inhalation technique is not fully addressed, despite the FDA recommendation that the technique should be trained using an In-spire® spacer device. The variability of a consistent inhaler technique when patients use MDIs has been extensively reported and hence could affect the reproducibility of any method related to lung deposition in asthmatics, despite extensive training of the technique. Furthermore, the variability of salbutamol deposition would be enhanced by the pathophysiology of a patient's respiratory tract. Variability of the bioassay will also be introduced by the training effect of the inhalation technique with respect to inspiratory hyperresponsiveness due to previous bronchoprovocation, and the length of salbutamol washout periods. Furthermore, the protocol is very demanding on the asthmatic subjects and our projection is that the drop out rate will be high, which, together with the strict inclusion criteria, may introduce bias. Nevertheless, to answer the criticism in the two letters, we are planning clinical studies to compare our urinary excretion method with a bronchoprovocation test and the influence of inhaler technique will be studied first.

In vivo deposition studies using a radio-label have indicated that the bronchodilator response seems to depend on the total amount delivered to the lungs. A recently reported abstract, using labelled salbutamol aerosols, has shown differences in regional lung deposition related to the technique and, when total lung deposition was high, there was a corresponding increase in the amount delivered to the different regions of the lungs. This is why we will evaluate the influence of inhaler technique in our bronchoprovocation studies. An ongoing study in our laboratories is showing a linear relationship between one, two, three, four, and five 12 inhalations. All inhaled products contain patient information leaflets describing the inhaler technique which should be used, and examination of these reveals different instructions. It may be the confusion created by these differences which causes patients to complain. If the pharmaceutical industry cannot agree on the standardisation of the information on how to use an MDI, then perhaps the British Thoracic Society should provide these guidelines. Any argument that different techniques are recommended because of the MDI formulations, characteristics, etc is not substantiated in the literature.

Combination chemotherapy and radiotherapy in advanced pulmonary blastoma

We were interested to read the recent case report of Dr Chin et al (August 1994;49: 838-9) describing a case of pulmonary blastoma in an adult presenting as a chronic loculated effusion. We admitted a 57 year old man in 1991 with left shoulder pain, hoarseness, dyspnoea and Horner’s syndrome. Chest radiography revealed a 11 × 12 cm mass in the upper zone of the left lung. Thoracic computed tomography scan revealed a well circumscribed mass within the lateral aspect of the left lung, with a narrow connection to the lung. These features were consistent with a primary left lung tumour, most likely a pulmonary blastoma. A computed tomographic scan revealed mediastinal invasion by the mass. No distant metastases were detected. The patient was inoperable and hence a follow-up CT scan was performed without further treatment. We obtained informed consent regarding the use of chemotherapy, radiotherapy alone, or in combination. We gave combined modality treatment using cisplatin, etoposide, and Adriamycin as chemotherapy. After two cycles of chemotherapy 6000 cGy radiotherapy was given to the lesion and a 75% regression was noted in the tumour.
mass. After radiotherapy two further cycles of chemotherapy were given. Unfortunately the patient died of neutropenic sepsis in the 10th month of treatment.

We believe that combined chemotherapy and radiotherapy can be used in this immunohistoopathologically and clinically rare tumour.

SERAP HASTÜRK
YURDANUR ERDOĞAN
AYSE ÖZYLDIRIM
BCE CAKIR
YILDIZ TEKE
Austürk Chest Diseases Hospital,
Ankara, Turkey


BOOK NOTICE


Epidemiology of Lung Cancer is a comprehensive overview of this malignancy in terms of environmental causes, lifestyle factors, familial aggregations, individual susceptibility, and genetic determinants. These and other circumstances of exposure are covered in separate chapters, with each chapter standing on its own. The careful reader will achieve, in a time effective way, a nicely balanced, comprehensive update of what is known today about factors capable of increasing or decreasing the incidence of lung cancer in human populations.

The critical reviews and the summing up of evidence on each of the human exposures are based on empirical findings, mainly epidemiological studies in the form of population-based investigations or hospital-based multicentre studies of lung cancer conducted around the world during the last five decades. In most cases the results are studied in the light of evidence of carcinogenicity in experimental animals and other available information on genetic and related effects of the exposure. Exposures considered exhaustively are tobacco smoking (active and passive) – which is by far the most important single risk factor for lung cancer, air pollution, radon, asbestos and manmade fibres, arsenics, silica, diet and – most importantly – interactions thereof, in particular with tobacco smoking. In addition, a full chapter is devoted to the documentation and discussion of the role of individual susceptibility for developing lung cancer.

Overall, the book is well written, clearly organised, and comprehensive in scope. The authors who have contributed to this work are well recognised in the field. In my opinion it is a very useful book for anyone who is involved in the treatment and care of patients with lung cancer. As written by Sir Richard Doll in the introduction chapter: “Epidemiology has already taught us enough for it to be possible to ensure that lung cancer ceases to be the most common form of fatal cancer throughout the world and that it returns to the place it occupied in the nineteenth century among the least common human cancers, if society is prepared to act on the knowledge obtained.” – JHO

NOTICES

4th European Congress of Extra-corpooreal Life Support

The 4th European Congress of Extra-corpooreal Life Support will be held in Bergamo, Italy on 10-12 May 1995. For further information please contact Mr Matteo Salvi, ECMO Conference, Centro Congressi Giovanni XXIII, Viale Papa Giovanni XXIII, 106, 24121 Bergamo, Italy. Telephone: +39 35 236435. Facsimile: +39 35 236474.

Clinical Applications of Pulmonary Function Testing

A course on “Clinical Applications of Pulmonary Function Testing” organised by Professors J M B Hughes and N B Pride will be held at the Hammersmith Hospital, 2 and 3 November 1995. The course will consist of lectures, demonstrations and case discussions on physiological background, methods and applications of usual and not so usual pulmonary function tests and will be of interest to doctors and pulmonary function technicians. For further information contact the Wolfson Conference Centre, Royal Postgraduate Medical School, Hammersmith Hospital, London W12 0NN. Telephone: +44 181 740 3117/3245. Facsimile: +44 181 740 4950.

Figure 2. Schematic representation of systemic bioavailability of (A) fluticasone propionate and (B) budesonide given by respective dry powder inhaler devices.