

genic latex proteins in their products. In the glove purchase process, this information has been given to the locally responsible employees in our region.

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Improper treatment of anaphylaxis

I WAS DISTURBED and dismayed to read in two separate case reports in your issue of June 1995 (vol. 50, no. 6) that in two of the three patients, the treatment of the anaphylactic episodes did not include the most fundamental of all, i.e., epinephrine.

In the first case report, that by Novembre et al. entitled "Skin-prick-test-induced anaphylaxis", the patient, upon developing anaphylaxis, was treated by administration of intravenous corticosteroids and oral antihistamines. Both have an onset of action taking hours. The fact that the symptoms disappeared in a few minutes was more a matter of luck than management.

Fortunately, in the second case, the patient was indeed treated with subcutaneous epinephrine.

Then, in a different case report by Dechamp et al. entitled "First report of anaphylactic reaction after fig (*Ficus carica*) ingestion", it was noted that a 77-year-old woman developed itching, urticaria, angioedema, asthma, and gastrointestinal complaints. Yet, at the hospital emergency ward where she was sent, the patient was given only a 4-mg injection of betamethasone. Fortunately, she recovered despite the treatment, which could not have been effective.

Anaphylaxis may be life-threatening. A major cause of death is shock and/or airway obstruction.

Blood pressure support and relief of airway obstruction by subcutaneous epinephrine, intravenous normal saline to maintain intravascular volume, and supplemental oxygen would be the first line of treatment. H₁-

blocking antihistamines are perhaps second line and corticosteroids probably third line in this situation.

If the authors in the second report chose not to use epinephrine because of the older age of the patient or were concerned by the presence of chest pain, it behooves them to explain that this was the reason for withholding epinephrine rather than ignoring its use altogether.

Perhaps the Journal should have reconsidered publishing these papers submitted without proper emphasis on the appropriate pharmacotherapy for this dangerous condition.

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Allergic contact dermatitis to chloramphenicol

CONTACT with topical medicaments applied to the skin or mucosa can give rise to various clinical manifestations of immunologic and non-immunologic origin. The list of topical drugs most likely to elicit contact dermatitis changes over the years. Apart from neomycin, the incidence of sensitization, caused by topical use, to other antibiotics has diminished. That incidence depends mainly on the intrinsic sensitizing power of the medicament and secondarily on its frequency of use in clinical

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