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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Primary pulmonary hypertension

SIR,—Dr Tim Higenbottam's leading article (6 December, p 1456) is an impressive account of state of the art scientific medicine. My practice has a patient who has received treatment for this condition and is now back in the community, complete with central venous line through which she is receiving prostacyclin. It has improved her quality of life, but my partners and I have had anguished discussions about the moral dilemmas raised by her case.

We are prescribing the prostacyclin Flolan (Wellcome), which costs £103 per ampoule (according to our local pharmacist), and she is receiving two ampoules every 12 hours. The cost to the community budget of improving this one patient's quality of life is therefore £150 000 a year, plus the cost of all the infusing equipment. This is double the average GP's expenditure on drugs for his or her entire list. I have telephoned my family practitioner committee and regional medical officer, who have informed me that I am perfectly free to prescribe this drug if I feel it is "clinically justified." Having been told by the hospital that she was being discharged to the community on this drug, how can her GP then refuse to prescribe it if he does not feel it to be clinically justified because of its great expense, and the lack of evidence that it will change the prognosis of the patient's condition?

It is clear that this form of treatment can be afforded. The question remains whether it should be afforded in a cost limited health service. Is this where the priority for limited funds should lie when renal physicians are being asked to select patients for dialysis because of limited resources?

ANONYMOUS

Asthma mortality: comparison between New Zealand and England

SIR,—It must have been tempting for Dr M R Sears and colleagues (22 November, p 1342), who have previously published a nationwide study of asthma deaths in New Zealand,[1] to compare their findings with those of a similar study conducted in two regions of England.[2] The comparison has, however, two major flaws.

Firstly, and common to both studies, the age group (15-64 years) studied is more liable to diagnostic error than, say, a 5-34 age group, since in older patients the cause of death may be chronic obstructive airways disease rather than asthma. That error may well have differed in size between the two studies and, if so, might have influenced the reported difference in "asthma mortality" (table I).

Secondly, the New Zealand study conducted from August 1981 to July 1983 was compared with one conducted in England two to three years previously. Apart from the inherent disadvantage of using what is in effect a historical control group, there is the more specific objection that a single radical difference between the two studies on therapeutic policy, such as the use of bronchodilator nebulisers in the home (common in New Zealand in 1981-3 but virtually non-existent in England in 1979), may have influenced other aspects of patient care. These could have included the prescription of other drugs, such as oral corticosteroids, the patient's perception of when it is essential to call a doctor, and perhaps even the general practitioner's perception of the need to respond immediately to such a call so that admission to hospital, if indicated, is not delayed.

No evidence is available to indicate whether the use of bronchodilator nebulisers in the home contributed to the recent increase in the number of deaths from asthma in New Zealand. To test such a hypothesis one would have to identify all patients for whom that treatment was available in 1981-3 (there were at least 6000 in 1982[3]) and compare their death rate with that of a group of matched controls, who might comprise, for example, patients whose asthma was severe enough to require nebulised bronchodilators in hospital or at a health centre but who did not subsequently acquire a nebuliser for domiciliary use. The collection of data for such a comparison would be formidable but not impossible. If the controls had a lower mortality that could incriminate nebulisers as a possible cause of death, whereas the opposite finding would suggest that they might help to prevent a fatal outcome. Without that type of information the comparison made in the article of the drug treatment given in the two studies is not particularly useful. I am equally unimpressed by the comparative assessments of patient compliance and "preventable deaths" between the two studies, since these rely on the insecure processes of memory recall and subjective judgment.

An earlier article from New Zealand[1] further illustrates the importance, when making comparisons with England and Wales, of excluding the Maori and Pacific Island Polynesian population from asthma mortality statistics. These two ethnic groups in the 1981-3 study accounted for 48% of the deaths from asthma in those aged 5-34, although they constituted only about 15% of the population. If the same is broadly true of earlier and later years the peak total death rate of 4·1 per 100 000 in 1979 would represent a death rate for caucasians of 2·4 (3·5 times the figure for England and Wales) and that of 2·2 in 1983 a caucasian death rate of 1·3 (only 1·5 times the figure for England and Wales). There are indications, as yet unconfirmed, of a further fall towards the 1985 English figure of 0·88 per 100 000 for the same age group.

Assuming that the pattern I have identified for the 5-34 age group is based on valid figures (and the authors will no doubt challenge me if they are wrong) the following conclusions emerge.

(1) In caucasians mortality from asthma increased from 1·3 times the figure for England and Wales in 1975 to 3·5 times in 1979. It fell back to 1·5 times the England and Wales figure by 1983 and may now be lower still.

(2) This, the second "epidemic" of asthma deaths in New Zealand, waxed and waned over about five years (1976 to 1981 or 1982), much as did the first epidemic between 1965 and 1970. Between the two epidemics the total death rate (including all ethnic groups) remained much higher in New Zealand than in England and Wales, but that could be explained by the very high mortality in Maoris and Pacific Island Polynesians (8·6 per 100 000 for the 5-34 age group in 1981-3, *v* 1·5 in caucasians).

(3) Two rises and falls in asthma mortality, each lasting about fives years, occurring over 20 years are unlikely to be caused by "natural" factors such as changes in the incidence or severity of asthma, in environmental allergen exposure, or in the prevalence of viral infections. Changes in patient care related to the introduction and supervision of new forms of drug treatment would seem to be of much greater relevance.