

## Correspondence

### Epidemiology of sarcoidosis in the Isle of Man

SIR,—Dr SB de C Baker and his team on the Isle of Man are to be congratulated on an excellent epidemiological analysis of sarcoidosis on the island (June 1987;42:420-30). The inference of their work is that there is a communicable factor as a result of prolonged close contact. This is analogous to tuberculosis, where close and lengthy contact with a source case increases the risk of an individual's developing the disease. However, their work does not rule out a common response to one or more other causative or contributory environmental factors shared by the cases. Indeed, the remarkable lack of cases occurring in married couples would point to a work (or non-domestic) related environmental factor, although what this might be is open to conjecture. One factor which has not apparently been analysed is the possible effect of cigarette smoking. Is there any evidence that sarcoidosis patients were more likely to be cigarette smokers than non-tuberculosis controls? If so, was there any pattern in the linked cases as regards cigarette smoking—that is, did some "linked groups" smoke while others did not? If the latter were true, this would point to different causative agents being responsible in different groups, cigarette smoking being a permissive factor.

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SIR,—Dr Ayres is correct in saying that we cannot completely rule out some other environmental factor common to all the cases of sarcoidosis. However, the work was commenced on the assumption that there might be such a factor and the information sought at interview was designed to cover a wide range of possible factors: industrial, agricultural, domestic, and recreational. No common factor other than person to person contact was found in a heterogenous group of people with very different life styles.

The smoking habits of the majority of the subjects were recorded and there was no significant difference between the sarcoidosis patients and the general controls, but the tuberculosis group smoked more frequently and more heavily ( $p < 0.01$ ).

The lack of cases in married couples is not incompatible with a communicable disease. What is the incidence of overt tuberculosis in the spouses of tuberculous patients? In our tuberculosis controls tuberculosis was recorded in the spouse of one. We found no definite examples of sarcoidosis in both partners, although there were two pairs who were suspected. As the disease was not proved, the spouses were not included in the study.

If sarcoidosis is a communicable disease then the possibility of the development of immunity has to be considered. The age distribution of patients with the disease is compatible with increasing immunity with age, possibly related to subclinical or unrecognised disease; and this may be relevant in the interpretation of the figures for couples and, as we speculated, could explain the different incidence in those of Manx ancestry.

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### Pleurectomy for chylothorax associated with intestinal lymphangiectasia

SIR,—The report of Dr DS Barrett and associates (July 1987;42:557-8) was of great interest to me because of my own interest in pleurodesis in patients with various conditions, including chylothorax.<sup>1-3</sup> Of the various methods tried in my department, talcum powder was insufflated intrapleurally in hundreds of patients, mostly with pleural effusion and recurrent pneumothorax, and resulted in complete pleurodesis in over 90% of cases. I had an opportunity to use talcum powder in seven patients with massive chylothorax resistant to other conservative forms of treatment and complete pleurodesis occurred in all.

Although talcum powder has been implicated in the aetiology of pleural mesothelioma, this is known to be caused by asbestos fibres—a common contaminant of talcum powder though not present in pure talcum powder. The talcum powder we use is mined in Italy in accordance with the requirements of the British Pharmacopoeia and is free of asbestos.

I prefer my conservative method to the much more traumatic pleurectomy, and, with all respect to the excellent results achieved by Dr Barrett and his colleagues, would advise them to try talcum powder.

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- 1 Weissberg D. Talc pleurodesis: a controversial issue. *Le Poumon et le Coeur* 1981;37:291-4.
- 2 Weissberg D, Kaufman M. The use of talc for pleurodesis in the treatment of resistant empyema. *Ann Thorax Surg* 1986;41:143-5.
- 3 Weissberg D. The surgical management of recurrent or persistent pneumothorax: pleuroscopy and talc poudrage. In: Kittle CF, ed. *Current controversies in thoracic surgery*. Philadelphia: WB Saunders, 1986:46-50.

## Book notices

*Bronchial Hyperresponsiveness*. JA Nadel, R Pauwels, PD Snashall. (Pp 426; £49.50.) Oxford: Blackwell Scientific Publications, 1987. ISBN 0-632-01056-8.

The most exciting part of this largely European, multi-author book is the preface by Jay Nadel, which gives a glimpse of a rapidly developing field of scientific interest, and a degree of perspective on a highly complex pathophysiological situation. This is followed by several large, hard worked, comprehensively referenced, but somewhat heavy chapters on normal control of the airways and their nerves, muscle, and secretions. Next comes another comprehensive chapter on bronchial provocation tests. Its main weakness is in its handling of the statistics of reproducibility and the need for high precision, especially in laboratory research. Most of the rest of the book is taken up with possible explanations for the phenomenon of airway hyperresponsiveness. Firstly, there is