

review, 56 of which were acted upon (26.9%).

The finding that 44% of patients were receiving drugs likely to cause adverse reactions in elderly people is a cause for concern, in view of the numbers of elderly people admitted to hospital as a result of their medication.¹⁻³ It is also noteworthy that for 71% of the potential adverse drug reactions identified by a surgery-based medication review, symptoms likely to arise from the drug were being experienced by the patient.

The study has shown that a pharmacist can make a useful contribution to both the medication review process and adverse drug reaction monitoring for elderly patients in the community. As the differences between the two groups of patients in terms of numbers of recommendations made and reports of drugs likely to cause adverse drug reactions were not statistically significant, there is no need for a pharmacist to undertake visits routinely to patients aged 75 years and over; review of the notes would seem to be sufficient.

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Treating acute asthma

Sir,

Patients commonly present to general practitioners with acute asthma associated with respiratory tract infection. The British Thoracic Society guidelines condemn the use of antibiotics in the absence of bacterial infection, and are unclear about the best dose, length of course and method of stopping oral steroids in such situations.¹

A postal questionnaire, checked for face validity, was sent to all 205 general practitioner principals in Bath District Health Authority in March 1993 and a reminder sent to non-respondents four weeks later. Respondents were asked to outline their management of case histories of an adult and a child presenting with acute asthma associated with respiratory tract infection. The cases were constructed in such a way that they could be managed

according to British Thoracic Society guidelines in a general practice setting, without admission to hospital.

Replies were received from 185 doctors (90.2% response rate) of whom 83.2% stated that there was an asthma clinic in their practice and 36.7% reported that they had a special interest in asthma.

Of 179 respondents, 93.3% reported that they would prescribe oral steroids to the adult with acute asthma associated with respiratory tract infection, and of 169 respondents, 87.6% reported they would prescribe oral steroids for the child. With one exception the oral steroid of choice was prednisolone. The modal initial dosage of prednisolone was 40 mg for the adult and 30 mg for the child. The modal duration of treatment with prednisolone was five days for both the adult and the child (Table 1).

Of 167 respondents, 89.2% stated that they would not tail off the course of steroids if the course lasted five days or less, but 46.7% stated that they would tail off the prednisolone if the course lasted between five and 14 days.

Oral antibiotics would have been prescribed for the adult by 66.5% of 179 responding general practitioners and for the child by 58.0% of 169 respondents.

There is some evidence that a 10-14 day course of prednisolone is required to produce maximal response in adults and hence a five day course may represent undertreatment in adults.² A study by O'Driscoll and colleagues suggests that tailing off steroid therapy is unnecessary if the course of treatment is less than 10 days, providing that inhaled steroids are continued. The prescription of antibiotics is contrary to the British Thoracic Society guidelines which are based on hospital studies suggesting that oral antibiotics offer little benefit in acute asthma management.¹

These findings suggest that there is a need to evaluate the common practice of

prescribing oral antibiotics in asthma attacks associated with respiratory tract infection in general practice. Clarification of the duration of oral steroid therapy and the need for tapering the course of oral steroids would also be welcome.

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GPs and minor surgery

Sir,

I agree with Dr Kneebone on the training of general practitioners in minor surgery, in that well conducted and organized training courses are necessary to improve the practical skills of general practitioners (editorial, *March Journal*, p.103). However, as well as a sound foundation of basic surgical principles and stitchcraft, I feel that emphasis should also be placed on improving anaesthetic skills.

Correctly used local anaesthetics can provide excellent surgical anaesthesia. However, nerve and field blocks require anatomical and pharmacological knowledge, together with practical skills, to ensure safe administration of local anaesthetic in the correct dose and at the correct anatomical site. Only when so

Table 1. Doctors' reported length of oral steroid therapy for a child and adult presenting with acute asthma associated with respiratory tract infection.

No. of days of oral steroid therapy	No. of GPs reporting length of treatment for	
	Child	Adult
1	6	3
2	13	9
3	43	36
4	8	8
5	60	59
6	1	6
7	9	27
9	1	1
10	1	7
11+	0	2
Until peak flow returns to normal	3	3