absorptiometry (DEXA) in corticosteroid associated osteoporosis. We reported to the summer 1991 meeting of the British Thoracic Society1 our experience of 19 patients (13 female) with corticosteroid dependent asthma. Twelve of these patients had sustained at least one vertebral compression fracture. The mean corticosteroid dose and treatment duration for this fracture group was 10-1 mg prednisolone/day for 13 years and 13-9 mg prednisolone/day for 9-6 years in those patients without fracture (NS). The mean L2-L4 density was significantly lower in those patients with fractures (0-797 g/cm² versus 1-143 g/cm², p < 0-0001). The mean neck of femur density was also significantly lower in those patients with fractures (0-718 g/cm² versus 0-901 g/cm², p < 0-005). The study by Dr Luengo and colleagues used dual photon densitometry, which is known to be a less precise measure than DEXA,1 and this may explain why in their study, though spinal density was higher in asthmatic patients without fractures, the difference was not statistically significant. It would appear therefore that a single measure of L2-L4 density by DEXA is a useful screening test for corticosteroid-associated osteoporosis.

Finally, in their discussion the authors ignore the effect of the menopause on the changes described. There is significant evidence that premenopausal women, who (if untreated) probably make up most of “group 1,” are protected from corticosteroid associated osteoporosis, presumably by the effects of oestrogen.2

**AUTHORS’ REPLY**

We thank Dr Gallacher and colleagues for their interest in our article comparing bone mineral mass as a predictor for vertebral fractures in steroid dependent asthma. In our study we found that the mean L2-4 density was lower in steroid dependent patients with vertebral fractures than in those without fractures. The difference, however, did not reach statistical significance. In contrast, they found that the values obtained by bone densitometry were significantly lower in steroid dependent asthmatic patients with fractures than in patients without fractures. Unfortunately, neither their letter nor the abstract of their work offers information about important aspects such as the age of subjects and the selection of patients for their study.

We defined 99 consecutive steroid dependent asthmatic patients and detected vertebral fractures in 32 (prevalence 32%) while they investigated 19 patients, 63% of whom suffered fractures. This very high prevalence of vertebral fractures suggests that selection bias operated in the inclusion of patients in their study. We also noted that in this study patients with fractures were much older than subjects without fractures and thus comparison of absolute values of bone density between the two groups could be misleading. We agree that the menopause should be considered as an independent factor in patients having continuous steroid treatment. But the suggestion that the bone of premenopausal women is “protected” against the deleterious effect of steroids cannot be substantiated by the study of Boyce et al (their reference 3) because this did not include a control group of asthmatic patients not having steroid treatment. On the other hand, it has been found that steroid treatment decreases osteocalcin concentrations in both premenopausal and menopausal women. As osteocalcin is a marker of bone formation this finding also argues against the hypothesis of Dr Gallacher and his colleagues.

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**Bronchial compression as a result of lung herniation after pneumonectomy**

We read with interest the paper of Dr K F Whyte and others (November 1991;46:895-7) concerning a 40 year old housewife with a right pneumomectomy syndrome. A thoracotomy to attempt a corrective procedure was unsuccessful because of right apical pleural adhesions and the patient remained severely disabled.

We have seen five patients with the right pneumomectomy syndrome in the past two years, seven months to 13 years after right pneumonectomy. All have been treated with the implantation of an expandable mammary prosthesis into the right hemithorax to correct the position of the thymus gland and the left lung. Two patients are the subject of a report that will be published.1 All five patients experienced an immediate and important reduction of dyspnoea. Pulmonary function improved and bronchoscopy showed a considerable decrease of bronchial compression in all patients. The improvement was sustained in four patients; in the other patient, who had the pneumonectomy 13 years previously, a cica-tricial hernia occurred at the site of the implantation. A Marlex Mesh patch has been attached to the thoracic wall, and a new expandable prosthesis will be inserted.

We believe that implantation of an expandable mammary prosthesis is the treatment of choice in the right pneumomectomy syndrome.

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1988 a 23 year old woman from a poor, predominantly white Teddy, designated by the council as an area of deprivation, presented with smear positive pulmonary tuberculosis. Screening of contacts revealed 10 with pulmonary tuberculosis, eight of whom were children (range 4-8 years). All but two of the children and one adult were asymptomatic; in six cases the place of contact was the school or community centre. A further 10 children had unexplained granuloma 2 or 3. We have responded to children who have had tuberculosis in a microepidemic, with infant BCG vaccination. The incidence of tuberculosis in a microepidemic is usually much lower than in a true microepidemic, because the number of active tuberculosis cases was too small for statistical comparison. We have recently examined the effects of our neonatal BCG immunization programme, and the number of babies, on the Heaf status of schoolchildren routinely tested at the age of 12–13 years.1 Of 5013 non-Asian children tested, 6% had a positive Heaf test and 2% had evidence of previous TB, compared with 47% of 366 Asian children tested. On the basis of current Department of Health guidelines, 8% of non-Asian and 75% of Asian children had appropriate immunity, avoiding the need for repeat BCG immunization. The high prevalence of grade 1 and 2 Heaf responses in Cork, and the surprising observation that rates were higher in children who had not received infant BCG immunisation, presumably reflects a higher prevalence of tuberculosis in the Irish community. We believe that, as suggested in a recent editorial in the *British Medical Journal*, neonatal BCG immunization should be offered routinely in areas of social deprivation in the United Kingdom.

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