Bilateral empyema and purulent pericarditis due to Haemophilus influenzae capsular type b


Correction

Diaphragm strength in patients with recent hemidiaphragm paralysis

In the paper by Dr CM Laroche et al (February 1988) errors occur on pages 172 and 173. In table 3 the figures in parentheses in the last two lines are SDs and should be under the cm H2O not the % predicted columns. In table 4 the mean and SD figures should each move one column to the right.

Notice

J Levy scoliosis research scholarship 1988

Applications are invited for the J Levy scoliosis research scholarship from physicians, surgeons, and those in allied specialties, including those in training. The scholarship is intended for the use of graduates of British medical schools while working in orthopaedics or allied subjects in the British Isles. The scholarship is worth £15 000 and is to further research into scoliosis and in particular methods of early detection and prevention. The closing date for applications is 31 August 1988. Applicants should apply, stating clearly how they intend to use the scholarship and giving a curriculum vitae, to Mr John Dove FRCS, secretary and treasurer of the British Scoliosis Society, 31 Quarry Avenue, Hartshill, Stoke-on-Trent ST4 7EW.

Book notices


There are many reports on the results of lung function tests in healthy children and it would be entirely reasonable for a potential reader to ask whether there was a need for yet more normal data. I would claim that the data in this book by Zapletal and his colleagues are different from previous reports and do make a significant new contribution. The number of children and adults included is not particularly large—173. What is different is that the children were studied with virtually all the techniques available for studying pulmonary physiology in cooperative children. These include all the standard measurements on standard spirometry, flow-volume curves, helium and plethysmographic static lung volumes, lung compliance, total pulmonary and airways resistance, gas diffusion, work of breathing, and physiological deadspace. Some data are included on the work of breathing in a small group of healthy young adults. Although this book does not provide all the information needed to set up the lung function techniques considered, Dr Zapletal and his group, who have perhaps contributed more to our knowledge of normal data on children than anybody else, have provided all the data on the methods used to define the exact circumstances in which these studies were carried out. Possible sources of error are fully described, the means and 95% confidence limits calculated, and the relationships of one measurement to another explored in considerable depth. The reference section is extensive and the latter half of the book contains 284 tables giving lung function data related to height, body surface area, and static lung volumes. I am sure that all those concerned in all but the most basic lung function measurements in children will find this book an invaluable reference source.—ADM


This book of 300 pages provides a clear, comprehensive, and yet concise guide to thoracic surgery. There are introductory chapters which cover anatomy, physiology, development and congenital abnormalities. Other chapters review preoperative investigations and the techniques of endoscopy. The style of the book is didactic and certainly not all thoracic surgeons would agree with all methods of management, but such an approach produces a uniform and very readable text. There is no condition met by thoracic surgeons which is not covered in this book, which includes a chapter on subphrenic abscess. In many areas the book excels in providing clear, practical guides such as the techniques of thoracotomy and rigid oesophagoscropy. An outstanding feature is the high quality of the radiographs, which is unusual in a book of this size. It is, however, disappointing not to find clearer details of the management of chest drains and the handling of a postoperative air leak. Some discussion of methods of improving respiratory function before thoracotomy in those with marginal function would be welcome. At the end of the book there are sections on coronary artery surgery and
Correspondence

Desmoplastic mesothelioma

Sir,—Dr T Machin and colleagues (February 1988;43:155–6) provide a useful platform for the discussion of the critical histopathological assessment of mesotheliomas and their subtypes, particularly the desmoplastic variant. They correctly emphasise the difficulties of diagnosis with small biopsy specimens but are misleading in their assertion that desmoplastic mesothelioma is a variant of the sarcomatous type of mesothelioma. We have recently completed a necropsy study of 40 pleural mesotheliomas from Glasgow shipyard workers and have found desmoplastic areas to occur as frequently in otherwise pure epithelial types of tumour as in sarcomatous types. We would therefore emphasise most strongly that desmoplasia in itself gives no indication of the histological appearance of other areas of the mesothelioma in question.

We note that the assumptions of Dr Machin and colleagues are based on biopsy specimens alone, which we would hardly deem adequate sampling for the accurate subclassification of a tumour that is known for its histological heterogeneity.1

Adams and Unni2 are misrepresented in this short report of Dr Machin and colleagues on two occasions. Firstly, Adams and Unni did not suggest that the desmoplastic tumour was a variant of the sarcomatous type; indeed they noted epithelial elements in as many as five desmoplastic tumours and reported that desmoplastic components were present in all three of their mesotheliomas with a predominantly tubopapillary pattern. Secondly, although Adams and Unni did not indicate the proportion of their cases with bony metastases that were either desmoplastic or sarcomatous, they did note that five of their six patients with bony metastases showed either one pattern or the other, suggesting that metastasis to bone is not rare with this pattern of mesothelioma.


••This letter was sent to the authors, who reply below.

Sir,—We thank Drs Thomas and Burnett for their comments on our paper. It remains our position that desmoplastic mesothelioma is usually a variant of sarcomatous mesothelioma. As shown in an earlier paper from the Canadian Tumour Reference Centre,1 however, a small proportion of desmoplastic mesotheliomas have a biphasic or purely epithelial component. We agree with Drs Thomas and Burnett that desmoplastic areas are commonly found in all types of diffuse mesothelioma. What is distinctive about the desmoplastic mesothelioma, as emphasised in our paper, is that "much of the tumour is fibrous." It is the dominance of the fibrous component which makes differentiation from fibrous pleurisy so difficult. The biopsy material in our patients was generous and clearly indicated the dominance of desmoplasia.

We did not imply that Adams and Unni (ref 2 above) had suggested that desmoplastic mesothelioma was a variant of the sarcomatous type. We simply noted that these authors had found bony metastases in a small number of desmoplastic mesotheliomas and the closely related sarcomatous form. The fact that osseous metastases in their material were largely confined (five of six cases) to sarcomatous and desmoplastic mesotheliomas could be taken as further evidence of a close biological relationship between the two histological types.

Experience at the Canadian Tumour Reference Centre is that bony metastases are very uncommon in mesothelioma. They were not observed in 27 cases of desmoplastic mesotheliomas previously reported from the centre.1 We also note that they are rare in material previously reported from Glasgow.2

The uniqueness of the two cases lay in the occurrence of multiple bony metastases in the absence of clinical evidence of metastases to the other sites.

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