Thorax

The Journal of the British Thoracic Society
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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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ISSN 0040-6376

Published by BMJ Publishing Group, and printed in England by Latimer Trend & Company Ltd, Plymouth

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An International Perspective

University of Liverpool

Friday, 28th June 1996

An international panel of speakers will address topical issues related to lung cancer with particular reference to early diagnosis and intervention.

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Imperial College
OF SCIENCE, TECHNOLOGY AND MEDICINE
University of London

National Heart & Lung Institute and Royal Brompton Hospital

Advances In Respiratory Medicine

22 - 26 April, 1996

Course Organiser: Dr Margaret Hodson

This course will update physicians in important clinical developments in respiratory medicine. It is intended for respiratory physicians, general physicians and senior registrars (or equivalent) with special responsibilities for respiratory medicine. Contributors will come from many European countries.

Topics Will Include

Pharmacology and management of Asthma, critical care, sleep related disorders, lung transplantation and updates on the management of fibrosing lung disease, cystic fibrosis and 'COPD' together with case presentations.

Speakers

Experts from the UK and guest speakers from mainland Europe

Course Fee: £450.00

CME accreditation sought

Enquiries and payments should be made to: Imperial College School of Medicine at the Conference Centre, National Heart & Lung Institute, Dovehouse Street, London SW3 6LY. Telephone: 0171 351-8172 (24 hr answering service), Facsimile: 0171 376-3442

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At the leading edge of research, innovation and learning

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 cortico-steroid 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 (£4.34)
Beclazone 100 Easi-Breathe Inhaler PL 0530/0452 (£8.24)
Beclazone 250 Easi-Breathe Inhaler PL 0530/0453 (£18.02)

■ **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 doses 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-adrenocepter 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. Bake B. Larsson S. Eur J Respir Dis 1987;**70**:93-98
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 Elfellah M.J. et al. The Pharmaceutical Journal; 1994; **253**:467-468
5 MIMS, July 1995
6 Data on file, Baker Norton
7 Based on IMS Data

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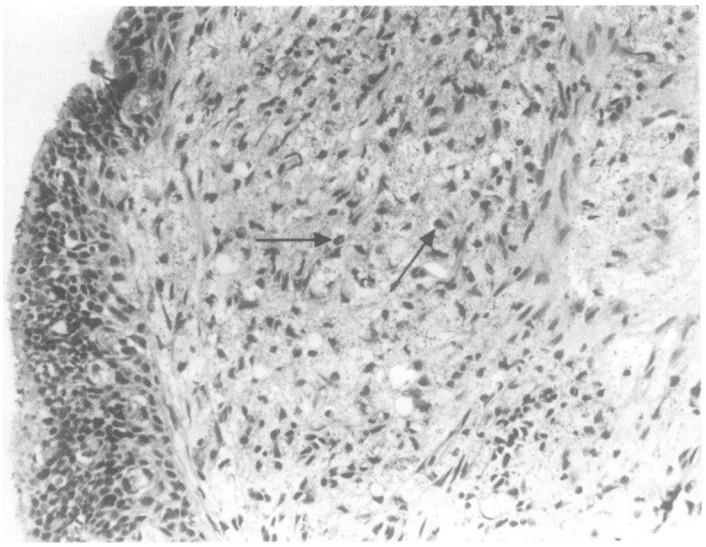

Figure 2 Histological features of an endobronchial lesion with PAS positive diastase resistant foamy macrophages (arrows). Magnification × 100 reduced to 80% in origination.

and there is some doubt as to whether the granulomata were due to direct infection or resulted from a delayed hypersensitivity reaction. Differential diagnosis should include Wegener's granulomatosis, although this diagnosis was rejected in our patient in view of the negative anticytoplasmic antibody test and his benign clinical course.

We feel that the concept that dissemination of infection to organs outside the gastrointestinal tract occurs late in the evolution of the disease should be challenged, as diarrhoea and biochemical evidence of malabsorption may be absent while involvement elsewhere may be significant, as our case suggests. Our patient did not consent to having biopsy samples taken of the small bowel until several months of treatment had been completed, in spite of being persistently requested to do so. The absence of diagnostic changes at this stage is not surprising and is consistent with his excellent clinical and radiological response to antibiotics. We suggest that this case represents a unique presentation of Whipple's disease and that pulmonary manifestations of this disorder should be extended to include pulmonary nodules and endobronchial lesions which may be mistaken for features of malignancy. Pulmonary involvement may be the presenting feature of the condition and offers the opportunity to diagnose the disease at a stage where response to treatment is likely to be both more rapid and complete than if it is delayed until manifestations of gastrointestinal involvement appear.

1 Whipple GH. A hitherto undescribed disease characterized anatomically by deposits of fat and fatty acids in the intestinal and mesenteric lymphatic tissues. *Bull Johns Hopkins Hosp* 1907;**18**:382–91.
2 Russo FR. Whipple's disease. Review of the literature and report of two cases. *Arch Intern Med* 1952;**8**:600–14.
3 Clancy RL, Tomkins WAF, Muckle TJ, Richardson H, Rawls WE. Isolation and characterization of an aetiological agent in Whipple's disease. *BMJ* 1975;iii:568–70.
4 Kelly JJ, Weisiger BB. The arthritis of Whipple's disease. *Arthritis Rheum* 1963;**6**:615–32.
5 Cho C, Linscheer WG, Hirschkorn MA, Ashutosh K. Sarcoidlike granulomas as an early manifestation of Whipple's disease. *Gastroenterology* 1984;**87**:941–7.
6 Winberg CD, Rose ME, Rappaport H. Whipple's disease of the lung. *Am J Med* 1978;**65**:873–80.
7 Symmons DP, Shepherd A, Boardman P. Pulmonary manifestations of Whipple's disease. *J Med* 1985;**56**:497.
8 Enzinger FM, Helwig EB. Whipple's disease: a review of the literature and report of fifteen patients. *Virchow's Arch Pathol Anat* 1963;**336**:238–69.
9 Rodarte JR, Garrison CO, Holley KE, Fontana RS. Whipple's disease simulating sarcoidosis. A case with unique clinical and histologic features. *Arch Intern Med* 1972;**129**:479–82.
10 Otto HF, Siemssen S, Sill V. Zur Differentialdiagnose von Morbus Whipple und Sarcoidose. Klinische-bioptische Untersuchungen. *Deutsch Med Wochenschr* 1972;**97**:1343–7.

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BOOK REVIEW

A History of Breathing Physiology. Donald F Proctor. (Pp 416; $150.00). New York: Marcel Dekker, 1995. 0 8247 9653 5.

I very much enjoyed reading this book. It is, like the proverbial football match, an affair of two halves. All but one of the first 10 chapters is written by the editor, and in these he traces up to the 17th century the story of the struggle to understand the nature and purpose of breathing. After the customary coverage of Babylonian, Egyptian and Greek physiology, there is a chapter on Galen which helps to explain how his ideas, although wrong, became so authoritative. However, Dr Proctor's chief loves are clearly the English physiologists of the 17th century, particularly Mayow, and he devotes five chapters to them, providing a lot of detail on their lives and achievements, but unfortunately also with much repetition. He tackles the question of why they drifted into different fields of enquiry after coming so close to understanding the whole mystery, leaving it for Lavoisier, a century later, to provide the final essential missing piece in the jigsaw with the discovery of oxygen.

The second half of the book consists of eight chapters by various authors who bring the story up to date in their respective fields from pulmonary surfactant to regulation of breathing. These vary in quality; that by Permutt on the pulmonary circulation is outstanding. The book is lavishly illustrated and well produced, apart from the chapter on da Vinci in which the 14 illustrations, their legends, and their text references have been shuffled into total non-correspondence which is disappointing in a book that is so exorbitantly priced. – SF

NOTICE

1st Congress of Surgery of Bosnia and Herzegovina

This Congress, which was originally planned for 8–11 October 1995, will now take place in Sarajevo on 12–15 May 1996. For further information please contact the Congress Committee. Telephone: 387 71 44 55 22. Fax: 387 71 47 19 76.