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evidence increasingly indicates that this procedure should be avoided in general with deaths from asthma tends to disappear, whereas the findings for fenotrol remain firm (a similar pattern occurred in the Saskatchewan study, which also used an unmatched control group). When this problem is corrected, however, either by using an appropriate control group (group A) or by adjusting for markers of asthma severity (table, top of p574), then the association of asthma drugs in general with deaths from asthma tends to disappear, whereas the findings for fenotrol remain firm (a similar pattern occurred in the Saskatchewan study, which also used an unmatched control group). The table shows that control group A provides an adequate match for asthma severity, whereas some confounding exists in the unmatched results for control group B. We drew this conclusion in the publication in Thorax, but Drs Lanes and his coworkers have simply repeated our analysis but misrepresented our conclusions.

When the hazards of fenotrol are being considered it is important to note that all of the evidence should be considered with the knowledge that there is now a wealth of epidemiological, experimental, and clinical evidence that fenotrol is more hazardous than other commonly used beta agonists. In New Zealand mortality from asthma started when fenotrol was introduced in 1976, and continued until our first study was published in 1989; the death rate then fell by one half, and is now similar to that in other countries. It is important to search for alternative explanations, but the evidence increasingly indicates that confounding by severity is not a plausible explanation, and that the association between fenotrol and deaths from asthma is likely to be causal.

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Pleurial abstraction: a new method of pleurodesis?

Pleurial abstraction, as a means of pleurodesing the lung, is not a new technique, as implied by the plethora of Mr UU NKere and others (August 1991;46:596-8). We and most thoracic surgeons in Australia have been performing transaxillary thoracotomies, apical bullae stapling, and abdominal pleurodesis for at least 20 years. At the Prince Charles Hospital—a cardiothoracic hospital serving Queensland—in the period January 1985-December 1990, 320 patients were operated on in our thoracic surgical service for spontaneous pneumothorax. The mean age was 28 years and M:F ratio was 1:4.1.

Surgery was performed via the following surgical approaches: transaxillary thoracotomy (TAT) 244 patients, bilateral TAT 12 patients, lateral thoracotomy 52 patients, anterior thoracotomy 6 patients, posterolateral thoracotomy 6 patients. Pleurodesis was achieved thus: pleural abrasion 185 patients, talc with or without abrasion 42 patients, pleurodesis 84 patients, talc with or without pleurodesy 4 patients, other or unknown 5 patients. The mean postoperative hospital stay was four days. There were recurrences requiring surgery in 20 patients and recurrent non requiring surgery in three patients.

I think you must agree that from our experience pleural abrasion is not a new method. We agree, however, with the authors that it is a highly suitable technique with good results. If combined with a transaxillary approach—often an incision no more than 2 inches (5 cm) wide—it is a cosmetically acceptable form of treatment for spontaneous pneumothorax, and we will continue to use this procedure.

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AUTHORS' RESPONSE
We are grateful to Drs Cole and Matar for sharing their extensive experience of surgery for pneumothorax with us. It was with some misgivings that we accepted the editorial decision to change the original title of our paper from "A safe and effective method of pleurodesis" to "New method of..." The only aspect of the technique which, as far as we are aware, has not been previously described is the use of a domestic pan scourer to achieve pleural abrasion and even this is not our invention, as it was being used by Drs MacArthur and Poole at King's College Hospital 20 years ago. Despite the fact, however, that pleural abrasion has been in widespread use in North America and, as we now know, in Australia for many years not many observers using the technique routinely have published their results, and in the United Kingdom there remains the belief outside a small circle of thoracic surgeons and enlightened chest physicians that surgery for pneumothorax calls for more than pleurodesis through a large and painful incision. Indeed, it was the inaccurate and sometimes alarming perception that many of our patients had appeared to receive that prompted us to put our experience together, and in that the subject seems now to have received a wider medical airing than before our principal objective has, in part, been fulfilled.


Shunting through a patent foramen ovale

The phenomenon of shunting through a patent foramen ovale, as recently reported by Dr L Berry and others (January 1992;47:60-1), has interested me for some time. I

Those authors emphasised the important point that shunting flow was detected by transoesophageal echocardiography but not by transthoracic echocardiography — this is not recognised by all echocardiologists. A characteristic feature of this syndrome is platypnoea and orthodeoxia — that is, more pronounced breathlessness and hypoxaemia in the upright than in the supine position. Thus the shunt measurements should probably be made with the patient in the upright position if possible.

The incidence of probe patient foramen ovale is about 25%, but so long as left atrial pressure exceeds right atrial pressure the valve leaflet acts as a closing flap. In the fetus the inferior vena cava empties anatomically and functionally through the foramen ovale into the left heart. In the adult a probe patent foramen ovale is most easily penetrated with a cardiac catheter passed from a femoral vein, not from the brachial vein. Unfortunately Dr Berry and her colleagues did not state which approach they used in their catheterisation.

For two reasons I doubt their explanation that the mechanism for the shunt is caused by mediastinal distortion caused by right pneumoconiosis. Firstly, and as mentioned above, the normal anatomy favours blood flow from the inferior vena cava to the left heart when the flap is pressed open. Secondly, this is an instance where shunting occurs after pneumoconiosis and after severe respiratory failure in chronic obstructive lung disease. A more likely mechanism of the different shunting in different positions is the changing relationship between the right atrial and pulmonary pressures. This, in turn, depends on the function curves of the right and left ventricles: apparently they cross, so that at low "venous return" right atrial pressure exceeds left atrial pressure, and at higher "venous return" left atrial pressure exceeds, or approaches, right atrial pressure.

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Persistent alveolar increased permeability to 99mTc DTPA in patients with advanced HIV infection

In their paper regarding the diagnostic value of 99mTc DTPA clearance "Pneumocystis carinii pneumonia Dr D S Robinson and his colleagues (October 1991;46:722-6) emphasised the specificity of the shape of the clearance curve by noting that none of their patients who did not have pneumocystis pneumonia had a biphasic curve in both the upper and the lower zones of the lung.

We have observed three HIV infected homosexual men who did not have Pneumocystis carinii pneumonia in whom 99mTc DTPA transfer time (mean (SE) T20) ranged from 3:1 to 4.6 (mean 4.3) minutes and was biphasic in the upper, mid and lower zones over a follow up period of four, 18, and 31 weeks. This compares with a mean 99mTc DTPA transfer time in five HIV patients with pneumocystis pneumonia of 3.1 (1.4) (range 1.8-9.6) minutes and significantly lower than transfer times in HIV positive patients with various non-pneumocystis pneumonia chest condi-
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