LETTERS TO THE EDITOR

BCG vaccination by multipuncture method

I write in response to the article by Al Jarad et al on this topic. The first study to compare the efficacy of BCG vaccination and its side effects using the Bignall multipuncture device with the reusable handle and disposable heads was the pilot study of neonatal BCG vaccination carried out in 1992 for the Department of Health in our health authority.1

In previous studies in neonates and children under two, referenced in the paper by Al Jarad et al., an 18–20 needle percutaneous head gave approximately the same degree of tuberculin conversion as did intradermal vaccination but, to achieve this in older children and adults, 36–40 punctures were required. This would require either a 40 needle head or a double vaccination with two × 18–20 needles. This is why percutaneous BCG is currently only licensed for children aged under two years. Although in neonates2 and in Al Jarad’s study in older children the rate of tuberculin conversion was lower with percutaneous than with intradermal vaccination, tuberculin conversion does not necessarily equate to lower efficacy. In the early studies on BCG the protective efficacy of the vaccination was related to the presence of a scar after vaccination, but not to the tuberculin test result after vaccination. Those with a BCG scar but a negative post vaccination tuberculin test—that is, no tuberculin conversion—had the same degree of protection against tuberculosis over the 15 years following vaccination as did those with a scar and a positive post vaccination tuberculin test.3

The multipuncture method is undoubtedly easier to use in neonates because their very thin skin makes intradermal vaccination di¢icult. However, it is not possible to equate the BCG vaccine in neonates to a low prevalence of tuberculosis because they can delay treatment and additional problems in most patients with motor neuron disease are the only way for those patients who reject tracheostomy but require ventilatory support. However, we are in agreement with Polkey et al that this treatment must be performed by trained staff in respiratory care units. Moreover, these units are the best place to prevent respiratory morbidity and mortality, to enhance cooperation between patients, relatives and caregivers, and to manage clinical and psychological problems during the terminal phase of the disease.

In our experience the care of patients with motor neuron disease outside respiratory care units needs to be improved. These patients must not be negatively discriminated against compared with other chronic patients receiving even more expensive but socially accepted treatment. We must therefore try to ensure that all patients with motor neuron disease have access to specialist care at home.

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AUTHOR’S REPLY

We wish to read the review by Polkey et al pointing out the need to use all means possible to enable patients with motor neuron disease to achieve the best quality of life.

The authors state that, in order to maintain 24 hour ventilatory support, nasal ventilation must be complemented with alternative strategies during the day that are not suitable for widespread use in district general hospitals. We consider that it is possible to maintain 24 hour non-invasive ventilation in patients with motor neuron disease if nasal ventilation is combined with other non-invasive techniques such as mouth piece ventilation or a pneumobelt, and with manual or mechanical inspiratory muscle aids to clear secretions in those patients whose weakness makes spontaneous coughing ineffective.4 It is important to provide additional support to patients because they can delay tracheostomy and additional problems in most patients with motor neuron disease are the only way for those patients who reject tracheostomy but require ventilatory support.

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AUTHOR’S REPLY

We thank Dr Servera and colleagues for their interest in our paper. We agree that patients with motor neuron disease should have access to specialist expertise where this is necessary. However, we are also conscious that travel can be difficult for some patients with advanced disease and our experience is that, in many cases, satisfactory palliation can be achieved using non-invasive positive pressure ventilation alone. This treatment could theoretically be


Respiratory care units for non-invasive mechanical ventilation in motor neuron disease

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Ashma deaths in Scotland and in Wales

It is surprising to say the least that, although the two inquiries into asthma deaths published recently in Thorax 1 made the point that most asthma deaths occurred outside hospital, this was not the case at all. The findings of the Scottish Confidential Inquiry into Asthma Deaths (SCIAD) 2 and of the Confidential inquiry into asthma deaths in Wales 3 are not in keeping with the opinions of those who worked in the respiratory intensive care facilities. They have prevented some, or even many, of the domestic deaths.

The Respiratory Unit at the Northern General Hospital in Edinburgh first addressed the question as to whether more prompt admission to a hospital with respiratory intensive care facilities could have prevented some, or even many, of the domestic deaths. They reported in 1975, 4 and 1987. These showed that the death rate in patients admitted under the scheme was only 0.3%, substantially lower than that recorded in asthmatic patients admitted to other Edinburgh hospitals which relied on conventional admission procedures.

The asthma self-admission scheme was widely welcomed as a measure which could save lives and was copied in many other parts of district hospitals and specialist centres. The scheme was more fully described in the November 1999 issue of Thorax 4, 5 and 6. These showed that the deaths which would have been prevented by fast track admission and, with the more widespread administration of oxygen and nebulised bronchodilators by paramedical ambulance crews, there are other reasons for emphasising the use of normal referral services, as well as promoting patient self-management to minimise the occurrence of such episodes.

AUTHORS’ REPLY We are aware of the work to which Dr Grant refers, and agree that self-admission schemes prevented asthma deaths by avoiding the delays that sometimes occur with conventional admission procedures. Different versions of self-admission schemes operate throughout Wales, but there is no uniform practice and it is possible that a few deaths in our series might have been prevented had such a scheme operated everywhere. However, in most cases it is unlikely that the outcome would have been different, particularly when patients failed to take their inhaled corticosteroids. As Dr Grant points out, it is difficult to assess the impact of the scheme in a study such as SCIAD 2 in a paper of suitable length for publication.

AUTHORS’ REPLY The place of nebulised inhaled corticosteroids in the treatment of patients with asthma is difficult to assess, but Dr J M Hill’s editorial in Thorax was inaccurate and below acceptable standards for a major medical journal.

Nebulised fluticasone

The place of nebulised inhaled corticosteroids in the treatment of patients with asthma is difficult to assess, but Dr J M Hill’s editorial in Thorax was inaccurate and below acceptable standards for a major medical journal.

Nebulised fluticasone is frequently referred to, yet all the studies referenced 1 have only been published as abstracts (sponsored by the manufacturers of fluticasone) in supplements to journals. There are insufficient details for these papers to be properly scrutinised. They have not been subject to proper peer review and should have no place as the sole references for a new treatment for asthma in the editorial of a major medical journal.

Dr Hill states that “it is clear from a number of studies that fluticasone is twice as potent as budesonide at a mg for mg dose” but references this with a study which compares fluticasone with beclometasone and not budesonide.

This is clearly incorrect. She forgets that different inhaled devices influence potency ratios. Thus, fluticasone in a Diskhaler may be equipotent with budesonide in a Turbhaler and fluticasone in a metered dose inhaler may be equipotent with beclometasone in the newer, smaller, particle, CFC free inhaler (Qvar). 1

As far as nebulised steroids are concerned, she seems unaware that different nebuliser systems may affect the amount delivered to the lung by a factor of four or more. 2 Is this not important to mention? Also, the respirable fraction of nebulised steroid aerosols depends on the physical and chemical nature of the steroid molecule. For example, beclometasone might be equipotent with budesonide in metered dose inhalers, but beclometasone solution nebulises poorly and has been withdrawn from use. So, what is the potency ratio between nebulised fluticasone and budesonide? The answer is unknown, simply because there are no comparative studies.

Finally, any article, editorial or otherwise, and especially one that makes unfavourable comparisons between drugs—should be accompanied by a declaration of competing interests. There is nothing wrong with having a competing interest but one should, if not know, Dr Hill should have stated these interests in the same detail as reported recently in a review article on asthma drugs in the BMJ. 3

Conflict of interests: neither Dr Todd nor his spouse have shares in any pharmaceutical company. He has received payment from Astra, Boehringer, 3M, Forest Laboratories (USA), GlaxoWellcome, MSD and Zeneca for presentations/lectures in the past five years. He has only received payment for research from GlaxoWellcome (fluticasone).

3 Grant IWB. Deaths from asthma. BMJ 1986:1:575.
AUTHOR'S REPLY The author thanks Dr Todd for his constructive comments on her review article.1

There are few published randomised controlled trials of nebulised fluticasone or budesonide in the treatment of asthma. Despite this, these agents are being actively marketed by the pharmaceutical industry so it is vital that the debate about the place of these agents in the treatment of asthma should continue. The author therefore thinks that it is justifiable to review what evidence is available, accepting its limitations in abstract form.

The author apologises for incorrectly quoting a paper comparing the potency of budesonide and fluticasone. The correct reference is cited below. However, the author had presumed that the readers of Thorax would be well aware that data comparing different inhaled corticosteroids apply only to the type of inhaler used in any comparison, and that this basic principle did not require explanation.

Dr Todd's comments about different nebuliser systems and drug solubility are well taken. However, this was a short review of the available clinical evidence for the use of nebulised corticosteroids in the treatment of asthma. It was not possible to, nor did I, review nebuliser pharmacokinetics and, as Dr Todd states, there are no comparative studies of the potency ratio of nebulised budesonide and fluticasone.

Finally, neither Dr Hill nor her spouse has shares in any pharmaceutical company manufacturing asthma treatments. She has received payment from GlaxoWellcome, Boehringer, Bayer, Abbott Laboratories, and Astra for presentations/lectures and for attending meetings in the last three years.

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2 Barnes NC, Hallett C, Harris TAJ. Clinical experience with fluticasone propionate in asthma: a meta-analysis of efficacy and systemic activity compared with budesonide and beclomethasone dipropionate at half the microgram dose or less. Respi Med 1998;92:95–104.

Pyoderma gangrenosum

Wang et al report an interesting case of systemic pyoderma gangrenosum (PG) with associated lung injury.1 They recognise the importance of excluding Wegener's granulomatosis (WG) in patients with respiratory symptoms and cutaneous ulceration, but in their case seem only to have done this on clinical and histopathological grounds. A more complete assessment should include testing for cANCA and anti-protease 3 (PR3).1

We are currently treating a 54-year-old ex-smoker who presented for investigation of haemoptysis and who subsequently developed epithelial ulceration and skin lesions resembling PG. Initial investigations were Hb 11.3 g/dl, WBC 9.4 × 10^9/l, platelets 370 × 10^10/l, ESR 86 mm/h, and CRP 181 mg/l. Renal function was normal. The chest radiograph showed alveolar shadowing in the left lower zone and an HRCT scan confirmed pulmonary infiltrates. Fibreoptic bronchoscopy and transbronchial biopsy specimens were normal. Skin biopsy specimens showed epithelial cell necrosis and acute inflammatory changes with no evidence of vasculitis or granulomas, consistent with PG. The ANCA assay was positive with a cytoplasmic distribution and was directed against the proteinase 3 epitope. Despite the absence of histological evidence, the clinical features and positive ANCA supported a diagnosis of WG. One month into treatment with pulsed intravenous methylprednisolone and cyclophosphamide the patient is clinically better with resolution of haemoptysis, healing of the pyoderma-like lesions, and a fall in the CRP (to 21 mg/l).

Patients with WG frequently present with non-specific signs and symptoms and a high index of suspicion is important.1 This case highlights the importance of testing for ANCA in patients with PG and respiratory tract symptoms as the treatment of WG requires prolonged immunosuppression for at least a year. Whilst PG itself may be associated with pANCA,3 testing for cANCA,4 the presence of cANCA directed against PR3 is highly suggestive of WG. The histological features of WG are often patchy in distribution and the absence of the characteristic findings of vasculitis, granulomas, and necrosis does not exclude the diagnosis.5

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AUTHOR'S REPLY I would like to thank Dr Perkins and colleagues for their interest in our article and for their suggestions. The ANCA assay was only introduced in our hospital in 1997 so we could not use this method to distinguish between WG and PG before that time. The diagnosis of WG in our hospital depends mainly on histopathological examination. In September 1999 the patient came for re-examination. All drugs had been stopped for more than four months, she had no symptoms, and all investigations (including chest radiograph, ESR, and CRP) were normal.

Hoffman et al reported the treatment outcome of 158 patients with WG.1 One hundred and thirty three patients received standard treatment of daily low dose cyclophosphamide (2 mg/kg/day) plus prednisone (1 mg/kg/day). This protocol produced marked improvement or partial remission in 91% of recipients; 75% experienced complete remission with a median time of 12 months. Less than 10% of patients so treated experienced remission as late as six years after beginning the protocol. However, 10 cases received corticosteroid only. In this group only two of six cases with limited WG (without renal injury) achieved sustained remission. The authors concluded that the course of WG had been dramatically improved by daily treatment with cyclophosphamide and corticosteroid; other treatment regimens had not achieved such high rates of remission and successful maintenance. Compared with Hoffman's standard protocol, the dose of cyclophosphamide and duration of treatment in our patient were lower and shorter, respectively. We feel it is unlikely that the clinical picture would have improved so significantly within 10 days if the diagnosis was WG. Of course, the best way is to perform an ANCA test and we intend to do so.

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Therapeutic equivalence of inhaled salbutamol

The meta-analysis by Hughes et al was hindered by difficulties in comparing trials that were often flawed and of varied design.1 The authors correctly pointed out that, in most of the studies, the use of an equivalence test as the null hypothesis was invalid. In addition, all but two of the studies looked at the bronchodilator effects in the presence of basal airway tone, when the top of the dose response curve for bronchodilator response occurs in mild to moderate asthma at a salbutamol dose of approximately 200 µg for chlorofluorocarbon (CFC) or hydrofluoroketane (HFA) pressurised metered dose inhalers (pMDIs).2 To construct a proper dose response curve to estimate relative bronchodilator potency would therefore necessitate the use of doses much lower than 200 µg or evaluation of patients with more severe asthma. Two of the cited studies evaluated functional antagonism against histamine induced bronchoconstriction in patients with mild to moderate asthma. However, in such patients the dose response curve for bronchoconstriction is relatively shallow. For example, in a recent study of 72 patients with mild to moderate asthma a fourfold increment in the dose of formoterol Turbuhaler (from 6 µg to 24 µg) only resulted in a shift in methacholine hyperresponsiveness of one doubling dose.1

One simple way of evaluating bioequivalent doses of inhaled salbutamol is to evaluate the relative respirable lung dose, which can be quantified as lung bioavailability from the relative respirable lung dose, which can be defined as the mass of drug that is delivered to the lung per unit mass of drug administered (Fig. 1). This parameter is typically measured using a device in a standardised manner and inhaled salbutamol is evaluated using the standardised method. The first test of bioequivalence in human volunteers was performed in our laboratory using an identical design in which a nominal dose of 1200 µg salbutamol was administered via different devices in healthy volunteers.3 Where the same device was evaluated in two or more

studies, the highest value for $C_{\text{max}}$ was used. A significant difference between devices was assumed where respective 95% confidence intervals did not overlap. The results are shown in fig 1.

There were no differences in lung dose between CFC-pMDI, HFA-pMDI, and the dry powder inhalers, although the Accuhaler produced lower levels than the Diskhaler. As expected, the addition of a Volumatic spacer increased the lung delivery for both CFC-pMDIs and HFA-pMDIs. When used in combination with a Volumatic spacer there was greater delivery with HFA than with CFC. The Sidestream nebuliser resulted in a lower relative lung dose than any of the other devices. However, if an adjustment is made to reflect the usual 2500 µg nominal dose administered by nebuliser ($C_{\text{nom}} = 2.52$ ng/ml), the lung dose is similar to the adjusted value for a 400 µg nominal dose from a Nebulizer spacer with HFA-pMDI ($C_{\text{nom}} = 2.96$ ng/ml).

 Although decreased airway calibre in asthmatic patients will reduce the lung dose of salbutamol from a given device, the relative difference in lung bioavailability between devices will remain the same and is related to the bronchodilator response. Measurement of the lung bioavailability of salbutamol in healthy subjects may therefore represent a simple in vivo method for preliminary quantification of the relative lung dose from different inhaler devices to select rational doses for subsequent clinical equivalence studies in asthmatic patients.

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NOTICE

International Pediatric Respiratory and Allergy Congress

The International Pediatric Respiratory and Allergy Congress will be held on 1–4 April 2001 at the Prague Congress Center, Prague, Czech Republic. For further information contact the Congress Secretariat at the Congress Centre, Czech Medical Society, JEP Sokolská 31, CZ-120 26 Prague, Czech Republic. Telephone +4202 2946889 or +4202 297271; fax +4202 294610 or +4202 2416836. Email: lonekova@cls.cz


Respiratory care units for non-invasive mechanical ventilation in motor neurone disease

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