disease it is important to recognise new primary tumours and their possible influence upon survival. The appearance in a single patient of more than one of the malignancies associated with cigarette smoking is further evidence of the hazard of this habit.

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¹ Royal College of Physicians, *Smoking and Health Now*. London, Pitman Medical, 1971.

² Dische, S, *British Journal of Radiology*, 1973, **46**, 13.

³ Clemmensen, J, and Bernerskov, V, *Biomedicine*, 1973, **19**, 198.

⁴ Registrar General's Statistical Review, 1968-1970, *Supplement on Cancer*, pp 139 and 192. London, HMSO.

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Canadian sheet dermatitis

During 1971-2 there was an epidemic of dermatitis in the Ottawa area of Canada caused by Wabasso polyester-cotton bed sheets.¹ We have seen several patients with a similar dermatitis over the past 18 months. All had used Wabasso bed sheets.

Present series

Since April 1975 we have seen nine patients with widespread dermatitis who had recently purchased cheap Canadian bed sheets. Three days to two weeks after starting to use the sheets they had developed severe itching and burning sensations, especially at night. When pillow-cases had also been purchased, redness of the ears and puffy eyelids were early complaints. In some cases several members of one family were affected, and in others one bed partner was spared.

Clinically the cases looked similar and were recognisably different from other forms of contact dermatitis from fabrics. The most characteristic feature was red follicular lesions, especially on the limbs. There was wide variation in the severity of the rashes, the most severely affected patients having large, continuous areas of redness and oedema (see figure) and swollen faces with puffy eyelids. The axillae and other skin folds were spared, and nightwear gave some protection. Patients had often been diagnosed as having drug eruptions, scabies, or toxic erythemas.

Wabasso bed sheets can often be recognised on sight or from the patient's description. They are brightly coloured, either uniformly or, more often, in large abstract or floral patterns employing several colours. Mauve, pink, blue, yellow, and green are the most common. The patient may remember that the packet the sheets were in was printed in French as well as English or was stamped "Made in Canada."

Patch tests with the patients' own sheets produced negative results in five out of eight cases tested, and there were no positive patch test results with formaldehyde. Only one patient reacted to a standard formaldehyde clothing resin patch test. Laundering the sheets helped in only one case, in which tolerance was reported after three washes. Once the patients stopped using the sheets the rash usually resolved in three to four weeks.

Comment

When patients approach us with suggestions about the cause of their ailments our response depends on our previous conditioning. In this instance an identical dermatitis had already been reported in Canada.^{1 2} The dermatitis first occurred shortly after a sheet manufacturing company changed its processing methods in the permanent-press resin treatment of polyester-cotton sheets from a slow cold process to a hot flash process.³ The offending agent was shown to be a fragmentation product of permanent-press resin polymer that was rendered unstable in the presence of heat and moisture.²

Follicular lesions on buttocks becoming confluent over back.

The epidemic in Canada halted when the company discontinued the implicated processing method. All our patients bought the sheets from street markets or similar outlets rather than from high-street stores. It would be interesting to know how sheets made unsaleable in Canada because they produce a dermatitis appear on sale in Britain and perhaps in other countries. Correct diagnosis of Canadian sheet dermatitis rests on the triad of its follicular, clinical appearance, its involvement of usually more than one member of the family, and the frequently negative results on patch testing with the offending sheets.

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¹ Panaccio, F, Montgomery, D C, and Adam, J E, *Canadian Medical Association Journal*, 1973, **109**, 23.

² Wilkinson, R D, *Canadian Medical Association Journal*, 1973, **109**, 14.

³ Wilkinson, R D, personal communication, 1976.

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Paroxysmal brain stem dysfunction as presenting feature of multiple sclerosis

Paroxysmal disturbances are differentiated from other transient episodes in multiple sclerosis by their explosive, short-lived, repetitive occurrence and by their localisation to the brain stem or cervical cord.¹ They have been reported in this disease but not as the sole presenting feature.¹⁻⁴ We have recently seen a patient whose paroxysmal attacks