Editor's preface

Français à la page suivante

The misery of seasonal allergies was first described in 1565 by the Italian anatomist Leonardo Botallo, physician to the rich and powerful and to an unfortunate person who could not tolerate roses. This "rose fever" was described in 19th-century England as "summer catarrh," and culprits ranging from sunshine to ozone to grass pollen were suspected. In 1871 an asthmatic physician, Charles Blackley, gave credibility to the pollen theory when a self-administered skin test elicited a strong reaction. By trapping airborne pollen on kites flown at 500 m he demonstrated how far-ranging the allergen can be. He advised evasive action: spend the summer on a yacht.[1]

A more feasible approach is to relieve the symptoms of hay fever with medication. Given the wide range of prescription and over-the-counter remedies available, how should physicians approach first-line treatment? In this issue (page 1123) Elizabeth Juniper and colleagues report on their randomized management study of terfenadine, a nonsedating antihistamine, and fluticasone, a nasally administered topical steroid. They found no significant difference in benefit between starting treatment with terfenadine and adding fluticasone as required, and starting with fluticasone and adding terfenadine as required. Samuel Freedman (page 1141) responds to these findings by noting the recent move by the US Food and Drug Administration to withdraw approval for terfenadine (because of its rare but life-threatening cardiotoxic effects). He suggests starting therapy with drugs that are safer than terfenadine and cheaper than both terfenadine and fluticasone.

Aboriginal people in Canada are 3 to 4 times more likely to commit suicide than nonaboriginal people. Brian Malchy and colleagues (page 1133) report that from 1988 to 1994 suicide rates in Manitoba were almost 7 times higher among aboriginal adolescents than among nonaboriginal adolescents, and that there were striking differences between these groups in help-seeking behaviour. Their study represents an important first step in addressing a serious public health problem.

Many of us in this country have wood-burning stoves. Although their most evident hazard is accidental fire, using these stoves to burn inappropriate materials can also have devastating results. David Janigan and colleagues (page 1171) describe the case of a man who had been renovating his family room and decided to burn scrap building materials in his wood-burning stove. Within hours he was taken to hospital with bronchiolitis obliterans. The authors review the toxicity of combusted building materials and point out that the presence of life-threatening fumes is not always signalled by smoke. James Hogg (page 1147) reviews the pathology of bronchiolitis obliterans and provides us with stunning photomicrographs. — JH

Reference

1. Walton J, Barondess JA, Lock S, editors. *Oxford medical companion*. Oxford (UK): Oxford University Press; 1994.