Correspondence

Bronchoalveolar lavage in talc induced lung disease

SIR,—Dr A A Redondo and his colleagues (1988;**43**:1019–21) report a case of inhalational talcosis with abnormal findings in bronchoalveolar lavage fluid. They wonder if lymphocytosis with predominance of $T8^+$ lymphocytosis is a typical finding in talc lung. They also suggest that there is no previous report of lavage findings in talcosis. We had the opportunity to perform bronchoalveolar lavage in eight talc millers exposed to pure talc (Luzenac, French) with pneumoconioses after a long exposure (mean 29·5 years). Lavage findings were characterised by a macrophage alveolitis. No case showed a high lymphocyte count in the lavage fluid (mean 7% (SEM 5%) lymphocytes), but there was a tendency towards polynucleosis (5% (4%)).[1]

In another study we reported that mineralogical analysis of lavage fluid can provide information about the heterogeneity of inhaled talc.[2]

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1 Leophonte P, de Vuyst P, Dumortier P, Rouquet RM, Didier A. Données cytomorphologiques et minéralogiques du lavage bronchoalvéolaire au cours de la pneumoconiose par le talc français. In: Le Bouffant L, ed. *Silicosis and mixed-dusts pneumoconiosis*. Paris: INSERM, 1987:93–8. (Colloque INSERM 155.)
2 De Vuyst P, Dumortier P, Leophonte P, Vande Weyer R, Yernault JC. Mineralogical analysis of bronchoalveolar lavage in talc pneumoconiosis. *Eur J Respir Dis* 1987;**70**:150–6.

AUTHORS' REPLY We appreciate the comments of Dr De Vuyst and colleagues. We are familiar with their work in the mineralogical analysis of bronchoalveolar lavage fluid from six talc workers with interstitial changes on chest radiographs. Although it is likely that talc had a role in the pathogenesis of interstitial lung disease in these patients, exclusion of other causes of interstitial lung disease in talc workers (especially asbestosis, present in some amount in the lavage fluid in each of the six cases reported) is extremely difficult, if not impossible. An important control group—that is, those workers exposed to similar levels of talc but without radiologically evident disease—was not reported. Chest radiographic findings may be a later development in talc induced lung disease, as suggested by our case report. Moreover, the association of talc with granulomas on open lung biopsy in this patient is unique in the reported cases and strongly supports a causal relation of the patients to symptoms. The striking suppressor T lymphocyte predominance in bronchoalveolar lavage fluid may reflect early pathogenetic mechanisms of talc induced lung disease. It is possible that the presence of neutrophils in the bronchoalveolar lavage fluid in a group of talc workers, as reported by Leophonte *et al* (their ref 1), reflects a later phenomenon in fibrosis, similar to that occurring in fibrotic sarcoidosis.[1] Is granulomatous disease an early development in patients who go on to develop "talc lung" of the type characterised by Dr De Vuyst and his coworkers? If this question is to be answered, patients will need to be studied before the onset of fibrosis. As suggested by our case report, bronchoalveolar lavage may have a prominent role in such an investigation.

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1 Roth C, Huchon GJ, Arnoux A, Stanislas-Leguern G, Marsac JH, Chrétien J. Bronchoalveolar cells in advanced pulmonary sarcoidosis. *Am Rev Respir Dis* 1981;**124**: 9–12.

Book notices

Disorders of Ventilation. John Shneerson. (Pp 389; £55.) Oxford: Blackwell, 1988. ISBN 0-632-01668-X.

The provision of long term ventilatory assistance for patients with respiratory failure has until recently been considered a minor and often eccentric specialty. In the past few years, however, there has been a proliferation of evidence that failure of the skeletal or neuromuscular elements of the respiratory system are just as important as the lungs in the development of ventilatory failure. There has consequently been a pressing need for a reference book on this subject to remove much of the mysticism surrounding the practice of ventilatory support, and also to establish the case for treatment in a group of patients who would otherwise suffer through the ignorance of their doctors. This comprehensive volume by Dr Schneerson covers the areas which are relevant to the investigation and management of patients with ventilatory failure arising from scoliosis, neuromuscular disease, and less common disorders. The first third of the book covers the basic underlying physiology and pathophysiology. This is followed by descriptions of the individual disorders of ventilation and, separately, by the different methods of treatment, both historical and current. All the chapters can stand alone and are generously illustrated by plates, line drawings, and flow charts. There is a magnificent set of references containing over 3400 entries and going up to 1987. The style of the book is very conservative and it is not a radical text or a "How to do it" manual. There is also notable underemphasis of some important recent subjects, such as nasal intermittent positive pressure ventilation and respiratory muscle rest in airway obstruction. I assume that this reflects the rapid growth of the specialty as well as the author's natural caution, and that they will be included in