that it was about the health of general practitioners rather than that of patients. At a time when there are so many articles on burn-out and depression among our profession, I expected it to provide further evidence that health promotion and the screening of healthy adults are a rod for our own backs. The government wish regular screening programmes to be set up when there is scanty, if any, evidence in their favour.

We now have the facility to scare people on an unprecedented scale and the raising of awareness of health problems together with its usual bedfellow, heightened anxiety, cannot really be viewed as healthy. If we are going to mention asymptomatic conditions, which the doctor rather than the patient defines as important, then we had better prepare ourselves for more work, counselling people through years of worry.

After all the hard work we may put in, people will eventually move house or die. We may like to feel that we are indispensable, but the truth is otherwise. Feelings of frustration, anger, loss and guilt are as much a part of our experience as that of our patients. Burn-out as a result of performing medical work which is not proven to change the course of disease or its outcome, is of no use to the doctor or his patients.

We should be spending at least as much time looking to meet our own needs as we spend looking after those of our patients and as a profession we should be far more zealous in the care of our fellow members than we are at present.

C.L. MANNING

95 Langham Road
Teddington TW11 9HG

Asthma — still a challenge for general practice

Sir,

In his discussion paper Kevin Jones gave a comprehensive overview of the primary care management of asthma (June *Journal,* p.254). One omission was that of drug-induced or exacerbated asthma. The drugs most commonly involved are beta-blockers, and non-steroidal anti-inflammatory drugs including aspirin, both of which are widely prescribed. The Committee on Safety of Medicines continues to receive reports of deaths owing to bronchospasm in patients receiving beta-blockers.[1] Most of these deaths occurred in patients with asthma or a history of obstructive airways disease, and were therefore preventable.

In 1986 I undertook a retrospective survey of all patients aged 17 years and over discharged from Selly Oak hospital in 1985 with a primary discharge diagnosis of asthma. One hundred and sixty five patients were identified, and the notes of 136 (82.4%) were traced. Four patients, aged between 63 and 75 years, were taking beta-blockers on admission. Propranolol was the agent involved in each case and it had been taken for between one week and 18 months prior to the onset of asthmatic symptoms. The asthmatic symptoms had lasted from one to four weeks before admission, and in two patients had worsened suddenly over one and five hours, respectively. Two patients were moribund on admission and would have died but for immediate medical intervention: one required ventilation for one day. All four patients left hospital alive and well. The patient who required ventilation was known to be asthmatic and had received propranolol on the advice of the hospital in spite of this. The other three patients were undiagnosed asthmatics.

It is impossible to predict from the chronicity or severity of asthma which patients are likely to bronchoconstrict with beta-blockers, nor whether the induced bronchospasm will be minimal or life threatening. The period between starting beta-blockers and a severe attack of asthma is similarly variable. Although cardioselective agents are considered to be safer, the degree of bronchospasm produced in asthmatics is unpredictable.[2] Thus all beta-blockers should be contraindicated in patients with asthma. In addition, all patients for whom beta-blockers are being considered should be screened for symptoms suggestive of asthma and undiagnosed asthma should be considered in any patient who becomes dyspnoeic while taking beta-blockers.

D.G. SWAIN

Sandwell District General Hospital
Lyndon
West Bromwich
West Midlands B71 4HJ

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2. Skinner C, Palmer KNV, Kerridge DF. Comparison of the effects of acebutolol (sectral) and practolol (eraldin) on airways obstruction in asthmatics. *Br J Clin Pharmacol* 1975; **2**: 417-422.

Sir,

Dr Kevin Jones (June *Journal,* p.254) highlights some of the main deficiencies of asthma care and suggests three major points that practices should address — prevalence of asthma, asthma therapy and follow up.

As general practitioners we should ask ourselves several specific questions concerning the management of asthma in our practices:

1. Is the cumulative prevalence of asthma in the practice between 10 and 15%?[1,2]
2. Is the incidence of new cases of asthma in the practice over 9% per year per partner with an average list size?[1]
3. Is the therapy asthmatics receive appropriate? Are their drug delivery systems and inhaler techniques suitable? Are patients who use symptomatic bronchodilators regularly receiving preventive regimens?
4. What percentage of acute exacerbations of asthma requiring emergency treatment are successfully treated in the practice? (Over 80% in some trials.[3])
5. Do the asthmatics who experience recurrent exacerbations requiring emergency treatment despite adequate prevention regimens (approximately 8% of the asthma population) know when to obtain medical advice? Do they possess a peak flow meter? Do they know their predicted and best ever peak expiratory flow readings (often considerably different in this group) and have they been instructed to act accordingly if the value is less than 60–70% of normal?[4]
6. Is there a recall and follow-up system appropriate to the needs of the whole spectrum of the asthma population in the practice?

The answers to these questions not only reflect the standard of care we provide for our asthmatic patients but also provide a measure of one important aspect of clinical care that is suitable for internal or external monitoring.

R.M. JENKINS

Davenal House
28 Birmingham Road
Bromsgrove B61 0DD

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Sir,

Kevin Jones (June *Journal,* p.254) has written a plea for improved asthma care in general practice. What has been omitted and is absent from most review articles on this subject is the reluctance of many general practitioners to implement this