WORKING GROUP ON CONSUMER ALLERGY RISK FROM ENZYME RESIDUES IN FOOD

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Summary

In recent years, claims have been made by the media and some consumer organisations that enzyme residues in bread and other foods can result in allergic responses in the consumers of that food.

AMFEP established an Expert Group to evaluate whether residual enzymes in foods are an allergy risk for consumers. The Expert Group was asked to investigate existing scientific data and to report the results of the findings.

The main questions were whether enzymes in, for example, bread can sensitise a consumer of the bread, and subsequently if the presence of the enzyme residue could induce symptoms of allergy.

A further question was if a person with existing allergy to common allergens could develop allergy symptoms upon eating foods containing residual enzymes by cross reaction. This is not uncommon in the case of food allergy.

The literature survey was made to search for general food allergy, epidemiology and to find cases of food related enzyme allergy. In addition a survey of enzyme producers' files was carried out to look for adverse reactions to food enzymes.

High daily doses of industrial enzymes in are prescribed for patients with insufficient function of the pancreas. The literature on adverse events was reviewed and telephone interviews were undertaken with authorities and university hospital departments to check if experience of enzyme related gastrointestinal allergy were observed but not published.

Studies of common food allergy indicate a relatively low prevalence of about 2% of populations in Europe and the United States. There is however, a significant discrepancy between the perception of being allergic to foods (15%) and those that can be verified as food allergy (2%).

Yet, there are no firm data of the doses required to sensitise a person via the gastrointestinal tract, but the doses required to induce sensitisation seem to be very high. Indeed, patients with insufficient enzyme production of the pancreas need to take industrial enzymes in doses 100.000 - I million times higher than the amounts found in food.

There are no published cases of people that have been sensitised by the ingestion of food with residual enzymes, and even people who ingest high daily doses of enzymes as digestive aids are not reported to have gastrointestinal allergy to enzymes, even after many years of daily intake.

There are a few case histories of people who had reactions to papain, extracted from the papaya fruit. Papain in powder form is used as a meat tenderiser in some countries. It is unclear if the sensitisation in these cases occurred by inhalation of the powder or by ingestion of the meat with the papain.

One case history described a person who reacted with hay-fever upon eating a lactase tablet. This case was incomplete in describing the possible source of sensitisation.

There are 2 cases of people with baker's asthma and allergy to α-amylase, and wheat flour who developed symptoms after the ingestion of bread. The symptoms were somewhat more pronounced after bread prepared with α-amylase than bread without. One case with occupational allergy to α-amylase reacted upon ingestion of a very high test-dose of pure α-amylase, but not at lower doses. Four other persons with occupational α-amylase allergy did not react at any dose.

The question of cross reactions between common moulds and enzymes produced in related moulds was described in a double blind placebo controlled food challenge study of asthma patients with allergy to Aspergillus fumigatus. This mould is closely related to *Aspergillus oryzae* and - *niger* which are used for the production of industrial α-amylase. None of the test persons could be challenged to elicited symptoms by eating bread prepared with enzymes.

The expert group concludes that there are no scientific indications that the small amounts of enzymes in bread and other foods can sensitise or induce allergy reactions in consumers.

Employees with respiratory occupational enzyme allergy should be informed that in rare cases, symptoms may be induced by ingestion of food with residual enzymes. Enzyme residues in bread or other foods do not represent any unacceptable risk to consumers.

1.0. Introduction

Since the late 80'ies, and particularly since 1992 it has been repeatedly claimed that enzyme residues in foods may represent a hazard to consumers in the form of allergies, and that a certain percentage of the population are at risk of having allergicy reactions to enzymes in bread and other foods.

In particular it has been claimed that consumers were at risk of developing severe allergy symptoms caused by α-amylase. The public was somewhat alarmed and there have been complaints, questions and other reactions of concern to bakers and other suppliers.

The media's interest was based on results from a study by Schata[1], published only as a 1/2-page abstract which does not allow for scientific evaluation.

However the issue was effectively raised within the public, and industry had no data with which to make a response.

Since 1992, the issue of allergy risk in consumers have emerged from time to time on television in the TV and the printed media. The general issue as it has emerged over these years is that there is a concern in the public that enzymes are unsafe, and as far as the bakers and the flour improvers are concerned, require and request data to oppose the allegations.

An additional concern is the possible cross reaction between enzymes produced by fermentation of certain moulds which may be related to common moulds. In theory, a person with a preexisting allergy to *Aspergillus sp.* might react to enzymes from e.g. *Aspergillus niger or A. oryzae*.

2.0 Background
2.1 General

In the public mind there is some confusion about the frequency of allergy, and in particular on food allergy. However, in the scientific community there seem to be consensus of the following:

- The frequency of common allergy (all allergies included) is 20 - 30%, in most populations around the world. The figure is increasing. Part of the increase may be due to higher awareness and improved diagnostic methods, however, a true increase cannot be ruled out.
- The frequency of occupational allergy in bakers is 8 - 27%. About 30 - 35%, of the bakers with occupational allergy to flour have an additional respiratory allergy to α-amylase and/or other baking enzymes.
- There is a reasonably good documentation of the frequency of food allergy in the general population at 1 - 2%. However, the frequency of perceived food allergy allergy in the general population is 12 - 16%
- Food allergy does not differ from inhalation allergies with regard to the biological mechanisms taking place in the immune system. Any 'true' allergy is based on allergy antibodies (IgE). Allergy antibodies are produced by the white blood cells called lymphocytes after the allergen has been introduced to these cells by inhalation or by ingestion. This process is called 'sensitisation'.
- Sensitisation then, is merely the event of the body recognising the foreign aller genic protein and reacting to it by producing allergy antibodies specifically recognising the particular allergen.
- Sensitisation is not a disease.
- It only becomes an allergic disease if the person develop symptoms related to exposure to the particular allergen.
- Not all sensitised people exhibit symptoms of allergy have allergy-symptoms.

2.2 Occupational respiratory allergy

allergy caused by inhalation of airborne particles of proteins, incl. Enzymes

Fungal enzymes, bacterial enzymes and extracted plant and animal enzymes are equally capable of inducing respiratory allergy - Papain and Bromelain[2-4], Trypsin[5], protease's from the skin yeast Candida albicans[6], from bacteria/ subtilisins[7,8], fungal amylases[9,10], bacterial amylases[11], fungal hemicellulases[12], lipases[13], xylanases and cellulases14,15 are all examples of industrial enzymes known to induce allergic sensitisation and respiratory occupational allergy. This is a feature characterised by highly purified enzyme protein products rather than the origin or the methods of production.

They all share the structural and biological properties that may cause sensitisation when inhaled.

The classical food allergens are also capable of inducing respiratory allergy when they are brought into a dust- or aerosol form and inhaled. Soya[16], eggs[17,18], milk[19] and fish[20] are just examples. Soya may be one of the best described examples of epidemic inhalation allergy to an allergen also well recognised as a food allergen[21].

3.0. Food allergy

3.1. Allergy caused by ingestion of proteins in foods

Eight percent of children under 3 years of age are allergic to food[22]. In, and in this age group, milk, egg, fish and soya are examples of common allergens. Many of these allergies disappear with age, but food allergy is seen also in older children and in adults. The overall frequency of verified food allergy is 1 - 2% of the population[22-25].

Food allergy is the adverse reaction to food characterised by allergic sensitisation to food proteins and elicitation of symptoms by ingestion of the same food proteins.

Symptoms

The symptoms of food allergy are gastrointestinal with vomiting and diarrhoea, sometimes accompanied by urticaria, asthma or hay-fever. Generalised very severe reactions occur in rare cases.

Many food allergies are very mild, with symptoms of itching and burning sensation in the mouth. This is also a feature of most of the well known cross-reactions between common inhalation allergens and foods. An example can be found in patients with a birch pollen allergy who also react to e.g. fresh apples, without having a specific allergy to apples. Another well known cross reaction is that of latex and bananas. There are a number of such cross reactions between common pollen allergens and certain foods.

Types of food allergens

Examples of 'true food allergens' are proteins in milk, egg, soya, wheat, fish, nuts and, peanuts and a few more. There are others, but only about 10 food allergens account for more than 95% of severe cases. However the list of food allergens is extremely long and a large number of food allergens only give rise to allergy in sporadic cases.

The common features of food allergens are largely shared by those of respiratory allergens. However, foods are very often treated by cooking and other physico-chemical means that may destroy part of the protein structure and thereby its allergenic properties.

Properties of food allergens

The molecular weights of allergens are typically in the range of 10 -70 (90) kDa.

They have a number of 'epitopes', i.e. sequences of 8 - 16 amino acids. These are the structural 'units' which can be identified by the immune system and lead to production of specific IgE (sensitisation). In the sensitised individual the specific IgE readily recognises the epitopes on the par-ticular protein, resulting in allergy symptoms. Some of these epitopes are described in literature26-28.

Food allergens are stable to digestion and most also to heating by cooking, and in most cases, food allergens can represent a very large proportion of the food itself Enzymes are not well described with regard to neither their fate after ingestion nor their allergenic properties after cooking.

The TNO Institute performed a study[58] on native α-amylase from *Aspergillus oryzae* in a gastrointestinal model simulating the physiological events in the stomach.

The results indicate that about 92%, of the epitopes of the α-amylase are destroyed and about 8%, of the epitopes on the α-amylase are intact at the delivery from the stomach to the duodenum.

However, it can be expected that the proteolytic pancreatic enzymes will reduce even further, the remaining 7 – 8%, of the α-amylase during the passage through the duodenum.

Doses at which food allergy occurs

The doses and other conditions necessary to sensitise an individual are not well known. It is believed that the sensitising doses must be considerably higher than doses required for elicitation of symptoms in patients already sensitised. There are many examples of sensitised people reacting to trace amounts of allergens in the food - some of them with fatal outcomes.

It is therefore understandable that there is some focus on hidden allergens like traces of milk, nuts and peanuts in other foods.

Steinman[29] wrote a leading article in the August 1996 issue of J. Allergy Clin. Immunol. regarding hidden allergens in food. It is representative of the concern in the medical profession and in the public. He suggested a number of preventive measures including labelling in clear language. His article does not mention enzymes.

Food produced by GMO's

Genetically Modified Organisms (GMO's), and enzymes produced by GMO's have raised concern in general and also specifically for enzymes used in food processing.

Scientists in the fields of gene technology[30-33] and allergy seem to agree that gene technology and the results thereof expressed in foods should not cause concern with regard to allergy risk. However, gene technology does bring about new proteins, and it is important to be aware that some of these new proteins may be allergenic.

Genetically modified proteins may, or may not share allergenic properties with traditional allergens. This would relate to the nature of the protein as it does in all other circumstances, and there are no examples of involuntary (or voluntary) changes of allergenicity of proteins in food.

A possibility may be that in the future, gene technology may be used as a tool to produce less allergenic proteins. This might be a future example of voluntary change of allergenicity.

Enzymes produced by GMO's have been on the market in some countries for many years. Enzyme producers have not experienced any difference in allergenicity of these enzymes as compared to traditional extracted or fermented enzymes. They appear to have the same sensitising potential as are capable of sensitising exposed employees at the same rate as traditional enzymes.

3.2. Epidemiology of Food Allergy

In a survey of 5000 households in the USA carried out in 1989, 1992 and again in 1993[25] it was found that 13.9 -16.2% of the households reported at least one member to be allergic to foods.

A study of food allergy in a random sample of 1483 adults in Holland[23] showed that 12.4% reported allergy to foods, but by controlled tests only 2.4% could be confirmed by Double Blind Placebo Controlled Food Challenge (DBPCFC).

In Spain, 3034 patients from the outpatient allergy clinics at two hospitals were tested for food allergy[24]. The patients were tested by skin prick, RAST and open food challenge. They found 0.98% positive to one or more foods.

When looking at food additives, the same pattern emerges. In a survey of a population sample in the UK, 7% claimed to have reactions to food additives. Double blind challenge tests could verify only 0.01 - 0.23% to be true reactions to food additives[34].

The frequencies of confirmed food allergy in different countries in Europe and the USA are quite uniform at 1 - 2.5% of the populations.

A number of explanations to the discrepancy of perception and verified cases has been offered. There are indications that the public attribute a number of conditions to ‘something in the food’ and consider themselves allergic without ever having it tested.

A certain number of perceived food allergy may be induced by members of the medical profession, conducting less efficiently controlled test programs. In some cases, patients are declared food allergic solely based on skin prick tests -which may well over-diagnose food-reactions. High focus on food allergy in the media combined with personal and psychological conditions may also play a role. Actually some specialists in food allergy consider the psychological disorders the most important differential- diagnosis from food allergy.

A diagnosis must rest upon a combination of a medical history and objective tests to confirm or reject the tentative diagnosis. In the field of food-related allergies, the diagnostic test systems have been difficult to establish. However, the Double Blind Placebo Controlled Food Challenge (DBPCFC)[35,36], is the method of choice to confirm or reject indications of food allergy that may derive from the patient’s perception and in many cases also from skin prick testing.

The experience from food allergy centres is that objective test programs to confirm or reject a suspected ‘food allergy’, requires skin- and blood tests and up to 6 placebo controlled challenges to be reliable.

Therefore a diagnosis of food-related allergy, based solely on medical history and a skin prick test is not good clinical practice and must be regarded un-ethical

3.3. Enzymes in food

In theory, enzyme sensitisation and allergy symptoms may be induced by direct ingestion of consumer products containing enzyme residues may occur

The tendency in recent years to focus on allergy and food allergy in particular may explain part of the marked discrepancy between the public perception of allergy to food - and the relatively few cases that can be verified in controlled clinical tests.

Papain is relatively widely used as a meat tenderiser, often supplied in a powder form to apply to the meat before cooking.

In 1983 Mansfield and co-workers[37] published a case story of a person who had allergicy symptoms after ingestion of papain used as a meat tenderiser. - Later, in 1985 they reported a study of 475 patients[38] with allergy of which 5 had a positive skin prick test to Papain.

The 5 papain positive were subjected to oral challenge with papain and all had positive reactions to the challenge.

Unfortunately, the challenge was only single blinded, and there is no report of occupational exposure or the use of powdered meat tenderisers that may have caused respiratory sensitisation.

In one other case story by Binkley[39], described below in the section 3.6.2, it can’t be totally excluded that sensitisation took place by ingestion of a food product containing relatively high amounts of industrial produced enzymes.

A recent review by Wûthrichl[40] of enzymes in food concluded that orally ingested enzymes are not potent allergens and that sensitisation to ingested enzymes is rare as is also the case of reactions to bread in bakers with occupational allergy to enzymes.

The member companies of AMFEP have not registered, experienced or heard of consumers that have become sensitised to enzymes or enzyme residues in consumer products by ingestion.

It has not been possible to verify the claims in the media of such cases, and they seem as yet un-substantiated as examples of enzyme allergies in consumers. The patients presented and the symptoms and tests described are not documented, merely describing sensations and feelings,however presented as facts.

A large proportion of adverse reactions to food must be ascribed to digestive disorders such as intolerance to for example gluten and lactose, which are not allergic reactions.

3.4. The Theory of cross reactions

people sensitised with common moulds might react to enzymes produced in related moulds

The theory that people with allergy to common moulds which are related to those used for the fermentation of enzymes might react to enzyme residues in food was one of Schata's[1] claims and was given relatively high coverage in the media.

The theory could not be readily rejected as cross-reactions are relatively common in allergy. A number of food allergy reactions are merely cross reactions than caused by primary sensitisation.

The most commonly used moulds for fermenting enzymes are *Aspergillus oryzae* or *A. niger*.

According to the theory, people with allergy to *Aspergillus*-moulds would be a high risk population. *Aspergillus* allergy occurs in less than 0.5%, of the population.

A study by Cullinan[41] was conducted with the objective of testing if patients with a well-documented allergy to the widely distributed common mould *Aspergillus fumigatus* reacted upon the ingestion of bread prepared with enzymes of *Aspergillus* origin. The study was a double blind placebo controlled food challenge study on 17 *Aspergillus* allergic people.

The 17 test persons all had allergy antibodies to *Aspergillus fumigatus*, but in addition, 6 also reacted at the skin prick test to the enzymes produced in *A. oryzae* or *A. niger*.

Each patient was challenged with bread baked with the 2 enzymes in standard doses and with placebo bread baked without enzymes. Allergy symptoms and a number of general physiological parameters were monitored before, during and for 24 hours after the challenge.

No allergicy reactions were seen upon ingestion of enzyme containing bread as compared to placebo bread.

This study clearly demonstrates that patients who must be considered at the highest risk for cross reactions to baking enzymes do not react with clinical symptoms when they eat enzyme containing bread containing enzymes.

It is a general experience that once a person is sensitised, even very small amounts of the allergen can elicit allergy symptoms.

In the case of baking enzymes it seems well documented that even patients with severe asthma caused by *Aspergillus fumigatus* did not react to the baking enzymes produced in *A. oryzae* and *A. niger*.

3.5. Food related reactions in occupationally sensitised people

The situation of possible reactions to enzymes in bread in patients with occupational allergy to enzymes

There are a few papers describing cases of allergy symptoms elicited by the ingestion of enzymes in people who have occupational allergy to enzymes:

Kanny & Moneret-Vautrin,.[42] and Baur & Czuppon[43] each describes one patient who since late childhood, has had asthma and occupational asthma with allergy to flour and enzymes for several years. Both patients were tested for elicitation of symptoms by ingestion of bread baked with and without enzymes. Kanny & Moneret-Vautrin's patient was tested in a blinded design, Baur's patient in an open, non-controlled programme. In both cases the result was elicitation of respiratory symptoms after challenge with bread baked with enzymes. Baur's patient also had a slight reaction to bread without enzymes, however not as pronounced as the reaction after the enzyme containing bread.

Losada et al[44] investigated occupational allergy to α-amylase in a pharmaceutical plant and found a number of employees sensitised to α-amylase. None reported reactions related to ingestion of bread. Five patients, all positive to α-amylase were given oral doses of native α-amylase in doses up to 10 mg.

At this dosage, one of the 5 test persons reacted with respiratory- and generalised allergy symptoms. Four did not react.

Baur et al[45] described the possible background for consumer sensitisation to α-amylases in bread. 138 subjects, of which 98 were allergic, and 11 bakers with occupational allergy were tested. The bakers reacted to α-amylase as may be expected. None of the atopics and none of the control persons reacted to skin prick test with α-amylase. Two atopics had weak RAST to native α-amylase and one reacted also to heated ce-amylase. Reactions to other related compounds, for example *Aspergillus* was not tested.

Tarlo and co-workers[46] reported results of testing for papain allergy in 330 allergy patients. - Seven had positive RAST and Skin prick test but none of them had any gastrointestinal or other allergic symptoms to papain.

The elicitation of gastrointestinal symptoms upon respiratory sensitisation is also reported for flours. One example is reported by Vidal et al[47] and describes a man with occupational asthma after exposure to flours and other grain dusts. He was sensitised to barley, and experienced gastrointestinal reaction upon ingestion of foods and beverages made from barley.

Enzyme producers and other companies handling concentrated enzymes do see cases of employees being sensitised to baking enzymes. These would be the people at the highest risk of reacting to enzyme residues in bread.

However, none of the members of AMFEP had any reports of sensitised employees who had experienced allergy symptoms in connection to ingestion of bread, and there are no reports of α-amylase sensitised employees avoiding bread.

Cases of people with occupational allergy to flours and food-related reactions to ingestion of flours/bread do occur. One case report describes a person with asthma to barley dust and also with reaction to beverages and foods produced from barley.

The conclusion from these reports of people with pre-existing occup. allergy to α-amylase is:

- Allergic reactions after ingestion of enzyme containing foods are described in 3 individuals.
- The 3 cases are people with definite occupational respiratory allergy to flour and an additional sensitisation to α-amylase. It means they are most probably sensitised by inhalation of flour dust and enzyme dust and not by eating bread or other foods with enzyme residues in it.

3.6 The consumption of enzymes for medical purposes and as digestive aids:

Many people around the world eat enzymes for medical purposes or for convenience as digestive aids.

In many countries enzymes are used routinely as digestive aids by healthy people. The number of people in the world, frequently eating enzyme preparations must be counted in millions.

A number of diseases require the daily addition of enzyme preparation to the food to compensate the patient's insufficient production of digestive enzymes.

3.6.1. Medical uses:

Medical use of enzyme preparations are subject to clinical trials, the results of which are normally reported to the health authorities, and such adverse effects are described in the pharmacopoeia/registry of drugs.

Patients with chronic pancreatitis suffer from insufficient production of digestive enzymes from the pancreas. They are dependent on daily intake of enzymes, some of these produced from *Aspergillus* and other moulds, some extracted from animal glands. The doses of these enzymes are in the order of gram's a day. - we have not been able to identify published documentation of allergy to enzymes in these patients, and the drug registry's does not even mention allergy as an adverse effect.

Proteolytic enzymes and mixtures of different enzymes are commonly used for treatment of a number of physical lesions and also for a number of more special conditions[48-50].

The enzymes are administered in the form of tablets with mixtures of enzymes and in doses of 6 to 600 mg per day, in some cases several times more.

We have not been able to find any evidence of sensitisation or allergy symptoms caused by the ingestion of enzymes from these enzyme preparations. One example is the use of enzymes given as tablets for the treatment of non-articular rheumatism. Uffelmann[51] describes a double blind study of 424 patients, of which 211 received enzyme treatment. The daily doses of the mixed enzyme preparations was 240 mg Lipase, 240 mg Amylase, 1,44 g Papain, 1,08 g Bromelain and 2.4 g Pancreatin,. This dosage was given for 8 weeks and no serious adverse effects and no allergy reactions were reported.

Patients with Cystic Fibrosis suffer a hereditary disease characterised by severe lung symptoms and insufficient production of digestive pancreatic enzymes. They too are dependent of daily intake of grain-doses of enzymes. - There are a few reports of parents and hospital staff who have become sensitised by inhalation of dust from these enzyme preparations[52-54]. This of course might also happen to the Cystic fibrosis patients when they handle the enzyme preparations themselves. However no cases of enzyme allergy in Cystic Fibrosis patients have been described, but there are reports of allergy to common food allergens[55].

An informal telephone survey on unpublished cases of enzyme allergy to European Cystic fibrosis Centres, resulted in only one possible case. The patient was a boy who reacted with vomiting after administration of the enzyme preparation containing amylase, protease and lipase. - The enzyme treatment had been stopped because of suspected allergy to the enzymes. However, testing for specific allergy antibodies by Maxisorp RAST[56] did not confirm sensitisation to any of the enzymes. Challenge tests have not been performed[57]

3.6.2. Digestive aids one possible case of allergy to digestive aid enzymes

In some cultures the use of digestive enzymes after large meals is very common. Enzymes for this purpose are ‘over the counter’ (OTC) drugs. We have found no studies of possible allergy to enzymes in these populations. That may be irrelevant if no-one ever thought of the possibility that enzymes might be the cause of allergicy symptoms had not been considered. - However, with millions of people using enzymes frequently, some cases of adverse effects in the form of allergic symptoms would be expected to emerge and be described in the literature. In most patients with allergic reactions, symptoms would appear immediately or very shortly after the intake.

Binkley[39], described a case of allergic reaction to ingested lactase. This patient had a respiratory allergy with positive skin prick test reaction to *Aspergillus sp*.

He had had two incidents with allergic reactions in the form of swelling and burning s tion of Lactaid tablets. The lactase was produced from fermentation of Aspergillus oryzae. Skin prick test with extracts of Lactase tablets gave a very strong positive reaction. He had not taken Lactaid tablets previous to the first experience of symptoms, but he had taken milk products containing lactase from *Saccharomyces fragilis* and from *Kluyveromyces lactis*. Although highly unlikely, it may be speculated if these may cross react with Lactaid. In this case it seems unlikely that sensitisation was caused by the Lactaid tablets as the symptoms appeared the first time he ever took Lactaid. It could be a ‘cross reaction’ based on sensitisation to yeast-produced lactase and symptoms elicited by the ingestion of Lactaid. Another possibility may be a cross reaction from his pre-existing *Aspergillus sp.* allergy.

This case may be regarded a possible but not verified case of oral sensitisation to enzymes in food.

A few other consumers haves claimed allergy to these OTC drugs but thorough testing has not verified allergy to enzymes in any of these cases.

With the background of the very high awareness of food related allergy in the populations, the widespread use of digestive aid and medical uses of enzymes should have attracted interest if allergy to ingested enzymes were of importance. However, up to now, only the single case mentioned above have been described.

To evaluate the risk of sensitisation from ingestion of enzymes and eventually experience of symptoms, we are aware of only the one case that may have become sensitised by ingestion.

This has to be related to the total number of people world-wide who ingest enzymes for short periods of time as part of a medical treatment, and to those who are dependent of daily intake of high amounts of digestive enzymes.

4.0. Conclusion

The working group has studied the available literature on these subjects and came to the conclusion that from a scientific point of view there is no indication that enzyme residues in bread or in other foods may represent an unacceptable risk for consumers.

Lack of scientific data is not evidence of lack of risk, and the working group realises that evidence of ‘no risk’ is extremely difficult or impossible to generate.

The group wish to stress that a ‘zero-risk’ can never be proved by science, and it must be anticipated that even an extremely low risk (e.g. 1 in 50 or 100 millions) of verified allergy to enzymes in food may well be perceived as a significant and unacceptable risk by the public in which more than 10% believe they are allergic to food.

Scientific data are of high value as the credible background for promotion to the public, to trade organisations and individual customers and for an ongoing dialogue with opinion leaders and consumer organisations.

It is the opinion of the group that many cases of perceived allergy to enzymes may be attributed to insufficient diagnostic procedures employed by members of the medical profession.

A minimum requirement for establishing a diagnosis of food related enzyme allergy should be a well conducted DBPCFC.

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