

est' — and for all I know (my history also being shaky) that could well have been a red-hot piece of news. Now, in my postanatomy years I could have continued the conversation just a little further: "*Levator labii superioris alaeque nasi*", I could have added. But that would probably have left the poor fellow for ever wondering what came next, which smacks of a hellish rather than a heavenly situation and so, one hopes, would have been inappropriate.

Surely those 2 years of anatomy must have been more of a good thing than these musings so far indicate.

Maybe they were. Not too long ago I engaged in a five-round bout with the computer that confronts all those who covet the LMCC and I emerged a victor. Prior to that, to meet certain requirements for registration I had submitted a report from my old university on my status as a medical student. I was surprised and even after all these years just a little gratified to find that I had held a place in the upper half of my class.

Perhaps after all my old professor of anatomy wrought more than I wot.

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Sudden sniffing death

To the editor: In a recent issue of *CMAJ* (114: 671, 1976) Dr. S. Fogel reported a case of "sudden sniffing death" (SSD), in which a young girl died after deliberately inhaling an aerosol frying pan lubricant. He presented the following references supporting the theory that, after deliberate deep inhalation, fluorocarbon aerosol propellants, by a cardiotoxic mechanism, induce cardiac arrhythmia and sudden death. Aviado¹ has demonstrated experimentally in several different species of animal the proarrhythmia effect of fluorocarbons on the heart. Bass² has proposed that fluorocarbons in high concentrations act synergistically with endogenous catecholamines to induce cardiac arrhythmia. In reviewing 110 SSD cases Bass² noted that sudden deaths due to inhalation of a volatile substance or aerosol product frequently occur following stress or exercise, both of which cause the release of endogenous catecholamines. In all five SSD cases investigated in North Dakota during the past 2 years I have noted that the deceased had been in a situation of heightened sympathetic activity, such as masturbation.

Fogel failed to mention two references that I believe are of particular interest in that they present some clinical evidence of the ability of fluorocarbon aerosol propellants to produce

cardiac arrhythmia. First, in an article on research into halogenated-hydrocarbon-induced cardiac arrhythmias at DuPont's Haskell Laboratory, Mullin and colleagues³ referred to unpublished work by Kehoe, who in 1943 "noted a significant cardiac arrhythmia in a human experimentally exposed to 11% fluorocarbon 12 for 10 minutes." Certainly an individual inhaling the contents of a plastic bag full of an aerosol product would be exposed to an atmospheric concentration of fluorocarbon greater than 11%. Second is a case report by Kamm⁴ on the death of a 16-year-old boy who had inhaled the contents of an aerosol spray deodorant. After inhalation the youth collapsed and was rushed to the emergency room of a local hospital, where an electrocardiogram revealed ventricular fibrillation.

Manufacturers of certain aerosol products implicated in numerous SSD cases have questioned the validity of applying animal data to the human situation and have pointed out the danger of a fluorocarbon cardiotoxic theory based on empirical case reports. However, it is worth while to note that many of these manufacturers now have propellants other than fluorocarbons in their products.

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References

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OHIP mystery

To the editor: Recently my secretary was checking on outstanding payments from OHIP for the past few weeks and discovered we had not been paid for quite a few for some time. We were not too alarmed at first because this had happened before and we found out that the payments had been made to my namesake in another part of the province — an inexcusable but not uncommon occurrence in any government-run organization. However, this time, when my secretary phoned the local office — she had by now worked out that the outstanding sum owed to us was over \$1000 — she was told that there was no record of us having submitted the OHIP cards. When it was pointed out to the officer in charge that

HALOG CREAM

Halcinonide 0.1%

Halog Cream (halcinonide, 0.1%) is intended for use as an anti-inflammatory agent for topical application. Halog Cream, 0.1%, provides 0.1% halcinonide, in a specially formulated water-washable base consisting of glyceryl monostearate, cetyl alcohol, myristyl stearate, isopropyl palmitate, polysorbate 60, and propylene glycol.

ACTION: Halog Cream, 0.1%, produces significant or complete therapeutic responses in patients with acute or chronic corticosteroid-responsive dermatoses.

INDICATIONS: Halog Cream, 0.1%, is indicated for topical application for relief of the many acute or chronic corticosteroid-responsive dermatoses.

CONTRAINDICATIONS: Tuberculous, fungal and most viral lesions of the skin (including herpes simplex, vaccinia and varicella).

Halog Cream is not intended for use in the eye nor in the external auditory canal of patients with perforated eardrums.

WARNINGS: Systemic side effects may occur and must be kept in mind particularly during use over large areas or for an extended period of time. Occasionally, symptoms of steroid withdrawal may develop when the medication is stopped after prolonged use.

Pregnancy: Safety has not been established. Potential benefit should be weighed against possible hazard.

PRECAUTIONS: If local infection (other than those cited in CONTRAINDICATIONS) exists, suitable concomitant antimicrobial therapy should be administered. If a favourable response does not occur promptly, application of the corticosteroid should be discontinued until the infection is adequately controlled by appropriate measures.

If local irritation or sensitization develops, halcinonide cream should be discontinued.

Occlusive Dressing Technique: The use of occlusive dressings increases the percutaneous absorption of corticosteroids and the possibility of systemic effects. For patients with extensive lesions it may be preferable to use a sequential approach. The patient should be kept under close observation during prolonged occlusive therapy.

Thermal homeostasis may be impaired if large areas of the body are occluded.

Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive.

If infection develops, discontinue the use of the occlusive dressings and institute appropriate antimicrobial therapy.

ADVERSE REACTIONS: Significant local irritation is uncommon; a transient burning sensation may occur in some patients. The use of corticosteroids under occlusive dressings is known to produce miliaria, folliculitis, pyoderma, or localized cutaneous atrophy; striae occasionally develop. Erythema, dryness, itching and change in skin pigmentation have been reported with topical steroids.

SYMPTOMS AND TREATMENT OF OVERDOSAGE:

Mild, reversible suppression of adrenal function, ecchymoses of the skin, peptic ulceration, hypertension, aggravation of infection, hirsutism, acne, edema and muscle weakness due to protein depletion are all toxic symptoms of corticosteroids. Animal studies suggest that overdosage may result in swollen breasts or lactation. Treatment is symptomatic; corticosteroid administration should be discontinued.

DOSAGE AND ADMINISTRATION: Usual adult dosage range: 2 to 3 applications daily.

Occlusive Dressing Technique: Gently rub a small amount of the Halog Cream, 0.1%, into the lesion until the cream disappears. Then re-apply the cream, leaving a thin coating on the lesion and cover with a pliable non-porous film. Good results have been obtained by applying Halog Cream, 0.1%, under occlusion in the evening and reapplying Halog Cream, 0.1%, without occlusion in the morning (i.e. — 12-hour occlusion). Reapplication of the preparation is essential at each dressing change.

DOSAGE FORMS: Halog Cream is supplied as cream formulation containing 0.1% halcinonide, in tubes of 15, 30 and 60 g.

STORAGE: Store at room temperature. Avoid freezing. Avoid prolonged storage at temperatures exceeding 30°C.

Product monograph available to physicians and pharmacists on request.

References: 1. Data on file, Squibb Institute of Medical Research. 2. Sudilovsky A, Clewe TH: *J Clin Pharmacol* 15:779-784, 1975. 3. Clark RF, Clement ER: *Arch Dermatol* 111:731-733, 1975.



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