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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Saving asthmatics

SIR,—Your leading article on saving asthmatics (9 June, p 1520) raises many important points, but places insufficient emphasis on certain measures which are vital to survival in a crisis.

It is stated, for example, that if deterioration occurs in spite of adequate treatment or patients fail to respond to their usual bronchodilators a short course of oral corticosteroids *may* (my italics) be required; but such treatment is in fact mandatory if unnecessary deaths are to be prevented. There is also no mention of oxygen in the treatment of an acute attack despite the accepted fact that such patients are hypoxaemic, that hypoxaemia is aggravated by bronchodilators, and that when death occurs it is due to hypoxic cardiac arrest. Perhaps the reason for this omission is that the article refers only to treatment in the home, but hypoxaemia is just as dangerous there as it is in hospital. There is no reason why general practitioners should not carry portable refillable oxygen cylinders in their cars, and administer oxygen before and after they give injections of powerful bronchodilator drugs to patients with severe attacks of asthma.

Useful as peak flow meters are in the management of bronchial asthma, it is simplistic to suggest that occasional spot measurements of peak expiratory flow rate at routine clinic or surgery attendances will detect early deterioration in more than a small minority of instances. Most patients are well aware when their asthma is getting seriously out of control; their real problem is how to obtain effective treatment quickly enough—particularly if they are subject to fulminating attacks, for which immediate admission to a hospital with facilities for respiratory intensive therapy is imperative. The solution of this problem was the prime objective of the Edinburgh emergency asthma admission service,[1] which has now been operating successfully for the past 10 years. Other workers[2 3] have acknowledged that this type of service can save many lives, and it is strange that such an obvious method of "saving asthmatics" should have received such lukewarm support in your leading article. Perhaps the failure of respiratory physicians to organise a self-admission policy is partly responsible for the "depressing reality" of the unchanged asthma mortality statistics, despite the major therapeutic advances which have dramatically reduced the morbidity of the disease.

Modern resuscitative measures are now so effective that very few patients die from asthma if they reach hospital alive. Although it would be interesting, as your leading article proposes, to discover why young people die from asthma, it would be more sensible to adopt a procedure for expediting their admission to hospital, and then to inquire into the reasons why they might otherwise not have survived.

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[1] Crompton, G K, and Grant, I W B, *British Medical Journal*, 1975, **4**, 680.
[2] Macdonald, J B, Seaton, A, and Williams, D A, *British Medical Journal*, 1976, **1**, 1493.
[3] Macdonald, J B, *et al*, *British Medical Journal*, 1976, **2**, 721.

SIR,—Fifteen years' experience in the care of the adult asthmatic[1] supports two of the principles underlying good control of asthma stated in your leading article (9 June, p 1520), but contradicts the recommendation given for treating acute severe asthma. Our studies of the natural history of 65 acute severe attacks showed that their state evolved over days or weeks.[2] This meant that for subsequent patients there was plenty of time to alter treatment at home or in a clinic, and this prevented the development of the severe, life-threatening grades of asthma.

While agreeing that good control requires "education of patients; careful supervision; and prompt recognition and treatment of deterioration," I regard the first of these principles, education of patients, to be of paramount importance. Frequent outpatient supervision of the 1 500 000 adult asthmatics in the United Kingdom is an impractical proposition.[3] Experience with 300 asthmatics over nine years showed that "the great majority of asthmatics could be taught how to recognise worsening of their asthma and to communicate with a doctor, who then altered the treatment."[2] An essential feature of our service is that the patients had at all times easy access to a doctor with appropriate knowledge and attitudes. As a result of this organisation only one of our registered patients died from asthma and this was due to failure to comply.

The leading article states that "before sending the patient to hospital the doctor should give an intravenous injection of 300 mg of hydrocortisone and an intravenous injection of 250 mg of aminophylline, both injections given slowly." This contradicts our practice, which is to give a steroid when this is indicated. I have defined criteria for using steroids in acute asthma and the results to date show that one-third of the patients recover without the need for a steroid. This study should help to rationalise this aspect of the total care.

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[1] Jones, E S, *Proceedings of the Royal Society of Medicine*, 1971, **64**, 1151.
[2] Davis, B, Gett, P M, and Jones, E S, *Thorax*, in press.
[3] Clark, T J H, and Godfrey, S (editors), *Asthma*. London, Chapman and Hall, 1977.

SIR,—The leading article "Saving asthmatics" (9 June, p 1520) rightly draws attention to the failure over the last 30 years to improve survival in acute attacks. Among suggestions