exercise training effect, it is important that it is recognised and not falsely attributed to treatment benefit.

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Post-pneumonectomy pulmonary oedema

In the article by Dr L Verheijen-Breemhaar and others (April 1988;**43**:323–6) I felt that not enough information was given to put the figures into perspective.

What is the incidence of pulmonary oedema after any operation in the general population and, more specifically, after lobectomy in what must be a matched group? There was no mention of anaesthetic technique and this undoubtedly has changed between the years of 1975 and 1988, with the introduction of new induction agents, muscle relaxants, and opiates, all capable of influencing recovery. Epidural anaesthesia with both local anaesthetics and opiates and the use of opiate infusions have meant that a return of pain at the end of surgery, causing an increase in venous return, tachycardia, and increased cardiac output, all capable of precipitating pulmonary oedema, is no longer de rigeur.

The reasons given for pulmonary oedema by the authors should cause problems only immediately after operation and I would be loth to attribute the event on day 7 to such a cause.

Poor conduct of anaesthesia will undoubtedly precipitate pulmonary oedema in these patients—that is, poor analgesia, poor reversal, undue sedation and inability to sit up, and excessive transfusion. Having briefly reviewed 47 consecutive pneumonectomies in this hospital and found no evidence of pulmonary oedema, I consider that it is not an integral part of the postoperative course if attention is paid to anaesthetic detail. Thus I would have appreciated more information on this point.

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AUTHORS' REPLY In reply to Dr Bell's comments we would like to make the following remarks. Our patients are operated on in a modern cardiopulmonary surgical unit. Anaesthesia techniques do not differ significantly from those generally used. During the 1975–84 period pulmonectomy or lobectomy was performed in 502 patients. In only one patient, who was suffering from chronic cryptogenic alveolitis, pulmonary oedema occurred. Extensive data on the start of symptoms were not presented in the article. In all patients symptoms started within 48 hours of thoracotomy. In one patient, who underwent a second thoracotomy within 24 hours because of severe postoperative haemorrhage, dyspnoea started on the first postoperative day. Because symptoms progressed very slowly it was one week after pneumonectomy before artificial ventilation had to be instituted. We are convinced that postpneumonectomy pulmonary oedema as described by us and by others is a real entity. In our opinion the data as presented by Dr Bell do not exclude that such a complication may occur. We fully agree, however, that attention to anaesthetic detail, including perioperative and postoperative fluid balance, is paramount in preventing postpneumonectomy oedema.

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Book notices

AIDS Therapeutics in HIV Disease. M Youle, J Clarbour, P Wade, C Farthing. (Pp 162; £7·95.) Edinburgh: Churchill Livingstone, 1988. ISBN 0-443-04029-X.

This short pocket book, written largely by authors from St Stephen's pharmacy and genitourinary medicine departments, takes a systems orientated approach to the treatment of problems related to human immunodeficiency virus (HIV) infection. There are 14 brief chapters (115 pages) covering the main systems, plus chapters on HIV testing, retroviral treatment, disinfection, psychological aspects, and terminal care. The rest of the book comprises appendices—largely reproduced drug information sheets. The authors confess that their book is written from their experience with homosexual men and it offers little specific guidance to the special areas of haemophilia, intravenous drug abuse, or paediatrics. Nevertheless the authors have valuable personal experience to relay at a time when respiratory physicians are increasingly seeing patients with pulmonary and other manifestations of AIDS. There are no illustrations other than a few line diagrams and tables. Certain areas of text could, I think, have been tabulated to aid rapid reference by busy clinicians. The large amount of cross referencing from one chapter to another was particularly irritating. It is unlikely that a physician's diagnostic skills will be increased by this book as it is not intended to be a guide to treatment. The basic structure of the book would be improved if the clinical systems review were consolidated into a chapter, the other chapters dealing with each infecting organism in turn. This would mean that, for instance, the diagnosis, clinical aspects, and treatment of cytomegalovirus infection were not dealt with in four separate chapters. In certain areas the book appears to have been hastily compiled and there are minor inaccuracies and some omissions; doses of foscarnet, itraconazole, and ketoconazole are omitted, and the chapters on terminal care are vague and inadequate. An arrow is going the wrong way in the flow chart on page 16 and the reason for the two separate prophylactic regimens is not clear. No mention is made of the suggestion from the United States that anti-tuberculosis treatment might need to be lifelong, nor is there any real guidance on artificial ventilation or any mention of treatment for *Legionella* infection. Written