

Tuberculosis in the UK, 1994

With reference to your excellent "series" on the control and prevention of tuberculosis in the UK (November 1994;49:1085-9; December 1994;49:1193-1200), the control of tuberculosis in the community – both in terms of patient management and contact tracing – sits uneasily on the current health care reforms. One factor already alluded to is the ability of hospitals to avoid contracting for these services even though they may be sited in the best places to undertake them.¹ The process of contact tracing is essentially about the provider requiring the purchaser to purchase with virtually no choice in the matter. A purchaser has the right to object or refuse. A provider may have no source of revenue if the patient, contact, recent immigrant, or whoever else requires screening is not registered with a family practitioner, and may therefore object to providing these services.

The American tuberculosis experts have not been slow to draw attention to the importance of maintaining tuberculosis control in the public sector, despite health care reforms.^{2,3} I believe it is important that we do the same.

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- 1 Davies PDO. Tuberculosis screening falls foul of reforms. *BMJ* 1993;307:59.
- 2 Frieden TR, Fujiwara PI, Hamburg MA, Ruggiero D, Henning KJ. Tuberculosis clinics. *Am J Respir Crit Care Med* 1994;150:893-4.
- 3 Hopewell CP. The baby and the bath water. The case for retaining categorical services for tuberculosis control in a reformed health care system. *Am J Respir Crit Care Med* 1994;150:895.

Transfer of severe asthmatics

The recommendation by Cochrane (January 1995;50:1-2) and Fergusson and colleagues (January 1995;50:81-2) for early nebuliser medication during ambulance transfer of severely breathless asthmatics must be tempered by the recognition that bronchodilator responsive cardiac asthma¹ could be an alternative diagnosis in the older patient due to increased bronchial reactivity resulting from left ventricular failure (LVF),² the latter requiring investigation and treatment in its own right. An additional confounding factor is the fact that, in some elderly patients, the natural history of allergic asthma includes a transformation into the symptomatology of cardiac asthma as a result of the supervention of age-related causes of LVF such as myocardial infarction (which may be pain-free)³ and aortic stenosis. One such example is an 82 year old asthmatic patient with radiographically validated LVF resulting from pain-free myocardial infarction in whom an unrecordable peak expiratory flow rate (PEFR) increased to 120 l/min after 5 mg nebulised salbutamol. Following the recognition of the cardiac component of his illness, he received treatment for cardiac failure in addition to inhaled corticosteroids and bronchodilators with eventual increase in PEFR to 290 l/min. In this patient the stig-

mata of allergic airways disease included a blood eosinophil count of 1400/mm³ and a serum immunoglobulin E level of 1100 IU/ml (normal level <80). The association of bronchial asthma and aortic stenosis was exemplified by the onset of acute asthma in a 78 year old woman which required several readmissions during the subsequent two year period. Her condition was characterised by radiologically clear lung fields and predictable and satisfactory responses to nebulised bronchodilators. Due to the presence of an aortic systolic murmur she had also undergone echocardiography which showed a peak gradient of 44.9 mm Hg across the aortic valve. In the course of time she did, indeed, eventually experience an episode of acute breathlessness and wheezing which proved to be the result of radiologically validated LVF. On that occasion her symptomatic relief was incomplete after nebulised salbutamol.

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- 1 Plotz M. Bronchial spasm in cardiac asthma. *Ann Intern Med* 1947;26:521-5.
- 2 Editorial. Cardiac asthma. *Lancet* 1990;335:693-4.
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BOOK NOTICES

Snoring and Obstructive Sleep Apnea. 2nd Edition. David N F Fairbanks and Shiro Fujita. (Pp 266; \$91.00.) New York: Raven Press, 1994. 0 7817 0196 1.

The last decade has brought an increase in the understanding and awareness of the importance of the sleep apnoea syndromes. The early availability of many sleep laboratories in North America led to the development of surgical approaches to the management of sleep apnoea without the benefit of adequately controlled trials to define outcome.

This multi-author book is now the second edition of the text which concentrates on surgical aspects of snoring and sleep apnoea. The contributors are mainly ENT surgeons from the USA. Two of the chapters are by authors recently deceased and, as they were both pioneers in the development of upper airway surgery, these are reprinted from the first edition for their historical and educational significance. There are chapters on the diagnosis and consequences of obstructive sleep apnoea, followed by the medical management which contains only a relatively brief mention of nasal CPAP therapy. The remainder of the book is concerned with the description of surgical operations and patient selection, which is often out of date. There are some wonderful diagrams of the different variations of uvulopalatopharyngoplasty and the complications of this procedure are discussed. There is a good chapter on anaesthetic aspects, and the book also describes sleep apnoea in children.

It is a great pity that among the wealth of surgical information it is difficult to understand the exact place of upper airways surgery in sleep apnoea, especially in mild disease. We know that patient compliance with CPAP is generally inadequate, while some patients are unable to tolerate the equipment. Although there is an enthusiastic chapter on tracheostomy for CPAP failures, this should only be used exceptionally and further research is required on the role of surgery in these circumstances.

This book is largely aimed at the ENT surgeon and probably its main value is in the description of surgical techniques. I hope that it will stimulate ENT surgeons to evaluate more critically their procedures and the interaction with medical management. However, I would recommend that departmental respiratory libraries obtain a copy for reference and historical interest of the wide number of treatments that have been tried in sleep apnoea. – JAW

Handbook of Sleep-Related Breathing Disorders. JR Stradling. (Pp 296; £40.00.) Oxford: Oxford University Press, 1993. 0 19 261834 2.

"Only connect . . ." E M Forster's memorable phrase might be considered the motto of those interested in sleep-related breathing disorders. Once a connection was made between snoring at night and excessive sleepiness by day, it became possible rapidly to elucidate the underlying pathophysiology and to develop effective treatments. In consequence, large numbers of patients who had previously been ignored were also able to make the connection between their symptoms and the possibility of a better life style. The result of this has been a deluge of referrals to respiratory physicians, either from family physicians or ENT specialists, requesting that patients be screened for sleep apnoea and treated accordingly. Since neither the anatomy of the upper airways nor the physiology of sleep were ever taught well in most medical courses, it is not surprising that many respiratory physicians feel uneasy when confronted with this new challenge. They can now sleep easier in their own beds with the publication of this book which is a comprehensive, authoritative, and accessible account of what any interested respiratory physician might need to know to set up a sleep and breathing disorders service. Dr Stradling is an internationally recognised authority in this field which is at present dominated by the need to diagnose and treat patients with sleep apnoea and related conditions.

This book gives a clear and up to date explanation of the underlying pathophysiology of breathing at night in normal subjects and patients with compromised upper airways. There are sections covering the clinical features, long term consequences, and the contentious area of differing methods of diagnosis. Having campaigned for the use of simpler and cheaper methods of diagnosing sleep and breathing problems, it must be of some satisfaction to him to know that even relatively affluent countries, such as the USA, are now adopting this approach to deal with the very large number of patients who require these investigations. Paediatric and treatment aspects are well covered and the section on other causes for excessive sleepiness is well worth consulting for those who are at a loss



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