drug. We consider that this leaves insufficient time for reliable identification of the offending drug or drugs. We agree that the drugs should probably be re-introduced in this order.

A further difficult problem is the re-introduction of chemotherapy after an episode of acute liver failure. Certainly it is our policy, as discussed by Mitchell et al., to change to drugs with no history of hepatotoxicity in patients fortunate enough to have survived this complication.

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1 Mitchell I, Wendon J, Fitt S, Williams R. Anti-
    tuberculous drugs and liver failure. Lancet
2 Moulding TS, Redeger AK, Ganel GC. Twenty
    years' experience with tuberculous meningitis
3 Thompson NP, Caplin ME, Hamilton MI, et al.
    Anti-tuberculosis medication and the risks and
    dangers and recommendations in manage-

AUTHORS' REPLY The editorial set out rec-
    ommendations on the management of hep-
    atic reactions after due consideration of both
    the risks of tuberculous itself and the risk from
    the drug treatment. There have been 45 deaths from liver reactions to currently
    recommended first-line antituberculous drugs since 1963, with isoniazid implicated
    in a maximum of 25 of these. Over the same period of time there have been 272 000 no-
    tified cases of tuberculous (all forms), with pulmonary disease—which makes up the
    majority of cases—carrying an overall mor-
    tality of some 5%. The most recently pub-
    lished annual infectious disease statistics show
    418 deaths from tuberculosis in 1994,1 and the
    level of tuberculous deaths has been at that
    level for the last five years, and sub-
    stantially higher in the earlier part of the
    period 1963–94. The risk of dying from tuber-
    culosis is therefore clearly at least 200 times
    higher than that of a fatal hepatic reaction
    from the treatment, and inadequate treat-
    ment must intuitively raise the mortality of
    the disease still further.

We would agree that cases of hepatic toxic reactions may arise from inadequate clinical
    monitoring and particularly from failure to modify or to discontinue treatment when
    clinical and biochemical abnormalities have ap-
    peared. This makes it even more important that all cases of tuberculosis are under the
    care of physicians trained in its management, and with recommended dosages and dur-
    ations of drugs.2 In the paper by Mitchell et al
    from the King's unit referred to by Devlin
    and colleagues no dosages, drug durations, or
    patient weights were given, so it was not
    shown that correct management led to the
    problems reported.

Devlin et al accept that their recom-
    mendations that chemotherapy be with-
    drawn if liver transaminase activity reaches
    three times normal is not based on firm data.
    The suggestion that isoniazid at least should
    be withdrawn at this level does not seem
    logical. A large, mainly prospective, study of
    reactions to antituberous treatment
    showed that the incidence of hepatotoxic re-
    actions was lowest to isoniazid at 0.3%, being
    appreciably higher to pyrazinamide (1.25%)
    and rifampicin (1.4%).

The editorial does not mention that the essence of treatment of three times normal for
    modification of treatment may well be undis-
    covered. Some patients with such treatment
    levels of transaminases as a result of extensive
    or disseminated tuberculous who already face
    a significant mortality would be denied the
    most effective antituberculous drugs, thus
    increasing further their mortality from the
    disease. The emergence of multiple drug re-
    sistant tuberculous, which is often due to
    inadequate treatment and compliance moni-
    toring, is a further reason why standard
    chemotherapy should not be altered without
    strong justification.

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1 Office for National Statistics. Communicable Dis-
    ease Statistics 1994 England and Wales. Series
    MB2, No 01. HMSO, 1996.
2 Subcommittee of the Joint Tuberculosis Com-
    mittee of the British Thoracic Society. Chemo-
    therapy and management of tuberculosis in the
    United Kingdom: recommendations of the
    Joint Tuberculosis Committee of the British
3 Ormerod LP, Horsfield N. Frequency and type of
    reactions to antituberculosis drugs: ob-
    servations on treatment. Tuberc Lung Dis
    1996;77:37–42.

Pneumomediastinum following Politzer's manoeuvre

The report by Dr Torres-Melero and co-
    authors of a case of pneumomediastinum
    following the use of an air turbine
    rhinopharynx drill during a dental extraction (March 1996; 51:339–40) contains some interesting points
    about iatrogenic pneumomediastinum.

A 35 year old man was recently admitted as an emergency with a complaint of severe neck and retrosternal pain, dyspnoea,
    vomiting, and agitation. These symptoms
    suddenly appeared during Politzer's manoeu-
    vre carried out for the treatment of acous-
    tic problems. Clinical examination showed
    subcutaneous emphysema in the neck and
    anterior chest wall with swelling around the
    eyes and over the cheeks. The patient had no
    pre-existing lung disease. Blood pressure and
    pulse, laboratory tests, electrocardiography
    and arterial blood gas tensions were normal.
    Chest radiography showed pneumo-
    mediastinum, bilateral apical pneumothorax,
    and subcutaneous emphysema. A large
    quantity of air was noted in the gastro-
    intestinal tract on the abdominal
    radiograph. A computed tomographic scan confirmed the presence of air in the soft tissues of the neck,
    extending through the mediastinum to the
    diaphragm, with detachment of the medi-
    astinal pleura and the apical parietal pleura
    bilaterally. The lungs were not collapsed.
    An osseopetal contrast study was performed to
    exclude any lesions in the digestive tract; no
    abnormalities were noted. Fibreoptic endo-
    scopy found no lesions in the mucosa of the
    rhinopharynx. The patient was treated
    conservatively and his clinical condition
    improved within 48 hours; he was discharged
    well six days after admission. A follow up

book reviews


This volume of over 500 pages pulls together many different strands of the anatomy, physiology, and therapeutics of the pulmonary circulation and its disorders. It is particularly strong in the evaluation of the pulmonary circulation in special environments and includes chapters by Jack Reeves on high altitude and high altitude pulmonary...