LETTERS TO THE EDITOR

BOOP associated with nitrofurantoin

Cameron et al. reported two cases of bronchiolitis obliterans organising pneumonia (BOOP) associated with the use of nitrofurantoin. These patients had a favourable outcome after treatment with corticosteroids. We wish to report a similar case.

An 82 year old woman presented in 1997 with a two year history of a cough productive of white sputum and gradually increasing breathlessness. She gave a history of 41 pack years of smoking but had stopped 23 years previously. Before referral she had received treatment with inhaled steroids and bronchodilators but without any effect on her symptoms. She had been taking nitrofurantoin 50 mg at night for prophylaxis against urinary tract infection for the previous four years. Her general health was otherwise good, there was no previous history of lung disease, and no exposure to noxious fumes or dusts.

She was breathless on minimal exertion and had fine inspiratory crackles at both lung bases extending up to the mid zones; there was no finger clubbing. Her oxygen saturation dropped from 95% breathing air at rest to 87% after climbing two short flights of stairs. Her lung function showed a restrictive defect extending into all areas.

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AUTHOR'S REPLY

I would like to thank Dr Thomas for his interest in my article. He is critical that patient centred outcomes were not included in my discussions. Patient centred outcomes have been increasingly discussed, but a number of questions need to be answered before these are accepted. Just because health care practitioners and patients are using different words or terminology does not mean they are not interested in the same objective. A patient’s desire to be able to play sport and a practitioner’s aim to prevent exercise induced asthma are just different ways of articulating the same goal. Furthermore, patients may have an incomplete understanding of their disease and the consequences and permutations of management. A patient may consider that an important outcome to them is to be able to stop all their inhalers and to smoke 20 cigarettes per day without getting wheezy, but I doubt that Dr Thomas would think that either of these were reasonable outcome measures to look at in a clinical trial. The physician must not only listen to patients’ concerns, but must also educate them as to the short and long term consequences and permutations of particular behavioural and treatment patterns. Unless care is taken, uncritical acceptance of patient centred outcomes may have negative as well as positive features. Furthermore, it needs to be established in well controlled clinical trials that adding patient centred outcomes makes a fundamental difference to clinical trial outcome. My paper was also about the interrelations between different outcome measures. It is difficult to make comparisons when measures cannot be repeated frequently, and at present most research using quality of life questionnaires just administers these at the beginning and end of a trial, so comparisons with lung function, symptoms, and (f) agnostic use which can be measured frequently and changes in quality of life are difficult.

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I wish to share my own experience in this field, which has led me to a somewhat different conclusion. In our laboratory measurement of capsaicin sensitivity in over 200 healthy volunteers, as well as in a smaller group of stable asthmatic patients in whom cough was not a reported complaint, demonstrated no significant difference in cough reflex sensitivity between these two groups. Our findings are consistent with those of previous investigations, and support the well documented dissociation between cough and bronchoconstriction, responses that are controlled by distinct neural pathways. We have recently shown, however, that asthmatic subjects in whom cough is the sole or predominant symptom have significantly enhanced cough sensitivity compared with stable asthmatics without cough. I would therefore suggest that individuals with cough variant asthma form a distinct subgroup of asthmatics in whom the afferent airway receptors controlling cough are hypersensitive, whereas those in whom cough is not a significant feature do not differ from normal subjects in terms of cough reflex sensitivity. Lending further support to this concept is our recent demonstration that the leukotriene receptor antagonist zafirlukast inhibits capsaicin sensitivity and symptomatic cough in subjects with cough variant asthma but does not affect cough reflex sensitivity in patients with stable asthma without cough or in healthy volunteers.

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AUTHORS' REPLY

We were interested to read Dr Dicipingaitis’ comments about our paper. We are familiar with his contributions to the ongoing discussion about the role of sex differences in the response to inhaled capsaicin. The methodology used in his laboratory is similar to our own but clearly differences in the dosimeter output might influence the response. Our study was not directed at this specific issue and is not appropriately powered to exclude a significant sex related difference in responsiveness in our control population. We believe our asthmatic patients to be more severe than those which he quotes in reference 5, and certainly our patients with COPD have evidence of substantial persisting pathology which we think is more likely to explain their enhanced responses. In our relatively large patient and control group combined we saw no evidence of sex differences in the degree of capsaicin response. This makes us suspect that enhanced responsiveness in our test population is due to their underlying disease rather than to other factors. Clearly, this view cannot be extended to the important area of idiopathic cough where differences in sex may play a role.

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Basic and Clinical Allergy 2001

Basic and Clinical Allergy will be held at the National Heart & Lung Institute, Imperial College School of Medicine, London on 31 May and 1 June 2001 at the Postgraduate Medical Centre, Northern General Hospital, Herries Road, Sheffield S5 1LJ, UK. For further information contact Mr G Rocco, Consultant Thoracic Surgeon. Telephone +44 114 271 4950. Fax +44 114 261 0350. Email: grocco@tany.fsnet.co.uk

The Sheffield Seminar

“The Sheffield Seminar” will take place in Sheffield, UK, yearly starting next May. The meeting will focus on all aspects of cardiothoracic surgery, starting next year with general thoracic surgery topics. It will take place on 31 May and 1 June 2001 at the Postgraduate Medical Centre, Northern General Hospital, Herries Road, Sheffield S5 1LJ, UK. For further information contact Mr G Rocco, Consultant Thoracic Surgeon. Telephone +44 114 271 4950. Fax +44 114 261 0350. Email: grocco@tany.fsnet.co.uk

PEDIATRIC ALLERGY

The 2nd World Congress of Pediatric Thoracic Disciplines will take place in Izmir, Turkey on 26–28 April 2001. For further information contact Professor Dr Oktay Mutaf, Ege University Faculty of Medicine, Pediatric Thoracic Surgery, Izmir, Turkey. Fax +90 232 3751288; email: omutaf@med.rgr.tr.edu

4th International Symposium on Angiotensin II Antagonism

The 4th International Symposium on Angiotensin II Antagonism will be held at the Queen Elizabeth II Conference Centre, London, UK on 3–5 April 2001. For further information contact the Secretariat, Hampton Medical Conferences Ltd, 127 High Street, Teddington, Middlesex TW11 8HH, UK. Telephone +44 020 8977 0011; fax +44 020 8977 0055; email: ALFA@hamptonmedical.com