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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.

Saving asthmatics

SIR,—Your leading article on saving asthmatics (9 June, p 1520) raises many important points, but places insufficient emphasis on certain measures which are vital to survival in a crisis.

It is stated, for example, that if deterioration occurs in spite of adequate treatment or patients fail to respond to their usual bronchodilators a short course of oral corticosteroids *may* (my italics) be required; but such treatment is in fact mandatory if unnecessary deaths are to be prevented. There is also no mention of oxygen in the treatment of an acute attack despite the accepted fact that such patients are hypoxaemic, that hypoxaemia is aggravated by bronchodilators, and that when death occurs it is due to hypoxic cardiac arrest. Perhaps the reason for this omission is that the article refers only to treatment in the home, but hypoxaemia is just as dangerous there as it is in hospital. There is no reason why general practitioners should not carry portable refillable oxygen cylinders in their cars, and administer oxygen before and after they give injections of powerful bronchodilator drugs to patients with severe attacks of asthma.

Useful as peak flow meters are in the management of bronchial asthma, it is simplistic to suggest that occasional spot measurements of peak expiratory flow rate at routine clinic or surgery attendances will detect early deterioration in more than a small minority of instances. Most patients are well aware when their asthma is getting seriously out of control; their real problem is how to obtain effective treatment quickly enough—particularly if they are subject to fulminating attacks, for which immediate admission to a hospital with facilities for respiratory intensive therapy is imperative. The solution of this problem was the prime objective of the Edinburgh emergency asthma admission service,¹ which has now

been operating successfully for the past 10 years. Other workers^{2,3} have acknowledged that this type of service can save many lives, and it is strange that such an obvious method of "saving asthmatics" should have received such lukewarm support in your leading article. Perhaps the failure of respiratory physicians to organise a self-admission policy is partly responsible for the "depressing reality" of the unchanged asthma mortality statistics, despite the major therapeutic advances which have dramatically reduced the morbidity of the disease.

Modern resuscitative measures are now so effective that very few patients die from asthma if they reach hospital alive. Although it would be interesting, as your leading article proposes, to discover why young people die from asthma, it would be more sensible to adopt a procedure for expediting their admission to hospital, and then to inquire into the reasons why they might otherwise not have survived.

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¹ Crompton, G K, and Grant, I W B, *British Medical Journal*, 1975, **4**, 680.

² Macdonald, J B, Seaton, A, and Williams, D A, *British Medical Journal*, 1976, **1**, 1493.

³ Macdonald, J B, et al, *British Medical Journal*, 1976, **2**, 721.

SIR,—Fifteen years' experience in the care of the adult asthmatic¹ supports two of the principles underlying good control of asthma stated in your leading article (9 June, p 1520), but contradicts the recommendation given for treating acute severe asthma. Our studies of the natural history of 65 acute severe attacks showed that their state evolved over days or weeks.² This meant that for subsequent

patients there was plenty of time to alter treatment at home or in a clinic, and this prevented the development of the severe, life-threatening grades of asthma.

While agreeing that good control requires "education of patients; careful supervision; and prompt recognition and treatment of deterioration," I regard the first of these principles, education of patients, to be of paramount importance. Frequent outpatient supervision of the 1 500 000 adult asthmatics in the United Kingdom is an impractical proposition.³ Experience with 300 asthmatics over nine years showed that "the great majority of asthmatics could be taught how to recognise worsening of their asthma and to communicate with a doctor, who then altered the treatment."² An essential feature of our service is that the patients had at all times easy access to a doctor with appropriate knowledge and attitudes. As a result of this organisation only one of our registered patients died from asthma and this was due to failure to comply.

The leading article states that "before sending the patient to hospital the doctor should give an intravenous injection of 300 mg of hydrocortisone and an intravenous injection of 250 mg of aminophylline, both injections given slowly." This contradicts our practice, which is to give a steroid when this is indicated. I have defined criteria for using steroids in acute asthma and the results to date show that one-third of the patients recover without the need for a steroid. This study should help to rationalise this aspect of the total care.

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¹ Jones, E S, *Proceedings of the Royal Society of Medicine*, 1971, **64**, 1151.

² Davis, B, Gett, P M, and Jones, E S, *Thorax*, in press.

³ Clark, T J H, and Godfrey, S (editors), *Asthma*. London, Chapman and Hall, 1977.

SIR,—The leading article "Saving asthmatics" (9 June, p 1520) rightly draws attention to the failure over the last 30 years to improve survival in acute attacks. Among suggestions

made for improved management is the routine use in severe asthma of intravenous aminophylline. This is unexceptionable as a statement of the present consensus, but may no longer be appropriate.

Aminophylline has been known to cause sudden death since 1943,¹ when Merill recorded three personal cases and two other fatalities reported to him. He said, "I feel that aminophylline should be used only when safer drugs have failed to give relief." A further three deaths were documented in 1948.² In 1971 Camarata *et al.*,³ in a review of cardiac arrest in the critically ill, identified an immediate potentially remediable cause in 33 out of 132 cases. In 13 of these the coup de grâce was intravenous aminophylline given over three to five minutes. They recommended abandonment of its use.

A leading article in the *Lancet*⁴ reminded that agitation, convulsions, tachycardia, hypotension, and sudden death are complications of intravenous aminophylline. It was pointed out that bronchodilation occurs at serum concentrations of only 10 µg/ml, which may be achieved by relatively low-dose infusion. This may be comparatively safe but is a more cumbersome procedure, unsuitable for resuscitation outside hospital and inconvenient for casualty departments.

An alternative bronchodilator is intravenous salbutamol,⁵⁻⁸ which is as effective as aminophylline^{7, 8} and safer,^{5, 6} and may be conveniently used as a bolus of 100-500 µg intravenously.^{5, 7} Though a single injection of 500 µg salbutamol costs about five times as much as 250 mg aminophylline, its greater safety surely makes it the drug of first choice, as previously suggested in your columns.⁹

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¹ Merill, G A, *Journal of the American Medical Association*, 1943, **123**, 1115.

² Bresnick, E, *et al*, *Journal of the American Medical Association*, 1948, **136**, 397.

³ Camarata, L A, *et al*, *Circulation*, 1971, **44**, 688.

⁴ *Lancet*, 1973, **2**, 950.

⁵ Fitchett, D H, *et al*, *British Medical Journal*, 1975, **1**, 53.

⁶ Femi-Pearce, D, *et al*, *British Medical Journal*, 1977, **1**, 491.

⁷ Williams, S J, *et al*, *British Medical Journal*, 1975, **4**, 685.

⁸ Johnson, A J, *et al*, *British Medical Journal*, 1978, **1**, 1013.

⁹ *British Medical Journal*, 1978, **1**, 873.

Colostrum deficiency

SIR,—In animals colostrum deficiency syndromes are well recognised in the very young. For example, fetal zinc deficiency develops in infant mice fed only on mature mouse milk¹; "scours" (*Escherichia coli* diarrhoea) can be a scourge in calves.

In man the situation represents a cultural void that is quite underinvestigated—mainly, perhaps, because colostrum has been passively considered as a sort of "throw-away" interim secretion before the real thing materialises. In fact, in the first five days' post partum colostrum is a highly concentrated source of an extraordinarily wide range of "host resistance factors" (humoral and cellular), and, less appreciated, of some nutrients,² notably vitamins A, E, B₆ and B₁₂, zinc, certain amino-acids (cystine, taurine), calcium, carnitine, etc.

Immediate colostrum deprivation syndromes can then include neonatal diarrhoea (*E coli*,

rotaviruses), which can be fatal. In fact, dosed colostrum has been given daily to all in a low-birth-weight unit to control endemic diarrhoea.³ The later effects of colostrum deficiency may be due to neonates not receiving these "depot-doses" of vitamins E and A etc. Clinically significant ill effects may be noted only in special circumstances—that is, in premature infants and in countries where subsequent intakes of retinol are low.

On cans of powdered formula intended as a substitute for bitches' milk (Esbilac), there is the caveat: "All puppies should receive their dam's milk for at least two days, if possible. The colostrum gives extra nutrition and temporary immunity against some diseases." Dr H Barrie's point of view (10 February, p 410) exemplifies similar stereotyped medical thinking related to breast-feeding in general until recent years.⁴ Perhaps refocusing research attention on colostrum as an undoubtedly significant biological bridging fluid may put Dr Barrie's anxieties to rest and ensure that human babies are rated higher than second-class puppies.

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¹ Nishimura, H, *Journal of Nutrition*, 1953, **49**, 79.

² Jelliffe, E F P, *Nutritional Composition of Colostrum*. In press.

³ Largaia, A M, *et al*, *Archivos Argentinos de Pediatría*, 1974, **72**, 109.

⁴ Jelliffe, D B J, and Jelliffe, E F P, *Human Milk in the Modern World*. Oxford, OUP, 1978.

Communication with patients

SIR,—I write to commend Dr Ann Oakley's Personal Paper (31 March, p 861) which was written with such refreshing style and candour that one looks forward to the novel she promised to devote herself to next year. The contrast between this completely healthy attitude and that exhibited in the Special Article on "Fighting cancer—one patient's perspective" in the *New England Journal of Medicine*¹ deserves to be quoted in any textbook or article on British and American attitudes to disease. The latter article recorded the experiences of another PhD who kept his tumorous testicle to himself for three months and then delayed the entirely proper exploration advised, because he felt he had little control over the decision to perform orchidectomy should it prove malignant. Only when a chest radiograph showed a metastasis did he consent to exploration. There were several more examples of that patient's demands to be a backseat driver without the necessary knowledge of how to control the car. There was no evidence that that patient felt at all grateful that his medical attendants had obviously saved his life in spite of his own recalcitrance. It is apparent that Dr Oakley is not without manipulative tendencies of her own, but at least her approach seems to have been reasonable and her demands did not interfere with the management of her malignancy.

She does complain about patient-doctor communication, and I would like to take her up on that point. There are doctors who are so uncommunicative even to their colleagues that one would wonder how they ever fathered children (these medicos all seem to be male), but most of us who are primarily concerned in the management of malignancy do talk to our

patients. Patients, on the other hand, are a very varied lot, ranging from the stoic or the elderly, who often prefer to place themselves completely in the hands of their medical attendant, to those who reiterate the same querulous and sometimes irrelevant question at each consultation. Between lie the intelligent, who may or may not trust the advice given and who demand and merit a full explanation. But it all takes time, and, with an appointment schedule slipping far behind, doctors are not to be too harshly blamed if their explanations become more brief as the meeting progresses. It is not uncommon for the same patient who demands a lengthy discussion to complain about being kept waiting because the previous patient or relative has also required a prolonged session.

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¹ Fiore, N, *New England Journal of Medicine*, 1979, **300**, 284.

Continuous lumbar epidural analgesia for labour and delivery

SIR,—We wish to reply to the comments made by Dr R Derom and others (19 May, p 1351) as we disagree with their conclusions. At Pembury Hospital we have taken a special interest in the breech delivery since 1972 and would agree with the comments of Dr Selwyn Crawford's review on continuous lumbar epidural analgesia for labour and delivery (13 January, p 72).

In 1972 we suggested that asphyxia was of special significance in the management of the breech labour as the risk of cerebral damage during delivery of the head would thereby be increased, and we showed that early detection of asphyxia was possible by routine fetal blood sampling in the second stage of labour.¹ In 1976 we suggested the intensive management of the breech labour using fetal blood sampling in the second stage to determine the mode of delivery, and we are still continuing a long-term paediatric follow-up of these cases correlating their second-stage and delivery pH values.²

Many clinicians have reservations regarding the use of epidural analgesia in the management of vaginal delivery because of the theoretical risks of an increased incidence of breech extraction and prolonged labour. However, as mentioned by Crawford's review, there have been several recent papers advocating epidural analgesia³⁻⁵ which suggested that the incidence of breech extraction was not increased, although Crawford found the second stage of labour increased. All these surveys were retrospective, however, and epidural analgesia was given in only a small proportion of all the breech deliveries.

In 1976 we conducted a prospective trial for 12 months with conditions identical to those for our 1976 paper, the only exception being that epidural analgesia was advised.⁶ There were 59 singleton breech deliveries of greater than 32 weeks' gestation which were induced (plus three fetal abnormalities excluded from the trial); epidural analgesia was established in 86% of these patients. We found the mean duration of labour to be 7 hours 42 minutes in the epidural group, compared with 7 hours 52 minutes in the control group. Surprisingly, it was necessary