

paramount as the deleterious effects of poorly controlled asthma are generally accepted to exceed the theoretical risks of treatment with inhaled steroids.

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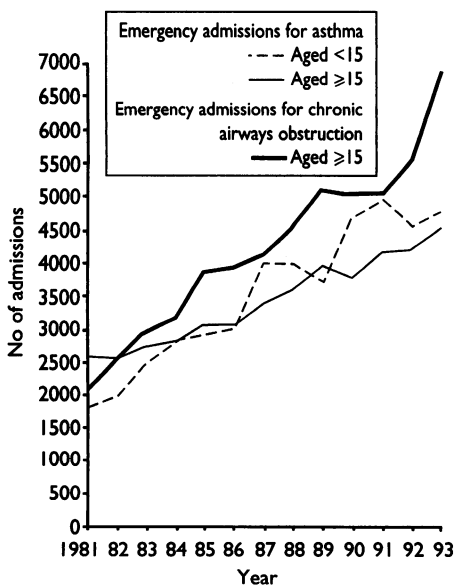
- Phelan PD. Asthma in children: epidemiology. *BMJ* 1994;308:1584-5. (18 June.)
- Agertoft L, Pederson S. Effects of long-term treatment with inhaled corticosteroid on growth and pulmonary function in asthmatic children. *Respir Med* 1994;88:373-81.
- Barnes PJ. Asthma: what is there left to find out? *BMJ* 1993;307:814-5.
- Niana T, Russell G. Asthma, inhaled corticosteroid treatment and growth. *Arch Dis Child* 1992;67:703-5.
- Brown PH, Matusiewicz SP, Shearing C, Tibi L, Greening AP, Crompton GK. Systemic effects of high dose inhaled steroids: comparison of beclomethasone dipropionate and budesonide in healthy subjects. *Thorax* 1993;48:967-73.

Emergency admissions increasing in Scotland

EDITOR,—S J Hyndman and colleagues have reviewed trends in admissions to hospital for acute asthma in East Anglia over the past 15 years and have identified a flattening of the rate of increase.¹ They have been hampered in their comparison with the general experience in England and Wales by changes in the system for gathering information.

Continuous data on admissions to hospital in Scotland are available from Scottish morbidity records collated centrally since the early 1960s. The data for admissions for asthma (strictly, discharges) have recently been reviewed, and the figure shows the trend in the number of admissions, for patients aged <15 and ≥15, during 1981-93. The figure shows no evidence of any flattening in the rate of increase in emergency admissions for asthma in Scotland over this period.

Hyndman and colleagues review possible reasons for change in admission rates. Locally, there is no evidence either that patients with milder asthma are being admitted² or that the upward trend is due to a change in diagnostic preference from "chronic airways obstruction," for which admissions are also continuing to rise (figure). That readmission rates are stable in Scotland is suggested by the fact that the number of patients as



Numbers of emergency admissions for asthma and for chronic airways obstruction (not elsewhere coded), Scotland, 1981-93.

a proportion of the number of admissions each year is stable at 71-75% for those aged <5 and 78-81% for those aged ≥15.

The underlying causes of the observed flattening in the rate of increase in admissions to hospital in East Anglia are worth exploring further, not least to shed some light on whether this flattening indicates good practice in the care of patients with asthma or the opposite.

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1 Hyndman SJ, Williams DRR, Merrill SL, Lipscombe JM, Palmer CR. Rates of admission to hospital for asthma. *BMJ* 1994;308:1596-1600. (18 June.)

2 Bucknall CE, Robertson C, Moran F, Stevenson RD. Improving management of asthma: closing the loop or progressing along the audit spiral? *Quality in Health Care* 1992;1:15-20.

Thunderstorm peak in Luton

EDITOR,—Virginia Murray and colleagues draw attention to the widespread impact of a thunderstorm on the night of 24 June on the number of patients with asthma attending accident and emergency departments across the south east of England.¹ My experience in general practice was similar. I was on call for the local deputising service at the time. The thunderstorm occurred in Luton between 2100 and 2200, and the first call for a visit to a patient with asthma occurred at 2120. In all, 23 calls out of 56 were to patients with asthma. Most of these patients complained of hayfever with difficulty in breathing, implying that they were not usually accustomed to wheeze.

Attendances at the accident and emergency department of Luton and Dunstable Hospital reflected the same pattern: 24 of 89 patients attended with asthma or acute shortness of breath. On the morning of 25 June five of the 10 patients who attended the surgery complained of asthma, which had started at the same time as the thunderstorm.

If my experience was repeated across the rest of the country there was a huge increase in cases of acute asthma over a short period; study of this would be well worth while.

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1 Murray V, Venables K, Laing-Morton T, Partridge M, Thurston J, Williams D. Epidemic of asthma possibly related to thunderstorms. *BMJ* 1994;309:131-2. (9 July.)

Somatostatin in gastroenterology

More studies needed

EDITOR,—We noted with concern the enthusiasm with which A Shulkes and J S Wilson endorse the use of somatostatin and its analogue octreotide in gastroenterology.¹ In particular, we have reservations concerning the reported role of octreotide in the management of enterocutaneous fistula since, despite a successful pilot study,² more studies seem warranted to clarify the timing and the cost-benefit of such treatment. Indeed, more recent studies of patients with such fistulas have failed to show any therapeutic advantage of octreotide.³

The work cited by Shulkes and Wilson was not, as they say, a controlled trial of octreotide but was a trial of a continuous intravenous infusion of

native somatostatin.⁴ The impracticality and financial implications of such treatment, which was associated with only a six day improvement in the time taken to healing, seem difficult to justify. In addition, Shulkes and Wilson fail to take into account that the article quoted lacks relevant clinical information, such as the timing of the infusion of somatostatin, the causes of non-closure of the fistulas, and the indications for stopping treatment and for reoperation. Furthermore, four patients were transferred from the group receiving placebo to the group receiving somatostatin after 15 days of total parenteral nutrition.

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1 Shulkes A, Wilson JS. Somatostatin in gastroenterology. *BMJ* 1994;308:1381-2. (28 May.)

2 Nubiola P, Badia JM, Martinez-Ródenas F, Gil MJ, Segura M, Sancho J, et al. Treatment of 27 postoperative enterocutaneous fistulas with the long half-life somatostatin analogue SMS 201-995. *Ann Surg* 1989;210:56-8.

3 Scott NA, Finnegan S, Irving MH. Octreotide and postoperative enterocutaneous fistulae—a controlled prospective trial. *Acta Gastroenterol Belg* 1993;56:266-70.

4 Torres AJ, Landa JI, Moreno-Azcoita M, Arguello JM, Silecchia G, Castro J, et al. Somatostatin in the management of gastrointestinal fistulas. *Arch Surg* 1992;127:97-100.

Authors' reply

EDITOR,—We stated in our editorial that a "lack of randomised controlled trials with sufficient numbers" had "hampered clinical progress" with respect to accurate delineation of the role of somatostatin and its analogues in gastroenterology. The data from G L Carlson and colleagues illustrate the problem. In 1987 they concluded, after a blind crossover trial in 14 patients, that "octreotide significantly reduces enterocutaneous output and accelerates their spontaneous closure."¹ In 1989 they confirmed the success of the initial trial with a study of 27 patients, this time calling octreotide a "significant advance in the conservative treatment of . . . enterocutaneous fistulas."² In 1993, however, they seem to have resiled from their initial position after a trial in only 19 patients, published in a regional journal.³

We were aware of the apparently contradictory publications of Carlson and colleagues, but we found the multicentre trial of Torres *et al* to have been carefully conducted and to have contained the largest number of patients (20 in both the somatostatin and control groups),⁴ and hence we cited it.

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1 Nubiola-Calonge P, Badia JM, Sancho J, Gil MJ, Segura M, Sitges-Serra A. Blind evaluation of the effect of octreotide (SMS 201-995), a somatostatin analogue, on small bowel fistula output. *Lancet* 1987;ii:672-3.

2 Nubiola P, Badia JM, Martinez-Ródenas F, Gil MJ, Segura M,