REFERENCES


To the Editor:

We are grateful to Dr. Monteserin and colleagues for their correction of the typographical errors in our papers and also for providing clarification of his data. Of major interest, the increased prevalence of the S variant for \( \alpha_1 \)-antitrypsin in asthmatics is again indicated, this time in a population from Spain.

Charlotte Colp, M.D., F.C.C.P.,
Department of Ambulatory Care,
Beth Israel Medical Center,
New York; and
Jack Lieberman, M.D., F.C.C.P.,
Department of Medicine,
UCLA/Veteran Administration Medical Center,
Sepulveda, California

More on Asthma Prevention

To the Editor:

Dr. Bailey's response to Dr. Unger's critique on the former's not necessarily benign neglect on preventive measures in controlling asthma is like preparing a pot of chili with only bell pepper.

Even if the pulmonologists choose to ignore allergen immunotherapy as an effective form of antiallergy treatment, the general lack of understanding on effective measures to reduce allergen exposure amounts to poor medical practice.

None of us would argue Dr. Bailey's fear that restricting a patient's life-style excessively is undesirable. We allergists have come to the same conclusion by providing our patients the information as well as the tools to handle their indoor allergen exposure. There is simply no excuse for anyone treating patients with allergic asthma to be ignorant of the recent advances in house dust mite and cat allergen avoidance measures. Our ultimate goal, of course, is to serve our patients better.

John T. Chiu, M.D., F.C.C.P.,
Allergy Medical Group, Inc,
Newport Beach, California

REFERENCES


104:325-26


To the Editor:

Thank you very much for your letter regarding my response to Dr. Unger's critique (Chest 1993; 104:326). While I would not want to leave the tabasco sauce out of a pot of chili, I would not want to put in too much either. While I believe that allergy therapy has a distinct place in the treatment of asthma, it should be in a supporting role rather than as the main character, which currently for most patients is the proper use of inhaled steroids.

I am in complete agreement with you that there is no excuse for anyone treating patients with asthma to be ignorant of the recent advances in house dust mite and cat allergen avoidance measures. These are of vital importance and should be used aggressively.

William C. Bailey, M.D., F.C.C.P.,
Division of Pulmonary and Critical Care Medicine,
University of Alabama School of Medicine,
Birmingham, Alabama

Talc Slurry for Pleurodesis

To the Editor:

There is continuing concern about the best palliation for malignant pleural effusions. This is especially true since tetracycline is no longer available as a sclerosing agent. Talc has become recognized as an excellent sclerosing agent; however, it is often not recognized that thoracoscopy is not required for satisfactory talc sclerosis. Recent review articles suggest that general anesthesia and thoracoscopy are necessary. During the last year, we have had excellent results from a talc slurry injected through a simple chest tube.

The techniques of the use of talc slurry have been well described by Weissberg. Briefly, an adequate bore chest tube is inserted and the pleural cavity drained dry. Two grams of sterile talc in a slurry with 50 ml of normal saline solution is injected followed by an additional 25 to 50 ml of saline solution to clear the tube. The tube is clamped for 1 to 2 h and the patient repositioned frequently. The tube is then reattached to underwater seal with suction. We do not know if repositioning is absolutely necessary. The suction is maintained until the daily chest tube drainage is less than 50 ml or for 4 days.

The outcome in our first eight patients is shown in Table 1.

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Cancer</th>
<th>Recurrence of Effusion</th>
<th>Survival, wk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Small cell, lung</td>
<td>None</td>
<td>ipsilateral; contralateral (4 wk)</td>
</tr>
<tr>
<td>2</td>
<td>Breast</td>
<td>None</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>Nonsmall cell, lung</td>
<td>Partial (10 wk)</td>
<td>13</td>
</tr>
<tr>
<td>4</td>
<td>Small cell, lung</td>
<td>None</td>
<td>Alive at 27 wk</td>
</tr>
<tr>
<td>5</td>
<td>Nonsmall cell, lung</td>
<td>None</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>Breast</td>
<td>None</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>Adenocarcinoma, primary unknown</td>
<td>None</td>
<td>Alive at 11 wk</td>
</tr>
<tr>
<td>8</td>
<td>Piform sinus</td>
<td>None</td>
<td>Alive at 9 wk</td>
</tr>
</tbody>
</table>

Talc Slurry for Pleurodesis

To the Editor:

Thank you very much for your letter regarding my response to Dr. Unger's critique (Chest 1993; 104:326). While I would not want to leave the tabasco sauce out of a pot of chili, I would not want to put in too much either. While I believe that allergy therapy has a distinct place in the treatment of asthma, it should be in a supporting role rather than as the main character, which currently for most patients is the proper use of inhaled steroids.

I am in complete agreement with you that there is no excuse for anyone treating patients with asthma to be ignorant of the recent advances in house dust mite and cat allergen avoidance measures. These are of vital importance and should be used aggressively.

William C. Bailey, M.D., F.C.C.P.,
Division of Pulmonary and Critical Care Medicine,
University of Alabama School of Medicine,
Birmingham, Alabama

Talc Slurry for Pleurodesis

To the Editor:

There is continuing concern about the best palliation for malignant pleural effusions. This is especially true since tetracycline is no longer available as a sclerosing agent. Talc has become recognized as an excellent sclerosing agent; however, it is often not recognized that thoracoscopy is not required for satisfactory talc sclerosis. Recent review articles suggest that general anesthesia and thoracoscopy are necessary. During the last year, we have had excellent results from a talc slurry injected through a simple chest tube.

The techniques of the use of talc slurry have been well described by Weissberg. Briefly, an adequate bore chest tube is inserted and the pleural cavity drained dry. Two grams of sterile talc in a slurry with 50 ml of normal saline solution is injected followed by an additional 25 to 50 ml of saline solution to clear the tube. The tube is clamped for 1 to 2 h and the patient repositioned frequently. The tube is then reattached to underwater seal with suction. We do not know if repositioning is absolutely necessary. The suction is maintained until the daily chest tube drainage is less than 50 ml or for 4 days.

The outcome in our first eight patients is shown in Table 1.

Table 1—Results of Talc Slurry

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Cancer</th>
<th>Recurrence of Effusion</th>
<th>Survival, wk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Small cell, lung</td>
<td>None</td>
<td>ipsilateral; contralateral (4 wk)</td>
</tr>
<tr>
<td>2</td>
<td>Breast</td>
<td>None</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>Nonsmall cell, lung</td>
<td>Partial (10 wk)</td>
<td>13</td>
</tr>
<tr>
<td>4</td>
<td>Small cell, lung</td>
<td>None</td>
<td>Alive at 27 wk</td>
</tr>
<tr>
<td>5</td>
<td>Nonsmall cell, lung</td>
<td>None</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>Breast</td>
<td>None</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>Adenocarcinoma, primary unknown</td>
<td>None</td>
<td>Alive at 11 wk</td>
</tr>
<tr>
<td>8</td>
<td>Piform sinus</td>
<td>None</td>
<td>Alive at 9 wk</td>
</tr>
</tbody>
</table>