emphasise the need to screen for HIV, syphilis, HTLV I and II, and hepatitis B and C. The published guidelines include a sample information sheet about screening for infectious diseases and sample instructions for the expression of milk and the personal hygiene of donors. Detailed guidance is given on all milk banking procedures including microbiological screening and pasteurisation. A minimum exposure of 57°C for 30 minutes or a maximum of 63°C for 30 minutes is recommended and the importance of rigorous quality control stressed. Common questions about temperature and length of storage are answered and recommendations made for the handling and thawing of frozen pasteurised breast milk. Standards for documentation are provided to permit tracing of a donor, if necessary.

Established milk banks and those in the process of being set up will find this document valuable. It draws together evidence from 41 papers. The working party feel that it would be helpful if there was uniformity of practice throughout the UK and these guidelines might promote this. They have been published by the British Paediatric Association and are available from the BPA office (5 St Andrews Place, Regent's Park, London NW1 4LB) at a cost of £4.

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- 2 Balmer SE, Wharton BA. Human milk banking at Sorrento Maternity Hospital, Birmingham. *Arch Dis Child* 1992; 67: 556-9.
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Efficacy and cost effectiveness of inhaled steroids in asthma in a developing country: an epilogue

EDITOR,—I am grateful to Drs Costello and Woodward for their commentary on my paper.¹

My patients were carefully selected on the degree of disability. Few paediatricians would have access to very large numbers of severe asthmatics and those included represent severe asthmatics in general with regard to the degree of severity, incidence of atopy, family history, age at onset, etc. Similar patients are the ones who consume the greatest amount of time and resources of health care providers. The clinical benefits demonstrated in the

paper, especially reduction in breakthrough wheezing and avoidance of repeated hospitalisations, would lead to significant savings on scarce resources, even in the public sector.

In the Sri Lankan non-fee levying public sector, till very recently, the management of these severe asthmatics revolved round the use of oral β agonists, oral theophyllines, and intermittent systemic steroids. However, I am pleased to report that on the basis of the work presented, the Sri Lankan Ministry of Health has agreed in principle to provide inhaled steroids through the paediatricians of the national health service. Presently, at Lady Ridgeway Hospital, we are able to prescribe these drugs to needy children, completely free of charge. This has resulted in a marked reduction in admissions for acute severe asthma.

The costs calculated were those that were incurred by the patients, inclusive of costs of hospitalisation, travelling, consultations, drugs, etc for the first year on treatment. The cost per consultation was Rs 125.00 (£1.55), inhaler Rs 500.00 (£6.60), and hospitalisation approximately Rs 600.00 to 800.00 (£8.00 to 10.50) per day. Each inhaler was sufficient for more than a month on maintenance dosage. The remarkable reduction of the costs (to about £6.00) per patient was achieved by very significant reductions in breakthrough wheezing and hospitalisations.

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- 1 Perera BJC. Efficacy and cost effectiveness of inhaled steroids in asthma in a developing country. *Arch Dis Child* 1995; 72: 312-6.