LETTERS TO THE EDITOR

Management of spontaneous pneumothorax

EDITOR,—Yeoh and colleagues were surprised to find that 80% of doctors opted to insert a chest drain for the initial management of a patient with a large pneumothorax, 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, and have the advantage over large intercostal drains in that they are free from the trouble-some complication of subcutaneous emphy-sema that follows blunt dissection through the parietal pleura. Narrow bore chest drains that are easy to care for, 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. 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.

S P HART
Respiratory Medicine Unit, Western General Hospital, Cressie Road, Edinburgh EH4 2XU, UK


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), 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., and this has been exceeded in the recent randomised trials by Andrivert et al. and Harvey and Prescott: 68% and 80% respectively. Besides, it is better tolerated by patients and is less painful. We recognise the limitations of success with aspiration in cases of larger pneumothoraces. Despite that, it is still successful in a significant percentage and thus should be considered the initial treatment for the most serious cases of pneumothorax.


Eosinophilic pericarditis caused by minocycline

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

In contrast, I am surprised that representa-tives 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 Lorell who, herself, correctly cites my work, which long ago established the four stages of electrocardiographic response.

D H SPODICK
Division of Cardiocascular Medicine, Saint Vincent Hospital at Worcester Medical Center, University of Massachusetts Medical School Correspondence to: Worcester Medical Center, 20 Worcester Center Boulevard, Worcester, MA 01608, USA DPSp002@WMCC.com


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

J S MORRIS
Consultant Physician, Princess of Wales Hospital, Briggad, UK


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, rhenatology, 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 ket comedextrinoid, plasma osnatrium, Rose-Waaler test, Lange curve. Some results units are unsuitable, for example, urinary sodium, given as mean and range, in mmol/l and µg/l (not used in the UK). Some interpretative advise is worryingly misleading; “decreased sodium may be found in diarrhoea and vomiting, glycosuria...” but no mention of mineralocorticoid deficiency—including Addison’s disease or diurnal hypernatremia. “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 hyperpara thyroidism 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.

S J IQBAL
Consultant in Biochemical Medicine, Leicester Royal Infirmary, Leicester, UK


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 Haji 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 actually 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.

M BURDEN
Senior Diabetes Specialist Nurse, Leicester General Hospital, Leicester, UK

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/BMJ Conference Unit, BMA House, Tavistock Square, London WC1H 9JP, UK (tel: +44 (0)20 7383 6409, fax: +44 (0)20 7383 6869, email: rosamund.snow@rsm.ac.uk).

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, on 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.