

Correspondence

Comparative trial of two non-sedative H₁ antihistamines, terfenadine and astemizole, for hay fever

SIR,—I have every sympathy with Dr MB Emanuel's continued inability to understand the ambiguity of our statement about tachyphylaxis (see *Thorax* August 1986;41:654) because I also missed it at the time. I have less sympathy with Dr Emanuel's agreement with me about the importance of studies of tachyphylaxis when he continues to ignore our finding that terfenadine does *not* show tachyphylaxis with respect to histamine wealing after six weeks' administration of either 60 or 120 mg twice daily. Nor can I accept his reassurances about capsule dissolution as adequate evidence of bioavailability or the magnitude of the biological effect of the terfenadine in the study of Drs PH Howarth and ST Holgate. Weal inhibition was not "about 70%" but about 50% of that found with the inactive capsule (67% with the active agent, less 15% with the inactive capsule), which is appreciably less than the 80–90% or more that we and others have found with terfenadine. But, while inadequacy of available drug must remain the probable explanation of the negative study of Drs Howarth and Holgate, the differences so often found in clinical trials are better resolved by further study than by interpretative reworking.

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SIR,—I agree with Professor Shuster that differences in clinical trials are better resolved by further studies than interpretative reworking, but a degree of interpretation is necessary to decide what further studies to carry out. The possible reduced bioavailability of encapsulated drug is an unlikely explanation for the findings of Drs Howarth and Holgate, as Girard *et al*¹ have shown acceptable short term efficacy of both astemizole and terfenadine with a similar formulation. The obvious difference between these studies was duration of therapy (Howarth and Holgate 8 weeks, Girard 8 days).

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- 1 Girard JP, Sommacal-Schopf D, Bigliardi P, Henauer SA. Double-blind comparison of astemizole, terfenadine and placebo in hay fever with special regard to onset of action. *J Int Med Res* 1985;13:102–8.

Leiomyomas of the lower respiratory tract

SIR,—We read with interest the article by Dr SH White and others (April 1985;40:306–11). We agree that the trachea is the least common site of leiomyoma of the lower respiratory tract. We would like to draw attention to two other published cases—the first by Allen *et al*¹ and the second by ourselves.² Our case was that of a young male regarded as having asthma in whom the diagnosis of large airways obstruction was pursued when he was shown to have a fixed slope on the forced expiratory spirogram.

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- 1 Allen H, Angel F, Hankins J, Whitley N. Leiomyoma of the trachea. *Am J Roentgenol* 1983;141:683–4.

- 2 Bouros D, Gasis A, Melissinos Ch, Blatsios V, Emmanouel A. Leiomyoma of the trachea masquerading as asthma [abstract]. *Cancer Detection and Prevention* 1984;7(special issue):442.

* * * This letter was sent to the authors and Dr Ibrahim replies below.

SIR,—I am grateful to Dr Bouros for comments on our paper and for drawing attention to the two cases of leiomyoma of the trachea reported recently.

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Book notice

Principles of Pulmonary Medicine. SE Weinberger. (Pp 337; figs; £19.95, soft back.) Philadelphia: WB Saunders, 1986. (0-7216-1559-7.)

The author, from the Harvard Medical School, aims to help medical students bridge the gap between basic physiology and clinical pulmonary medicine. Unlike many such books, this book covers not only those diseases where physiological measurement plays an important part but also the other major areas of clinical importance, including infections, lung cancer, and mediastinal disease, to mention a few. The book is well written, interesting, and most attractively presented, with plenty of line diagrams, x ray plates, and good black and white illustrations. The main points of each section are highlighted in the margin in green print; and each chapter has a good selection of references. Unfortunately, a student could not look to this book to give all the important information, for it is weak on the epidemiology of respiratory disease and on treatment, where the author aims to give only "the general principles of the therapeutic approach." Thus there is no information on the prevalence of asthma, sarcoidosis, or tuberculosis in different age groups or populations; the relationship between smoking and lung cancer is mentioned, but no more than that. The drugs used for asthma are listed, but with no practical advice on managing patients with asthma; tuberculosis treatment is discussed (two drugs for nine months) without reference to preventive measures, drug resistance, or the developing countries. When compared with other short undergraduate textbooks, Weinberger's book is one of the most interesting, but also less comprehensive and more expensive. I hope that most students will have access to it in their medical libraries, since it is excellent in those aspects of clinical pulmonary medicine which it covers.—JARF

Notice

Priorities in occupational lung disease research

A report entitled *Priorities in Occupational Lung Disease Research* has been produced by the Medical Research Council's Committee on Environmental and Occupational Health. The report identifies areas in which the council is particularly interested in receiving good applications for support. Copies are available from the Medical Research Council, 20 Park Crescent, London W1N 4AL.