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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 should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. 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.

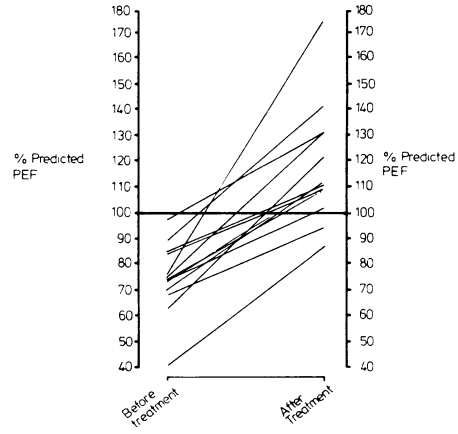
Management of asthma in general practice

SIR,—Retrospective inquiries into deaths from asthma during the "epidemic" in the 1960s disclosed many instances in which general practitioners had failed to recognise the severity of the terminal episodes.[1 2] The findings of a more recent study of asthma deaths[3] suggest that there is still a tendency for general practitioners to underestimate the severity of life threatening asthma and to give treatment which is inadequate or even inappropriate. This lends powerful support to those who believe that the present mortality cannot be reduced unless there is an extension of the policy whereby certain hospitals have provided open access for patients with acute asthma. Dr A G Arnold and Dr D J Lane (27 November 1982, p 1570) considered that a "shift of the primary care role towards hospital" was justified in the light of their findings from a prospective study of management of asthma in general practice.[4]

Present concern about standards of care of asthma in general practice is not restricted to the prevention of death. The greater than fivefold increase between 1970 and 1978 in children with acute asthma who were admitted to hospitals in the South West Thames Region without having been seen by their general practitioners[5] strongly suggests that the parents had less confidence in them than in hospitals. A survey in south east London reported that 46% of 9 year old children with wheeze were receiving no specific treatment,[6] while in Tyneside Dr A N P Speight and others (16 April, p 1253) found that 66% of children aged 7 years who had had episodes of wheeze in the previous year had never been prescribed a bronchodilator. These last authors considered that the failure to give specific treatment was clearly linked with an extreme reluctance of many general practitioners to label children as asthmatic. The preliminary findings of a study which we have recently carried out, however, indicate that undertreatment is also common in children in whom a diagnosis of asthma has been made.

We reviewed the case notes and interviewed the mothers of every child aged 7 to 15 years who was recorded as having asthma on the disease register of the Aldermoor health centre, a group practice on which this department is based. Evidence of undertreatment in the 51 children included a liability to asthma on running or playing games in 80%, disturbance of sleep by cough or wheeze in 28%, and considerable loss of time from school in 50%. We found the children's technique of inhaling cromoglycate and bronchodilators to be incorrect in 30%.

A detailed assessment of all the children was made at a time when their asthma seemed to be in remission. In 41% no previous measurement of peak expiratory flow rate had ever been made; furthermore, of the 12 children whose peak expiratory flow rate (after inhaling a bronchodilator aerosol) was less than 75% of predicted, a previous measurement had been made in only three. In 13 children the institution of treatment based on the findings at assessment led to a striking improvement in function (figure), accompanied by a greatly reduced intake of bronchodilators, the ability to play vigorous games, and undisturbed sleep. Many parents commented on an improvement in their children's general health and temperament. Four children were treated with cromoglycate aerosol, three with budesonide aerosol (a newly introduced topical corticosteroid), and six children received both, the aerosols being inhaled via a Nebuhaler aerochamber. Our experience of this device, which obviates the necessity for activating a pressurised canister synchronously with inspiration, leads us to believe that it is a major advance in treatment.



Peak expiratory flow rates before and after treatment.

Asthma is a pre-eminent example of a common but potentially serious disease, the management of which, with few exceptions, should be undertaken by general practitioners.[7] Yet it is undeniable that an onus now rests on general practitioners to show their competence to manage asthma effectively and safely, both over the long term and in acute attacks.

The findings of our study add further emphasis to the importance of assessment. It is almost 20 years since one of us[8] drew attention to the value of measuring peak expiratory flow rate in general practice, a message which has been repeated on many subsequent occasions.[7 9] Though many general practitioners now make regular use of peak