

nancies which have not been diagnosed by these relatively simple techniques.²

In such instances our next step would be thoracoscopy, a procedure which is done under general anesthesia but which results in little risk or discomfort for the patient.³ We use a double-lumen endotracheal tube for administering anesthesia in order to allow for collapse of the lung on the involved side thereby enabling the surgeon to get a thorough look at the pleural cavity. Biopsy is then performed under direct vision, and with safety. Using this technique we have been able to diagnose accurately all pleural effusions due to carcinoma in which pleural fluid cytology and pleural biopsy have been negative.

In some cases of nonmalignant pleural disease, and especially in patients with malignant mesothelioma, open pleural biopsy through a limited thoracotomy incision has been necessary to establish the diagnosis. The diagnosis of malignant mesothelioma is occasionally very difficult to establish short of providing the pathologist with a generous pleural biopsy specimen. When either of these techniques is used tetracycline can be instilled into the pleural cavity at the time of the procedure when the diagnosis of malignancy has been established thereby saving the patient the discomfort of this instillation at a different time.

Dr. Sahn is well-known for his expertise in pleural physiology and his article in the August issue is an excellent one. I mention these two invasive procedures only for the sake of completeness because I believe, as I am certain Dr. Sahn does, that the cause of a pleural effusion should be established with certainty whenever possible.

JAMES B. D. MARK, MD
Professor and Head
Division of Thoracic Surgery
Department of Surgery
Stanford University School of Medicine
Stanford, California

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AMA and a National Health Policy

TO THE EDITOR: I enjoyed reading your editorial¹ in the August 1982 issue about the project "Health Policy Agenda for the American People." As Chairman of the Steering Committee of this AMA-initiated project, I am pleased with the number of

articles and letters supporting the Health Policy Agenda.

However, there is one item in the editorial that I wish to correct. After the draft proposal was presented to the AMA House of Delegates in June 1982, the Steering Committee approved the addition of representatives from the Department of Health and Human Services, the Department of Defense and the Veterans Administration on the Steering Committee and on certain work groups. The National Conference of State Legislatures and the National Governors' Association are represented on the Advisory Committee.

Your editorial was excellent and thank you again for the support of this important project.

JOSEPH F. BOYLE, MD
Los Angeles
Chairman
Health Policy Agenda Steering Committee

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Ascaris Infection in Washington State

TO THE EDITOR: Pig manure, used as a fertilizer for vegetable gardens, is becoming increasingly popular among organic gardeners in Washington state. This popularity has resulted in large part from the increased price and decreased availability of cow manure. However, recent reports of *Ascaris* transmission from pigs to humans suggest that this practice may increase the risk of *Ascaris* infection.^{1,2} To investigate the association of exposure to pigs or pig manure with infection, a survey of Washington state residents with laboratory confirmed *Ascaris* infection was conducted.

Over an 18-month period from January 1981 through June 1982, there were 328 cases of *Ascaris* infection identified by the Washington State Public Health Laboratory. Of these, 71 percent occurred either in Asian refugees or other recently arrived aliens, 22 percent in migrant farm workers and 8 percent (25 people) in US citizens who were not farm workers.

The survey was limited to 23 people who were US citizens and had resided in Washington state for one year before diagnosis. Of the 23 people, 18 reported extended exposure to pigs (pigs, pig manure or old pig sties). Five of the people reported out-of-state travel; however, three of these also reported exposure to pigs in Washington state. One of the five traveled to Central America. There were 14 of the 23 people (61 percent) under 4

years of age. Eighteen controls were matched to cases on the basis of age, sex and county of residence. Controls were selected from *Ascaris*-negative people routinely interviewed for *Giardia* or *Campylobacter* infection. None of the controls reported exposure to pigs or pig manure.

Although *Ascaris* infections are usually asymptomatic, complications such as pneumonia or intestinal obstruction can occur. Since *Ascaris* occurs commonly in pigs, people who have pigs or who use pig manure should take precautions to avoid infection. Exposure to pigs should also be considered where other likely sources of *Ascaris* infection cannot be found.

PHYLLIS SHOEMAKER-NAWAS, BA
FLOYD FROST, PhD
JOHN KOBAYASHI, MD, MPH
*State Epidemiologist
State of Washington
Department of Social and Health Services
Seattle*
PHILLIP JONES, MD, MPH
*District Health Officer
Whatcom County Health Department
Bellingham, Washington*

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Usefulness of IDA Scanning

TO THE EDITOR: As a surgeon, I must agree with Krishnamurthy¹ (in the August 1982 issue) that IDA scans are a useful adjunct in the evaluation of patients with right upper quadrant pain. However, one must avoid a tautological trap in assuming that abnormal scan findings equal acute cholecystitis. The latter must be differentiated from such varied entities as perforated ulcers, leaking aortic aneurysms, pleurisy and myocardial infarctions.² Coexistent cystic duct obstruction has been found with these and many other disorders.

The accuracy and inaccuracy of IDA scanning, especially in chronic cystic duct obstruction, has been documented.^{3,4} Although Dr. Krishnamurthy has attempted to display the relative effectiveness of IDA scanning over other noninvasive methods by bayesian analysis, his data and the clinical condition of his patients have not been presented. Since acute cholecystitis is ultimately a pathological diagnosis, which of these patients came to laparotomy? On what basis are false negatives determined if no laparotomy has been carried out?

Although IDA scans provide timely evidence for pathological cystic duct obstruction, not every patient with this condition should undergo im-

mediate cholecystectomy; the dangerous period for increased operative risk in delayed cholecystectomy occurs days, not hours, after the onset of symptoms.⁵⁻⁹ IDA scans do not obviate a careful evaluation of the patient with right upper quadrant pain, nor should they be used as a rationale for rushing an ill-prepared patient to surgery.

JEFFREY L. KAUFMAN, MD
*Assistant Professor of Surgery
UMDNJ—Rutgers Medical School
Piscataway, New Jersey*

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Nuclear Armaments

TO THE EDITOR: The physicians' movement against nuclear weapons has based many of its activities and arguments on a preventive medicine model. It is said that nuclear war is a disease for which there is no cure and therefore the appropriate role of the medical profession is in prevention. This analogy supports the high level of activity on the part of physicians in efforts towards nuclear disarmament. Objectors to this stance generally take exception to either the notion of nuclear war as a medical problem or of medical care as a political activity. Arguments countering these objections are supported by examples from the history and current activities of the field of public health and of clinical preventive medicine.¹

An article in the August 1982 issue of *THE WESTERN JOURNAL OF MEDICINE* brought yet another example to mind. Chang and Levy² describe the significant problem of infant passenger trauma in automobiles, and bemoan the fact that so few parents are made aware of the need for restraining infants in special seats during automobile travel. They conclude that (1) the morbidity and mortality of injuries to infants in automobiles justifies an active concern on the part of physicians and (2) that the two activities most likely to be successful are direct education of