"typical" of usual interstitial pneumonia according to a more recent classification.[2] Other studies had shown a high prevalence of FA, even in recent onset RA.[3]

We have recently investigated the presence of pulmonary disease in 24 consecutive patients with RA without respiratory symptoms or signs and a normal chest radiograph. In all these patients we performed a chest HRCT scan as well as complete pulmonary function tests (PFTs). Our patients were predominantly women (22/24), of mean age 49.4 years (range 26–72), and 46% of them had a disease duration of less than 2 years. Only 33.3% were current smokers. We found TLCO of <75% in 50% of the patients; two patients had obstructive PFT and one patient restrictive PFT. Pleuropulmonary alterations were detected in 20.8% of the patients on the HRCT scan, but only one patient had an HRCT pattern suggestive of FA according to stringent criteria.[2] In all the other patients the alterations observed were mild and non-specific (pleural abnormalities, septal and non-septal lines, micronodules). Our data confirm a rather high prevalence of pleuropulmonary alterations in patients with RA, even in the absence of respiratory symptoms. However, we found evidence of FA much less frequently than Dawson *et al*.[1] This difference may only be partly explained by patient selection: not all our patients had respiratory symptoms and almost half of them had RA of short duration. The newly available diagnostic techniques such as HRCT scanning have increased interest in evaluating patients with connective tissue diseases. However, the clinical relevance of the frequently observed pulmonary alterations in patients with RA has still to be elucidated, as well as the best diagnostic approach to respiratory involvement in this multifaceted disease.

G Provenzano
Division of Respiratory Diseases, A.O. "Villa Sofia CTO", 90143 Palermo, Italy; giuseppe.provenzano5@tin.it

References

1 **Dawson JK**, Fewins HE, Desmond J, *et al.* Fibrosing alveolitis in patients with rheumatoid arthritis as assessed by high resolution computed tomography, chest radiography, and pulmonary function tests. *Thorax* 2001;**56**:622–7.
2 **Katzenstein AA**, Myers L. Idiopathic pulmonary fibrosis: clinical relevance of pathologic classification. *Am J Respir Crit Care Med* 1998;**157**:1301–15.
3 **Gabbay E**, Tarala R, Will R, *et al. Am J Respir Crit Care Med* 1997;**156**:528–35.

CD-ROM REVIEW

Paediatric Respiratory Examination

C O'Callaghan, W Stannard. Leicester, UK: OCB Media, 2001, £49.95 (students £25.00). ISBN 190403906

This CD-Rom has been produced as a multimedia based interactive learning tool for a wide spectrum of healthcare professionals including general practitioners, junior doctors, nurses, physiotherapists, and medical students. As such, it will find wide appeal to those who wish to learn or brush up on paediatric respiratory examinations.

The authors and designers should be congratulated for producing a CD-Rom which is highly intuitive and easy to navigate. The pictures, videos and case studies are of high quality and can be viewed with an informative running commentary, although unfortunately the commentaries cannot be fast forwarded or rewound to find passages of particular interest. The case studies provide excellent examples of classic paediatric auscultatory findings such as wheeze, stridor, and the fine inspiratory crepitations of bronchiolitis.

The *Paediatric Respiratory Examination* CD-Rom serves as a good template on which other system examination CD-Roms could be designed.

K Tan

NOTICE

Scadding-Morriston Davies Joint Fellowship in Respiratory Medicine 2002

This fellowship is available to support visits to medical centres in the UK or abroad for the purpose of undertaking studies related to respiratory medicine. Applications are invited from medical graduates practising in the UK, including consultants and irrespective of the number of years in that grade. **There is no application form**, but a curriculum vitae should be submitted together with a detailed account of the duration and nature of the work and the centres to be visited, confirming that these have agreed to provide the facilities required. Please state the sum of money needed for travel and subsistence. A sum of up to £15 000 can be awarded to the successful candidate, or the sum may be divided to support two or more applications. Applications should be sent to Dr I A Campbell, Secretary to the Scadding-Morriston Davies Fellowship, Llandough Hospital, Penarth, Vale of Glamorgan CF64 2XX, UK by **31 January 2002**.

CORRECTION

In the article entitled "Influence of age and disease severity on high resolution CT lung densitometry in asthma" by F Mitsunobu *et al* which appeared in the November 2001 issue of *Thorax* (2001;**56**:851–6), an error occurred in table 3 on page 854. The heading to the first column which appeared as "MLD (HU) (R^2 = 0.0524)" should read "MLD (HU) (R^2 = **0.524**)".