on condom usage except in case 3. Natural rubber has been well known to cause contact dermatitis. Recently other allergic reactions to rubber or latex products, such as rhinitis, asthma, and anaphylaxis, have also been described.1 2 Seaton and Cherrie reported a case of rubber glove asthma, and Turjanmaa et al described allergic reactions to rubber condoms.

Were there any relationships between condom usage and asthma in patients 1, 2, and 4? If so, allergy skin tests and radioallergosorbent testing for latex antigen should be done.

Hiroshi Kawane, M.D., F.C.C.P.,
Department of Medicine,
Kawasaki Medical School,
Kurashiki City, Okayama, Japan

Reprint requests: Dr. Kawane, Department of Medicine, Kawasaki Medical School, Kurashiki City, Okayama 701-01, Japan

REFERENCES
1 Shah A, Sircar M. Postcoital asthma and rhinitis. Chest 1991; 100:1039-41
4 Seaton A, Cherrie B. Rubber glove asthma. BMJ 1988; 296:531-32

To the Editor:

We thank Dr Kawane for the keen interest he evinced in our report.1 Regarding his query, none of our three male patients reported using a condom. We had advised condom usage to our female patient to rule out seminal plasma allergy. This condition occurs only in female subjects, and the symptoms are abolished by condom usage.2,4 There was no evidence of asthma or any other allergic manifestation that could be linked to rubber or latex usage, as suggested by Dr Kawane. Postcoital asthma and/or rhinitis in our patients could not be ascribed to any cause other than sexual activity.

Ashok Shah, M.D.,
Department of Clinical Research,
Vallabhbhai Patel Chest Institute,
University of Delhi,
Delhi, India

REFERENCES
1 Shah A, Sircar M. Postcoital asthma and rhinitis. Chest 1991; 100:1039-41

Preventive Pulmonary Medical Education

To the Editor:

In their article in the August 1991 issue of Chest, Glanz et al paint an incomplete picture of the physician's role in occupational health. They characterize occupational history assessment or screening as "secondary prevention." This truncated vision is common among physicians such as pulmonologists who occasionally see one aspect of occupational health.

Diagnosis of exposure-related disease or recognition of preventable exposure creates a clear mandate for intervention. Failure to actively engage in workplace interventions is the most important cause of missed diagnoses and failed treatments by pulmonologists and allergists. Useful interventions are more likely to be in the workplace than in the pharmacy. It is the physician's responsibility to set in motion steps leading to substitution for hazardous materials where possible, implementation of engineered ventilation and containment of emissions, wearing of personal protection where needed, and removal of the patient from the workplace when exposure is unavoidable. These are primary prevention strategies. They protect other individuals in the same environment as index cases.

Of interest, this well-known principle appears in the introductory sentence of an occupational pulmonary disease article in the same issue of Chest.2 Failure of specialists who deal intermittently with occupational health to recognize and implement their primary role in prevention relates to a problem that Glanz and coauthors describe briefly in their article—inadequate occupational/environmental training of medical students, residents, and even experienced pulmonologists.

Alan M. Ducatman, M.D.,
Environmental Medical Service,
Massachusetts Institute of Technology,
Cambridge, Massachusetts

REFERENCES

To the Editor:

We did not intend to "paint an incomplete picture of the physician's role in occupational health" in our article. Our mention of occupational history assessment or screening as secondary prevention was given only as an example, not to reflect our entire perspective on prevention in occupational health. We regret that our identification of three broad areas of preventive pulmonary medicine as "roughly parallel to the three levels of prevention might have inadvertently given that impression.

As Dr Ducatman pointed out, advocacy for and implementation of environmental modifications to reduce risk of lung disease in occupational settings are indeed primary prevention activities. In fact, they are areas in which many occupational physicians need both scientific updates and assistance/guidance in the strategies for helping to promote a healthy environment. We are well aware of these needs and are, in fact, including these concepts as an important component of an innovative continuing medical education course for occupational health professions in preventive pulmonary medicine.

We hope this will clarify our perspective and serve as assurance that we in no way meant to overlook the many important roles of physicians in reducing risks of pulmonary disease in occupational settings.

Karen Glanz, Ph.D., M.P.H., and
Stanley B. Fiel, M.D., F.C.C.P.,
Temple University,
Philadelphia