

LETTERS TO THE EDITOR

Diagnostic value of lung clearance of ^{99m}Tc DTPA compared with other non-invasive investigations in *Pneumocystis carinii* pneumonia in AIDS

We read with interest the paper by Dr D S Robinson and others (October 1991;46:722-6), which reported the finding of a biphasic or biexponential DTPA clearance curve and its use in the management of patients with HIV infection and pneumocystis pneumonia. We have found the test sensitive and useful.^{1,2} There are, however, some issues raised by the method used that are worth exploring. The most crucial point is the lack of separation of the patients with pneumocystis pneumonia and those that are smokers without pneumocystis pneumonia. This observation makes the suggestion that an analysis of the first seven minutes of data acquisition is sufficiently reliable to separate those with pneumocystis pneumonia from others who smoke unlikely. The methods of data acquisition and processing described might explain the insensitivity of the method. There are several problems.

Firstly, the patients inhale aerosol for four minutes, and yet the half time of the clearance reported by others is between one and five minutes^{1,3}; it is therefore likely that the initial fast component is at least partially obscured with this inhalation time.

Secondly, the aerosol inhalation was performed in the erect posture, which would result in reduced counts over the upper lobes (which also have faster transfer times than the lower). This would be a particular problem in sick patients who cannot remain still. Possibly this led to the reduced sensitivity in the measurements over the upper part of the lung.

Thirdly, the background radioactivity varies between the apex of the lung and the base^{4,5} and in the paper by Langford *et al* was found to vary in non-smokers.⁶ These variations have been found in "healthy" subjects when a bolus correction method was used. In patients with alveolitis, where perfusion will be altered as well as the amount of interstitial oedema, the background will be highly variable. Is the method that uses the interrenal area (with no bolus of DTPA) to correct for background radioactivity suitable in these patients (who have high renal activity and patchy lung oedema)?

The final point relates to the data analysis, which appears to show a longer first component time after curve stripping (table 2). We would be grateful for an explanation of how curve stripping results in a longer first component time than the raw data. Van der Wall *et al*³ also performed the exercise of examining the first seven minutes after the peak and found this to be a poor discriminator in smokers with pneumocystis pneumonia. When adequate curve stripping (but no background correction) was performed a mean first component half time of 3.3 minutes was found, resulting in the separation of the two groups, which compares favourably with our own data after curve stripping.¹

We believe that separation of the "alveolitic" group of patients can readily be achieved with DTPA aerosol, and this has been shown by another group² without background correction but with careful attention to the details of the scanning procedure and data analysis.

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AUTHOR'S REPLY The aim of our paper was to examine the suggestion that DTPA lung clearance might be a useful method of investigating HIV seropositive patients with respiratory symptoms. The future role of this investigation will depend on wider experience, from its application in different centres.

We note with interest the comments on methodological points. As we mentioned in our discussion, the main difference between our method and that used by O'Doherty and others stemmed from the faster flow rate they used and therefore presumably the smaller particle size. Possibly this would have a greater discriminatory value and, as we have said, we believe that this is an area for further investigation, though each centre is likely to have its own method until consensus is achieved. The seven minute clearance times for smokers did give significant separation in our study between those with and without pneumocystis pneumonia. Although differences were not as pronounced as for non-smokers, the important point was our finding that resolution did not appear to be improved by a longer scan time. We analysed upper and lower lung zones separately and did not find any difference between the two in discriminatory power for pneumocystis pneumonia; thus we did not detect any greater variability in upper than in lower lung zones. We would agree that sick patients might not tolerate the scan (in either erect or any other posture) but we think that DTPA scanning may not be an appropriate investigation in such patients. We have examined the effect of intravenous injection to determine background in some of our patients and this does not appear to improve our protocol significantly.

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Pleural abrasion: a new method of pleurodesis

The article by Dr UU Nkere and others (1991;46:586-8) made interesting reading. The title "a new method" was intriguing. We at St John's Medical College and Hospital, Bangalore, have used a similar method for many years with good results. Instead of the nylon scourer used by Dr Nkere and his colleagues we have used only dry gauze to abrade the pleural surfaces to the point of obtaining minute petechial haemorrhages. In addition, we resort to a form of "open chemical pleurodesis" by painting the opposing surfaces with a paste made of sterile talc powder and Betadine. We find that this helps to obtain a more complete and quicker pleurodesis. The rest of the technique is very similar to that of the authors. We agree with them that this is a safe and a simpler method of obtaining pleurodesis and avoids the complications associated with a standard pleurectomy.

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BOOK NOTICES

Complications in Cardiothoracic Surgery. Edited by John A Waldhausen, Mark B Orringer. (Pp 460; £78.) St Louis: Wolfe, 1990. ISBN 0 8151 9175 8.

The surgical mentality is essentially optimistic, and particularly so regarding the chest. Complications are consigned to small print when we are talking to either patients or colleagues and only with our current enthusiasm for audit are they the subject of frequent and detailed analysis. Few surgeons would wish to be regarded as an authority on their diagnosis or management! But Waldhausen and Orringer, with formidable conventional reputations in respectively cardiac and thoracic surgery, have edited an important and, in its scale, unique volume on this neglected area. The book covers the whole field, cardiac and thoracic, adult and paediatric. Introductory chapters include the complications of anaesthesia and of positions and incisions. They are followed by an extensive section on the general problems of cardiopulmonary bypass and myocardial preservation. There are then chapters devoted to individual procedures across the whole range of cardiac surgery. Thoracic surgery is perhaps less well served, having only a third of the whole book; but the chapters are well thought out and authoritative. The illustrations are excellent (as one would expect for the price) and frequently from definitive publications. The various contributors, entirely from North America, are to be particularly congratulated on the quality of the references following each chapter. Who will read this book? Senior surgeons who have "seen it all" will find much to learn from.