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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 should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

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.

Death from asthma in two regions of England

SIR,—This latest retrospective survey of the circumstances surrounding deaths from asthma (30 October, p 1251) follows many similar surveys conducted during the last 20 years.[1–4] It is distressing to note how similar the conclusions remain in the context of the continuing high mortality from this eminently treatable condition. Non-fatal cases of acute severe asthma are, of course, much more common than fatal cases, and one of the problems with this type of retrospective survey is that we learn nothing about the management of the whole spectrum of severe cases. Some data are available from Edinburgh,[5] but they are not necessarily typical since they come from an area that already operates a special admission service. We have accumulated data in the Oxford area by looking at cases managed outside hospital as well as those managed in hospital. Ours was a prospective survey in which there were no fatalities; it is described fully elsewhere.[6–8]

Most of the factors found to be associated with death by the British Thoracic Association were equally common in our group of patients with non-fatal acute severe asthma. We also found that many attacks had a rapid speed of onset.[6] Patients tended to have a history of frequent previous severe episodes and to be poorly supervised. In addition, they were inadequately treated before the index attack, adjusted their treatment inappropriately during the attack, and received treatment from their general practitioner which was less satisfactory than standard recommendations.[8] Encouraging findings in our study were the speed with which the general practitioners responded to the emergency calls and the infrequent use of sedative drugs. We suspect that the inadequate management described in this latest series of deaths from asthma is not confined to the few fatal cases but is widespread.

In our study general practitioners saw patients infrequently,[7] perhaps not often enough to maintain a high level of expertise. Given the increasing rate of self referrals to hospital[7 9] we believe that there is sufficient evidence to justify a shift of the primary care role towards hospital by the provision of emergency direct admission services even though this might be opposed by some general practitioners.[10] If all of the most severe cases are to be seen in hospital then the number of admissions could increase threefold,[7] thus necessitating more facilities. Few centres seem to be initiating this service—perhaps another example of the failure of the National Health Service in the present adverse economic climate.

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SIR,—The British Thoracic Association's article on deaths from asthma in two regions of England (30 October, p 1251) states that