LETTERS TO THE EDITOR

Diffuse mengaingal thickening associated with pleural mesothelioma

In a recent report (January 1990;44:70-1) Dr J B Murray and others report an interesting case of diffuse spinal metastases in a patient with pleural mesothelioma. As pointed out by the authors, cervical metastases from pleural mesothelioma are rare, with less than two dozen cases published. In addition, only three cases of central nervous system metastases diagnosed before death have been reported. Although the authors mention several studies which document the occurrence of metastases in malignant mesothelioma of the pleura, we would like to mention our 1987 necropsy study, with which the authors may not be familiar. In this report we reviewed 42 cases of pleural mesothelioma and found distant metastases in 32 (76%). Common sites of metastatic spread were the contralateral lung, kidney, liver, and adrenals. No relation between histological type and distant metastases was found.

Recently we also reviewed a case of pleural mesothelioma in a lift mechanic, in which a cerebral metastasis was documented by computed tomography. This patient presented with a right Horner's syndrome of uncertain aetiology and subsequently developed increasing confusion. Computed tomography of the head showed a metastasis in the left frontal area. The patient died one month later, and necropsy confirmed the diagnosis of mesothelioma. This is the third report of antemortem recognition of a brain metastasis in malignant mesothelioma.

The patient described by Dr Murray and others was noted to be a roofing contractor, as was the patient described by Reichel. These reports suggest the possibility of a mesothelioma hazard in this occupational group. Such reports highlight the need for rigorous investigation of a history of potential asbestos exposure in patients with this tumour as disease risk is recognised as not being confined to asbestos industry workers such as miners and insulators.

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Role of histamine released in hypertonic saline induced bronchoconstriction

Dr J P Finnegy's letter (January 1990;45:78) criticises the dose of terfenadine chosen by Dr S P O'Hickey and his colleagues (August 1989;44:650-3). In his reply Dr O'Hickey disputed this criticism and claimed that the dose of terfenadine he chose would have been adequate to interfere with histamine released by hypertonic saline because he found a reduction in histaminase responsiveness when this was measured by the topical application of inhaled histamine. Dr O'Hickey's reply shows a basic ignorance of the pharmacology of histamine and terfenadine, as such can be gleaned from perusal of any appropriate textbook.

It has long been recognised that very much higher doses of H1 receptor antagonists are required to antagonise endogenous "nascent" histamine. "It is not clear whether it is because these processes occur intracellularly or whether the receptors through which nascent histamine acts are of a different type to those antagonised by the common antihistamines (i.e. H1 receptor antagonists).

Dr O'Hickey and his colleagues may have been right in their conclusions but the rejection of Dr Finnegy's criticism is ill based.


AUTHOR'S REPLY We thank Dr Cullen for his letter and agree with his remarks and perception of the future for the treatment of this disease. The Midland group's paper was well known to us and our failure to include it in the discussion on maintenance therapy was an oversight for which we apologise.

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STEPHEN SPIRO.
Duration of chemotherapy in small cell lung cancer.

M H Cullen

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