THORAX

The Journal of the British Thoracic Society
A Registered Charity
President: GRAHAM CROMPTON

Notice to contributors

Thorax is the journal of the British Thoracic Society. It is intended primarily for the publication of original work relevant to diseases of the thorax. Contributions may be submitted by workers who are not members of the society. The following notes are for the guidance of contributors. Papers may be returned if presented in an inappropriate form.

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Authors should follow the requirements of the International Steering Committee of Medical Editors (*BMJ* 1979;1:532–5). Papers must be typed in double spacing with wide margins for correction and on one side of the paper only. They should include a structured abstract on a separate sheet (see below). Papers should contain adequate reference to previous work on the subject. Descriptions of experimental procedures on patients not essential for the investigation or treatment of their condition must include a written assurance that they were carried out with the informed consent of the subjects concerned and with the agreement of the local ethics committee.

ABSTRACT Abstracts, which should be of no more than 250 words, should state clearly why the study was done, how it was carried out (including number and brief details of subjects, drug doses, and experimental design), results, and main conclusions. They should be structured to go under the headings "Background", "Methods", "Results", and "Conclusions".

KEYWORDS Authors should include on the manuscript up to three key words or phrases suitable for use in an index.

STATISTICAL METHODS The Editor recommends that authors refer to Altman DG, Gore SM, Gardner MJ, Pocock SJ. Statistical guidelines for contributors to medical journals. *BMJ* 1983;286:1489–93. Authors should name any statistical methods used and give details of randomisation procedures. For large numbers of observations it is often preferable to give mean values and an estimate of the scatter (usually 95% confidence intervals) with a footnote stating from whom the full data may be obtained. The power of the study to detect a significant difference should be given when appropriate and may be requested by referees. Standard deviation (SD) and standard error (SE) should be given in parenthesis (not preceded by ±) and identified by SD or SE at the first mention.

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1 Anderson HR. Chronic lung disease in the Papua New Guinea Highlands. *Thorax* 1979;34:647–53.
2 Green AB, Brown CD. *Textbook of pulmonary disease*. 2nd ed. London: Silver Books, 1982:49.
3 Grey EF. Cystic fibrosis. In: Green AB, Brown CD, eds. *Textbook of pulmonary disease*. London: Silver Books, 1982:349–62.

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agement of malignant pleural effusion. Thoracoscopic inspection of the pleural space provides optimal conditions for effective pleurodesis by facilitating a dry pleural cavity and may be more important, with regard to success, than the choice of sclerosant. Nevertheless his experience with talc is most interesting, and we agree that further data in the form of a prospective randomised trial are required to clarify management which remains largely a matter of personal experience and reflects local expertise.

PT REID
RM RUDD
The London Chest Hospital, Bonner Road, London E2 9JX, UK

Corynebacterium parvum for malignant pleural effusions

I have read the article by Dr AG Villanueva *et al* (January 1994;**49**:23–5) on tetracycline pleurodesis for malignant pleural effusions. Tube thoracostomy drainage before instillation of tetracycline is necessary to achieve successful pleurodesis, and the authors found that short term drainage was as effective as long term drainage. Since insertion of a drainage tube is uncomfortable, the use of a sclerosing agent which can be injected into the pleural cavity without an intercostal tube is preferable. *Corynebacterium parvum* (CBP), unlike other sclerosing agents, has this feature. In fact, in the study by Leahy *et al*[1] treatment with CBP was as effective as tetracycline injected via an intercostal tube.

I wish to report results on 28 consecutive patients treated with intrapleural CBP (Coparvax, Wellcome Foundation, London, UK) without intercostal tube drainage. Four patients were not evaluable as they died within one month. A complete response (total resolution of pleural effusion after a maximum of three injections of CBP) was seen in 22 of the remaining 24 patients. The side effects were fever (in 50% of patients) usually lasting 2–3 days, and mild or moderate chest pain (32% of patients), both of which were effectively controlled with paracetamol or non-steroidal anti-inflammatory drugs.

These data confirm that instillation of CBP without intercostal tube drainage is an effective, simple, and well tolerated method of controlling malignant pleural effusions. Our patients had a longer survival time (mean 7·7 months) than that reported by Villanueva *et al*, and three are still alive with survival times of 11·3, 9·9, and 5·1 months. Our results are also superior to those of patients treated with talc (1·9 months in patients with low pleural fluid glucose levels and low pH and 5·7 months in patients with high glucose and high pH levels),[2] and to those treated with mustine (3·9 months).[3] This fact is emphasised by other authors[3,4] and suggests that CBP may be acting, not only as a sclerosant, but also as an immunostimulant.

Unfortunately, CBP has been discontinued by the Wellcome Foundation, as has injectable tetracycline. In Italy injectable tetracycline, doxycycline, minocycline, and rolitetracycline are not available. The treatment of malignant pleural effusions therefore currently requires more expensive agents or more invasive methods.

V FORESTI
Via Kennedy 32, 20097 San Donato Milanese, Milan, Italy

1 Leahy BC, Honeybourne D, Brear SG, Carrol KB, Thatcher N, Stretton TB. Treatment of malignant pleural effusions with intrapleural *Corynebacterium parvum* or tetracycline. *Eur J Respir Dis* 1985;**66**:50–4.
2 Sanchez-Armengol A, Rodriguez-Panadero F. Survival and talc pleurodesis in metastatic pleural carcinoma revisited. Report of 125 cases. *Chest* 1993;**104**:1482–5.
3 McLeod DT, Calverley PMA, Millar JW, Horne NW. Further experience of *Corynebacterium parvum* in malignant pleural effusion. *Thorax* 1985;**40**:515–18.
4 Felletti R, Ravazzoni C. Intrapleural *Corynebacterium parvum* for malignant pleural effusions. *Thorax* 1983;**38**:22–4.

BOOK NOTICE

Diseases of Occupations. 8th Edition. PAB Raffle, PH Adams, PJ Baxter, WR Lee. (Pp 804; £145.00). London: Edward Arnold, 1994. 0 340 55173 9.

Most British chest physicians also practise general medicine, and all will have passed the MRCP. At one time Hunter's *Diseases of Occupations* was essential reading for those taking the examination, not least because Donald Hunter was a notoriously idiosyncratic examiner. The original classic textbook in its later editions lost much of its value except as an historical reference, but this 8th edition has been completely rewritten, breaking at last with the original format but honouring the original purpose "to review with emphasis on its clinical aspects the problem of disease in relation to occupation". This task inevitably requires a team of contributors, and the editors have selected a strong one. They have also achieved a reasonable uniformity of style and structure which makes the book easy to read and clinically informative.

The first five chapters contain information on preventive legislation, compensation, and medical report writing that is not readily available elsewhere. The rest of the book consists of descriptions of occupational diseases as seen nowadays, properly emphasising the common problems of musculoskeletal, psychological, skin, and hearing diseases that are of interest to other specialists. The chapters on occupational lung disorders are concise, clearly written and accurate, but necessarily lack the detail to be found in more specialised textbooks. The short chapter on indoor air pollution is one that many who are confused by the various "sick building" syndromes will find particularly helpful.

This is a much better book than the 7th edition, and deserves to be in all hospital and medical school libraries. All doctors training in general medicine should read it and will find it opens their eyes to previously unappreciated causes of disease and possibilities for prevention. And with the growing interest in environmental causes of disease, who knows – it could even once again become essential reading for passing the MRCP! – AS

NOTICES

Scadding-Morriston Davies Joint Fellowship in Respiratory Medicine 1995

This fellowship is available to support visits to medical centres in the UK or abroad for the purpose of undertaking studies related to respiratory medicine. Medical graduates practising in the UK, including consultants and irrespective of the number of years in that grade, may apply. Applicants should submit a curriculum vitae together with a detailed account of the duration and nature of the work, the centres to be visited, confirming that these have agreed to provide the facilities required, and giving the sum of money needed for travel and subsistence. A sum of up to £12 000 can be awarded to the successful applicant, or the sum may be divided to support two or more applications. Applications should be sent by **31 January 1995** to Dr I A Campbell, Secretary to the Scadding-Morriston Davies Fellowship, Llandough Hospital, Penarth, South Glamorgan CF64 1XX.

Lung and Asthma Information Agency

The Lung and Asthma Information Agency aims to bring together, interpret, and disseminate information about lung disease in order to increase awareness and understanding of the burden of lung disease and of its prevention and care. It is jointly supported by the National Asthma Campaign, the British Lung Foundation, and the British Thoracic Society. Since its launch at the BTS Summer Meeting in July 1992 it has concentrated on three areas: the production of factsheets, developing a comprehensive respiratory database, and providing an information service to the sponsors. So far, it has produced factsheets on asthma mortality in the elderly, pneumonia mortality in the elderly, pleural mesothelioma, sickness absence from respiratory disease, respiratory tuberculosis, lung cancer and smoking, GP prescribing of drugs for respiratory disease, RSV in children, seasonal variations in asthma, air pollution, and asthma prevalence. From 1995 further factsheets will be distributed with *Thorax*, the first on "Trends in hospital admissions for asthma" appearing with this issue. Multiple copies of factsheets, back copies of earlier factsheets, and further information about the Agency may be obtained from: Elizabeth Limb, The Lung and Asthma Information Agency, Dept. of Public Health Sciences, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE. Tel: 0181 725 5489.

FELLOWSHIPS IN ASTHMA RESEARCH

Vacancies exist in January, April or July 1995 for Research Fellows with particular interests in asthma to work under the supervision of Drs. F. E. Hargreave and M. R. Sears at the Firestone Regional Chest and Allergy Unit, St. Joseph's Hospital and McMaster University, Hamilton, Ontario, Canada. Current research includes noninvasive studies of inflammation in asthma, studies of asthma management, and the epidemiology of asthma. Opportunities exist to collaborate with other research teams, and to undertake postgraduate training in biostatistics and epidemiology.

For further information, write to
Dr. M. R. Sears,
Professor of Medicine,
Firestone Regional Chest and Allergy Unit,
St. Joseph's Hospital,
50 Charlton Avenue East,
Hamilton,
Ontario,
Canada
L8N 4A6

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