results in low serum testosterone concentrations,[1] and while severely hypoxic patients are unlikely to have undergone surgery it is nevertheless important to establish that the findings of Mr Taggart and colleagues cannot be attributable to this factor. From the point of view of follow up of apparently cured patients to detect metastasis, the post-operative reduction of lung function, the further diminution with passage of time, and indeed the mere aging of the patient are all factors that would make the interpretation of such measurements of serum testosterone extremely difficult.

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1 Semple Pd'A, Watson WS, Beastall GH, Bethel MIF, Grant JK, Hume R. Diet, absorption and hormone studies in relation to body weight in obstructive airways disease. *Thorax* 1979;**34**:783–8.

***This letter was sent to the authors, who reply below.

SIR,—In reply to the points raised by Dr Moore-Gillon, we apologise for the oversight in not having stated the ages of the patients in the various groups. The mean was 60 (SD 5) years for patients undergoing curative surgery, 62 (8) for patients undergoing palliative surgery, and 58 (13) for patients undergoing minor elective surgical procedures; there was no significant difference in age between these groups.

Lung function tests are performed routinely to ensure that our potential surgical candidates have sufficient respiratory capacity to tolerate the proposed operation. Although a degree of chronic obstructive airways disease is commonly present, none of our operated patients had the severity of obstructive airways disease known to produce a low serum testosterone concentration[1] as these patients would be very unlikely to survive pneumonectomy or even lobectomy.

Although there is a decline in circulating testosterone concentrations in older men, the serum concentration remains within the normal range until the eighth decade.[2] The mean age of our surgical candidates was 60 years in the curative group and 62 in the palliative group, and a useful period of follow up is therefore available before the development of a serum testosterone concentration outside the normal range.

Finally, we would like to re-emphasise a point made in our paper—that, until further evidence is available, a low serum testosterone concentration should be used only in conjunction with the results of other investigations, as an early indicator of recurrent disease in patients after "curative" surgery.

1 d'A Semple P, Watson WS, Beastall GH, Bethel MIF, Grant JK, Hume R. Diet, absorption, and hormone studies in relation to body weight in obstructive airways disease. *Thorax* 1979;**34**: 783–8.
2 Bremner WJ, Vitiello MV, Prinz PN. Loss of circadian rhythmicity in blood testosterone levels with aging in normal men. *J Clin Endicrinol Metab* 1983;**56**:1278–81.

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Book review

Pulmonary pathology. 2nd ed. MS Dunnill. (Pp 632; £95.) Edinburgh: Churchill Livingstone, 1987. ISBN 0-443-03396-X.

The first edition of *Pulmonary Pathology* appeared in 1982, and rapidly established itself as a standard reference work. In this second edition the number of pages has been increased from 496 to 631 by the addition of new chapters on small biopsy specimens and pulmonary cytology. The text has been extensively revised, and the references updated. The opening chapter on pulmonary defence mechanisms is followed by sections dealing with chronic bronchitis, asthma, bronchiectasis, and emphysema. Subsequent topics include pneumonia, pulmonary fibrosis, and pulmonary vascular disease. Carcinoma and other neoplasms are considered, and a chapter is devoted to pulmonary lymphomas, lymphoproliferative disorders, and granulomatous vasculitis. Twenty or so pages deal specifically with neonatal and paediatric pulmonary disease. Miscellaneous disorders, including pulmonary amyloid, alveolar microlithiasis, and idiopathic pulmonary haemosiderosis, are also covered. The text concludes with a brief appendix on pulmonary anatomy and histology. The new chapter on small biopsies reviews the techniques that have become available as a result of recent developments in instrumentation. The handling of fibreoptic, drill, and transbronchial biopsy specimens is outlined, together with their limitations and likely yield. The older established methods of pleural biopsy and open lung biopsy are also dealt with. An additional chapter on pulmonary cytology has been contributed by Dr Winifred Grey. As well as describing the microscopy of cytological material in the commoner neoplastic and non-neoplastic diseases, Dr Grey comments on technical aspects and describes how appearances vary with the type of specimen. Like the first edition, this book is an important contribution to pulmonary pathology. The text is clear and concise, the illustrations of a high standard, and the references comprehensive and up to date. It will be of value not only to general and specialised histopathologists but also to physicians and surgeons with an interest in chest disease.

Notice

Scandinavian Association for Neonatal Extracorporeal Membrane Oxygenation (ECMO)

Experiences in neonatal ECMO and research in long time perfusion will be the subject of the association's meeting on 27–29 May 1988 at the Riverton Hotel, Gothenburg. The deadline for abstracts is 20 March. Details from the association's secretariat (Dr LG Friberg), Paediatric Surgical Clinic, Östra sjukhuset, S-416 85 Gothenburg, Sweden (tel 046-031-374620).