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January 8, 1993

Aerosol Leather Conditioner — Continued

are conducting epidemiologic investigations and research studies to further define the association between illness and use of this product.

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Editorial Note: Preliminary information indicates the outbreak is associated with the use of Wilsons Leather Protector distributed nationally by Wilson's, the Leather Experts, headquartered in Minneapolis. Leather Protector is sold nationally at more than 550 stores owned by Wilson's; the stores are operated under several names. Typically, one or two applications of the protector are intended to be applied to new leather garments. Preliminary information suggests that some persons who experienced symptoms had used the product indoors or in other areas with limited ventilation. The new product was distributed to Wilson's stores in late November 1992; however, stores did not sell the new product until the old product supply was exhausted. Sales of the product in Oregon began during December 20-26, 1992.

From December 27 through December 31, 1992, following publicity and contact by the OHD and CDC, poison centers in at least 17 other states reported persons who experienced spray-associated symptoms; Poison centers in California received at least 70 such reports; Washington, 40; and Colorado, 35. Reports were also received from Georgia, Idaho, Maine, Massachusetts, Minnesota, New Hampshire, New York, Ohio, Pennsylvania, Utah, Vermont, Virginia, West Virginia, and Wisconsin.

The product is packaged in 5-ounce black aerosol cans with red and white lettering. The cans are a new formulation of Wilson's Leather Protector that had previously been sold in a 7-ounce can. The new formulation is made exclusively for Wilson's. The major product changes involved a shift from carbon dioxide to propane as the propellant and from 1-1-1 trichloroethane to isooctane as the solvent. The 5-ounce can of leather protector spray contains 1.2% FC-3237, a proprietary solution of a fluorosilyl polymer.

The most commonly reported symptoms suggest an acute chemical pneumonitis (1) or a hypersensitivity pneumonitis (2). Some patients have had symptoms consistent with inhalation fevers such as polymer-fume fever (e.g., chest tightness, headache, shivering, fever, weakness, and shortness of breath). This syndrome is caused by inhalation of fumes containing pyrolytic products released when fluoropolymers are heated to high temperatures. In most cases, patients with polymer-fume fever have been cigarette smokers (3,4). However, it is also possible that an unknown contaminant in the leather spray may be causing this illness.

Persons should be warned against using Wilson's Leather Protector. In addition, any spray containing polymers or solvents should only be used in areas where there is adequate ventilation.

A provisional case definition used by the OHD includes the onset of any pulmonary symptom (i.e., chest pain, shortness of breath, and nonproductive cough) 8 hours or less after exposure and either radiographic evidence of pulmonary infiltrates or at least two pulmonary symptoms and at least one pulmonary symptom lasting 12 hours or more. CDC has requested that state health departments report cases to CDC using a standardized case report form available from CDC's Air Pollution and Respiratory Health Branch, Division of Environmental Hazards and Health Policy, Epidemiology.

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Aerocal Leather Conditioner — Continued

for Environmental Health, telephone (404) 488-7320. Further consumer information regarding this product is available from the Consumer Product Safety Commission, telephone 800 638-2772.

References

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Current Trends

Air Pollution Information Activities at State and Local Agencies — United States, 1992

Because air pollution is a pervasive environmental health problem in the United States, one of the national health objectives for the year 2000 is to increase from 48.7% to 85.0% the proportion of persons who live in counties that have not exceeded any air quality standard during the previous 12 months (1). Public support for air pollution control efforts is critical if the national health objective is to be achieved. To characterize public health information activities related to air pollution, in 1992, the State and Territorial Air Pollution Program Administrators (STAPPA) and the Association of Local Air Pollution Control Officials (ALAPCO), with the assistance of CDC, conducted a survey of state and local air pollution control agencies. This report summarizes the findings of that survey.

In July 1992, a questionnaire was mailed to 225 state, territorial, and local air pollution control agencies. Agencies that did not respond were contacted by telephone. The questionnaire sought information on attainment of National Ambient Air Quality Standards, publication of an air quality index (e.g., the Pollutant Standards Index [PSI]²), issuance of forecasts or warnings, communication with outside health officials, distribution of educational materials, and evaluation of health information and on air pollution issues of greatest concern to the community. Of the 55 STAPPA agencies, 48 (87%) responded to the questionnaire; of the 170 ALAPCO agencies, 149 (88%) responded (overall response rate: 85%). Together, responding agencies represented 48 states, the District of Columbia, and the Virgin Islands. No agency was represented more than once.

Of the 197 respondents, 134 (68%) represented jurisdictions that had exceeded one or more National Ambient Air Quality Standards during the preceding 3 years. State and local agencies that represented such areas were more likely to calculate the PSI—

²The PSI converts the daily measured concentrations of five major pollutants (ozone, carbon monoxide, particulate matter, nitrogen dioxide, and sulfur dioxide) into a number on a scale of 0-500. The index value of 100 corresponds to the National Ambient Air Quality Standard for that pollutant. Intervals on the PSI scale are associated with descriptive terms (e.g., "good" [0-50], "moderate" [50-100], or "unhealthy" [100-500]).