The diagnosis of pleural mesothelioma is challenging. While thoracoscopy usually yields adequate diagnostic material, it is a relatively cumbersome procedure that must be performed by well trained chest physicians. Not all patients with pleural effusions are candidates for thoracoscopy. Based on our observation, thoracoscopy should not be withheld in patients with an hMAM positive pleural effusion of unknown origin on the assumption that such positivity is suggestive of metastatic breast cancer.

The potential diagnostic role of hMAM detection in patients with a pleural effusion is unknown. In MM patients we found no correlation between hMAM positivity and cytology. This observation indicates that these two non-invasive diagnostic tools are non-redundant and have the potential to yield independent information. Further studies with larger samples—which include non-malignant effusions as well as effusions secondary to malignancies of different origin—will be necessary to investigate the potential role of hMAM analysis in the work up of patients with a pleural effusion of unknown origin.

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References

HIV testing in TB clinics: a problem in practice?

The London Regional Office of the Communicable Disease Surveillance Centre (CDSC) has stated that all patients diagnosed with tuberculosis (TB) should be offered an HIV test. We sought to implement this by introducing a programme within two central London hospitals with high rates of TB, where TB specialist nurses saw all patients early in their treatment course and discussed HIV testing. A standard protocol was used which covered the reasons for offering a test, the “pros and cons” of testing, and the actual process involved (including how the results would be given). Staff training and support was supplied by local HIV psychologists. Pretest discussion took an average of 10–15 minutes per patient and was usually performed within the first month of treatment.

Between July 2002 and July 2003 there were 247 new cases of TB. The median age was 33 years and 60% were male. The main ethnic groups were black African (40%), white (22%), and Indian (11%). Eleven (4%) were already
known to be HIV positive and were excluded from further analysis. Of the remaining 236, 131 (56%) were offered an HIV test. 109 (83%) of those offered took this up and 18 (17%) of sample tested, 8% of all TB patients) were found to be HIV positive.

When subjects were divided on the basis of where the diagnosis of TB was made, striking differences in HIV rates were noted (table 1). Inpatients were much more likely to be offered, to accept, and to test positive on HIV testing. There was no difference in the demographic parameters between inpatients and outpatients, although inpatients tended to have more symptoms and to be smear positive (data not shown). Where no HIV test was offered, we found common themes in patient care. The most important of these was a lack of TB nurses to offer testing, and patients being diagnosed outside the focused TB service. A problem specific to the out-patient setting was the lack of appropriate patient education. This was offered, we found common themes in patient care. The most important of these was a lack of TB nurses to offer testing, and patients being diagnosed outside the focused TB service. A problem specific to the out-patient setting was the lack of appropriate patient education. This was offered, we found common themes in patient care.

The most common reason given by patients who declined to undergo testing was a perceived inability to cope with the dual diagnosis (46% of cases), especially if the initial diagnosis of TB itself had been difficult to deal with. Such individuals would rarely agree to further discussion on HIV testing at a later date. Other reasons—such as patients regarding themselves to be at low risk of HIV infection—were much less frequently reported (10%).

The overall high rate of HIV co-infection is in line with other metropolitan studies. Our data, as well as that of others, may appear to suggest that we should predominantly target inpatients (in whom the rates of HIV were 20 times greater than in outpatients). However, given the increasing HIV/TB rates in the UK, we feel that this is a short sighted approach given the increasing HIV/TB rates in the UK, we feel that this is a short sighted approach. There is need for in-depth qualitative analysis to explore issues such as the timing of the discussion on HIV testing and the belief systems and coping mechanisms of individuals.

Despite attempts to provide a focused HIV testing service within our TB clinics, we find low rates of uptake. Much of this stems from an apparent failure to offer testing to almost half our patients. This may be an overestimate as it is conceivable that other healthcare workers might have discussed testing but not documented it in the patient’s notes. Data systems need to be implemented which can accurately capture this information.

Achieving HIV testing targets will require dedicated resources as well as improvements in both staff and patient education. This would argue for a greater interaction between local TB and HIV services.

Table 1 Numbers of outpatients and inpatients with active tuberculosis and unknown HIV status offered and accepting an HIV antibody test, and numbers found to be positive

<table>
<thead>
<tr>
<th></th>
<th>Outpatients</th>
<th>Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offered HIV test</td>
<td>88 (49%)</td>
<td>43 (74%)</td>
</tr>
<tr>
<td>Offered HIV test</td>
<td>61/88 (69%)</td>
<td>42/43 (98%)</td>
</tr>
<tr>
<td>HIV positive</td>
<td>1/61 (2%)</td>
<td>17/42 (40%)</td>
</tr>
</tbody>
</table>

*p value: 0.001; †<0.0001

<table>
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<tr>
<th>Offered HIV test</th>
<th>88/131 (67%)</th>
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**References**


**Suppression of HPA axis in adults taking inhaled corticosteroids**

Fluticasone propionate, a frequently prescribed potent inhaled corticosteroid, is an effective and generally safe treatment for chronic asthma. However, rare cases of dose related systemic absorption of inhaled corticosteroids leading to suppression of the hypothalamic-pituitary-adrenal (HPA) axis have been reported, particularly in children.

Using the insulin tolerance test (ITT), we report two cases of symptomatic adrenocortical suppression in asthmatic adults taking inhaled fluticasone. The two patients reported here were selected from a review of 59 patients undergoing ITT for investigation of suspected HPA dysfunction. Patient 1, a 38 year old woman (weight 49.9 kg) with a history of chronic asthma and allergic rhinitis, was referred for investigation of a 2 year history of fatigue, presyncope, and reduced libido. She denied symptoms of neuroglycopenia, thyroid dysfunction, head-aches, arthralgia, myalgia, weight change, constipation, and diarrhoea. Past history included depression (in remission, on no current treatment) and bulimia nervosa. Menses were regular. There was no history of postpartum haemorrhage. Medications included fluticasone propionate/salmeterol xinafoate (Seretide) 250/25 μg one inhalation twice daily and mometasone furoate mono-hydrate (Nasonex) nasal spray 50 μg each nostril twice daily. However, adherence and dosing were variable. Of note, the patient reported that her presenting symptoms improved significantly whenever she had received oral steroids for asthma exacerbations in the past. Initial blood results are shown in table 1. Given low early morning cortisol levels in the absence of increased levels of adrenocorticotropic hormone (ACTH), an ITT was performed which revealed HPA axis suppression (table 1). Magnetic resonance imaging (MRI) demonstrated loss of upper concavity of the pituitary gland. Prednisone 2.5 mg/day was commenced and the dose of fluticasone propionate/salmeterol xinafoate was reduced to 125/25 μg one inhalation twice daily, with good symptomatic response. The patient was concurrently diagnosed with celiac disease following small bowel biopsy.

Patient 2, a 61 year old woman (weight 55 kg) with chronic asthma, treatment resistant osteoporosis, Hashimoto’s hypothyroidism and celiac disease, reported fatigue, presyncope, neuroglycopenia, adrenergic symptoms of hypoglycaemia, anorexia and weight loss. Menopause was premature at age 45 years. There was no history of significant haemorrhage. Medications included inhaled fluticasone propionate (Flixotide) 250 μg and salmeterol xinafoate (Serevent) 50 μg one inhalation of each twice (for 12 months prior to presentation).

As morning cortisol levels were low and the ACTH level was normal, an ITT was undertaken which demonstrated suppression of the HPA and growth hormone axes (table 1). Pituitary MRI scan was unremarkable.

Prednisone 2 mg/day was commenced with symptomatic improvement. The dose of prednisone was reduced to 1 mg/day without recurrence of presenting symptoms. Using the ITT, we detected HPA suppression in two adult asthmatic patients taking inhaled/ intranasal corticosteroids. The variable and unpredictable absorption of inhaled corticosteroids, low body weight, and intermittent adherence and dosing in patient 1 may have contributed to the patients’ symptoms of adrenal insufficiency. The high lipophilicity of fluticasone, which results in an extended volume of distribution and prolonged elimination half life, is thought to account for the greater frequency of adrenal insufficiency in patients taking fluticasone compared with other inhaled corticosteroids.

Adrenal suppression in asthmatic adults taking inhaled fluticasone is thought to occur less frequently than in children, particularly in patients taking <800 μg/day, due to a lower effective steroid dose per unit body surface area. However, previous studies have used relatively insensitive discriminators of HPA dysfunction such as early morning serum and salivary cortisol levels, 24 hour urinary free cortisol, and the 250 μg cosyntropin stimulation test to examine the integrity of the HPA axis in adult asthma patients taking inhaled corticosteroids.

We are aware of no previous study that has used the ITT, the current ‘gold standard’ of HPA dysfunction, in this patient group. Although potentially dangerous in patients with seizure.
HIV testing in TB clinics: a problem in practice?

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