

air-purifying respirators is that they do not provide a strain on an individual's respiratory system.

It should be noted that a study has reported a significant reduction in the number of infected health care workers in intensive care wards when ventilation rates were increased, even when these workers did not use "adequate" respiratory protection.¹⁵ These results suggest that amount of ventilation in a setting is also important in the occupational transmission of SARS CoV.¹⁵ This finding suggests not only that multiple factors are involved in the prevention of infectious disease among health care professionals, but also that the SARS CoV can be transmitted by an aerosol route in an occupational setting.

Regardless of the type of respirator employed, it is necessary that appropriate fit-testing be conducted and that respirator use be at a 100% level when managing potential cases of SARS.^{4,12} In general, commercially available non-elastomeric respirators cannot be efficiently fit-tested, because they do not provide the face seal that is required to protect against such a highly infective virus.

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References

1. Draft: Public health guidance for community-level preparedness and response to severe acute respiratory syndrome (SARS). Centers for Disease Control and Prevention website: <http://www.cdc.gov/ncidod/sars/sarsprepplan.htm>. Accessed 17 December 2003.
2. Wong RS. Severe acute respiratory syndrome in a doctor working at the Prince of Wales Hospital. *Hong Kong Med J* 2003;9:202-5.
3. Wong CY. Severe acute respiratory syndrome and biology, air quality, physics, and mechanical engineering. *Hong Kong Med J* 2003;9:304-5.
4. Lange JH. SARS respiratory protection [Letter]. *CMAJ* 2003;169:541-2.
5. Nevalainen A, Willeke K, Liebhäber F, Pastuszka J, Burge H, Hennington E. Bioaerosol sampling. In: Willeke K, Baron PA, editors. *Aerosol measurements: principles, techniques and applications*. New York: Van Nostrand Reinhold; 1993:471-92.
6. Singh K, Hsu LY, Villacian JS, Habib A, Fisher D, Tambyah PA. Severe acute respiratory syndrome: lessons from Singapore. *Emerg Infect Dis* 2003;9:1294-8.
7. First data on stability and resistance of SARS coronavirus compiled by members of the World Health Organization (WHO) laboratory network. WHO website: www.who.int/csr/sars/survival_2003_05_04/en/. Accessed 15 Nov 2003.
8. Seto WH, Tsang D, Yung RW, et al. Effectiveness of precautions against droplets and contact in prevention of nosocomial transmission of severe acute respiratory syndrome (SARS). *Lancet* 2003;361:1519-20.
9. Ho AS, Sung JJ, Chan-Yeung M. An outbreak of severe acute respiratory syndrome among hospital workers in a community hospital in Hong Kong. *Ann Intern Med* 2003;139:564-7.
10. Scales DC, Green K, Chan AK, et al. Illness in intensive care staff after brief exposure to severe acute respiratory syndrome. *Emerg Infect Dis* 2003;9:1205-10.
11. Tsui PT, Kwok ML, Yuen H, Lai ST. Severe acute respiratory syndrome: clinical outcome and prognostic correlates. *Emerg Infect Dis* 2003;9:1064-9.
12. Lange JH. The best protection [Letter]. *CMAJ* 2003;168:1524.
13. Hsueh PR, Hsiao CH, Yeh SH, et al. Microbiologic characteristics, serologic responses, and clinical manifestations in severe acute respiratory syndrome, Taiwan. *Emerg Infect Dis* 2003;9:1163-7.
14. Oh VM, Lim TK. Singapore's experience of SARS. *Clin Med* 2003;3:448-51.
15. Jiang S, Huang L, Chen X, et al. Ventilation of wards and nosocomial outbreak of severe acute respiratory syndrome among healthcare workers. *Chin Med J (Engl)* 2003;116:1293-7.

Wrong emphasis in case report on cholestatic jaundice

To the Editor—I am concerned by the emphasis placed in the case report titled "Cholestatic jaundice caused by sequential carbimazole and propylthiouracil treatment for thyrotoxicosis" that was published recently by Chan et al in the Journal.¹ According to the report, "extreme caution should be taken when a patient develops hepatotoxicity in response to one type of antithyroidal agent, because cross-reactivity may develop in response to a second type of antithyroid drug". From the description of the case, the patient was treated for only 2 weeks when he developed pruritus to carbimazole. Treatment was changed to propylthiouracil and jaundice developed again, only 2 weeks after starting treatment. These intervals were very short and therefore unlikely to be avoided by any changes in the frequency or monitoring currently practised. It is usual practice that all new patients are treated and followed up at 2- to 4-weekly intervals. A single case report as such is unlikely to change our prescribing habits of starting carbimazole therapy and changing to propylthiouracil if any side-effects occur with the former drug.

In my view, the real emphasis of the case should be in the caution that we must exert in the use of steroid treatment for conditions of which the pathogenesis is uncertain. In this case, steroids were used as a sort of last-stage attempt. Indeed, the patient's subsequent course of fulminant pneumonitis can be attributed to steroid use, and it is fair to say the patient died of complications of steroid treatment. The patient did not die because of antithyroid treatment.

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Reference

1. Chan AO, Ng IO, Lam CM, Shek TW, Lai CL. Cholestatic jaundice caused by sequential carbimazole and propylthiouracil treatment for thyrotoxicosis. *Hong Kong Med J* 2003;9:377-80.