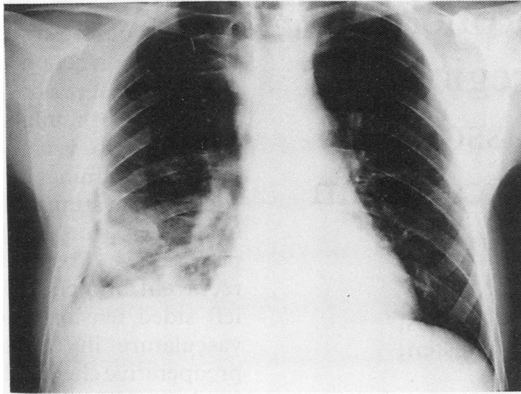


Figure 2 Patient 2: Posteroanterior radiograph of chest showing right hydropneumothorax.



pleural trauma by needles inserted into central veins. Central venous injection was not attempted by either of our patients.

Several pulmonary diseases described in intravenous drug misusers may produce a secondary pneumothorax, notably miliary tuberculosis and pneumonia.<sup>8,9</sup> In the same way a spontaneous pneumothorax without any pulmonary lesions has been reported in a patient not misusing drugs who had mitral valve endocarditis.<sup>10</sup> Except for the case recently reported by Aguado *et al*,<sup>4</sup> we know of no other reports of secondary pneumothorax from septic pulmonary emboli during the course of tricuspid endocarditis. The pneumothorax must be due to progression of septic pulmonary

infiltrates with subsequent leakage of air into the pleural cavity.

Consequently, in patients with active right sided endocarditis who present with pleuritic chest pain, dyspnoea, or haemoptysis a secondary pneumothorax must be suspected.

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- 3 O'Donnell AE, Pappas LS. Pulmonary complications of intravenous drug abuse: experience at an inner-city hospital. *Chest* 1988;94:251-3.
- 4 Aguado JM, Arjona R, Ugarte P. Septic pulmonary emboli: a rare cause of bilateral pneumothorax in drug abusers. *Chest* 1990;98:1302-4.
- 5 Zorc TG, O'Donnell AE, Holt RW, Pappas LS, Slakey J. Bilateral pyopneumothorax secondary to intravenous drug abuse. *Chest* 1988;93:645-7.
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## BOOK NOTICES

**Asthma in Practice.** Mark Levy and Sean Hilton. (Pp116; £12.50.) London: Royal College of General Practitioners, 1992. ISBN 0 85084 165 8.

Asthma is an increasingly important problem for general practitioners. Yet all too often its diagnosis may be missed or made late. Furthermore, there is evidence that the quality of its management is highly variable. This excellent book by two leading general practitioners summarises very neatly the growing concerns about how general practitioners should care for their asthmatic patients. It is very well written and brief enough to be read in an evening. It covers the pathogenesis and diagnosis of asthma and reviews the evidence concerning the apparent increase in its prevalence. It discusses the management of asthma by age group and includes a special chapter on the role of the practice nurse and asthma clinics, including examples of protocols and so on. There is a separate discussion of health education in asthma and ways in which the practitioner can audit his performance and monitor the use of inhalation devices. Thus it is as much a practical manual for the doctor in his surgery as a textbook. There is also a brief glance at the future developments in asthma care, particularly how clinical performance can be assessed by means of quality of life measures. The General Practitioners in Asthma Group is discussed for those doctors who would like to make asthma a special interest. All in all this is a very good buy for any practice library. It is well referenced and indexed and its illustrations, although in monochrome, are apt and well chosen. If I have any criticisms they relate to the somewhat scant handling of the issue of allergy. Particularly I would have liked more

explanation on the importance of looking for allergens, such as pet danders, in patients who are relatively unresponsive to steroids. I would also have liked a more thorough account of occupational asthma. But any increase in the size of the book may have detracted from its readability, which is one of its major virtues.—Md'S

**Manual of Clinical Problems in Pulmonary Medicine.** 3rd edition. Edited by Richard A Bordwo and Kenneth M Moser. (Pp521; £16.95.) Edinburgh: Churchill Livingstone, 1991. ISBN 0 316 10272 5.

The preface to the first edition states that the book aims to provide the reader with a concise framework with which to approach a clinical problem and to direct him or her to the relevant publications comprising the basis for traditional diagnostic and therapeutic "wisdom." This third edition very successfully meets these original aims, maintaining the format and style of the previous editions. A great deal of information is packed into the 500 pages, organised into manageable and logically grouped sections. A minor criticism is the small print size, presumably selected to ensure "pocketbook size." A particularly attractive feature of the book is the key references, with a note about their findings, which accompany each topic. Inevitably there is a North American flavour, reflected in some of the pulmonary infections and in 56 annotated references on pulmonary complications of sickle cell disease. There are excellent contributions on pulmonary thromboembolism from Dr Moser, but by contrast the section on airways disease is somewhat disappointing with respect to the important issues of home nebuliser treatment and criteria for long term oxygen. Nevertheless, a third edition is a welcome replacement for well thumbed earlier editions, with the updated key references excellent value in themselves. For those unfamiliar with the book this is a clinical handbook that can be highly recommended to clinicians of all grades working in respiratory medicine.—SWB