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SIR,—Dr Sheila Jennett omits an easily treated cause of snoring—myxoedema. Richard Asher wrote: "The onset of snoring in a hitherto silent sleeper is a little recognised symptom of myxoedema, and its disappearance after the administration of thyroid is gratifying not only to the patient (and to her husband) but serves to confirm the diagnosis."¹

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- 1 Asher R. In: Avery Jones F, ed. *Richard Asher talking sense*. London: Pitman Press, 1972:9.

Time to abolish cremation fees

SIR,—Dr S B Lucas and his colleagues (18 August, p 435) have clearly failed to understand the reasons for the difference between death certification and cremation certification. The purpose of the former is to provide epidemiological information about the cause of death. It is a gratuitous service provided by the doctor in attendance (undefined) on the deceased person during the last illness (also undefined). The doctor is required only to state the cause of death "to the best of his knowledge and belief." The body does not even have to be seen after death, and the certifying doctor is not legally required to notify the coroner if he notices anything suspicious. The death has to be registered by the "qualified informant" within five days, and it may be all of this time before the registrar (who is obliged to notify the coroner) becomes aware that there is no death certificate, or that the proffered certificate indicates that the coroner should be informed.

The cremation procedure, however, requires that the cause of death be "definitely ascertained" to ensure that those who require further investigations are not prematurely cremated—a process which destroys all evidence, with the possible exception of radioactive poison. Any proposal to abolish cremation certification without first of all introducing a radical improvement in death certification is irresponsible. The extent to which the position has been misunderstood by the authors is shown by their selection of deaths in the very young and very old as those in which cremation certificates can most justifiably be removed. It is the very young and the very old who are most susceptible to violent deaths and in whom the signs of violence may be the most difficult to detect.

The confirmatory cremation certificate (form C) requires the doctor to state whether or not a careful external examination of the body has been carried out. In alleging that no such examination is carried out, and that the form is completed "on a nod from the mortuary technician that all is well," the authors are accusing their colleagues of fraud. Whatever may be the position in their own hospital, there is no evidence that this is the case elsewhere, whether at other hospitals, or where the patient—as still occurs very frequently—dies at home.

The authors also complain that no advice is available on the taxation position when the

fees are remitted in whole or in part to other persons or organisations. The position is, of course, exactly the same as that with fees earned for any other service. The BMA has obtained a ruling from the Inland Revenue on such arrangements. In short, the ruling says that when a hospital doctor (assessed under schedule E (PAYE)) has made over cremation fees to a charity the doctor is assessable on any sums even if they are paid direct to the charity. The doctor will escape liability only if the fees are assigned in advance and paid direct to the medical charity. If this is done for up to six years payments of tax levied during the period on fees should be reclaimed. General practitioners (under schedule D) will have to enter into an irrevocable deed of covenant with the charities concerned. The period of the deed should exceed three years and the amount not exceed £5000 a year. This should put them effectively in the same position as doctors assessed under schedule E.

Finally, the authors claim that excessive fees are being charged by doctors for completing cremation certificates. This is the first time that I have heard this allegation, and it is very unlikely that more than a few doctors are charging more than the amount recommended by the BMA. The authors say they get their information from undertakers, whose views on cremation certification are well known, and they say that the amounts charged are unjustified. The fact is that over the past 30 years the fees for medical certificates have increased by less than the Retail Price Index.

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SIR,—Congratulations to Dr S B Lucas and colleagues on their letter urging the abolition of cremation fees. The whole business is sordid, demeaning, and unworthy and it shows the profession up in the worst possible light; reform is long overdue. We should be entitled only to expenses incurred by having to travel to view a body before signing the form.

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SIR,—Dr S B Lucas and his colleagues are utterly confused about cremation forms and fees. They seem to believe that the fees paid are too high, that no fees should be paid at all, and that form C should be abolished.

Firstly, the BMA recommended fee for signing form C is £16.80, not £33.60. The latter is the total fee for signing forms B and C, which is, of course, halved between the two doctors concerned. Only very rarely in my experience does the doctor ask for more than the recommended fees.

Secondly, the fee is payable simply because the doctor is being asked to do something for the patient (or his next of kin) which he desires but is not essential for his health, in just the same way as a fee for a private sick note is payable. Is there anything wrong in that?

Finally, it is desirable that two separate doctors who are not in partnership certify that the person is dead and the cause of death before cremation. Once cremated there can be no further chance of examining the body or its contents forensically. As a cremation referee I

know that occasionally the body has not been properly examined—and I make sure that this is rectified before I allow the cremation to proceed. That, after all, is one of my functions. No doubt there are one or two bad cremation referees who do not bother with this, but that does not negate the value of the system as a whole.

The present cremation system works, is a deterrent to crime, and should be left alone.

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Drugs for asthma in New Zealand, Australia, and the United Kingdom

SIR,—I cannot agree with Dr Gabrielle Keating and others (11 August, p 348) that the higher sales of drugs for asthma in New Zealand than in the United Kingdom and Australia represent overprescribing.

Before 1979 there was no significant difference between the percentage increases in sales of sympathomimetic aerosols and inhaled steroids between New Zealand and the UK. The appreciable rise in sales in New Zealand has occurred from 1980 onwards and probably reflects increasing awareness of the epidemic of fatal asthma, which began in 1975 and has appeared to level off since 1979. More worrying is the appreciable recent increase in sales of oral theophylline preparations, which have more serious toxic effects than other drugs commonly used in asthma prophylaxis,¹ are a known cause of hidden morbidity,² and pose a hazard if intravenous aminophylline is given for acute severe exacerbations of asthma.³

The drugs studied by Dr Keating and others are those commonly used in maintenance treatment of chronic asthma, and their use is unlikely to be relevant to asthma mortality. They specifically excluded from their analysis sales of nebuliser solutions of β_2 agonists, which, although a small portion of total drug sales, are in many centres the first line of treatment in acute severe asthma. Furthermore, overreliance on them in the absence of other treatment has been blamed for the epidemic of fatal asthma.⁴ It is unfortunate that oral or parenteral steroid prescriptions cannot be related to asthma as these drugs are essential in managing life threatening acute severe asthma.

The prevalence of asthma, at least in childhood, in New Zealand and in the UK is similar,^{5,6} but childhood asthma is grossly underdiagnosed in the UK, and even where the diagnosis has been established it is often undertreated.⁷ The higher sales of drugs for asthma in New Zealand may reflect what many of us are trying to achieve in the UK by good clinical practice. Overreaction to the findings of Dr Keating and others and fear of subtle adverse effects of drug treatment on asthma mortality may worsen the UK problem of undertreatment of asthma.

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- 1 Woodcock AA, Johnson MA, Geddes DM. Theophylline prescribing, serum concentrations, and toxicity. *Lancet* 1983;ii:610-3.
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- 4 Grant IWB. Asthma in New Zealand. *Br Med J* 1983;286:374-7.
- 5 Sears MR, Jones DT, Silva PA, Simpson A, Williams SM. Asthma in seven year old children: a report from the Dunedin multidisciplinary child development study. *NZ Med J* 1982;95:533-6.
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- 7 Speight ANP, Lee DA, Hey EN. Underdiagnosis and undertreatment of asthma in childhood. *Br Med J* 1983;286:1253-6.

Deaths from asthma

SIR,—We recently reported the seasonal variation and time trends in deaths from asthma in England and Wales and noted that the trend had increased in the later years of the study (1980-2) (28 July, p 233). Closer examination of the trend with the inclusion of the 1983 data (fig) indicates that the monthly mortality rate in the 5-34 year age group continued to rise and has doubled over the seven years 1977-83. The yearly mortality rate (table) does not show obvious predominance by any one five year age group.

Asthma mortality in those aged 5 to 34 in England and Wales from mid 1960 to mid 1983.

Many factors may have contributed to the trend. There may have been a true increase in the mortality with no change in the size of the asthmatic population. The increasing trend in childhood asthma admissions (28 July, p 235)¹ could, however, be a reflection of an increase in the asthmatic population. The change in International Classification of Diseases classification in 1978 may have increased the numbers of deaths classified as being due to asthma, but evidence indicates that this contribution is minimal in the 5-34 age group.¹

The rise in mortality in the 1960s occurred only in Australia, New Zealand, and England and Wales. Recently New Zealand reported a later appreciable increase starting around 1974, and it is likely that similar factors are involved in New Zealand and England and Wales. An examination of recent trends in drug sales does not support the hypothesis that the increase in

New Zealand is due to toxicity (11 August, p 348). But the increased sales of anti-asthma drugs in recent years may have created a greater reliance on available treatment and consequently encouraged inappropriate assessment and a reluctance to call for help.

This trend warrants urgent investigation. A national confidential inquiry into all deaths from asthma is long overdue and would be the most effective way of clarifying the factors involved.

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- 1 Jackson RT, Beaglehole R, Rea HH, Sutherland DC. Mortality from asthma: a new epidemic in New Zealand. *Br Med J* 1982;285:771-4.

SIR,—Dr A Khot and others (28 July, p 235) show an increase in admissions for childhood asthma from spring through to autumn. They note the surprising drop in admissions during August with the paradoxical increase in deaths from asthma during that month in the 5-14 year age group. They wonder what is happening in August and whether these findings are artefacts.

Certainly in the seaside areas we are seeing a great increase in asthma with a peak in August, and we suggest this is for the following reasons.

(1) The influence of the house dust mite in holiday accommodation. This accommodation is often uninhabited for most of the year, tends to be more cramped than the patient's home, and tends to have spare bedding (usually inferior) stored in various places. The concentration of house dust mites is greater in bedding that is little used.

(2) We believe that there is an emotional strain on the patient when he finds that he is becoming ill away from home and this may exacerbate his condition.

(3) Tourists often leave their regular drugs at home.

Whether there is a drop in admissions to hospitals serving the seaside areas in August we do not know, but one factor that may be operating in holiday compared with urban areas is that the first point of contact is more likely to be with the GP than with the casualty department.

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SIR,—Dr A Khot and Mr R Burn emphasise the need for epidemiological scrutiny of the seasonal variation and time trends of deaths from asthma (28 July, p 233). As they are

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R BURN

B WHYTE
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aware from communication with this unit, we published a similar analysis of deaths from asthma in the 5-34 age group during the years 1962-77 in England and Wales.¹

Further analysis showed a similar late summer increase in asthma deaths in all age groups, 5-34, 35-55, and 55 plus (figure). An

Deaths from asthma in England and Wales in those aged 5-34 (—), 35-54 (---), and 55 or over (· · ·) between 1960 and 1969 in January to March (top) and in July to September (bottom).

analysis of aerobiological challenge during these years showed no link with pollen but a striking association with raised hyaline ascospore concentrations in these months. These spores are found in abundance in the late summer, derive from the largest class of fungi—the Ascomycetes, and reached concentrations in Cardiff of over 9000/m³ of air. It is unfortunate that these spores are so difficult to study but it is known that they produce asthma when given as a challenge.²

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- 1 Jenkins PF, Mullins J, Davies BH, Williams DA. The possible role of aeroallergens in the epidemic of asthma deaths. *Clin Allergy* 1980;11:611-20.
- 2 Herxheimer H, Hyde JA, Williams DA. Allergic asthma caused by fungal spores. *Lancet* 1966;i:572-3.

SIR,—It was disappointing to note that the original message from the British Thoracic Association report on deaths in asthma¹ together with reports from other centres have not been heeded, as Dr Nigel Wood and Dr R H Baker admit (21 July, p 186). The recent report to which they refer (23 June, p 1870) emphasised the problem of patients with rapidly progressing attacks, and there were 23 such patients who had had a fatal attack lasting less than one hour and were found alive. Of these 15 had suffered from previous rapid attacks. In general, they were found in an extreme state. It was for this group that we suggested that if there is any delay in obtaining

Yearly death rates from asthma per million persons (respective age ranges) in England and Wales from 1974 to 1983 (information from Office of Population Censuses and Surveys)

Year	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Age group (years)										
5-9	0.51	1.28	1.29	3.17	2.43	1.40	2.33	2.19	1.64	2.39
10-14	5.35	3.99	4.70	5.93	5.22	5.78	4.86	8.48	8.17	7.06
15-19	7.48	7.30	6.28	4.53	6.51	6.86	8.95	11.86	7.94	8.71
20-24	6.77	7.14	5.33	7.90	5.19	9.65	7.21	10.68	9.15	13.23
25-29	5.46	7.57	6.21	7.97	8.71	7.98	8.67	12.45	15.06	9.95
30-34	7.33	9.79	7.86	7.55	7.29	9.40	8.75	7.53	7.11	11.46