the UK may not see a single case of tuberculosis in several years.

Nevertheless, given the consequence of pulmonary tuberculosis to the individual and society, it is appropriate for clinicians and general practitioners to ensure that tuberculosis is among the differential diagnoses in patients with relevant symptoms and signs and to investigate for tuberculosis fairly promptly. Every attempt should be made to obtain a microbiological diagnosis. As Jolobe points out, it is also true that patients with smear-negative culture-positive tuberculosis can transmit infection, although less so than those who have a positive smear from direct sputum examination.[4] Exclusive extrapulmonary tuberculosis is, however, not infectious and the suggestion to the contrary is erroneous.

In view of the current rise in the incidence of tuberculosis, without high case detection and the adequate treatment of cases, tuberculosis may not remain an uncommon illness in the UK. Vigilance for both pulmonary and extrapulmonary tuberculosis is required.

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CORRECTION

doi:10.1136/thx.2005.040444

The paper entitled "Anticholinergics in the treatment of children and adults with acute asthma: a systematic review with meta-analysis" by G J Rodrigo and J A Castro-Rodriguez (Thorax 2005;**60**:740–746. doi:10.1136/thx.2005.047803) was published twice online first, on one of those occasions with an incorrect DOI (doi:10.1136/thx.2005.040444).

Table 1 Statistical analysis of the case-control study

	Co-dominant				Dominant (AA/AG *v* GG)				Recessive (AA *v* AG/GG)			
	AA	AG	GG	p value	AA/AG	GG	OR (95% CI)	p value	AA	GG/AG	OR (95% CI)	p value
Controls	84 (41%)	82 (41%)	36 (18%)		166	36			84	116		
Cases	99 (47%)	93 (44%)	18 (9%)	**0.021**	192	18	**2.31 (1.27 to 4.23)**	**0.006**	99	111	1.25 (0.85 to 1.85)	0.276
Acute	30 (42%)	32 (45%)	9 (13%)	0.576	62	9	1.49 (0.68 to 3.28)	0.358	30	41	0.99 (0.57 to 1.71)	0.97
Chronic	59 (52%)	47 (41%)	8 (7%)	**0.021**	106	8	**2.87 (1.29 to 6.42)**	**0.007**	59	55	0.67 (0.43 to 1.07)	0.095

Significant associations are shown in bold.

(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 importance of the association of *BTNL2* rs2076530 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.

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Asthma and allergies in Germany

We read the study by Zöllner and colleagues published recently in *Thorax* about the levelling off of asthma and allergies among children in Germany between 1992 and 2001.[1] We have published a study looking at the same issue and using a similar protocol (ISAAC)[2] to assess the symptoms, diagnosis, and severity of asthma and allergies in more than 15 000 children aged 6–7 and 13–14 years between 1995 and 2000 in Münster, Germany.[3] We found a tendency towards an increase in current symptoms of asthma and allergies in both age groups, but more so among girls.[3]

Indices of diagnosis either remained the same or increased in parallel with the increase in symptoms, arguing against a change in diagnostic behaviour as an explanation for our results. Indices of severity also showed a homogenous increase in the 5 year study period, pointing towards an increase in the overall burden of asthma and allergies within the society.[3]

Regrettably, these results, coming from Germany, were not considered in either the discussion of Zöllner's report or in the affirmative title that no increase in asthma and allergies occurred in Germany in the 1990s. Even more regrettable is the fact that when our study was alluded to in the discussion and conclusion of the paper by Zöllner *et al*, it was cited—contrary to our results—as one of the studies showing a decrease or levelling off of asthma and allergies among children.[1]

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Authors' reply

Unfortunately, the paper by Maziak *et al*[1] published in *Allergy* was listed as reference number 18 instead of number 21 in the reference list of our paper.[2] We apologise for any misunderstanding which may have arisen from this error. A correction is published below.

In the paper by Maziak *et al*[1] the prevalences in 1994/5 and 1999/2000 are compared. As we know from our own studies, trend analyses based on (only) two time points may be difficult and should be interpreted with caution. Indeed, 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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Reference

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CORRECTIONS

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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.

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The paper entitled ''Anticholinergics in the treatment of children and adults with acute asthma: a systematic review with meta-analysis'' by G J Rodrigo and J A 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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In the paper entitled ''Hormone replacement therapy, body mass index and asthma in perimenopausal women: a cross sectional survey'' by F Gómez Real *et al* published in the January 2006 issue of *Thorax* (2006;**61**:34–40), the fourth author should be **K A Franklin**, not K Franklin.

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Bronchiectasis and non-tuberculous mycobacterial pulmonary infection

We read with great interest the paper by Wickremasinghe *et al* on the prevalence of non-tuberculous mycobacteria (NTM) in patients with bronchiectasis.[1] They showed that the prevalence of NTM was uncommon (only 2%) both in 50 newly referred patients and 50 follow up patients. However, the authors stated in the Discussion that ''it is now our practice to screen our patients routinely once a year'' because a large number of NTM isolates (28%) were detected by routine surveillance in their retrospective analysis of 71 patients with NTM sputum isolates.[1]

NTM pulmonary infection associated with bronchiectasis is increasing worldwide.[2] However, should routine periodic screening for NTM infection be necessary for all adult patients with bronchiectasis? Is sputum culture a sufficiently sensitive method to exclude active NTM infection? Are negative sputum studies sufficient to dissuade one from the diagnosis of active NTM infection?

Bronchiectasis in general can manifest in one of two forms: as a local or focal obstructive process of a lobe or segment of a lung or as a diffuse process involving most of the lungs.[3] In patients with diffuse bronchiectasis the disease is more likely to be associated with specific causes such as infection (NTM infection, *Aspergillus* infection), congenital conditions (primary ciliary dyskinesia, cystic fibrosis), or immunodeficiency.[3]

High resolution computed tomography (HRCT) has proved to be a reliable and non-invasive method for the diagnosis of bronchiectasis. The pattern and distribution of abnormalities revealed by HRCT scanning are influenced by the underlying cause of bronchiectasis. Multiple small nodules (and sometimes cavity or cavities) combined with diffuse (or widespread) bronchiectasis are reported to be the typical HRCT findings of NTM pulmonary infection associated with bronchiectasis,[4–6] which was also suggested by Wickremasinghe *et al*.[1] In patients with these characteristic HRCT findings, 34–50% of patients have active NTM pulmonary infection, especially *Mycobacterium avium* complex infection.[4 6] These abnormalities are usually confined to, or most severe in, the right middle lobe and the lingular segment of the left upper lobe in NTM pulmonary infection. This presentation is therefore now referred to as ''nodular bronchiectatic disease''.[2] Multiple small nodules around ectatic bronchi on the HRCT scan have been reported to represent peribronchial granuloma and caseous material.[4 5]

The diagnosis of this type of NTM pulmonary infection is often delayed because symptoms are mild and excretion of NTM in sputum is intermittent with few colonies retrievable in culture. Many patients therefore require bronchoscopic examination or lung biopsy for diagnosis of NTM pulmonary disease.[7] In clinical practice, HRCT scans should therefore be performed in patients with suspected bronchiectasis. NTM pulmonary infection could be suspected in selected patients who have multiple pulmonary nodules combined with diffuse bronchiectasis on the HRCT scan. Multiple sputum specimens should be examined in these patients. However, the poor sensitivity of sputum cultures suggests that, in situations where multiple sputum cultures are non-diagnostic, bronchoscopy should be performed to adequately exclude or diagnose NTM pulmonary disease.

We consider that there is no clear evidence to support the routine surveillance for NTM infection in all adult patients with bronchiectasis.

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Authors' reply

We would agree with much of the content of the interesting letter from Drs Koh and Kwon, particularly the details of *Mycobacterium avium* complex infection and the use of CT scans in making the diagnosis.[1] We have also had experience of bronchoscopy and biopsy being necessary to make the diagnosis in some cases with suggestive radiology. The one point on which we disagree is the value of routine annual screening of sputum for acid fast bacilli, and our practice of sending three samples in all patients with a deterioration in their clinical condition which is not explained or not reversed by usual treatment.

The value of this practice will require a large prospective study with cost-benefit analysis and attention paid to false negative results. However, we would argue in favour of this approach for the following reasons. Most patients have a CT scan when bronchiectasis is first suspected. Our study[2] has shown that these patients may (rarely) in the future contract NTM infection which adversely affects their condition.

As Drs Koh and Kwon state, this may be insidious and go unsuspected for long periods. In our study[2] most patients with infection (rather than colonisation) had a heavy bacterial load (smear positive) which would make it likely that routine screening would detect the patient. Repeat CT scans in all cases that might raise suspicion of NTM is impractical. Lastly, about 50% of cases with diffuse bronchiectasis remain idiopathic even after full investigation,[3] and our understanding of the pathogenesis of NTM infection is just beginning to increase. The data produced from closely studying NTM in our population of bronchiectatic patients may provide useful information in the future.

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CORRECTION

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CORRECTION

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The paper entitled "Anticholinergics in the treatment of children and adults with acute asthma: a systematic review with meta-analysis" by G J Rodrigo and J A 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.