Pakistan. This past year, new training initiatives began. The IMC started an eight-month program to upgrade the clinical skills of Afghan physicians, began a four-month program to train Afghans as field microscopists, and conducted a formalized retraining program for previously trained medics. Gradually, Afghanistan's shattered health care system is being rebuilt.

In addition, the IMC has expanded its services to other regions of the world. In Honduras, health care services were provided to more than 130,000 Nicaraguans displaced by civil war. In southeast Angola, the IMC is conducting an immunization program to inoculate 60,000 children and women of childbearing age and to train local personnel. This program also includes emergency food, agricultural assistance, and nutritional and water assessments. Future health care and training projects are planned for other African countries, Central America, and for Cambodia and Kurdistan.

The IMC is the compilation of its medical personnel, many of whom volunteer to work under difficult conditions. Many challenging opportunities exist in the international health care field. I invite you to join our corps and train people to help themselves.

For further information on IMC programs, your readers can call the Recruitment Department at (213) 670-0800. Travel expenses, room, board, medical insurance, and a monthly stipend are provided.

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Preventing the Contact Dermatitis Caused by a Transdermal Clonidine Patch

To THE EDITOR: The centrally acting antihypertensive agent, clonidine, is now available in a transdermal treatment form and has been shown to be highly effective in the control of hypertension.[1-3]

This "Catapres-Transdermal Therapeutic System" (Boehringer Ingelheim, Ltd) is a multilayered skin patch in three sizes that continuously delivers either 0.1, 0.2, or 0.3 mg of clonidine systemically and daily for seven days before being replaced. With its use, patient compliance is greatly enhanced and the "steady state" of drug delivery decreases the incidence of adverse side effects, except for one troublesome problem—an erythematous, pruritic rash beneath the patch in about 12% to 20% of patients.[2,3] The rash may occur with treatment with all three patch sizes and is more common in white patients. It frequently causes patients to discontinue the use of transdermal therapy.

My several attempts to prevent this rash—more frequent changes of the patch or the use of steroid creams around the patch—all resulted in failure. Three years ago I began pretreating the skin application site with an aerosolized spray medication containing beclomethasone dipropionate. The results have been gratifying.

This anti-inflammatory agent is marketed as Vancenase Nasal Inhaler (Schering) and is contained within an aerosol canister with a propellant that dries instantly on contact with the skin, thereby creating ideal conditions for clonidine patch application. The original Vancenase is used, not the aqueous preparation.

In this pretreatment, the skin application site is first cleansed with an alcohol pledget and allowed to dry. The center of the site is marked and "bracketed" with four metered doses at close range of the aerosolized beclomethasone. The patch is then applied in the usual fashion to this prepared area.

In three years, I have encountered 15 patients with a "patch rash" and have treated all of them in this manner. In 12 patients, the rash has been prevented as long as they continued this pretreatment before applying a clonidine patch. When they failed to do so, the rash promptly reappeared, only to disappear when the beclomethasone spray was again used. In the 3 patients who did not respond to this pretreatment, the patches were discontinued, and oral agents were employed.

The 12 patients who did respond favorably have now been observed every 4 to 12 weeks for an average of 15 months without any reappearance of the contact dermatitis.

The good control of the hypertension in these 12 patients has not deteriorated with this treatment. No significant changes in their therapeutic regimens have been made during this follow-up period. This would indicate that the beclomethasone spray does not diminish the absorption or action of the clonidine applied to the skin surface.

Clinicians and patients alike have applauded the use of the transdermal clonidine patch. It is regrettable that contact dermatitis sometimes mars its performance. The pretreatment procedure described may allow us to continue this effective treatment in many of our hypertensive patients.

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Possible Complications of Acupuncture

To THE EDITOR: I read with great interest the report by Wright and colleagues in the January 1991 issue on bilateral tension pneumothoraces resulting from acupuncture.[1] Eight years ago I saw a similar case of bilateral tension pneumothorax in a nonasthmatic patient that was initially mistaken for an anaphylactic reaction.

Report of a Case

The patient, an elderly Chinese man, was brought to the emergency department by ambulance in severe respiratory distress. He was brought from an acupuncture office where he had just received treatment by acupuncture for unilateral shoulder pain. His skin was covered with oil of wintergreen.

On arrival, he had tachypnea, was unable to speak, and he had hypotension with a systolic blood pressure of 80 mm of mercury and sinus tachycardia. He was diaphoretic with marked use of the accessory muscles of respiration. Auscultation of the chest revealed faint inspiratory and expiratory wheezing symmetrically. The trachea was midline. The patient was promptly intubated and was administered intrave-