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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.

Trends in the hospital care of acute childhood asthma 1970-8: a regional study

SIR,—As one whose main medical preoccupation is childhood asthma I would like to comment on some of the points raised by Dr H R Anderson and others (1 November, p 1191), particularly in regard to policy of care.

Asthma can be an alarming condition; treatment should be early rather than late. The paediatric department in which I am involved embraces two hospitals; open admission is encouraged in both. At present, this enables some 434 children with asthma to have immediate access to the children's wards if they so wish. Because of the prescience of two consultants (a former and a present one) accommodation is also available to admit with the child the mother, the father, or if need be both. This helps to overcome the stress of hospital admission to the child. This open door arrangement is rarely used as a matter of simple convenience, but it is certainly used for children with asthma of varying severity. This largely depends on how frightening or distressing the situation becomes at home, how different families respond to this, and how readily other help is available. Most parents voice relief at having easy access to hospital, particularly with younger children, and often ask to retain this facility even when moving some distance away. The provision of such a service helps to relieve some of the stress that

asthma can provoke, or add to, in families, as well as providing early treatment for the asthmatic child. There can be no doubt that the advantage of this system is immeasurable for many children, whatever it may be in terms of cost to the NHS and regardless of any effect it might have in reducing the mortality rate. As it is, an assessment of the benefit of increased hospital care in relation to the mortality rate in childhood asthma is difficult as the death rate is already very low. Any real assessment of benefit would have to compare the number of children who achieved a wheeze-free state after continued hospital care with the number who achieved this without it, and such evidence would be extremely hard to find.

If one accepts what parents say it appears to be the exception rather than the rule for family doctors to see their young patients between attacks of asthma: few visit them in hospital as used to be the case. With open admission, often brief, the hospital is partly culpable for this by not informing the family doctor of admission until discharge. It is in the calm between the storms, however, that suggestions can more effectively be made towards the important aspects of preventive care and continuing assessment of drug therapy. It is easy just to provide an aerosol bronchodilator and even easier to use it. This

can on occasion lead to abuse in young people, even dependence (Committee on Safety of Medicines)^{1,2}; further, there are indications that bronchoreistance may develop after prolonged overusage,¹⁻³ and possibly other unwanted side effects. Much more can be done towards long-term care; follow-up between attacks is welcomed by mothers not only for the treatment of their child's asthma to be reviewed, but to discuss the problems to which this distressing ailment can give rise. Without some such follow-up there is certainly an inadequacy of ambulatory care, and if the family doctor's commitments are such that he cannot provide it (or if this tiresome illness does not inspire his interest; we are not all "hooked" on asthma) then it seems preferable that a comprehensive policy of informed care is provided by the hospital.

This policy seems to find acceptance here; it is certainly appreciated by the families concerned. If on rare occasions it appears to be resented by the family doctor, perhaps on the grounds that the hospital is preaching in his parish, then it can only be laudatory that he continues to view his flock with such pastoral care. But surely the aim of all of us is to help those in distress; there can be few more distressing sights than a recurrently suffocating child struggling for breath, and it seems

essential for those children that hospital and general practice agree a policy towards the best management of their common and curious affliction.

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¹ Edwards JG, Holgate ST. *Brit J Psychiatry* 1979;134: 624-6.

² Gaultier M, Gervais P, Lagier G, Danan L. *Therapie* 1976;31:456-70.

³ Connolly ME, Davies DS, Dollery CT, George CF. *Br J Pharmacol* 1971;43:389-402.

The investigation of sinusitis

SIR,—I was staggered to read in your leading article on the investigation of sinusitis (22 November, p 1373) that DHSS statistics show that half a million working days are lost each year from sinusitis. I have been a GP for 17 years, and I find it is a diagnosis that I hardly ever make—say once or twice a year at the most. Yet I am aware that my fellow GPs diagnose it far more frequently. Sceptical readers will immediately say that sinusitis is one of my blind spots, but six months as an ENT house surgeon in a London teaching hospital before coming into general practice stimulated a lifelong interest in ENT problems. I have also had the misfortune to suffer a very painful attack of frontal sinusitis personally. So I am not altogether unaware of the occurrence of this condition. In fact, I have often wondered where all those patients who needed antral washouts and Caldwell-Luc procedures came from.

Dare I suggest that sinusitis is a label often attached to patients with facial pain of obscure origin—a handy way of terminating a consultation which might otherwise have led to a diagnosis of atypical facial pain, which is invariably a manifestation of depression. I have grave doubts about drawing conclusions from DHSS statistics if these in turn are constructed from the information on doctors' certificates. The same could be said of conclusions drawn from death certificates.

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SIR,—Your leading article on the investigation of sinusitis (22 November, p 1373) takes no heed of reality in that it recommends the use of an uncomfortable and unnecessary investigation which would be of little help in everyday management.

A procedure is described for the aspiration of infected material from the middle meatus, and this is claimed to provide accurate bacteriological diagnosis of sinusitis. Most cases of acute sinusitis are treated by general practitioners without the guidance of accurate bacteriological diagnosis and the article states that "this is incorrect practice." Far from concluding that "blind" antibiotic therapy is wrong, there must be many doctors who would consider this investigation "incorrect practice" in that the benefit (that in a small number of cases where "blind" therapy has not worked then the results of antibiotic sensitivity tests available some days later may assist further management) does not outweigh the discomfort caused to the majority who would get better on "blind" therapy anyway.

Firstly, a "blind" antibiotic is likely to be the correct one, since the prescriber will take

the likely organism and its expected sensitivity into account in choosing it. As long as we continue to update our information—for example, about current antibiotic-resistant strains—then such treatment is far from truly "blind": it is well informed.

Secondly, antibiotics play only a small though significant role in the management of sinusitis. Drainage of mucopus by use of steam, and decongestants—not to mention the roles of improving general health, and surgery—are all-important. In all probability acute sinusitis can be considered a self-limiting disease in which symptomatic treatment, aimed at pain relief and drainage, is the most important line of management in most cases. Success in the acute illness and in avoiding complications is largely dependent on these measures and on the general health of the individual and much less often to do with antibiotics. Sinusitis is an acutely unpleasant condition with potentially serious complications so it would be unreasonable to withhold antibiotics, but to assault a sensitive orifice for the sake of an occasional improvement in appropriateness of drug is not a sensible approach, however scientific it may be.

The conclusion to be drawn from the article is that the author is more concerned with treating organisms than with treating patients. In a condition that is largely managed in general practice this approach is inappropriate. It is only in the tip of the iceberg, those few cases proceeding to complications and hospital management, that such uncomfortable investigation is justifiable.

WILLIAM M I EVANS

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SIR,—Your recent leading article (22 November, p 1373) describes a useful method of confirming the diagnosis of sinusitis by aspirating and culturing infected material from the nose. Unfortunately it does little to remind us of the importance of an adequate history and clinical examination in excluding other even more numerous conditions presenting with headache. These also cause absence from work and commonly masquerade as sinusitis, often to the extent of the patients receiving and apparently benefiting from antibiotics and other treatment appropriate for sinusitis; sometimes even more promptly than the genuine article. An even simpler, quicker, and cheaper diagnostic measure than Bridger's is transillumination of the sinuses with a clinical torch, which will demonstrate the presence of an antrum infection in all but the thickest skulls long before the patient is cured with the very drug to which his infecting organism is reported to be insensitive.

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SIR,—The leading article (22 November, p 1373) on the investigation of sinusitis prompted me to raise aspects of this disease, which is frequently diagnosed incorrectly on insufficient evidence.

Many patients consult their doctors because of frontal headache or of pain in the face without any symptoms referable to the upper respiratory tract. They are diagnosed as having sinusitis, and nose drops or antibiotics are prescribed. The symptoms continue and when told by an ENT specialist that there is

no evidence of sinusitis they are puzzled and often resentful.

Many genuine cases of sinusitis present without reference to the face or the head—for example, secretory otitis media, persistent cough, persistent sore throat, or laryngitis. Sinusitis may present as severe epistaxis. Therefore a searching investigation of the sinuses is required in these cases, which must include x-ray examinations and possibly antrum washouts.

A method was quoted of aspirating a specimen of sinus contents by inserting a flexible plastic tube into the middle meatus of the nose. Very often the nasal mucous membrane is swollen and anaesthesia is necessary in order to insert the tube and shrink the mucous membrane. Progress into the antrum might be impeded by oedema of its mucous membrane, making the procedure uncertain and unpleasant for the patient.

An antrum washout carried out after adequate local anaesthesia is a painless certain method of evacuating the antral contents and obtaining an uncontaminated specimen for bacteriological examination. It will also assist in the rapid resolution of the sinusitis if present.

J SIEGLER

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SIR,—I have not written to you before although I have previously been tempted by the line taken by some of your leading articles. You tell us (22 November, p 1373) that most cases of acute sinusitis are treated by general practitioners and that they normally respond rapidly to treatment, but that the treatment that normally rapidly cures the condition is incorrect because bacteriological specimens, which previously were relatively useless, were not obtained. You then continue your "purist" thinking by describing a time-consuming technique for obtaining specimens which prove that most sinusitis is caused by organisms the general practitioners were treating in the first place. I found your tone arrogant and incorrect.

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Prevention of mumps

SIR,—Your leading article on the pros and cons of mumps vaccine (8 November, p 1231) appears to come to the conclusion that the cons outweigh the pros. Although the survey by the Association for the Study of Infectious Disease, which you quote, shows that serious complications or sequelae of mumps are rare, the disease is unpleasant and I question some of the assumptions upon which other points made against vaccination are based.

You mention that mumps vaccine could be given with measles vaccine as it is in the United States, but imply that the 50% acceptance rate of measles vaccine in the UK makes this approach unsatisfactory. A more positive approach would be to use the addition of mumps vaccine to measles vaccine as a basis for an intensive educational campaign. It is well known that a big reduction in the incidence of an infectious disease by vaccination requires a high acceptance rate of the order of 80-90%. By achieving this we would automatically overcome another potential drawback to vaccination which you mention: an increase in the incidence of mumps in