

mand from the suffering doctor an acknowledgement that he or she truly is the patient.

The consequences of delayed help or poor treatment are depressingly frequent. I believe that these deaths are preventable and remember the words of a colleague, who said that each time one of these individuals goes he takes his family with him.

Name supplied but withheld from publication at writer's request

Informed consent to HIV testing

I could not agree more with Dr. James E. Parker's short, clear and sensible argument (*Can Med Assoc J* 1989; 140: 262) in favour of HIV testing with no legal restraints.

Harold R. Roby, MD
304 Clifton Ave.
Windsor, NS

Laboratory reports of chlamydial infections in Canada in 1987

This Epidemiologic Report (*Can Med Assoc J* 1988; 139: 1160-1162) is one of the grossest examples of the abuse of statistics that I have seen in a long time. Although I am neither an epidemiologist nor a statistician, even I can see that the information presented is meaningless nonsense.

Tables II and III are complete fiction and totally misleading. They present not incidence rates of infection, as the headings state, but incidence rates of positive test results per 100 000 population, rates that bear little, if any, relation to incidence rates of infection, since the rates of testing are so vastly different in the various provinces.

My Table I demonstrates the discrepancy of the reporting. Al-

though the latest figures readily available to me were for 1977, the relative populations of the provinces probably were not too different 10 years later. Where I have not included the percentage of reports it is because all we are told is that each area accounted for fewer than 2%. We have no idea how small the percentages actually were; any one of them (including that for Quebec) could be infinitesimal.

In comparing the percentages in my table it is not surprising that the reported "rate of infection" among people aged 15 to 24 years in Alberta is approximately triple the "rate of infection" in Ontario (see Table III of the Epidemiologic Report) since the rate of testing in Alberta is triple that in Ontario. Furthermore, the only conclusion that can be drawn about Quebec is not that its rate of chlamydial infection is unusually low but that the medical profession in that province is testing only a tiny portion of the population at risk. It is incredible (in the sense of totally unbelievable) that chlamydial infection in New Brunswick is over 150 times as prevalent as in the contiguous province of Quebec.

In order for these statistics to have any meaning we need to know the percentages of the population tested in terms of geographic region, sex and age distribution.

Table I — Percentages of population and of laboratory reports of chlamydial infection among people aged 15 to 24 years by province or territory

Province or territory	Percentage	
	Population	Reports
Ontario	35.9	40.0
Alberta	8.2	24.1
British Columbia	10.7	15.6
New Brunswick	2.9	8.1
Manitoba	4.4	5.2
Saskatchewan	4.0	2.4
Quebec	27.0	
Nova Scotia	3.6	
Prince Edward Island	0.5	
Newfoundland	2.4	
Yukon	0.1	

A minor irritant is the fact that the "male" column precedes the "female" column in Table I, whereas in Tables II to IV the order is reversed.

Rein T. Paasuke, MD, CM, FRCPC
118 Primrose Dr. SE
Medicine Hat, Alta.

Management of acute asthma

Although the data presented in their article "The value of pulmonary function tests in the management of acute asthma" (*Can Med Assoc J* 1989; 140: 153-156) provide evidence that spirometry may not be useful in predicting the need for hospitalization Drs. James R. Worthington and Jan Ahuja have overlooked the fact that the severity of asthma is difficult for both patients and physicians to assess.¹ Reviews of asthma mortality have all shown that failure to appreciate the severity of a particular attack contributes significantly to avoidable deaths.² Other factors that need to be considered in deciding whether to admit or to discharge include current symptoms suggestive of poor control (nocturnal waking, early morning chest tightness and requirement for β_2 -agonist therapy), historical features, including previous hospitalization and, in particular, previous mechanical ventilation, recent requirement for emergency department assessment and current requirement for corticosteroid therapy.

Although the authors list hydrocortisone among the drugs used in their emergency department treatment regimens it is unclear how many patients in their study received corticosteroid therapy. This is an important omission, for others have shown that the use of corticosteroids in the emergency department reduces both the requirement for hospitalization and the relapse rate.^{3,4} If the majority of patients in this study received hydrocortisone for the acute attack and

Diet and the hypertensive patient.



Pfizer

corticosteroids as outpatients, this would be further supportive evidence and would suggest, as the paper implies, that previously cited criteria for hospital admission may be too generous. Superficial reading of the paper might suggest that objective evaluation of airflow does not contribute to the management of patients and that the absence of airflow measurements combined with the failure of physicians to use corticosteroids might lead to deaths.

Worthington and Ahuja have presented no data on the adequacy of outpatient control of symptoms. A recent prospective evaluation of outcome of our emergency department management of asthma showed that after 1 week of therapy, when — if appropriate therapy had been given — one would expect optimal control of symptoms, between 60% and 70% of patients had symptoms, including nocturnal cough, chest tightness on waking, wheeze and sputum production, all indicative of ongoing

poor control.⁵ The measurement of airflow allows one to assess the response to therapy, and when the patient's previous optimal results of spirometry are available one can judge more accurately the severity of the current attack.

J. Mark Fitzgerald, MB, FRCPC
Frederick E. Hargreave, MD, FRCPC
Firestone Regional Chest
and Allergy Unit
St. Joseph's Hospital
Hamilton, Ont.

References

1. Shim CS, Williams MH: Evaluation of the severity of asthma: patients versus physicians. *Am J Med* 1980; 68: 11-13
2. British Thoracic Association: Deaths from asthma in two regions. *Br Med J* 1982; 285: 1251-1255
3. Littenberg B, Gluck EH: A controlled trial of methylprednisolone in the emergency treatment of acute asthma. *N Engl J Med* 1986; 314: 150-152
4. Fiel SB, Swartz MA, Glans K et al: Efficacy of short-term corticosteroid therapy in out-patient treatment of acute bronchial asthma. *Am J Med*

1983; 75: 259-262

5. Fitzgerald JM, Hargreave FE: The assessment and management of acute life-threatening asthma. *Chest* 1989; 95: 888-894

[Drs. Worthington and Ahuja reply:]

In writing our paper we did not intend to review all aspects of the emergency department treatment of asthma but to assess the usefulness of the forced expiratory volume in 1 second (FEV₁) as an indicator for admission or relapse. Our results clearly show that the FEV₁ fails to identify patients who need admission or will suffer a relapse. However, an FEV₁ of more than 2.4 L at discharge has a negative predictive value of 94%; thus, spirometry can be useful in identifying patients who can safely be discharged.

Our paper does not imply that previously cited criteria for admission are too generous but, rather, that if one uses a value to