overlaps with the birch pollen season in many areas. By testing with Ole e 1 and Bet v 1 (major birch pollen allergen) one can identify the true cause of the reaction.<sup>5,6</sup>



Find out more about olive pollen allergy  
to improve patient management

**Identify primary sensitizations and understand cross-reactivity between different pollens in order to:**

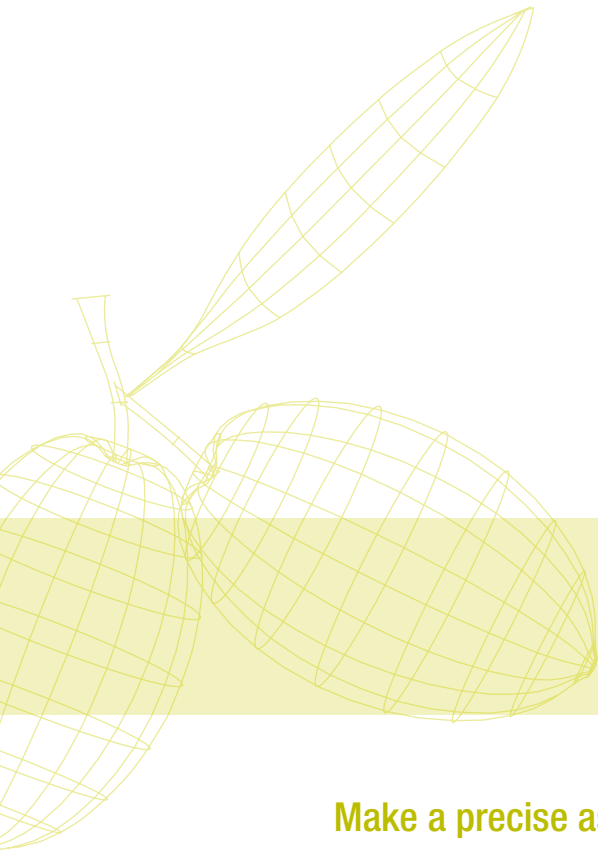
- Facilitate identification of patients and selection of appropriate extracts for immunotherapy<sup>10,12</sup>
  - Indications for SIT should be based on documented sensitization to specific olive pollen components.
  - Ideally the SIT extract should contain high concentrations of the matching olive pollen components.

**Benefits for the patient and patient management:**

A well-founded olive pollen diagnosis and proper immunotherapy can:

- Reduce allergic symptoms
- Improve the quality of life





### Make a precise assessment

ImmunoCAP Allergen components help you differentiate between "true" allergies and cross-reactivity

### Make a substantiated decision

A better differentiation helps you give relevant advice and define the optimal treatment

### Make a difference

More informed management helps you improve the patient's well-being and quality of life

**References:** 1. Barber, D. et al. Understanding patient sensitization profiles in complex pollen areas: A molecular epidemiological study *Allergy* 2008;63(11):1550–1558. 2. Barber D, et al. Degree of Olive Pollen Exposure and Sensitization Patterns. Clinical Implications. *J Investig Allergol Clin Immunol* 2007;Vol. 17, Supplement 1:63–68. 3. Castro AJ, et al. Pla 1 1 and Ole e 1 pollen allergens share common epitopes and similar ultrastructural localization. *J Investig Allergol Clin Immunol* 2007;17 Supplement 1, pp. 41–47. 4. Cuesta-Herranz J, et al. Differences among pollen-allergic patients with and without plant food allergy. *Int Arch Allergy Immunology* 2010;153:182–192. 5. García, B.E. et al. Oleaceae-induced pollinosis in an area with exposure to olive and ash trees. *Journal of Investigational Allergology and Clinical Immunology* 2011;21 (1):34–37. 6. Hauser M. et al. Pan allergen sand their impact on the allergic patient. *Allergy, Asthma & Clinical Immunology* 2010;6(1): 1–14. 7. Quiralte J, et al. Modelling diseases: The allergens of *Olea europaea* pollen. *J Investig Allergol Clin Immunol* 2007;17 Suppl 1:24–30. 8. Rodríguez R, et al. Olive pollen recombinant allergens: value in diagnosis and immunotherapy. *J Investig Allergol Clin Immunol* 2007;17 Suppl 1:4–10. 9. Rossi, R.E., et al. Sensitization profiles in polysensitized patients from a restricted geographical area: Further lessons from multiplexed component resolved diagnosis. 2011, *European Annals of Allergy and Clinical Immunology* 43 (6), pp. 171–175. 10. Schmid-Grendelmeier P. Recombinant allergens. For routine use or still only science? *Hautarzt* 2010;61(11):946–53. 11. Tordesillas, L., et al. Plant lipid transfer protein allergens: No cross-reactivity between those from foods and olive and *Parietaria* pollen. *International Archives of Allergy and Immunology* 2011;156 (3):291–296. 12. Valenta R, Twaroch T, Swoboda I. Component-Resolved Diagnosis to Optimize Allergen-Specific Immunotherapy in the Mediterranean area. *J Invest Allergol Clin Immunol* 2007; Vol 17, supplement 1:88–92.

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