Editors of journals have the responsibility to ensure that material that is published is soundly based, conducted, and interpreted; if it is, then the source of the funding is immaterial. If editors have any doubts about any of these then they do not publish the paper; again, the source of the funding is immaterial.

If those who take money from commercial sources are required to identify their interests, what of other potential conflicts? For example, I might be a member of the Conservative party and consider that it was individual behaviour that accounted for most ill health and interpret the results of my study accordingly. Alternatively, as a member of the Labour party I would have an interest in showing how urban deprivation and poverty were the cardinal determinants of health. Smith is surely not suggesting that all conflicts of interest should be enumerated at the end of a paper; if they were, the disclaimer might take up considerably more space than the subject matter.

Another point needs consideration—namely, the source of funds for medical research. Without the support of commercial organisations many medical scientists would be unable to carry out any research, and to deny them the opportunity to publish their work because they have received funding from commercial or other sponsors seems indefensible. At present the Medical Research Council is not able to attend to everyone's needs, nor are other important sources of funding such as the Wellcome Trust. Many of my colleagues undertake work that is supported by drug companies, and I doubt that their judgment is adversely influenced by this. In case it is, however, might not an agreeable alternative be for all the commercial sponsors to put money into a central fund that was administered by an independent board, which could allocate the money irrespective of the outcomes hoped for by the primary sources of the funds?

JAMES BIRD
Consultant physician

St Mary's Hospital,
London W2 1NY

1 Smith R. Questioning academic integrity. *BMJ* 1994;309:1597-8. (17 December.)

Most people are not disgusted by the Portman group

EDITOR,—To bracket the Portman Group with an organisation such as Forest is grossly unfair, as anyone familiar with the group's activities will know.¹ It is untrue to say that most people are "disgusted" by our activities. On the contrary, our participation in a wide range of prevention projects has been welcomed by everyone who recognises that the drinks industry has a role in tackling alcohol misuse. Indeed, it has won over many people who were sceptical. Most of our work in research, education, and practical measures that target particular problems such as drinking and driving is done in partnership with government departments and non-government organisations. Richard Smith may be disgusted but most people are not.

I very much regret the controversy caused by the Portman Group's plan to publish a critical commentary on *Alcohol Policy and the Public Good*, not because I think that we acted improperly but because that impression has been erroneously given. There is genuine disagreement about how best to prevent alcohol misuse, and we have as much right as anyone else to argue for or against a particular approach. The fact that we wished to obtain expert contributions to present our view should be to our credit. We do not believe that we know all the answers but we do believe in a balanced debate. Surely it is not suggested that only one side in the debate should have access to expert advice.

Unfortunately, the controversy has played into the hands of those who want to see confrontation between the industry and the health community. I am determined to prevent that because I am convinced that collaboration without illusions is the better way. Smith advises doctors and academics to "consider very carefully the ethical implications of all their actions." I have always accepted that the Portman Group should do no less.

JOHN RAE
Director

Portman Group,
London W1M 7AA

1 Smith R. Questioning academic integrity. *BMJ* 1994;309:1597-8. (17 December.)

Referral of women with breast lumps

EDITOR,—Justine Foster¹ disagrees with J M Dixon and R E Mansel's suggestion that general practitioners should not aspirate breast lumps.² I can understand that a general practitioner finds that aspiration of a cyst provides instant relief, and it is true that a surgeon will aspirate the cyst anyway. A patient who is presenting with a first breast lump, however, is more likely to have a solid lump than a cyst. In this situation, many general practitioners will not obtain a satisfactory aspirate for cytological examination since it requires a high level of practice to obtain cells in most smears. The best opportunity for getting an early diagnosis is then hampered. Patients resent having the test repeated unnecessarily.

If a patient is known to have cysts then the balance of probability is different and it seems sensible for the general practitioner to aspirate a new lump on the assumption that it may well be another cyst and easily relieved.

B M HOGGIN
Consultant surgeon

Hove,
Sussex BN3 4GF

1 Foster J. Referral of women with breast lumps. *BMJ* 1995;310:331. (4 February.)

2 Dixon JM, Mansel RE. ABC of breast diseases: symptoms, assessment, and guidelines for referral. *BMJ* 1994;309:722-6. (17 September.)

Appropriate prescribing in asthma

PACT data have drawbacks

EDITOR,—Jeannette Naish and colleagues describe the variations in the costs of prescribing respiratory drugs among general practices in one family health services authority.¹ While it is possible that better asthma care results in higher prescribing costs, the use of costs from prescribing analysis and cost (PACT) data to derive the volume of prescribing for asthma has two major drawbacks.

Firstly, PACT data are not linked to indication, and therefore one cannot assume that all bronchodilators or inhaled steroids prescribed are for use in asthma. For example, aggregate data from a research database based on general practice computer systems in the former Northern region show that 15% (1354/8985) of patients receiving inhaled steroids in 1992-3 had a diagnosis other than asthma. Thus the management of bronchitis and other obstructive airways diseases is a source of variation among practices in the prescribing of inhaled steroids.

Secondly, the cost of prescribing, as the authors acknowledge, is not a good measure of the amount of prescribing. The table shows the volume and cost of inhaled steroids prescribed in the 16 family health services authorities in the Northern and

Volume of prescribing and cost of inhaled beclomethasone, budesonide, and fluticasone in Northern and Yorkshire Regional Health Authority, 1993-4

Family health services authority	No of defined daily doses prescribed	Net ingredient cost (£)	Net ingredient cost/defined daily dose (£)
Cleveland	5 703 028	2 207 108	0.39
Cumbria	6 493 063	1 849 211	0.28
Durham	7 250 846	2 471 500	0.34
Northumberland	4 994 130	1 595 383	0.32
Gateshead	2 502 342	812 058	0.32
Newcastle	3 578 339	1 332 644	0.37
North Tyneside	2 134 631	783 882	0.37
South Tyneside	1 599 347	618 189	0.39
Sunderland	3 427 872	1 158 173	0.34
Humberside	8 873 858	3 067 972	0.35
North Yorkshire	7 577 784	2 603 121	0.34
Bradford	7 820 934	1 747 018	0.22
Calderdale	2 818 016	765 748	0.27
Kirklees	5 572 910	1 436 207	0.26
Leeds	9 058 999	2 806 670	0.31
Wakefield	3 706 345	1 373 148	0.37
Regional health authority	83 112 444	26 628 032	0.32

Yorkshire region in 1993-4. This varies almost twofold (£0.22-0.39 per defined daily dose), indicating that one of the principal determinants of total cost is the choice of product. This is not surprising since the basic NHS cost of comparable inhaled steroid treatments ranges from £0.17/day (200 µg beclomethasone twice daily by pressurised inhaler) to £0.44/day (100 µg fluticasone twice daily by Diskhaler).

The ratio of the rate of prescribing of bronchodilators to that of inhaled steroids has been suggested as a marker of prescribing quality in respiratory diseases.² Ratios, however, are influenced by changes in the numerator or the denominator, or both, so the same ratio can derive from any absolute prescribing rate, large or small. High quality prescribing in asthma therefore requires an appropriate range of prescribing of both prophylactic and bronchodilator treatments. The optimum rate of consumption of antiasthma drugs remains unknown, and the difficulties in accurately expressing drug consumption should not be underestimated.

MARK CAMPBELL
Manager, prescribing unit
D NICHOLAS BATEMAN
Medical director

SARAH J ROBERTS
Lecturer in medical statistics

JAMES M SMITH
Regional pharmaceutical adviser

NHS Executive,
Northern and Yorkshire Regional Health Authority,
Regional Drug and Therapeutics Centre,
Wolfson Unit,
Newcastle upon Tyne NE1 4LP

1 Naish J, Sturdy P, Toon P. Appropriate prescribing in asthma and its related cost in east London. *BMJ* 1995;310:97-100. (14 January.)

2 Audit Commission. *A prescription for improvement*. London: HMSO, 1994:26-7.

NHS Executive promotes prophylaxis

EDITOR,—In their paper on appropriate prescribing in asthma in east London Jeannette Naish and colleagues highlight the difficulties in defining and measuring good prescribing.¹ In both the paper and the Editor's choice, statements are made that pressure to reduce the cost of prescribing in asthma may lead to a reduction in prophylactic treatment, lower the quality of asthma care, and be cost ineffective. The implication of these statements is that the government's policy for rational prescribing has created or is intended to create such pressure.

None of the initiatives or guidance on general practitioners' prescribing with which the NHS

Executive has been associated in recent years has suggested that prescribing for asthma should be curbed. On the contrary, the many projects in family health services authorities and academic units on indicators of the quality of prescribing suggest that a high ratio of inhaled steroids to bronchodilators represents good practice, and this is the advice given by family health services authorities' medical and pharmaceutical advisers. The *MeReC Bulletin*, which is funded centrally, urged that the British Thoracic Society's guidelines should be followed²; the *Drug and Therapeutics Bulletin*, which the Department of Health sponsors for distribution to general practitioners, said the same.⁴ Colleagues and I—on public platforms and in conversation with the Royal College of General Practitioners and General Medical Services Committees—have often said that improvement in prescribing in asthma may be more expensive. Finally, a report by the Audit Commission, which the authors quote in another context, suggests that good prescribing in asthma may cost more.⁵

What we all wish to see is a reduction in ineffective or unnecessarily expensive prescribing, achieved through a more thoughtful approach. This should be based on evidence whenever possible and reviewed at reasonable intervals. General practitioners in Britain, who in general prescribe well, are responsible for the appropriate use of over £3bn of public resources spent on the 400 million items prescribed each year. Well made, these 400 million decisions will help to provide effective health care for patients through the best use of NHS resources.

PHILIP LEECH
Principal medical officer

NHS Executive,
Leeds LS2 7UE

- 1 Naish J, Sturdy P, Toon P. Appropriate prescribing in asthma and its related cost in east London. *BMJ* 1995;310:97-100. (14 January.)
- 2 Guidelines for the treatment of chronic asthma. *MeReC Bulletin* 1991;2:12.
- 3 New developments in the treatment of asthma. *MeReC Bulletin* 1993;4:21-4.
- 4 Corticosteroids in asthma. *Drug Ther Bull* 1990;28:45-6.
- 5 Audit Commission. *A prescription for improvement*. London: HMSO, 1994.

Cost and cost effectiveness are different

EDITOR,—Jeannette Naish and colleagues seem surprised at the relatively low levels of generic prescribing of drugs in asthma, especially steroids.¹ They should not be. Recent correspondence in the *BMJ* testifies to the controversy fuelled by commercial pharmaceutical interest in this field.^{2,3} This has also been manifest by promotional letters of claim and counterclaim sent to general practitioners by manufacturers of generic and proprietary inhalers. The even lower rate of generic prescribing of steroids partly reflects the fact that generic preparations of beclomethasone have become available only relatively recently.

The authors close by suggesting that good clinical practice and cost consciousness do not seem necessarily to go together. This confuses cost and cost effectiveness. Good prescribers will justifiably increase their treatment costs for asthma by prescribing more inhaled steroids. At the same time they can minimise costs without detriment to patients' care by increasing the use of generic drugs and by reserving sophisticated delivery systems for the patients who need them. Both strategies are likely to increase the cost effectiveness of care; the overall effect on cost remains to be seen.

DENNIS TRACEY
Medical prescribing adviser

Highlands Health Board,
Inverness IV2 3HG

- 1 Naish J, Sturdy P, Toon P. Appropriate prescribing in asthma and its related cost in east London. *BMJ* 1995;310:97-100. (14 January.)

- 2 Pearson M, Lewis R, Watson J, Ayres J, Ibbotson G, Ryan D, et al. Generic inhalers for asthma. *BMJ* 1994;309:1440. (26 November.)
- 3 Crompton GK, Prouse K. Matching inhalers and spacer devices. *BMJ* 1994;309:1584. (10 December.)

Good prescribing is encouraged

EDITOR,—Jeannette Naish and colleagues conclude that pressure to reduce the cost of prescribing in asthma may lead to a lowering of the ratio of prophylactic to bronchodilator treatments.¹ This would be contrary to the British Thoracic Society's guidelines and might worsen the quality of asthma care. Who is exerting pressure to reduce the cost of prescribing in asthma and how this conclusion may be drawn from the data presented in this paper are unclear to us.

We are pharmaceutical advisers to Camden and Islington Family Health Services Authority, and our concern is with quality and cost effective use of medicines. To this effect, general practitioners within the authority who audit their prescribing in asthma may be rewarded through the authority's prescribing incentive scheme, which makes payments for improvements in the quality of prescribing when financial savings have not been made. Local research from a health needs assessment and general practice project highlighted general practitioners' ratios of prophylactic to bronchodilator treatments and hospital admission rates for asthma; there was a negative correlation between them of $r=0.35$.² The issues regarding generic prescribing of treatment for asthma have been debated previously.^{3,4} Thus in Camden and Islington Family Health Services Authority positive pressure is applied to improve the quality of prescribing in asthma in line with the British Thoracic Society's guidelines.

Finally, we suggest that conclusions and key messages in papers should be worded according to the data collected.

CHERYL SHINE
Pharmaceutical adviser
AMALIN DUTT
Prescribing facilitator

Camden and Islington Family Health Services Authority,
London NW1 2LJ

- 1 Naish J, Sturdy P, Toon P. Appropriate prescribing in asthma and its related cost in east London. *BMJ* 1995;310:97-100. (14 January.)
- 2 Camden and Islington Family Health Services Authority and Health Authority. Asthma in your practice: morbidity, prescribing and hospital admissions. In: *Health needs assessment and your general practice*. London: Camden and Islington FHSA and HA, 1995.
- 3 Prescription Pricing Authority. *Asthma and inhaler therapy*. Newcastle upon Tyne: PPA, 1994.
- 4 Smith JM, Bateman DN. Clinical efficacy and safety of generic inhalers is well established. *BMJ* 1995;310:254. (28 January.)

Bottle feeding and the sudden infant death syndrome

Study was not large enough to show effect

EDITOR,—Major faults in R E Gilbert and colleagues' paper invalidate their claim that bottle feeding is not a risk factor for the sudden infant death syndrome.¹ In Britain a higher proportion of upper and middle class women breast feed. When the limited format of an observational case-control study is used adjustment for socioeconomic status may remove the effect of breast feeding. In New Zealand women in all social strata breast feed. Therefore, even when adjustments for socioeconomic variables were made, the New Zealand cot death study showed that bottle feeding was associated with the sudden infant death syndrome.²

In Gilbert and colleagues' study, for control infants, "The health visitor was asked to identify two infants living in the same neighbourhood."³ These controls were more likely to have the same feeding status as the case infants than truly random

controls (representative of the general population of infants in Avon) would have been.⁴ This unnecessary matching of neighbourhood will have underestimated the true association between outcome and exposure.⁵

The New Zealand cot death study reported on 465 cases and 1762 controls. Gilbert and colleagues' study, with only 98 cases and 196 controls and a wide 95% confidence interval (0.7 to 4.8) around the odds ratio of 1.8, had insufficient power to conclude that bottle feeding was not an independent risk factor for the sudden infant death syndrome. Readers are left with the question: "If a larger sample size had been taken even with the poor methodology and questionable adjustment for socioeconomic status would the lower 95% confidence limit have been above 1?" If it would have been then the media would have reported that bottle feeding caused the sudden infant death syndrome.

D M TAPPIN
Senior lecturer in community paediatrics

Department of Child Health,
Royal Hospital for Sick Children,
Glasgow G3 8SJ

- 1 Gilbert RE, Wigfield RE, Fleming PJ, Berry PJ, Rudd PT. Bottle feeding and the sudden infant death syndrome. *BMJ* 1995;310:88-90. (14 January.)
- 2 Ford RPK, Taylor BJ, Mitchell EA, Enright SA, Stewart AW, Becroft DMO, et al. Breast feeding and the risk of sudden infant death syndrome. *Int J Epidemiol* 1993;22:885-90.
- 3 Fleming PJ, Gilbert R, Azaz Y, Berry PJ, Rudd PT, Stewart A, et al. Interactions between bedding and sleeping position in the sudden infant death syndrome: a population based case-control study. *BMJ* 1990;301:85-9.
- 4 Ferguson AE, Tappin DM, Girdwood RWA, Kennedy R, Cockburn F. Breast feeding in Scotland. *BMJ* 1994;308:824-5.
- 5 Elwood JM. *Causal relationships in medicine. A practical system for critical appraisal*. Oxford: Oxford University Press, 1988:116-7.

Type of formula was not specified

EDITOR,—R E Gilbert and colleagues make no mention of the type of formula fed to the infants.¹ Presumably most were fed modern adapted formulas, but some of the older infants may have been given whole milk. This is critically important because the way in which cows' milk is modified greatly affects its sensitising capacity.

Taking advantage of the guinea pig's capacity to become anaphylactically sensitised to whole cows' milk, Anderson *et al* showed that different milk formulas differed dramatically in their sensitising capacity in this animal model.² Modern adapted milks, especially liquid concentrates, were particularly low in their sensitising capacity. This led Coombs *et al* to the view that various infant feeding formulas differed strikingly in allergenicity.³ In communities where less adapted feeding formulas or whole cows' milk are used (much of the developing world) cows' milk may have a more important role in the sudden infant death syndrome than reported here. As the classic hypothesis for the role of cows' milk in sudden infant death suggested an acute anaphylactic reaction to aspirated cows' milk⁴ the allergenicity of the cows' milk feed given in the bottle is of key importance in any analysis of the role of bottle feeding in the sudden infant death syndrome.

J A WALKER-SMITH
Professor of paediatric gastroenterology

Academic Department of Paediatric Gastroenterology,
Medical College of St Bartholomew's Hospital,
London EC1A 7BE

- 1 Gilbert RE, Wigfield RE, Fleming PJ, Berry PJ, Rudd PT. Bottle feeding and the sudden infant death syndrome. *BMJ* 1995;310:88-90. (14 January.)
- 2 Anderson KJ, McLaughlan P, Devey ME, Coombs RRA. Anaphylactic sensitivity of guinea pigs drinking different preparations of cow's milk and infant formulae. *Clin Exp Immunol* 1979;35:454-61.
- 3 Coombs RRA, McLaughlan P. Allergenicity of food proteins and its possible modification. *Ann Allergy* 1985;53:592-7.
- 4 Parish WE, Barrett AM, Coombs RRA, Gunther M, Camps FE. Hypersensitivity to milk and sudden death in infancy. *Lancet* 1960;ii:1106-8.