Dear Editor

Tuberculous empyema presenting after oleothorax

Forouhi and colleagues (1) describes a 78-year-old man who presented in 1989 with a discharging chest wall sinus and an associated pleural effusion. He had originally been treated in 1927 with an oleothorax after failure of pneumothorax therapy for pulmonary tuberculosis. They aspirated his pleural fluid, which was mineral oil; on culture it yielded Mycobacterium tuberculosis, sensitive to the usual chemotherapeutic agents. Despite treatment, he died.

The authors attribute his death to recognized complications of oleothorax therapy, but might not the entire illness have been avoided by a year of prophylactic isoniazid or other suitable chemotherapy, administered sometime in the intervening decades? Isn’t the real cause of death a failure of public health practice?

Are there other untreated ‘old tuberculars’, similarly at risk?

R. CARLEN
17 Main Street
Sayville
New York 11782–2501, U.S.A.
10 June 1994

Reference


Dear Editor

Analgesia and sedation in fibre optic bronchoscopy

We read with interest the recent short report by Williams et al. on the acceptability of intravenous midazolam for fibre optic bronchoscopy (1). However we are somewhat surprised by the method in which they undertake the procedure. It is well recognized that the topical nasal anaesthesia is perceived as the most unpleasant part of the procedure (2), although this may be improved by using lignocaine gel (3–5).

An alternative approach which we routinely follow is to give the intravenous sedation prior to application of 4% lignocaine solution via a Mackintosh atomizer. The nares are sprayed and after a few minutes to allow for anaesthesia, the atomizer is placed in the nostrils and the patient is encouraged to sniff during spraying, this is usually followed by a small cough. Good nasal anaesthesia is achieved and patients appear to cough less when the cords are formally sprayed via the bronchoscope, probably as the nasal lignocaine aerosol has already partially anaesthetized the larynx. Moreover as the patient is already sedated they have no recollection of either the spraying of the nose or passage of the bronchoscope.

The technique we describe is clean and simple to follow, allows a clear view, produces effective anaesthesia and is exceptionally well tolerated. We would recommend this technique of upper airway anaesthesia and suggest that it is logical to use sedation prior to the most unpleasant part of the procedure.

J. DIHENKER AND M. B. ALLEN
St. Luke’s Hospital
Little Horton Lane
Bradford BD5 0NA, U.K.
28 July 1994

References


Dear Editor

Treatment of asthma in childhood

In their recent paper (1) Agertoft and Pedersen describe 216 children with mild and moderate asthma who were followed for 1–2 yr (run-in) before being given budesonide (BUD) for 3–6 yr. The dose of BUD started at 800 µg day⁻¹ and was titrated up or down according to the degree of asthma control. The children receiving BUD were improved compared both with run-in and with a group of ‘control’