Correspondence

Haemophilus influenzae type b infections in adults

The report by Iggo and Higgins (July 1988;**43**:582–3) on empyema and pericarditis due to *Haemophilus influenzae* type b provides a valuable and interesting reminder that systemic infection due to this organism is not confined to young children or immunocompromised adults.

We have recently seen two cases of systemic *H influenzae* b infection in otherwise healthy 64 year old women—one with bilateral empyema and cellulitis of the lower limbs, the other with fatal septicaemic pneumonia. This prompted us to look at our other positive blood cultures over the last seven years. *H influenzae* b bacteraemia was recorded in 46 children under 6 years and eight adults. The latter, aged 28–86 (mean 63·5) years, presented with pneumonia in seven cases and with meningitis and arthritis in one case. Age aside, only the last patient was considered to be immunocompromised.

In a review of serious, mostly type b, *H influenzae* infections reported to the Public Health Laboratory Service Communicable Disease Surveillance Centre (CDSC) from 1977 to 1986, at least 14% occurred in patients of 15 years or older.[1] In 1988 some 1016 patients with *H influenzae* isolated from blood or cerebrospinal fluid were reported to the CDSC (unpublished data). Most cases were type b and the proportion of infections due to this type did not vary with age. One hundred and sixty five were known to be older than 15 and half of these were above 65 years of age. From the data available 20 adults had meningitis, 10 epiglottitis, and at least 30 lower respiratory tract infection.

It is clear that systemic *H influenzae* in adults in England and Wales is by no means exceptional. It appears to be more common in the elderly. Although not reported in a recent multicentre study of community acquired pneumonia in patients admitted to hospital,[2] when it does occur it often presents with pneumonia. Most serious *H influenzae* infections are due to type b strains, which are resistant to ampicillin in more than 20% of cases.[3] This should be borne in mind when selecting empirical treatment in severe adult pneumonia.

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1 Young, SE. *Haemophilus influenzae. PHLS Microbiology Digest* 1987;**4**:68–9.
2 Research Committee of the British Thoracic Society and the Public Health Laboratory Service. Community-acquired pneumonia in adults in British hospitals in 1982–1983: a survey of aetiology, mortality, prognostic factors and outcome. *Q J Med* 1987; **62**:195–220.
3 Powell M, Koutsia-Carouzou C, Voutsinas D, Seymour A, Williams JD. Resistance of clinical isolates of *Haemophilus influenzae* in the United Kingdom 1986. *Br Med J* 1987;**295**: 176–9.

Book notice

Immunology and Immunologic Diseases of the Lung. Ronald P Daniele. (Pp 705; £75.) Oxford: Blackwell, 1988. ISBN 0 86542 035 1.

The stated aim of this book is "to describe what is currently known about the lung as an immunologic organ." The 33 chapters are written by 36 North American (six from the University of Pennsylvania) and two UK authors. It is divided into three sections describing the structure and function of the lung's immune system (183 pages), pulmonary responses to immunologically mediated injury (102 pages), and immunological diseases of the lung (388 pages). Despite some well written and informative chapters the book falls short of its stated aim in each section. The time lapse between writing and publication, given the speed of advance in this subject, is sometimes all too obvious, and this applies in several respects to the two sections describing immunological mechanisms. For example, discussion on cytokines is limited to IL-1 and IL-2. TNF is mentioned only by name and IL-3, IL-4, IL-5, IL-6, and GM-CSF are ignored completely. Although the alveolar macrophage is considered in some detail there is only limited discussion on mechanisms of activation and down regulation and 1,25-dihydroxyvitamin D_3 is ignored completely despite its important role in granuloma formation and macrophage activation in tuberculosis and sarcoidosis. Similarly, the recent advances in the understanding of growth factor and cytokine influences on fibroblast function have somewhat "dated" the chapter on mechanisms of pulmonary fibrosis. The large "clinical" section also disappoints, but more by obvious omissions than because of direct criticisms of the subjects covered. The omissions—lung cancer is almost totally ignored, asthma receives scant coverage, chronic bronchitis and emphysema are scarcely mentioned, and pneumonia is covered only with respect to the immunocompromised host (an excellent chapter)—appear to be a deliberate editorial decision but the consequence is a book that concentrates heavily on the interstitial lung diseases and vasculitides while neglecting all the common respiratory disorders. In general, the text is well structured and the chapters are well referenced (although the quality of diagrams is variable). The omissions in this book, however, will probably make it merely a reference text for selected "dipping" rather than a volume that chest physicians or academics would want for their bookshelves.—APG

Notice

British Sleep Society

The inaugural meeting of the British Sleep Society will take place in Edinburgh on 4 and 5 September 1989. There will be original presentations and reviews from British and overseas speakers. Areas covered will include the physiology and pharmacology of sleep and breathing during sleep. Those interested in attending should contact either Dr Neil J Douglas, Department of Respiratory Medicine, City Hospital, Edinburgh EH10 5SB (031 447 1001), or Dr Colin M Shapiro, Department of Psychiatry, Royal Edinburgh Hospital, Edinburgh EH10 5HF (031 447 2011).