# THORAX

*The Journal of the British Thoracic Society*
*A Registered Charity*
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*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;i: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.

SI UNITS The units in which measurements were made should be cited. If they are not SI units the factors for conversion to SI units should be given as a footnote. This is the responsibility of the author.

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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.

SHORT PAPERS Short reports of experimental work, new methods, or a preliminary report can be accepted as two page papers. The maximum length of such an article is 1400 words, inclusive of structured abstract, tables, illustrations and references.

CASE REPORTS A single case can be published as a case report. It will be limited to 850 words, one table or illustration, a short unstructured abstract, and 10 references.

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# EDITOR

# THORAX

## The British Thoracic Society

invites applications for the post of Editor of Thorax which is vacant from January 1996 when the present editor completes his term of office. Interested parties should write in the first instance to:

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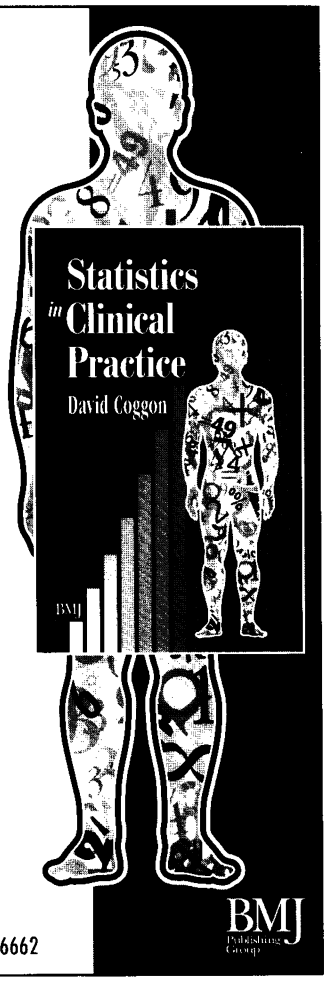


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## Beclazone *Easi-Breathe* Inhaler

**Beclomethasone Dipropionate BP**

(Please refer to full data sheet before prescribing)

■ **Presentation** Metered-Dose Aerosol supplied in a Breath-Operated Inhaler containing 200 doses. ***Beclazone 50 Easi-Breathe, Beclazone 100 Easi-Breathe*** and ***Beclazone 250 Easi-Breathe Inhalers*** deliver 50, 100 and 250 microgram Beclomethasone Dipropionate BP per actuation of the valve.

■ **Uses** Provides automatic actuation of inhaler with inspiration. For the management of bronchial asthma, especially in patients inadequately controlled by bronchodilators and sodium cromoglycate.

■ **Dosage and Administration** Use regularly. **Adults**, ***Beclazone 50 and 100 Easi-Breathe Inhalers;*** 100 microgram three or four times daily. ***Beclazone 250 Easi-Breathe Inhaler;*** 500 microgram twice a day or 250 microgram four times a day. **Elderly** no dose adjustment necessary, including patients with renal or hepatic impairment. **Children**, ***Beclazone 50*** and ***100 Easi-Breathe Inhalers;*** 50 to 100 microgram two to four times daily. ***Beclazone 250 Easi-Breathe Inhaler*** is not indicated for use in children.

■ **Contra-indications** Hypersensitivity to the ingredients.

■ **Precautions** Patients should be instructed in the correct use of inhalers. May induce systemic corticosteroid effects (with reduction in plasma cortisol levels) and adrenal suppression (above 2000 microgram daily) – monitor adrenal function and provide systemic steroids in appropriate cases of stress. Caution in patients with history of, or active pulmonary tuberculosis. Avoid sudden cessation of treatment.

■ **Pregnancy/Lactation** Use inhalers only if the potential benefit outweighs the risk.

■ **Side Effects** Paradoxical bronchospasm – discontinue use immediately and seek medical advice. Candidiasis, hoarseness or throat irritation – relieve by rinsing throat with water.

■ **Product Licence Numbers and Basic NHS Cost**
***Beclazone 50 Easi-Breathe Inhaler*** PL 0530/0451 £4.04
***Beclazone 100 Easi-Breathe Inhaler*** PL 0530/0452 £8.25
***Beclazone 250 Easi-Breathe Inhaler*** PL 0530/0453 £10.58

■ **Legal Category** POM.

■ **Further Information** is available on request from: Baker Norton, Gemini House, Flex Meadow, Harlow, Essex CM19 5TJ.

■ **Date of Issue** July 1995.

## Salamol *Easi-Breathe* Inhaler

**Salbutamol BP**

(Please refer to full data sheet before prescribing)

■ **Presentation** Metered Dose Aerosol supplied in a Breath-Operated Inhaler containing 200 doses. ***Salamol Easi-Breathe Inhaler*** metered-dose aerosol delivering 100 microgram of Salbutamol BP per actuation.

■ **Uses** Provides automatic actuation of inhaler with inspiration. For the treatment and prophylaxis of bronchial asthma.

■ **Dosage and Administration** For optimum results use as required. Each administration has a bronchodilator effect which should last about 4 hours. **Adults** (i) Acute bronchospasm and intermittent episodes of asthma, including relief of symptoms such as wheezing, breathlessness and tightness of the chest – one or two inhalations as a single dose. (ii) Chronic maintenance or prophylactic therapy – two inhalations three or four times daily. (iii) To prevent exercise induced bronchopasm – two inhalations should be taken before exertion. **Children** (i) Acute bronchospasm and episodic asthma, including relief of symptoms such as wheezing, breathlessness and tightness of the chest, or before exercise – one inhalation. (ii) Routine maintenance or prophylactic therapy – one inhalation three or four times daily. The dose in children may be increased to two inhalations if necessary. Children should be supervised.

■ **Contra-indications** In spite of the fact that salbutamol has been used intravenously and orally in the management of uncomplicated premature labour, ***Salamol Easi-Breathe Inhaler*** should not be used for managing premature labour or for threatened abortion. ***Salamol Easi-Breathe Inhaler*** is contra-indicated in patients with a history of hypersensitivity to any of its components.

■ **Warnings** Potentially serious hypokalaemia may result from beta2-agonist therapy. It is recommended that serum potassium levels are monitored when the hypokalaemic effect may be potentiated by concomitant drugs or hypoxia. Propranolol and other non-cardioselective beta-adrenoceptor blocking agents antagonise the effect of salbutamol.

■ **Precautions** Patients with hyperthyroidism, who are hypersusceptible or who are suffering from diabetes mellitus, serious cardiovascular disorders or hypertension should use salbutamol containing products with caution. Asthmatic patients whose condition deteriorates despite salbutamol therapy or where a previously effective dose fails to give relief for at least three hours should seek medical advice. Alternative or additional therapy including corticosteroids should be instituted promptly although adverse metabolic effects of high doses of salbutamol may be exacerbated by concomitant administration of high doses of corticosteroids. Patients should not increase the dosage or frequency of administration without seeking medical advice.

■ **Side Effects** Potentially serious hypokalaemia may result from beta2-agonist therapy (see Warnings). Salbutamol may cause fine tremor of skeletal muscle (particularly the hands), palpitations and muscle cramps. Slight tachycardia, tenseness, headaches and peripheral vasodilatation have also been reported but these are less usually associated with the inhalation dosage form. Hypersensitivity reactions have been reported very rarely. Reports of hyperactivity in children are rare with beta2 agonists.

■ **Pregnancy/Lactation** **Salamol *Easi-Breathe*** Inhaler should be used during pregnancy or lactation only after careful consideration by the medical practitioner that the expected benefit outweighs the risk. **Salamol *Easi-Breathe*** Inhaler should not be used for managing premature labour or for threatened abortion (see Contra-indications).

■ **Product Licence Number and Basic NHS Cost**
***Salamol Easi-Breathe Inhaler*** PL 0530/0399 £6.30

■ **Legal Category** POM.

■ **Further Information** is available on request from: Baker Norton, Gemini House, Flex Meadow, Harlow, Essex CM19 5TJ.

■ **Date of Issue** July 1995

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**References**
1. Lindgren S, Boke B, Larsson S. Eur J Respir Dis 1985; **70**: 95-105.
2. Crompton G K. Eur J Respir Dis 1982; **63** (Suppl 119): 101-104.
3. Goodman D E, et al. Am J Respir Crit Care Med 1994; **150**: 1256-1261.
4. Ellellah M I, et al. The Pharmaceutical Journal 1992; **253**: 607-608.
5. MIMS, July 1995.
6. Data on file, Baker Norton.
7. Based on NHS Data.

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secretions were high enough". Ms Webber, who reviewed the paper when it was first submitted, is entitled to question the ACBT technique described in this study. However, the authors should have followed the statement "at a higher lung volume" by "when secretions were in the upper airways". The physiotherapy during the study was supervised throughout by the same physiotherapist who is experienced and has a special interest in cystic fibrosis. The authors are therefore confident that the ACBT method used fulfils all of the characteristics of a satisfactory technique.

The only independent arbiters of the method used are the patient subjects themselves. One of the authors (RN) has therefore personally interviewed six of the more mature and easily available subjects who are known to carry out treatment of their fibrosis conscientiously. Each was first informed that a leading authority on the use of physiotherapy in cystic fibrosis had questioned the method of ACBT used and the validity of our findings, and that we needed to investigate whether the ACBT that they had been taught was correct. Each subject was asked the same non-committal question: "During ACBT, what characteristic must be fulfilled before you change from mid to low volume huffing to high volume huffing?" In each case the answer was when secretions are felt in the large upper airways. All have agreed that their names, addresses, and telephone numbers may be supplied to the editor if required.

We are therefore confident that patients under the care of the Newcastle Cystic Fibrosis Clinic are being taught and are performing ACBT correctly, and that the method used in the study was that described in the published version. We are equally confident that ACBT was used correctly during the study, and that it provides a true comparison between ACBT and autogenic drainage.

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# BOOK NOTICES

**Pulmonary Fibrosis.** Sem Hin Phan, Roger S Thrall. (Pp 984; $235.00). New York: Marcel Dekker, 1995. 0 8247 8851 6.

Pulmonary fibrosis arises in various clinical settings. It may be a sequel to occupational dust exposure, radiation, or chemotherapy. It can accompany connective tissue disease, follow acute lung injury, or arise alone as cryptogenic fibrosing alveolitis (idiopathic pulmonary fibrosis). In all cases the result is worsening breathlessness and a progressive restrictive ventilatory defect. The pathogenesis remains incompletely understood. Current treatments are inadequate and the prognosis generally poor. This is the first time that the excellent series on "Lung Biology in Health and Disease" has addressed this subject. Significant advances have recently been made in our knowledge of lung physiology, mechanisms of its response to injury, and the nature of fibrogenesis, both in the lung and in other organs. This volume is therefore very welcome.

The book comprises 25 chapters covering clinical aspects, pathology and physiology, extracellular matrix biochemistry, mechanisms of injury by agents such as bleomycin, hyperoxia, asbestos and radiation, the roles of cells and cytokines in fibrogenesis, and the possible involvement of platelet activating factor, complement and coagulation pathways. Finally, it devotes a chapter to future perspectives.

This is a collection of well written, extensively referenced accounts by experts in their fields. Each chapter provides state of the art information and introduces new perspectives. I especially enjoyed the chapters on pathology, bleomycin, alveolar epithelial cells and fibroblasts. Disappointingly, the clinical introduction presents a somewhat confusing classification that is not adhered to elsewhere in the book. There are frequent typographical errors, inconsistencies in illustration style, and the book might have benefited from more careful editing.

Nevertheless, as a compendium of current research it is indispensable to researchers. Clinicians will find limited guidance on patient management, but every teaching hospital library should purchase a copy, and all respiratory departments should have access to it. Let's hope your library purchases a copy; at $235.00 it may be beyond most individuals. – RC

**Asthma and Rhinitis.** William W Busse, Stephen T Holgate. (Pp 1488; £150.00). Oxford: Blackwell Scientific Publications, 1995. 0 865 42246 X.

This is a large, expensive book, although its weight and quality of authorship is, in the event, equalled by its weight of knowledge. Being multi-author there is occasional (sometimes irritating) overlap of areas covered. The index could be improved – a referral to "the characteristic histology of steroid resistant asthma" being dealt with elsewhere resulted in a fruitless search. Of the 1500 pages less than 10% are given to treatment/management. The feel is, therefore, of a book aimed more at the scientist than the clinician but, for the clinician with a scientific bent, this book holds a great deal of reasonably accessible information. A problem recently enumerated but long recognised is that text books are significantly out of date by the time they are published. This is inevitable and this book is no exception, although it can justly claim to be the most up to date text available. For instance, recent areas of major debate in the field of asthma are the possible role of air pollution in asthma and whether β agonists make asthma worse. I could find about half a page overall on air pollution and only passing mention of the β agonist debate. Nevertheless, the whole area of asthma and rhinitis is changing by the moment – updating a book of this size is just not possible using the printed page format. The advent of books such as this on CD ROM will surely reduce the lag between scientific advance and incorporation in the written word, and must be the way these volumes have to move as they will allow selective updates in those areas which advance the fastest. My criticisms are, however, minor and I can fully recommend this book for the active medical library, although individuals may find the cost prohibitive even though it works out at just 10p per page! – JGA

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# NOTICES

## European Asthma School

A three-day intensive course on experimental and clinical aspects of asthma will be held in Ghent, Belgium on 21–23 November 1995. For further information contact the Department of Respiratory Diseases, University Hospital, De Pintelaan 185, B9000 Ghent, Belgium. Phone: 32-9-2402611. Fax: 32-9-2402341.

## Occupational asthma in practice

A course on "Occupational asthma in practice" will be held at the National Heart and Lung Institute and Royal Brompton Hospital on 7 and 8 November 1995. Course organiser: Dr K M Venables. Enquiries to Conference Centre, telephone 0171 351 8172 (24 hour answering service). Fax 0171 376 3442.

## Mechanisms and treatment of airway inflammation in asthma and COPD

A meeting on "Mechanisms and treatment of airway inflammation in asthma and COPD: an update", organised under the patronage of the Italian Chapter of the American College of Chest Physicians, will take place in Taormina from 30 November to 2 December 1995. For further information contact the Organising Secretariat at Studio Santuccio SNC, 95124 Catania, Via Francesco Battiato 9, Italy. Telephone +39 95 317785/320999. Fax +39 95 320999 or the Scientific Secretariat at Istituto di Malattie Respiratorie, 95125 Catania, Via Passo Gravina 187, Italy. Telephone and fax +39 95 7594532.

# CORRECTION

## Lung injury in patients following thoracotomy

In the paper entitled "Lung injury in patients following thoracotomy" by J P Hayes *et al* which appeared on pages 990–1 of the September issue, lines 10–12 of the second paragraph of the Discussion on page 991 should have read "... our own incidence of **4·9%** following pneumonectomy is broadly comparable".