Salmeterol therapy in mild asthma

Sir,

The study by Hyland and colleagues (May *Journal,* p.214) showed that salmeterol therapy improved the quality of life of a group of patients with mild asthma (63.1% of patients improved with salmeterol, while 46.6% of patients improved with placebo). It would be logical that such a group of patients would feel better with additional bronchodilator therapy, whether it be xanthines, salmeterol or controlled-release salbutamol. It would be more appropriate, however, and in keeping with the British Thoracic Society guidelines,[1] to treat them with increased doses of anti-inflammatory drugs such as disodium cromoglycate or inhaled steroids.

The cost implications of using salmeterol to attain this marginal improvement in quality of life for people with asthma are enormous. In 1988 the total drugs bill for all asthma drugs was £228m.[2] It is estimated that if only half of the asthma sufferers in the United Kingdom were prescribed the recommended dose of salmeterol, the cost would be an additional £380m per annum. There is a place for salmeterol in the management of asthma but surely it is not to patch up the inadequate use of existing prophylactic therapy.

P G WEAVING

The Surgery
Brampton
Cumbria CA8 1NL

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Asthma care in general practice — time for revolution?

Sir,

Dr Jones confidently expects to witness a revolution in asthma care in the 1990s (June *Journal,* p.224). While treatment guidelines which are adhered to are a step forward,[1] they cannot provide the complete solution. A major restraint to providing appropriate treatment in adults is the difficulty in differentiating asthma from the other disorders that lead to airways obstruction.

This issue of diagnostic confusion was addressed in a survey of 2387 patients aged 40–70 years registered with an urban general practice.[2] There was considerable overlap in clinical and physiological features (including airways reversibility) between patients reporting diagnostic labels of asthma, chronic bronchitis and acute bronchitis. Furthermore for every patient with a diagnosis there were two to three other patients with similar symptoms with no diagnostic label. The diagnosis was important as wheezing patients labelled as asthmatic were three times more likely to be prescribed appropriate treatment than those labelled as chronic bronchitics and 12 times more likely to be prescribed appropriate treatment than those without a diagnostic label.[3]

An important step in making the diagnosis of adult asthma easier would be the introduction of a standardized nomenclature based on agreed criteria. The continuation of the opposing views expressed by followers of the Dutch[4] and British[5] theories of asthma aetiology suggest that this is unlikely. This inability to agree on what constitutes asthma will probably delay the treatment revolution in adults. This is worrying as most asthma deaths occur in the older age groups.[6]

P LITTLEJOHNS

Department of Public Health Sciences
St Georges Hospital Medical School
Cranmer Terrace
London SW17 0RE

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Which antidepressant?

Sir,

The discussion paper from Drs Matthew and Eagles (March *Journal,* p.123) provoked considerable discussion at our regular psychiatry liaison meeting. We came to rather different conclusions about the 'best buy' antidepressants in general practice. My partner and I meet our visiting psychiatrist every month to discuss the general practice management of patients with psychological and psychiatric problems. Our psychiatrist also holds a regular clinic based in our health centre.

Many otherwise fit patients without cardiovascular or urinary problems find that tolerance to the side effects of tricyclic antidepressants soon develops. Thus, in younger patients, the side effect profile of the older antidepressants need not be a bar to their regular use. We consider it reasonable to reserve the newer antidepressants for those who cannot tolerate the side effects of tricyclic antidepressants, and for the elderly in whom the risks are greater.

In addition, we were uncertain as to whether 'fatal poisoning per million prescriptions' was the most appropriate guide to problems of overdose. In severe or acute depression we would be punctilious about prescribing only small quantities of toxic drugs, with close monitoring of treatment and careful follow up. It is always difficult to predict which patients will attempt suicide, but exploration of any suicidal ideation and restriction of prescribing to small quantities will surely go far to reducing fatal overdoses.

Thirdly, while fluoxetine and fluvoxamine do indeed inhibit serotonin, they are extremely expensive drugs. Clomipramine also has 5-HT blocking properties, is much cheaper and can be used safely in general practice for those patients who have severe mixed anxiety and depression. A consultant referral is not mandatory in such cases.

In summary, there is still a place for the first generation of antidepressants, the newer agents being reserved for those in whom side effects are a serious problem or treatment with the older agents has failed.

AVRIL DANCZAK

Alexandra Park Health Centre
2 Whitswood Close
Alexandra Park
Manchester M16 7AW

Sampling endocervical cells on cervical smears

Sir,

We were interested to read the paper from the Cumbrian Practice Research Group (May *Journal,* p.192) comparing the Aylesbury spatula with the Cervex® cervix brush sampler. We have just completed a survey of 50 patients in our practice which differed methodologically in three respects: each patient had two samples taken, one with each instrument; only one operator performed the smears; and all the smears were read by one person at the laboratory on a blind basis.

The laboratory conclusions were as follows: two of the specimens taken with the cervix brush had endocervical cells present, while the corresponding smears

from the Aylesbury spatula had none; four of the smears taken with the cervix brush and the corresponding Aylesbury spatula specimens contained no endocervical cells. The remaining 44 pairs of results had endocervical cells present in both the cervix brush and the Aylesbury spatula smears. All 100 smears were adequate for screening, with the comment that the cervix brush specimens had noticeable amounts of blood present. This was also observed by the practice nurse, who said the cervix brush caused patients to bleed on contact.

Our conclusions therefore were that the Aylesbury spatula was equally effective as the cervix brush, and that on a cost basis, it was preferable.

FRAN BISHOP
DUNCAN WATNEY

Saxonbury House
Croft Road, Crowborough
East Sussex TN6 1DP

Sir,

In its paper on sampling endocervical cells on cervical smears the Cumbrian practice research group makes assumptions which are not backed by the facts (May *Journal,* p.192).

We all know that screening for cervical cancer has one major flaw; it is not reaching older women. To spend time and money on a minor aspect of technique is not sensible.

The research group is concerned about patient anxiety and inconvenience when cervical smears have to be repeated because the laboratory reports no endocervical cells, and repeat tests cost money too. However, if I get a good view of the cervix and rotate the spatula through 360 degrees I am satisfied that I have obtained a satisfactory smear. I only repeat the test earlier than usual if the smear is abnormal or cannot be interpreted. I am supported in this policy by the British Society for Clinical Cytology and the British Society for Colposcopy and Cervical Pathology in a statement quoted in the April 1990 issue of the *Journal.*[1]

Why did the research group ignore this statement? They presented the familiar idea that early diagnosis and treatment are of benefit, but that is very far from clear. Finally, they did not state that use of the cervix brush has yet to show any meaningful results in terms of mortality figures.

DECLAN FOX

Little Pubble, 2A Bunderg Road
Newtonstewart, Co Tyrone BT78 4NQ

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Management of weight problems

Sir,

In a recent paper on the management of weight problems (April *Journal,* p.147), the authors commented that general practitioners 'felt they had little success in achieving weight loss in patients'. This may be because, unknown to the general practitioner, the patient is also attending a private slimming clinic, and the medication and advice he or she is receiving there is undermining the general practitioner's treatment.

A few years ago, I worked in a private slimming clinic. The mainstay of the treatment was then, and still is, appetite suppressant drugs. Patients knew this, and expected to be prescribed the drugs. We asked all new attenders whether they would like us to inform their general practitioners that they were attending the slimming clinic, and what medication we had prescribed. Ninety per cent of patients did not want their general practitioner informed, presumably because they thought he or she would disapprove. Many patients had already consulted their general practitioner about their weight problem, and had not been prescribed appetite suppressants.

Centrally acting appetite suppressants do not improve the long term outlook in obesity[1] and may undermine the effectiveness of behaviour therapy.[2] However, they are advertised to the public as 'medically supervised weight loss'.

If a patient fails to lose weight despite dietary advice, enquire tactfully as to the kind of help they want, and whether they have sought help elsewhere. You may receive some surprising answers.

PETER GRAY

21 Burgess Avenue
Kingsbury, London NW9 8TX

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Patient participation groups

Sir,

I have read with interest the article entitled 'Patient participation in general practice: who participates?' (May *Journal,* p.198) and would like to comment on some of the points made. As chairman of the Berinsfield patient participation group for some years until 1990, I can speak with some knowledge and am sorry that none of the many achievements of the group have been acknowledged or even mentioned. In the early days of the group's existence attendance at the meetings was very much higher than reported in the paper and many more local organizations were represented. Difficulties experienced by patients and their comments and criticisms of the practice were aired, and after extensive discussion, were resolved. The present degree of satisfactory relationship between doctors, nurses, receptionists and patients owes much to these early discussions. One example in particular where discussion proved valuable was the wording of a letter to women patients regarding the cervical smear test, when an earlier letter from the practice elicited a poor response because of insensitive wording.

The writers of the article in the *Journal* may not be aware of the extent to which discussions at the patient participation group meetings filter down to patients in the area. It matters not whether the representative is of social class 1, 2, 3 or 4, but whether he or she is articulate and conscientious enough to pass on what is relevant. By the very nature of things it is reasonable to accept a lower turnout at meetings now, since as I indicated earlier, many of the original difficulties experienced by patients in the practice have been ironed out. Present meetings are very useful and must continue, so that any changes in the practice may be notified to patients, particularly at the present time when there is so much concern over the future of the National Health Service.

MARGARET ALLEN

Chilterns, Thame Road
Warborough, Oxfordshire OX10 7DS

Irritable bowel syndrome

Sir,

A retrospective study of problem oriented profiles of patients with irritable bowel syndrome in my practice yielded the interesting finding of a close association with spondylosis and regional pain syndrome. Perhaps practices using a computerized problem oriented system would be able to check to see if this is merely an artefact in my recording.

I would be most grateful to hear from any practices that could assist in this matter.

JOHN GOWEN

Strand House
South Abbey, Youghal
County Cork
Republic of Ireland