Thorax

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A Registered Charity
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Papers must be typed in double spacing with wide margins for correction and on one side of the paper only. They should include a structured abstract on a separate sheet (see below). Full papers should follow the basic structure of abstract, introduction, methods, results, discussion, references, and tables and figures as appropriate. They should not normally exceed 3000 words or include more than 30 references; priority will be given to papers that are concise. In each issue of the journal we will publish a small number of Rapid Communications, intended for reports of work of major importance in any areas of research, which will undergo an accelerated reviewing and publication process. Rapid Communications must not exceed 2000 words, 15 references, and two figures or tables. Short reports of experimental work, new methods or a preliminary report can be accepted as two page papers and should comprise no more than 1300 words including a structured abstract, one table or illustration, and a maximum of 10 references. Case reports should not exceed 850 words with one table or illustration, a short unstructured abstract, and 10 references.

ABSTRACT Abstracts, which should be of no more than 250 words, should state clearly why the study was done, how it was carried out (including number and brief details of subjects, drug doses, and experimental design), results, and main conclusions. They should be structured to go under the headings "Background", "Methods", "Results", and "Conclusions".

KEYWORDS Authors should include on the manuscript up to three key words or phrases suitable for use in an index.

STATISTICAL METHODS The Editors recommend that authors refer to Altman DG, Gore SM, Gardner MJ, Pocock SJ. Statistical guidelines for contributors to medical journals. *BMJ* 1983;**286**:1489-93. Authors should name any statistical methods used and give details of randomisation procedures. 95% confidence intervals should be quoted for main results given as means or medians. The power of the study to detect a significant difference should be given when appropriate and may be requested by referees. Standard deviation (SD) and standard error (SE) should be given in parenthesis (not preceded by ±) and identified by SD or SE at the first mention.

SI UNITS The units in which measurements were made should be cited. If they are not SI units the factors for conversion to SI units should be given as a footnote. This is the responsibility of the author.

ILLUSTRATIONS Line drawings, graphs, and diagrams should be prepared to professional standards and submitted as originals or as unmounted glossy photographic prints. Particular care is needed with photomicrographs, where detail is easily lost—it is often more informative to show a small area at a high magnification than a large area. Scale bars should be used to indicate magnification. The size of the symbols and lettering (upper and lower case rather than all capitals) and thickness of lines should take account of the likely reduction of the figure usually to a width of 65 mm. Four copies of each illustration should be submitted. Each should bear a label on the back marked in pencil with the names of the authors and the number of the figure, and the top should be indicated. Legends should be typed on a separate sheet. Authors must pay for colour illustrations.

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1 Anderson HR. Chronic lung disease in the Papua New Guinea Highlands. *Thorax* 1979;**34**:647–53.
2 Green AB, Brown CD. *Textbook of pulmonary disease*. 2nd ed. London: Silver Books, 1982:49.
3 Grey EF. Cystic fibrosis. In: Green AB, Brown CD, eds. *Textbook of pulmonary disease*. London: Silver Books, 1982:349–62.

REVIEWING PROCESS Papers submitted to *Thorax* will be assessed by the Executive Editors and those considered unsuitable for publication will be returned directly to the authors. All other papers will be peer reviewed by an associate editor and at least one other reviewer. Rapid Communications will be reviewed and returned to the authors within 4 weeks, and published 2 or 3 months after acceptance.

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THE LANCET CONFERENCE 1997 THE CHALLENGE OF

CALL FOR ABSTRACTS

The Lancet invites abstracts, in the form of posters, for a two day conference on The Challenge of Asthma. All four sessions will include invited lectures, and there will be a Chairperson's plenary lecture on day 1. A feature of Lancet conferences is generous time for discussion.

TOURS, FRANCE, OCTOBER 9/10 1997

CLOSING DATE FOR ABSTRACT SUBMISSIONS IS JUNE 2, 1997

The prevalence of asthma is increasing alarmingly world wide. Environmental factors, especially those related to "westernisation" (such as pollution, urbanisation, smoking, allergen exposure, and diet), and respiratory infections might play a part in the increasing frequency of the disease. Drug treatment is sometimes limited and controversial. Rising treatment costs and morbidity add to the economic burden on health services. More emphasis is needed on research into preventive measures, especially in children and others at high risk. The aim of our 1997 conference, the fourth in our Challenge series, is to focus on prevention and to identify future research and treatment goals.

The themes of the four sessions will be **Descriptive epidemiology – the problem; Mechanistic explanations; Environmental factors; and Towards prevention.**

Why is asthma prevalence increasing? How do environmental factors trigger the bronchial constriction, inflammation, and hyperreactivity that characterise asthma? What factors in pregnancy and in newborn babies lead to the development of asthma? What are the limitations of current treatment? Is prevention a realistic goal?

Registration and an evening reception will take place on Wednesday, October 8

Day 1 (October 9)

There will be two main sessions. The morning will focus on the epidemiology and natural history of asthma; the afternoon on immunopathology and genetics. Each session will have three guest lectures. Discussion and debate will form a major part of both sessions, and parallel poster sessions will be in progress throughout the conference. Selected posters will be presented and discussed during the sessions. The second session will end with the Chairperson's plenary lecture.

The conference dinner will take place in the evening of day 1.

Day 2 (October 10)

The day will have the same format as day 1, with sessions on environmental factors and prevention. An invited speaker will give a final overview of the conference. An investigator prize will be awarded for the best poster presentation.

Written overviews related to the topics of the four sessions will be circulated shortly before the conference to registered delegates, and will subsequently be published as a supplement to The Lancet.

Chair: Prof Anne Tattersfield Nottingham, UK

We invite abstracts on the following topics: Epidemiology; pathogenesis; treatment; and prevention.

Accepted abstracts should be prepared as poster presentations, to be displayed throughout the meeting. The Editor and selection committee will select certain posters for short oral presentation.

Deadline : Abstract forms must reach the London or New York office by June 2, 1997. Those received after that date will not be considered. Please do not send submissions by fax or e-mail.

Abstract forms (for posters only) are available from:

The Editor (Lancet Asthma Conference), The Lancet, 42 Bedford Square, London WC1B 3SL, UK
Tel +++ (0) 171 **436 4981** Fax +++ (0) 171 **436 7550** **e-mail: a.dillon@elsevier.co.uk**

The Editor (Lancet Asthma Conference), The Lancet, 245 West 17th Street, New York, NY 10011, USA
Tel 212 **633 3800** Fax 212 633 3850

LETTERS TO THE EDITOR

Lung transplantation in patients with cystic fibrosis

We read with interest the paper by Ryan *et al* (March 1996;51:302–5) describing their experience of pulmonary transplantation in patients referred from a single cystic fibrosis centre. We thought it would be useful to present similar data from a lung transplant centre serving several cystic fibrosis centres.

The Freeman Hospital Cardiopulmonary Transplantation Unit regularly assesses patients from six cystic fibrosis centres in the UK. To date we have assessed 137 patients on site, of whom only 12 have been considered unsuitable for transplantation. Of the 125 patients accepted, 36 have undergone pulmonary transplantation, 22 remain alive with an actuarial survival of 66% at two years and 38 have died awaiting transplantation. Fifty one patients are currently awaiting transplantation with 22 on the active list and 29 on the provisional list.

Our policy is to liaise closely with referring centres and review patients when the FEV_1 falls below 30% predicted, when there is evidence of unusually rapid and progressive fall in FEV_1, or when there is an increasing need for admission to hospital. Patients are placed on the provisional list when judged suitable for transplantation but are either too well or have correctable relative contraindications.

Shortage of donor organs continues to represent the major obstacle and cause of death associated with transplantation. The median wait from acceptance to transplantation is 242 days and our experience in cystic fibrosis is that, when actively listed, approximately 50% of patients will die before surgery.

We endorse the view that it is important to discuss with potential recipients their chances of receiving lung transplantation as well as the results of this procedure.

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Chronic hypoxia and pulmonary rehabilitation

We read with interest the editorial by Dr Wijkstra on pulmonary rehabilitation in the home (February 1966;51:117–18). We agree that accurate hospital assessment and selection of the patient with COPD is essential before enrolment into a pulmonary rehabilitation programme, whether performed as an inpatient, outpatient, or mainly in the home. However, Dr Wijkstra also suggests that patients with exercise hypoxaemia should be excluded from home programmes, which will include patients with more advanced COPD.

Few studies have investigated the effects of pulmonary rehabilitation in patients with severe COPD. In a recent controlled study of rehabilitation reported by Goldstein and colleagues[1] patients with a forced expiratory volume in one second (FEV_1) of less than 40% predicted were selected and showed improvements in exercise tolerance and quality of life after rehabilitation. Oxygen prescription during exercise was adjusted to maintain arterial oxygen saturation at 85–90% and rehabilitation continued at home after the initial inpatient programme. In a retrospective study patients with a mean FEV_1 of 20% predicted with severe hypercapnia ($Paco_2$ >7.2 kPa) showed increases in exercise capacity after physical training.[2]

Patients with more severe COPD have a greater impairment of quality of life related to the severity of their hypoxaemia,[3] and considerable anxiety and depression which further impairs activities of daily living. This patient group may be particularly suitable for home pulmonary rehabilitation programmes, although outcome measures may differ in view of the greater degree of disability present. Ambulatory oxygen devices are widely available to correct hypoxaemia during physical training and we have used these in the home without complications. More controlled studies are required to assess selection, effectiveness, safety, and costs of rehabilitation in patients with advanced COPD.

1 Goldstein RS, Gort EH, Stubbing D, Avendano MA, Guyatt GH. Randomised controlled trial of pulmonary rehabilitation. *Lancet* 1994;**344**: 1394–7.
2 Foster S, Lopez D, Thomas HM. Pulmonary rehabilitation in COPD patients with elevated Pco_2. *Am Rev Respir* 1988;**138**:1519–23.
3 Okubadejo AA, Jones PW, Wedzicha JA. Quality of life in patients with COPD and severe hypoxaemia. *Thorax* 1995;**51**:44–7.

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BOOK REVIEW

Occupational Lung Diseases. WKC Morgan, A Seaton. (Pp 680; $89.50). Philadelphia: WB Saunders, 1995. 0-721-64671-9.

The first edition of this well regarded book was published in 1975 and the authors have revised the text each decade since. Although a number of other experts have contributed, the two authors have continued to be involved in writing most of the chapters which gives the book a refreshing fluency and continuity which is so often lacking in many modern day, multi-author, multi-volume texts.

The first third of the book concentrates on the history, epidemiology, physiology, and pathophysiology of occupational lung disease. These chapters are well written and provide first class instruction for those contemplating research into occupational lung disease. I particularly enjoyed Anthony Seaton's chapter on the history of occupational lung disease and Alan Gibbs' chapter on pathological reactions of the lung to dust. One minor criticism would be that the chapter on lung function is rather long and contains detailed information on pulmonary physiology readily available elsewhere.

The remainder of the book is dedicated to specific occupational lung diseases. Each chapter opens with an account of the history and a thorough review of the epidemiology before moving on to clinical and pathological aspects of the condition. The disease coverage is comprehensive rather than encyclopaedic, but this has the advantage of producing a book which is not too weighty, and which can equally be read in the library or used in the field.

For me, however, the real strength of this book is its ability to stimulate interest in, and then guide, research into occupational lung disease. This is an excellent text and is recommended. – RH

NOTICE

Pharmacology of Asthma

A course on the Pharmacology of Asthma organised by Professor Peter Barnes will be held at Imperial College School of Medicine at the National Heart and Lung Institute in collaboration with the Royal Brompton Hospital, Dovehouse Street, London SW3 6LY on 25–28 November 1996. For further details please contact the Postgraduate Education Centre, National Heart and Lung Institute, Dovehouse Street, London SW3 6LY, UK. Telephone: 0171 351 8172. Fax: 0171 376 3442.

CORRECTION

Home assessment of peak inspiratory flow through the Turbohaler in asthmatic patients

In the paper entitled "Home assessment of peak inspiratory flow through the Turbohaler in asthmatic patients" by R J Meijer *et al* which appeared on pages 433–4 of the April issue there was a typographical error in the labelling on the X axis of figure 2. A correct version of the figure is reproduced below.

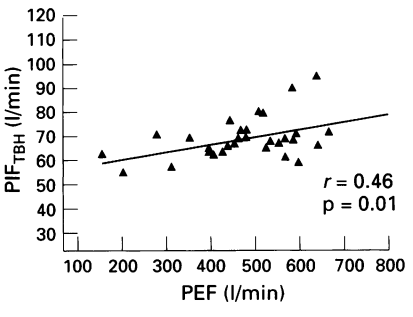

Figure 2 Correlation between peak inspiratory flow through the Turbohaler (PIF_{TBH}) and peak expiratory flow (PEF) at home. Data points are shown as individual means.