Being positive about the smear

At several points in the recently published Code of Practice 2000,1 dealing with the control and prevention of tuberculosis in the UK, a number of important actions and decisions turn on the results of sputum microscopy for acid fast bacilli (the “smear”). This simple, cheap, and rapid test is used to assess sputum infectivity and prompts decisions on isolation, initiation of treatment, and the need for and extent of contact tracing. It is also the major criterion used to assess specimen priority for advanced testing, including polymerase chain reaction (PCR) and automated culture.2

However, this procedure is unstandardised and smear positivity relative to culture varies from 60% to over 80%. Ziehl-Neelsen staining continues as a primary screen despite good evidence that auramine-based methods are more sensitive and quicker.3 Processing of sputum before staining may or may not involve digestion and/or concentration by sedimentation or centrifugation, despite advice and evidence that both improve the results.4 Quality control schemes assess the ability to stain and microscopically examine suspensions of mycobacteria, but not the critical issue of specimen processing before staining.

Less sensitive smear techniques may cause delays in the recognition and management of the index case, including the use of isolation facilities, and an unjustified view of low infectivity which will persist even after the culture is positive. Casual, particularly occupational, contacts of such patients will be at a significant disadvantage. Suboptimal smear techniques will also mean that some specimens meritting examination by enhanced methods will not be sent for such examination. The potential benefits of the Mycobacterium tuberculosis PCR will be unnecessarily compromised.

It is now nearly 120 years since Ehrlich first described the acid fastness of some organisms, including mycobacteria. We think it is long overdue that all mycobacteriologists accurately, optimally and, above all, consistently exploit their discovery.

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AUTHORS’ REPLY We agree with Dr Wechsler that it is possible that our patient’s asthma was deteriorating as a sign of incipient Churg-Strauss syndrome (CSS). He is right to remind physicians that CSS is one of several causes of worsening asthma. However, we believe that it is equally important to question whether the development of CSS is causally related to the recent prescription of a relatively new class of drug. Whatever the mechanism, physicians should be aware of the possible risk of CSS associated with the introduction of anti-leukotrienes and other therapies and should report all suspected cases to their national drug surveillance authority.

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Malignant mesothelioma

We wish to suggest a minor correction to the otherwise excellent editorial by Drs Steele and Rudd in your recent issue.1 The status of the forthcoming British Thoracic Society study of the management of malignant mesothelioma is that this study is being supported by the British Thoracic Society and the pilot study is being assisted by the Clinical Trials Unit of the Medical Research Council Funding for this purpose. The Medical Research Council Staff has been obtained through the BTS Scientific Committee and from two independent mesothelioma charities — The June Hancock Mesothelioma Research Fund and the Anthony Farmer Mesothelioma Research Fund.

We have approached the Medical Research Council with a bid for full funding of the final study but the outcome of the application is not yet known.

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Assisted discharge for patients with exacerbations of COPD

We wish to read with the interest the recent papers1–3 which report the findings of randomised controlled trials of early supported discharge for patients with exacerbations of chronic obstructive pulmonary disease (COPD). Both
found that a proportion of such patients presenting to hospital could be safely cared for at home with respiratory nurse support, without adversely affecting mortality or readmission rates.

A similar service to those described operated in the first time in Sheffield on the winter of 1997/8, supported by government money to ease the demand for beds during the winter. Although this did not involve randomising, our findings were essentially similar. Unselected patients with exacerbations referred by general practitioners for admission to hospital were reviewed and those fulfilling the British Thoracic Society guidelines on early discharge for patients with exacerbations of COPD were offered home treatment. Over a 4 month period 299 of 118 patients (25%) referred were found to be suitable for supported discharge, and we successfully treated the 22 patients who consented to participate. Although this was a small number of patients, there were no readmissions and no home deaths. The remaining 89 patients required admission because of respiratory complications (21 patients with pneumonia, seven by other) or coexisting medical conditions (17 cardiovascular, 28 others).

We also found that a proportion of suitable patients (seven of 29) did not want to participate in the home treatment scheme. Some of these simply wanted the reassurance of being in hospital, but two patients declined as they would have lost insurance scheme benefits for home care. The remaining 82 patients were offered home treatment. We were interested that two patients in our study did not want to participate in the home treatment scheme because they would have lost insurance scheme benefits. This is not one of the many problems with which we have to cope in the East End of Glasgow.

We were interested that two patients in Sheffield did not want to participate in the home treatment scheme because they would have lost insurance scheme benefits. This is not one of the many problems with which we have to cope in the East End of Glasgow.

BOOK REVIEW


This popular radiology text is now in its third edition. The challenge for the authors to contain so much information within just over 1000 pages has been successfully met.

The early chapters on plain radiographs are excellent building blocks for any trainee. The growing dependence on high resolution computed tomography (CT) is reflected in several chapters, but this is not at the expense of the plain radiograph. The value of positron emission tomography and magnetic resonance in problem solving are evaluated. CT pulmonary angiography is presented and compared with radionuclide imaging and invasive angiography.

Chapters are written from the viewpoints of both pathological location and aetiology. Where the less usual pathologies are discussed—for example, immunologically mediated, drug induced, and transplant related problems—or the more esoteric diseases are described, additional valuable clinical comments are given.

This book can be read from cover to cover; the clarity of the writing and the good illustrations help the pages to fly by. A major strength is that it can be used to help solve those perplexing cases. The index is written with a clear problem orientated approach, but do remember that the spellings are American.

This multi-modality, multi-subspecialty imaging reference text has been updated. Intended not just for radiologists, our medical, surgical, and allied professional colleagues would be wise to sequester it in their libraries. The illustrations are beautiful, the text is clear, and the references are weighty. —KP