

LETTERS TO THE EDITOR

Allergic alveolitis due to goose feathers in a duvet

It is not often that reports of rare conditions appear in textbooks before journals (November 1992;47:990-1). Allergic alveolitis due to feathers in cushions, however, was first described in 1975 in a patient in whom I had made the diagnosis some years before.¹ Although I have not seen a similar patient since, I thought it worthwhile writing in Crofton and Douglas's 4th edition: "One potential source of antigen that may be overlooked is feathers in cushions or pillows".² Incidentally, the patient I looked after had been ill, and a puzzle to her doctors, for about eight years. She had precipitating antibodies to bird serum but no exposure to birds and it was only on my second visit to her house that I tumbled to the possible cause, subsequently confirmed by challenge with the cushion feathers. She was cured by getting rid of the cushions.

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1 Morgan WKC, Seaton A. *Occupational lung diseases*. 1st ed. Philadelphia: Saunders, 1975:314.

2 Seaton A, Seaton D, Leitch AG. *Crofton and Douglas's Respiratory diseases*. 4th ed. Oxford: Blackwell, 1989:721.

Effect of dietary sodium on the severity of bronchial asthma

Drs D Lieberman and D Heimer (May 1992;47:360-2) reported the effect of three levels of salt intake on peak expiratory flow in patients with mild asthma. They found that a low dietary salt intake had no effect, although a low salt intake has been associated with a low prevalence of asthma in some epidemiological studies.

Reversal may be more difficult than prevention, and it is important to note that the mean sodium excretion rate of 84 mmol/24 hours recorded with their "low" salt diet is not particularly low for a therapeutic diet. In hypertension, for example, there is evidence that a mean sodium excretion rate of 90 mmol/day is very close to the upper limit for a measurable therapeutic effect.¹

The "low" salt diet for asthma still provided more sodium than potassium, giving a 24 hour urinary Na/K ratio of 1.12. In Australia the recommended dietary intake for potassium is 50-140 mmol/day, with an added recommendation that the Na/K ratio should not exceed 1.0.² Potassium has a natriuretic effect and this recommendation is intended for the whole population, on the evidence that it would help to prevent hypertension. It would be interesting to know if the electrolyte balance of a truly low salt diet has relevance to the treatment or prevention of asthma.

We have a consumer advisory group producing literature and a newsletter to help subscribers to achieve a sodium excretion

rate below 50 mmol/24 hours.³ Correspondence is invited to Salt Skip, GPO Box 1717, Hobart, Tasmania 7001, Australia.

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- 1 Beard TC. Effect of salt restriction on hypertension. *Lancet* 1989;ii:801.
- 2 Truswell AS, Dreosti IE, English RM, Rutishauser IHE, Palmer N, eds. *Recommended nutrient intakes: Australian papers*. Sydney: Australian Professional Publications, 1990: 191-8.
- 3 Anon. Salt Skip. *Australian Prescriber* 1991; 14:69.

Notification of tuberculosis: how many cases are never reported?

The article by CD Sheldon *et al* (December 1992;47:1015-18) highlights the difficulties and inaccuracies encountered in studies on the incidence and nature of tuberculosis based on notification systems. At present even small changes in the practice of notification could profoundly affect our concept of tuberculosis as a declining or increasing health problem.¹ Sheldon *et al* recommend, amongst other things, notification of all positive cultures by microbiologists (as in Scotland).

England and Wales, as well as Scotland, have excellent reference facilities in the form of the Public Health Laboratory Service Mycobacterium Reference Unit and the Regional Tuberculosis Centres. These laboratories receive almost all cultured mycobacteria from the regions that they serve and are therefore able to carry out detailed studies on the changing trends in disease due to tubercle bacilli and other mycobacteria, and to monitor changes in the incidence of drug resistance.²⁻⁴

Although providing an unequivocal diagnosis, bacterial culture is only positive in a proportion of cases of tuberculosis. Thus, surveys based on bacteriological studies suffer from the same problem as those based on the notification system. If, however, the two systems could be combined by means of a computer link a much clearer picture of tuberculosis in Great Britain would emerge. Such dual reporting would enable weaknesses in the notification system to be delineated and remedied and would also facilitate an audit of the efficacy of procedures for obtaining clinical specimens and for the primary isolation of tubercle bacilli and other mycobacteria from such specimens.

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- 1 Davies PDO. Recent developments in the management of the pulmonary complications of HIV disease. *Thorax* 1992;47:1084.
- 2 Grange JM, Yates MD, Collins CH. Subdivision of *Mycobacterium tuberculosis* for epidemiological purposes: a seven year study of the "Classical" and "Asian" types of the human tubercle bacillus in south-east England. *J Hyg* 1985;94:9-21.
- 3 Yates MD, Grange JM, Collins CH. The nature of mycobacterial disease in south-east England, 1977-1984. *J Epidemiol Community Health* 1986;40:295-300.
- 4 Yates MD, Grange JM. A bacteriological survey of tuberculosis due to the human tubercle bacillus (*Mycobacterium tuberculosis*) in south-east England: 1984-1991. *Epidemiol Infect* 1993 (in press).

Attenuation of exercise induced asthma by local hyperthermia

I read with interest the paper by Dr S L Johnston and colleagues (August 1992;47: 592-7) indicating that local hyperthermia (inspired air temperature 42°C) significantly decreased the response to exercise challenge and had a trend towards protection against histamine challenge at one hour.

As the authors mentioned, one possibility might be the interfering effect of increased temperature on local inflammatory mediators. That view is supported by our previous results, which showed that body temperature modulates the bronchial responsiveness caused by platelet activating factor (PAF) in the rabbit.¹ Infused PAF, which at normal body temperature induced significant bronchial hyperresponsiveness, caused considerable hyporesponsiveness to inhaled histamine at a higher core body temperature (41.2°C). The change in body temperature did not have a significant effect on the ability of PAF to induce neutropenia, thrombocytopenia, or to alter levels of hematocrit (an index of microvascular leakage), or plasma corticosterone. The known effects of temperature on PAF receptor affinity, an increase in metabolic breakdown of PAF, or reduced secretion of secondary mediators, may be plausible basic mechanisms.

Interestingly, there has also been a clinical report in which a decrease in body temperature was found to induce airways obstruction.² An increase in body temperature is also known to ameliorate asthma symptoms³ and, in the past, an artificial fever was once used to treat asthma.⁴

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- 1 Nieminen MM, Hill M, Irvin CG. Body temperature modulates the effect of platelet-activating factor (PAF) on airways responsiveness in the rabbit. *Agents Actions* 1991;32:173-81.
- 2 Chen WY, Horton DJ. Airways obstruction in asthmatics induced by body cooling. *Scand J Respir Dis* 1978;59:13-20.
- 3 Menger W, Menger D, Menger H. Der Einfluss von Saunabädern auf die Atemfunktion bei Kindern mit Asthma-Syndrom. *Prax Klin Pneumol* 1983;37: 304-7.
- 4 Schmengler FE, Eichhorn R, Rauch G, Renhard J. Die Behandlung des Asthma Bronchiale. In: Schmengler FE, Loos M, Rauch G, eds. *Asthma bronchiale*. Stuttgart: Ferdinand Enke, Verlag, 1959:101-34.

BOOK NOTICES

Year Book of Pulmonary Disease. Roger C Bone and Thomas L Petty. (Pp 513; US\$59.95.) Chicago: Mosby-Year Book, 1992. ISBN 0 8151 3884 9.

This is an interesting but curious book. The Mosby-Year Book Company publish 43 year books. This one is a collection of abstracts of papers published in 57 journals during 1990-1 selected by two eminent American respiratory physicians, Drs Bone and Petty. The 18 chapters of the book represent a conventional division between the standard topics of chest medicine and sensibly include sleep apnoea, critical care,

mechanical ventilation, and pulmonary transplantation amongst others. "AIDS and the lung" and "tuberculosis" which overlap are accommodated together in 34 pages. There are short sections on cystic fibrosis and pleural disease. The distribution of abstracted articles probably represents the editors' personal interests since, for example, there are 78 pages on COPD but only 16 on occupational lung disease and 26 on lung cancer. Each article considered is abstracted briefly under the headings of background, methods, results, and conclusions and then is followed by a discussion of the article (and often a wide discussion of related topics) over the byline of one of the editors. Additional references are included, perhaps up to six per comment.

A new and interesting feature is that each chapter is preceded by a separately written article up to six pages long by an expert in the field surveyed. These review a literature quite separate from the papers abstracted. The excellent "recent advances" review by Cherniak and Kvale on diagnostic procedures in pulmonary medicine, for example, systematically reviews the topic with 37 references to papers between 1987 and 1991, 31 of which were published in 1990–2. By comparison, following this just five articles published in 1990–1 are abstracted and only one of these was picked out by the expert "recent advances" reviewers. Similarly, the two page introductory review by Lillington on lung cancer considers 18 papers, 10 of which were published in 1990 or 1991; none of these were abstracted and reviewed in the 26 pages and 16 papers which follow.

So what is the general reader to conclude? It seems to me that the "recent advances" reviews probably represent a more accurate overview of the topics under consideration than the abstracted papers. The way in which these were chosen is not made clear. Some of the comments by the editors are, quite surprisingly, limited to discussions of their own practice. Even with these drawbacks, however, there is inevitably in a book of this length a great deal to interest the academically inclined physician and I found myself making many mental notes of papers to read more fully.

There are several abstracting services now available and regular users of these will not find much to interest them here. The book ought to have a wider appeal to physicians who like to have their up to date information in an accessible format with a critical introduction to the literature which should enable them to select carefully papers for particular attention. Likewise, using the subject and author indices a series of these books could represent an excellent way into the pulmonary literature for readers finding the electronic search systems unsatisfactory or wishing to have an alternative source.—MFM

Clinical Pulmonary Medicine. 1st ed. Lyle D Victor. (Pp 500; £43.) New York: Churchill Livingstone, 1992. ISBN 0 316 90246 2.

The preface of this book states that it is a practical book written to fill the large void in pulmonary text directed at the primary care physician. That goal is not achieved. The detail and balance of the chapters are inconsistent, varying on one hand from a 13 page chapter on normal sleep through

to a complex discussion of physiological measurements and invasive pulmonary investigations. Any book aimed at the primary care physician must be judged on its handling of the common conditions such as airflow obstruction, infections, thromboembolic disease, and cancer. The chapter on asthma is disappointing and emphasises the different management approach in North America with five and a half columns on theophyllines, one and a half columns on ephedrine, and half a column on inhaled steroids. The sole statement that "education and regular follow up of the patient is necessary for successful treatment" does little to guide the primary care physician in a management plan for asthmatic subjects. The details of pulmonary angiograms and pulmonary artery pressure may be of interest to some general practitioners, but most may prefer guidance on how long to anticoagulate their patients. The very important subject of symptomatic and palliative management of lung cancer patients is barely mentioned except for the statement that "it is obligatory for physicians to observe carefully for recurrence or a second primary in their patients." There are some gems—notably the excellent chapters on interstitial lung disease and tuberculosis—but I do not think that general practitioners, generalists, or respiratory specialists will lose out by not having this text on their bookshelf—JMcF.

If you wish to order or require further information regarding the titles reviewed here, please write to or telephone the BMJ Bookshop, PO Box 295, London WC1H 9JR. Tel: 071 383 6244. Fax 071 383 6662. Books are supplied post free in the UK and for BFPO addresses. Overseas customers should add 15% for postage and packing. Payment can be made by cheque in sterling drawn on a UK bank or by credit card (Mastercard, Visa or American Express) stating card number, expiry date and full name. (The price and availability are occasionally subject to revision by the Publishers.)

NOTICES

23rd Annual Fleischner Society symposium on chest disease

The 23rd Annual Fleischner Society symposium on chest disease will be held at the Westin Copley Place, Boston, Massachusetts on 6–8 May 1993. Further information can be obtained from the Fleischner Society, PO Box 16502, Irvine, California 92713–6502, Telephone (800) 321–6338, Fax (714) 752–7444.

Seventh World Conference on Lung Cancer

The International Association for the Study of Lung Cancer will hold its Seventh World Conference on Lung Cancer from 26 June to 1 July 1994 at the Broadmoor Resort in Colorado Springs, Colorado, USA.

Further information can be obtained from Linda Wise, Centennial Conferences, 5353 Manhattan Circle, Suite 103, Boulder, Colorado 80303, USA (telephone (303) 499 2299; fax (303) 499 2599).

Molecular biology of asthma

A two day course covering the basic principles of molecular biology and its application to the diagnosis, understanding, therapy, and future treatment of asthma will be held on 5 and 6 July 1993 at the National Heart and Lung Institute, London SW3 (course organisers: PJ Barnes and AB Kay). Further information from Education and Conference Centre, National Heart and Lung Institute, Dovehouse Street, London SW3 6LY (Tel 071 351 8172; Fax 071 376 3442).

Pharmacology of asthma

A course on the pharmacology of asthma will be held from 29 November to 2 December 1993 at the National Heart and Lung Institute, London SW3 (course organiser PJ Barnes). Further information from Education and Conference Centre, National Heart and Lung Institute, Dovehouse Street, London SW3 6LY (Tel 071 351 8172; Fax 071 376 3442).

Lung pathology

A comprehensive course of lectures and practical hands on microscopy sessions will be held at the National Heart and Lung Institute, Brompton Hospital, London on 26–29 October 1993 aimed at pathologists in training and consultant pathologists wishing to update their knowledge of lung pathology. Places are limited to 24. Fee £220 (US\$360). Programme and application form from Professor B Corrin, Pathology, Brompton Hospital, London SW3 6NP (Fax 071 351 8435).

11th Biennial Asian Congress on Thoracic and Cardiovascular Surgery

The 11th Biennial Asian Congress on Thoracic and Cardiovascular Surgery will be held on 21–25 November 1993 in Kuala Lumpur, Malaysia. Further details may be obtained from: 11th BACTCS Secretariat, Room 3, 5th Floor, MMA House, 124 Jalan Pahang, 53000 Kuala Lumpur (Tel 03 4429662; Fax 03 4421618).

LASER M2P

The third international conference LASER M2P covering the fields of material engineering, medicine and biology, and physics and chemistry will be held in Lyon, France on 8–10 December 1993. Details from Richard Moncorge, Conference Cochair, Université de Lyon, Bat. 205, F-69622 Villeurbanne Cedex, France. (Tel (33) 72 43 11 30).

Thorax editorial office

The Editorial Office of *Thorax* will be moving on 1 May 1993. The new address will be Thorax Editorial Office, Private Patients' Wing, University College Hospital, 25 Grafton Way, London WC1E 6DB, and all papers submitted after 1 May should be sent to the Executive Editor, Dr S Spiro, at that address.