LETTERS TO THE EDITOR

Management of spontaneous pneumothorax

EDITOR,—Yeoh and colleagues were surprised that 80% of doctors opted to insert a chest drain for the initial management of a patient with a large pneumothorax,¹ but the authors did not report which types of drain were used for pleural intubation. Narrow bore drains have been used successfully for the treatment of pneumothoraces for over a decade,^{2,3} and have the advantage over large intercostal drains in that they are free from the troublesome complication of subcutaneous emphysema that follows blunt dissection through the parietal pleura. Narrow bore chest drains that are quick, safe, and easy to insert by a Seldinger technique (for example, the Portex 12 FG drain kit) are now widely available and are very effective. In contrast (and contrary to the published guidelines), many practising respiratory and general physicians have found that pleural aspiration is a time consuming procedure that frequently fails.⁴ Typically, after laborious aspiration of two or more litres of air from the pleural cavity using a 50 ml syringe and then waiting for several hours for a further chest radiograph, it is found that the pneumothorax persists and the patient needs to have a chest drain inserted anyway. The availability of narrow bore chest drain kits means that in many centres “simple” aspiration will be largely abandoned in the treatment of moderate and large spontaneous pneumothoraces.

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- 1 Yeoh JH, Ansari S, Campbell IA. Management of spontaneous pneumothorax—a Welsh survey. *Postgrad Med J* 2000;76:496–500.
- 2 Conces DJJ, Tarver RD, Gray WC, et al. Treatment of pneumothoraces utilizing small caliber chest tubes. *Chest* 1988;94:55–7.
- 3 Laub M, Milman N, Muller D, et al. Role of small calibre chest tube drainage for iatrogenic pneumothorax. *Thorax* 1990;45:748–9.
- 4 Seaton D, Yoganathan K, Coady T, et al. Spontaneous pneumothorax: marker gas technique for predicting outcome of manual aspiration. *BMJ* 1991;302:262–5.

The authors respond:

Dr Hart has raised interesting points. However, our study aimed to establish the current practice of Welsh physicians in the management of spontaneous pneumothorax, comparing it with the guidelines published by the British Thoracic Society (BTS),¹ and highlighting some of the issues around variations from recommended practice. We hope to assist the BTS, which is set to review the evidence and revise the guidelines. The committee is debating the issues in the management, considering age of the patient, size and nature of the pneumothorax, and size of chest drain. Some of Dr Hart's points have already been discussed in our paper. We disagree with the suggestion that simple percutaneous aspiration should be abandoned. There is evidence that this treatment works in a significant proportion of patients. A 43%

success rate for simple aspiration was reported by Seaton *et al.*² and this has been exceeded in the recent randomised trials by Andrivet *et al.*³ and Harvey and Prescott⁴: 68% and 80% respectively. Besides, it is better tolerated by patients and is less painful.⁴ We recognise the lower rate of success with aspiration in cases of larger pneumothoraces.⁵ Despite that, it is still successful in a significant percentage and thus should be considered the initial treatment for the most.

- 1 Miller AC, Harvey JE. Guidelines for the management of spontaneous pneumothorax. *BMJ* 1993;307:114–6.
- 2 Seaton D, Yoganathan K, Coady T, et al. Spontaneous pneumothorax: marker gas technique for predicting outcome of manual aspiration. *BMJ* 1991;302:262–5.
- 3 Andrivet P, Djedaini K, Teboul JL, et al. Spontaneous pneumothorax—comparison of thoracic drainage vs immediate or delayed needle aspiration. *Chest* 1995;108:335–40.
- 4 Harvey J, Prescott RJ. Simple aspiration versus intercostals tube drainage for spontaneous pneumothorax in patients with normal lungs. *BMJ* 1994;309:1338–9.
- 5 Ansari S, Seaton D. Can the chest radiograph predict early outcome of spontaneous pneumothorax? *Eur Respir J* 1996;9(suppl 23):211.

Foreign bodies in the nasal cavities: a comprehensive review of the aetiology, diagnostic pointers, and the therapeutic measures

EDITOR,—We wish to congratulate the authors on the much overdue review of intranasal foreign bodies, which we read with interest.¹

Kalan and Tariq¹ and Davies and Bengert² have described application of local anaesthetic to the nasal passage by spraying it with 4% lignocaine (lidocaine) solution. Our experience shows that this method is very effective but makes the already apprehensive child more frightened. We wish to share our experience of the application of 4% lignocaine (lidocaine) by a more pleasant method.

After confirming the presence and the nature of the foreign body we explain the following procedure to the parent. The anaesthetic liquid at the end of the cotton bud (Q-tip) should be allowed to run off the bud into the nasal passage and the bud should not be inserted into nose.

We spray a good size drop of standard 4% lignocaine (lidocaine) solution on to the end of a cotton bud. Then with the child lying down we let the parent install the same into the side of the appropriate external nare under direct medical supervision. This effectively anaesthetises the nasal passage and aids removal. This method of local anaesthetic application does not upset either the child or the parent.

This successful method of effective application of local anaesthetic was acceptable to the child and appreciated by the parents.

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- 1 Kalan A, Tariq M. Foreign bodies in the nasal cavities: a comprehensive review of the aetiology, diagnostic pointers, and therapeutic measures. *Postgrad Med J* 2000;76:484–7.
- 2 Davies PH, Bengert J R. Foreign bodies in the nose and ear: a review of techniques for removal in the emergency department. *J Accid Emerg Med* 2000;17:91–4.

Eosinophilic pericarditis caused by minocycline

EDITOR,—Davey and Lallo present a well described and discussed case of eosinophilic pericarditis caused by minocycline.¹ Indeed, I find it particularly welcome because among the large numbers of drugs that appear to provoke pericardial disease,² conclusive demonstration of their precise role is quite difficult and the authors have overcome this.

In contrast, I am surprised that representatives of such a prestigious institution would make two errors in discussing the “typical ECG” of acute pericarditis. The first is citation of the editor of a multiauthored book as responsible for particular material (except, when the editor is an author); secondly, if citing Braunwald, the author to credit is Lorrill who, herself, correctly cites my work,^{3,4} which long ago established the four stages of electrocardiographic response.

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- 1 Davey P, Lallo DG. Drug induced chest pain—rare but important. *Postgrad Med J* 2000;76:420–2.
- 2 Spodick DH. Drug- and toxin-related pericardial disease. In: Spodick DH, ed. *The pericardium: a comprehensive textbook*. New York: Marcel Dekker, 1997: 411–16.
- 3 Spodick DH. The electrocardiogram in acute pericarditis: distributions of morphologic and axial changes by stages. *Am J Cardiol* 1974;33: 470–4.
- 4 Spodick DH. The pericardial rub: a prospective, multiple observer investigation of pericardial friction in 100 patients. *Am J Cardiol* 1975;35: 357–62.

The authors respond:

We are very grateful to Professor Spodick for pointing out his fundamental contribution to the field of pericardial disease, a contribution that was inadvertently overlooked in our article.^{3,4} Professor Spodick is the world authority on pericardial disease, and we would like to take this opportunity to acknowledge the tremendous contribution he has made.

Correction

An editorial error occurred in the article by Dr Ismail and Dr Bhat (Ismail M, Bhat RV. Thyrotoxicosis of a rare aetiology. *Postgrad Med J* 2000;76:799). The email address was incorrect; the correct address is ismohammed@hotmail.com

BOOK REVIEWS

The reviewers have been asked to rate these books in terms of four items: readability, how up to date they are, accuracy and reliability, and value for money, using simple four point scales. From their opinions we have derived an overall “star” rating: * = poor, ** = reasonable, *** = good, **** = excellent.

The Human Effect in Medicine. By Michael Dixon and Kieran Sweeney. (Pp 157; £17.95.) Radcliffe Medical Press, 2000. ISBN 1-85775-369-0.****

The aim of this book is to emphasise the therapeutic effect of the doctor and the self healing powers of the patient. The authors have written the text in the context of the limitations of modern technologies and medicine's inability to cure many diseases. The book explores the doctor-patient relationship with the purpose of producing better consultations to benefit both participants. Topics included are the placebo effect of the doctor-patient interaction, why it works, illnesses which respond to the placebo effect, and factors which determine its effectiveness. The authors include chapters on psychoneuroimmunology detailing the scientific basis of the placebo effect and mechanisms by which physicians can facilitate healing. The final section of the book looks at how the preceding theory can be translated into practical help for patients by improving the techniques of consultations. For example the authors discuss the value of empathy, relaxation, reassurance, improving self esteem, and the importance of information and self help groups.

This book is interesting, well written, and will stimulate health professionals to assess their professional practice. Although the book will primarily be of value to general practitioners, it is relevant to doctors in secondary care and all professionals who have direct contact with patients. The book was well illustrated with clinical examples and the history of the subject.

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21 Medical Mysteries. By J Dickinson. (Pp 253; £15.95.) The Book Guild, 2000. ISBN 1-85776-4994.****

Professor Dickinson has written an intriguing book. As a well known physician and clinical scientist he has witnessed at first hand medical mysteries being discussed and sometimes solved. In this volume he records his personal observations on a number of topics.

Each chapter is devoted to a particular illness, symptom, or physical sign. The topics are widely chosen and each is stimulating. In a section on asthma, for example, he suggests that television sets may be partly responsible for the increasing incidence of the disease. High voltages generated by television sets attract electrically charged dust particles which could act as lung irritants. Dickinson's chapter on fainting promotes his hypothesis of "collapse firing" of low pressure baroreceptors in the right heart consequent upon diminished venous return. This in turn leads to a centrally mediated dilatation of systemic blood vessels and loss of consciousness. Other chapters in the book ranging from Alzheimer's disease to chronic fatigue, irritable bowel syndrome to inflammatory bowel disease, and migraine to motor neurone disease have equal appeal and contain snippets of valuable information. There is an excellent chapter on finger clubbing and lucid chapters on essential and renal hypertension.

For whom is the book intended? The author clearly intends in his introduction that the book should be read by non-scientists. I suspect however that the volume will appeal mainly to clinicians as bedside reading. I

enjoyed this book and look forward to a second volume on medical mysteries.

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A Guide To Laboratory Investigations. 3rd Edition. By Michael McGhee. (Pp 163; £17.95.) Radcliffe Medical Press, 2000. ISBN 1-85775-357-7.**

This book aims to be a reference for general practitioners, their practice nurses, and hospital doctors "alike". There are six sections: haematology, microbiology, fertility and pregnancy testing, rheumatology, biochemistry, miscellaneous and there is a useful glossary of acronyms. In each section there are lists of laboratory tests and interpretative comments.

Much of the book is useful. However, some tests are given disproportionate description relative to the importance of utility, for example, faecal urobilinogen—has it ever been requested by anyone? Faecal fats and toxoplasmosis, including treatment, are mentioned extensively but nothing on treatment of urinary tract infections. Many tests are obsolete: urinary keto/oxosteroid, plasma oestriols, Rose-Waaler test, Lange curve. Some results units are unsuitable, for example, urinary sodium, given as mean and range, in mmol/l and mEq/l (not used in the UK). Some interpretative advice is worryingly misleading; "decreased sodium may be found in: diarrhoea and vomiting, glycosuria . . ." but no mention of mineralocorticoid deficiency—including Addison's disease or dilutional hyponatraemia. "Hypercalcaemia . . . at >3.7 mmol/l cardiac complications can be fatal", yet no mention of possible serious dysrhythmias with a high potassium. "Samples for suspected primary hyperparathyroidism should be taken on three consecutive days"; this is no longer necessary.

Although a small book, trying to cater for the varying needs is unlikely to meet everyone's expectations, there are too many examples of a lack of reliable information in how to undertake tests and how to interpret the results. It is not on my recommended list.

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Caring for Muslim Patients. Edited by Aziz Sheikh and Abdul Rashid Gatrad. (Pp 140; £17.95.) Radcliffe Medical Press, 2000. ISBN 1-85775-372-0.***

Caring for Muslim Patients is written by different authors and covers demographic and socioeconomic data, background on beliefs, customs and practices, and how this affects health, disease, and death within different family structures. Useful appendices steer readers to the world wide web for information and Muslim organisations.

This book contains a wealth of information about Islam, with examples from the Qur'an and case studies for illustration. There is little made of individual interpretation of religious writings and how this affects behaviour. One author states that use of donor sperm and eggs is categorically prohibited by Islam but this is likely to be interpreted differently by someone who needs this service from someone who does not.

In my own field of diabetes there is information on the Hajj so appropriate advice

can be given, information about Ramadan fasting, with suggestions about consultation before Ramadan to make changes in medication. Many suggestions made are standard practice in our diabetes unit. There is, however, no mention of educational materials to support patients and health professionals. Perhaps of necessity, generalisations are used but we prefer to individualise advice and ask people what they intend to do and negotiate "safety rules". An example: inquire if prepared to break their fast if hypoglycaemic (thereby exempt from fasting because acutely ill). Pressure to conform to the fast is not mentioned—my patients say it is difficult not to fast if everyone else is, and even more difficult to fast alone if deferred. There is no encouragement to health professionals to talk to and learn from their Muslim patients. I have learnt most from this method and it is an effective way of ensuring an equitable and culturally sensitive service.

In summary, a useful resource for all health services caring for Muslim people.

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DIARY

Royal Society of Medicine

23 March 2001: Key advances in rheumatoid arthritis
29–30 March 2001: TB drug resistance: from molecules to macroeconomics
Details: Rosamund Snow, RSM, 1 Wimpole Street, London W1G 0AE, UK (tel: +44 (0)20 7290 2904, fax: +44 (0)20 7290 2992, email: rosamund.snow@rsm.ac.uk).

6th European Forum on Quality Improvement in Health Care

29–31 March 2001: Bologna, Italy
Details: BMA/BJM Conference Unit, BMA House, Tavistock Square, London WC1H 9JP, UK (tel: +44 (0) 20 7383 6409, fax: +44 (0) 20 7383 6869, email: Quality@bma.org.uk, web site: quality.bmjpg.com).

5th Annual Conference on Self Directed Learning in General Practice

24 April 2001: London, UK
Organised by the Open Learning Unit, University College London, and sponsored by the *British Medical Journal*. The conference will be organised around the themes of:
● Revalidation
● Web based learning resources for self directed learning

The day will be based around small group workshops, with some offering hands-on training in the use of online learning resources. Places will therefore be strictly limited and allocated on a first come, first served basis. For further details please contact Marcia Rigby on m.rigby@ucl.ac.uk, tel +44 (0)20 7288 3246, +44 (0)20 7281 8004. A web site is in preparation.