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.

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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.

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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.

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- 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.)
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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.

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- 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.)
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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.

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