potential for confounding by severity when an unmatched control group is used. A similar problem 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 fenoterol remain firm (a similar pattern occurred in the Saskatchewan study). The table showed that control group A provides an adequate match for asthma severity, whereas some confounding exists in the unadjusted results for control group B. We drew this conclusion in the previous paper. Dr Lanes and his coworkers have simply repeated our analysis but misrepresented our conclusions.

When the hazards of fenoterol are being considered it is important that all of the evidence should be considered. There is now a wealth of epidemiological, experimental, and clinical evidence that fenoterol is more hazardous than other commonly used beta agonists. The peak New Zealand mortality epidemic started when fenoterol 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 fenoterol and deaths from asthma is likely to be causal.

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4 Crane J, Pearce NE, Burgess C, et al. Markers of risk of asthma death or readmission in the 12 months following a hospital admission for asthma. Int J Epidemiol (in press).

Pleural abrasion: a new method of pleurodesis?

Pleural abrasion, as a means of pleurodesing the lung, is a not new technique, as implied by the paper of Mr UU Nkere and others (August 1991;46:596-8). We and most thoracic surgeons in Australia have been performing transthoracic thoracotomies, apical bullae stapling, and apical 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 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, postero-lateral thoracotomy 6 patients. Pleurodesis was achieved thus: pleural abrasion 185 patients, talc with or without abrasion 42 patients, pleurodesy 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 recurrences not 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 transthoracic 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..." The one 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 Cole and Matar at King's College Hospital 20 years ago. Despite the fact, however, that pleural abrasion has been widespread use in North America and, as we now know, in Australia for many years not many surgeons 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 all pleurectomy 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.

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2 Hagen P, Scholz D, Edwards W. Incidence and size of patent foramen ovale in the traveling (October 1991;46:722-6) emphasised 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 died of pneumocystis carinii pneumonia in whom 99mTc DTPA transfer time (mean (SE) Tmn) 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 is significantly lower than transfer times in HIV positive patients with various non-pneumocystis pneumonia chest condi-
tions (60.3 (10.4, range 13.6–191) min; n = 19; p < 0.001).

The CD4 counts on the patients before the first 99mTc DTPA transfer were 120, 130, and 170 respectively. All three were smokers, as were nine of 19 with various non-pneumocystis pneumonia chest conditions, and all three were nebulised pentamidine, 30 mg monthly, as primary prophylaxis for pneumocystis pneumonia, as did eight of 19 patients without pneumocystis pneumonia. Bronchopulmonary lavage (all three) and transtracheal biopsy (two patients) had negative results. Open lung biopsy in the first two patients did not show any opportunistic infection. Both patients died—10 and 12 months after the initial 99mTc DTPA transfer.

Postmortem examination in the first patient showed cytomegalovirus and toxoplasma brain disease. The third is symptom free 10 months after the first test.

It is concluded that a rapid biphasic 99mTc DTPA transfer may be seen in advanced HIV infection in the absence of pneumocystis pneumonia.

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BOOK NOTICES

Asthma

This is the third edition of this text and many readers of Thorax will have purchased or have access to the first two editions. Readers of this review therefore need to know whether enough has been changed to justify a further purchase. The 1977 edition contained 409 pages, and by the time of the second edition in 1983 the subject merited an increase in length to 519 pages. This new edition is considerably longer and the original two editors have been joined by Tak Lee, professor of asthma and allergy at Guy’s Hospital. The text is essentially new and this is really a new book rather than an update of the previous edition. In only four or five chapters is the author the same as in a previous edition. The chapter on physiology remains as powerful and authoritative as previously but is now followed by a series of new and very well referenced reviews of airway responsiveness, neural mechanisms, mediators, and inflammation. The latter two are particularly strong and provide a very clear summary of current understanding in a didactic but fair manner. The diagrams and electronmicrographs are particularly clear and well presented in the section on inflammation. The previous edition’s chapter on pathology has now been replaced by a short but very readable section on both pathology and cytology, and this contains a useful description of the bronchial circulation. One of the most useful chapters in the first two editions was that by Ian Gregg on epidemiology and it bravely tackled the problem of international comparisons at some length. It has been replaced in this edition by a different but no less useful chapter, which looks carefully at both genetic and environmental influences on the prevalence of asthma. The sections on smoking, pollution, and diet are particularly good, and well referenced. This is an excellent, newly written summary of occupational asthma is rather awkwardly placed between the chapter on epidemiology and five very good chapters on pharmacology. That on β2 agonists was written recently and it covers much of the current controversies (but not necessarily the answers), and the chapters on steroids and other non-steroidal agents are clear and provide a good summary of the current position. The chapter on asthma deaths has been rewritten by one of the previous authors, but the subject begins to look rather historical and there are few references beyond the mid 1980s. The last 100 pages are on the more obviously clinical aspects of asthma—that on childhood asthma has been updated rather than rewritten but the summary on adult asthma is completely new. This is well written and referenced but let down by rather unimaginatively produced algorithms. This chapter includes a useful section on the interface and relationships between the general practitioner and the hospital doctor, but in any future edition the editors might wish to consider pulling together a separate chapter that looks at the specific question of delivery of care. I suspect that this book is used most by clinicians who require a source of information on basic mechanisms, epidemiology, and pharmacology rather than being purchased for its clinical content. As such it is more important than fulfilling its role and it is well produced and extremely well referenced. It is essentially a new book rather than a new edition and it can be strongly recommended to all who have any responsibility for those with this common condition.—MRP


This book is a delightful kaleidoscope of anecdote, story, and experience. It is written mainly by those engaged in the study and treatment of tuberculosis from the war years until relatively recently in Australia, New Zealand, and the Melanesian Islands. With over 40 contributors a wealth of variety and expertise, including “personal views” of lay patrons. It is divided into 12 chapters, each comprising several separate essays by authors on topics although topics seem to be arranged fairly randomly, moving from tuberculosis in Australia, then to New Zealand, on to Papua New Guinea, and back to Australia again, this in no way detracts from its ability to maintain interest right to the end. It is a book that both lay people and medical professionals will find stimulating and informative. For the epidemiologist, there is updated evidence that may make it easier to be accessible by normal literature searches. In particular, I found the chapter on tuberculosis in Papua New Guinea of interest. Tuberculosis did not affect the population in the central highlands of New Guinea until relatively recently, when epidemiological methods and data processing had reached a reasonably sophisticated state, so that a definitive statement on the temporal effect of tuberculosis on a totally non-immune population was made possible. Perhaps because it is written by older and wiser heads, much experience in tuberculosis, the writing becomes anglophile and the book by implication. “Recent economic events in X have widened the gap between rich and poor. The increase in poverty and unemployment is likely to result in an upsurge of tuberculosis over the next decade. Furthermore, the advent of AIDS will be associated with an increase in tuberculosis, especially in racial groups with a high incidence of previous infection.” This might be a book of 1983, new knowledge about the epidemiology of tuberculosis, and the need to update the book, but the book itself still remains an excellent source of information and a useful addition to the literature on tuberculosis.
Persistent alveolar increased permeability to 99mTc DTPA in patients with advanced HIV infection.
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Updated information and services can be found at:
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