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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

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.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Is bran useful in diverticular disease?

SIR,—Discussing your subject for debate "Is bran useful in diverticular disease?" (5 December, p 1523), Dr K W Heaton writes, "A problem with all controlled trials of bran is that the use of a standardised dose ignores the pronounced variability in people's response to bran and prevents the investigator from treating each patient as an individual, which is how he is treated in clinical practice."

It is nearly 30 years[1] since I maintained that statistically there is no reason against a trial with a variable dose. One merely changes the question asked from (*a*) "What is the upshot if some fixed dose of a drug (or foodstuff) is given uniformly to all patients?" to (*b*) "What is the upshot if clinicians in charge of patients give such varying amounts as seem, in their judgment, to be advisable?" In both cases the results in the *group as a whole* can be compared with those in a control group.

The only proviso, perhaps needful, is that one can certainly not subdivide the treated group to measure the effects of the different amounts, since those amounts have already been determined by the conditions and responses of the individual patients. That would be circular reasoning.

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[1] Hill AB. *N Engl J Med* 1952;**247**:113.

SIR,—Increasingly it becomes apparent that well-conducted clinical trials fail to provide the clinicians with clearcut answers which can be reproduced. The frustrations arising from the bluntness of this potentially most important research tool have been the subject of recent comment.[1-3] This difficulty has been highlighted again by the recent contradictory papers on the treatment of diverticular disease with bran. In his analysis of this problem Dr K W Heaton (5 December, p 1523) draws attention to the need for different series to relate to patients with similar degree of clinical severity.

I believe that this is an important general point and that clinical trials should relate to patients where further therapeutic help is really needed and exclude those whose symptoms settle spontaneously with non-specific care. It is these quick responders who can blur the difference between controls and those receiving the treatment under study. This point was appreciated by Sir Richard Doll[4] in his early classic studies on the factors influencing the rate of healing of gastric ulcer. He excluded the rapid healers by a second *x*-ray examination two weeks after the first one; and the remainder, where further help was really needed, were admitted into his series. The failure of so many later trials to follow this example I believe explains the difficulty of interpreting the significance of many peptic ulcer studies.

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[1] Sherry S. *Eur J Clin Pharmacol* 1980;**17**:79-80.
[2] Ritter JM. *Lancet* 1980;i:1126-27.
[3] Sancho, H, Hayat M. *Biomedicine* 1973;**18**:173-6.
[4] Doll R. *Scot Med J* 1964;**9**:183-96.

Misplaced confidence in nebulised bronchodilators in severe asthmatic attacks

SIR,—Dr A E Gale (14 November, p 1336) has described a hand-operated pump for nebulising a bronchodilator, which asthmatic patients can use if they have to travel long distances from home. Although his letter made no reference to death, the use of the running heading for this correspondence ("Deaths from asthma on holiday") might seem to imply that a nebulised bronchodilator is the most effective form of treatment in severe or life-threatening attacks. This is a misconception which it is essential to correct, particularly since an increasing number of general practitioners are considering the purchase of a compressor.

There is no doubt about the value of nebulised bronchodilators for treating mild attacks in young children[1 2] since the only form of bronchodilator which they may have taken already is tablets or syrup. Older children and adults, on the other hand, will almost invariably have taken a bronchodilator aerosol: provided that this has been taken correctly, it is difficult to understand why nebulising the same or another bronchodilator should be much more