Table 1  Baseline biochemistry and peak cortisol levels following insulin induced hypoglycaemia in two female adult patients taking inhaled/intranasal corticosteroids

<table>
<thead>
<tr>
<th>Patient 1</th>
<th>Patient 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00 cortisol (200-600 nmol/l)</td>
<td>169/198</td>
</tr>
<tr>
<td>08:00 ACTH (&lt;12 pmol/l)</td>
<td>4.5</td>
</tr>
<tr>
<td>Insulin-like growth factor-1 (0.4-1.6 U/ml)</td>
<td>0.54</td>
</tr>
<tr>
<td>Free thyroxine (10-21 pmol/l)</td>
<td>11</td>
</tr>
<tr>
<td>Thyroid stimulating hormone (0.3-4.3 mU/l)</td>
<td>0.77</td>
</tr>
<tr>
<td>Prolactin (50-370 mU/l)</td>
<td>224</td>
</tr>
<tr>
<td>Luteinising hormone (IU/l)</td>
<td>11.3</td>
</tr>
<tr>
<td>Follicle stimulating hormone (IU/l)</td>
<td>6.5</td>
</tr>
<tr>
<td>α-subunit (IU/l)</td>
<td>0.41</td>
</tr>
<tr>
<td>Anti-microsomal antibodies</td>
<td>Negative</td>
</tr>
<tr>
<td>Dehydroepiandrosterone (μmol/l)</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Normal ranges and units are in brackets. “Normal” peak cortisol level following hypoglycaemia >550 nmol/l. When more than one value is quoted, the tests were performed on different days.

*On thyroxine.
†Reference range (RR): females – premenopausal 2.5–130 IU/l, postmenopausal >15 IU/l, males 1.5–14 IU/l.
‡RR: females – premenopausal 1.6–33 IU/l, postmenopausal >16 IU/l, males 0.9–8.1 IU/l.
§RR: males and females – premenopausal 0.05–4.0 IU/l, postmenopausal 0.37–1.15 IU/l.
*RR: females – premenopausal 2.2–9.1 μmol/l, postmenopausal 0.3–1.7 μmol/l, males 5.3–9.9 μmol/l.

References

6 Fish HR, Chernow RB, O’Brian JR. Endocrine and neurophysiological responses of the pituitary to insulin-induced hypoglycaemia: a review. Metabolism 1986;35:763–80

BTNL2 gene variant and sarcoidosis

Sarcoidosis is an inflammatory granulomatous disorder that primarily affects the lungs, with involvement of other organs such as the brain, eye, heart, and skin can also be affected. The disease is characterised by non-casating granulomas and an exaggerated cellular immune response caused by increased inflammatory activity. The course of the disease is acute and mild in approximately 20% of all patients. In most patients a chronic stage develops which can lead to lung fibrosis. Although the exact pathogenesis of sarcoidosis remains unclear, familial clustering of the disease and the increased risk of relatives to develop sarcoidosis suggest that there might be a genetic predisposition to develop the disease.

A significant association was recently reported in Germany between sarcoidosis and a frequent single nucleotide polymorphism (SNP) in the BTNL2 gene, rs2076530. BTNL2 is a member of the immunoglobulin gene family and is related to CD89 and CD86 co-stimulatory receptors, although its exact function is unknown. rs2076530 is located on chromosome 6p21.3 in close proximity to the HLA gene cluster. rs2076530 is located at position 1 of the donor splice site in intron 5 and the associated A allele causes the usage of an alternative donor site leading to a 4 bp deletion at the mRNA level, frameshift, and premature truncation at the protein level. The rs2076530 SNP alone was also associated with sarcoidosis in a case-control study of white American subjects. No replication of the BTNL2 rs2076530 susceptibility to sarcoidosis has yet been studied in an independent German case-control study. We therefore performed a case-control association study in 210 patients with sarcoidosis and 202 controls. Written informed consent was given by each participant and the study was approved by the ethics committee of Bonn University School of Medicine.

The diagnosis of sarcoidosis was based on evidence of non-casating epithelioid cell granuloma in biopsy specimens and chest radiographic abnormalities. Different stages were defined as previously described. A chronic course was defined as disease over at least 2 years or at least two episodes in a lifetime. Acute sarcoidosis was defined as one episode of acute sarcoidosis which had totally resolved at the date of the examination. None of the individuals in the control group (healthy white German subjects of mean age 38.32 (15.53) years) had a history of lung disease or showed any symptoms of lung disease other than bronchitis or laboratory blood tests. Genotyping of rs2076530 was performed using the Taqman technique with a commercially available assay (Applied Biosystems, Germany). SPSS Version 12 was used for data analysis. The genotype distribution in the cohort were in accordance with the Hardy-Weinberg equilibrium.

The A allele frequency of rs2076530 was significantly increased in sarcoidosis patients compared with controls (A = 0.6929, G = 0.3071 in cases; A = 0.6188, G = 0.3812 in controls). It was significantly associated with an increased risk of sarcoidosis in codominant and dominant models (OR 3.46, 95% CI 1.27 to 4.23; p = 0.006, table 1), but not in a recessive model (p = 0.276). The calculated population attributable risk (PAR) for AA homozygotes and AG heterozygotes was 34.6%. Our results were in accordance with the reported association between BTNL2 and sarcoidosis and replicated the finding that A allele carriers of rs2076530 have a more than twofold increased risk of developing sarcoidosis compared with GG homozygotes in the German population.

We also examined whether this increased risk is present in both chronic and acute forms of sarcoidosis. Interestingly, we found that the chronic form—but not the acute form—was significantly associated with the A allele in codominant and dominant models (OR 2.87).
(95% CI 1.29 to 6.42), p<0.0069; table 1) with a PAR for AA homozygotes and AG heterozygotes of 50%.

This study underlines the association of the *BTNL2* rs2076350 variant with the susceptibility to develop sarcoidosis in a German population. Furthermore, our data suggest that susceptibility is preferentially towards the chronic form of the disease.

In their investigation, Maziak et al did not find a significant increase in the lifetime prevalence of asthma and hay fever, except in one subgroup. The effect found in 13–14 year old girls could also be due to a former underdiagnosis of asthma in girls, as discussed in their paper.

Since our results are based on six cross sectional surveys, we consider the title and the conclusion—that we did not see an increase in asthma and allergies from 1992 to 2001—to be appropriate.

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In the paper entitled “No increase in the prevalence of asthma, allergies, and atopic sensitisation among children in Germany: 1992–2001” by I K Zöllner et al which appeared in the July 2005 issue of *Thorax* (2005;60:545–8), the authors apologise for a mistake which occurred in the reference list. Reference number 18 should be number 21 and references 19–21 should be listed as 18–20.

doi: 10.1136/thx.2005.040444corr1

The paper entitled “Anticholinergics in the treatment of children and adults with acute asthma: a systematic review with meta-analysis” by G J Rodgers and J Castro-Rodriguez (10.1136/thx.2005.040444) has been published previously on 17 June 2005 as a *Thorax* Online First article but under the incorrect DOI (10.1136/thx.2005.047803). The publishers apologise for this error. The definitive version of the article can be found at the following citation: *Thorax* 2005;60:740–6.

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