LETTERS TO THE EDITOR

Asthma: a follow up statement from an international paediatric asthma consensus group

Sir,—We read with interest the follow up statement from an international paediatric asthma consensus group.1 We are surprised that the authors are not more emphatic about the value of peak flow monitoring in recognising severe episodes of asthma. The authors state that patients should ‘understand the use of peak flow meters’ and that ‘action plans should . . . include instruction on the signs that indicate worsening of asthma’. Comparative guidelines for adults have been much more explicit about the use of peak flow meters in the recognition of severe episodes of asthma.2,3

Every asthmatic child over 5 years old who attends our outpatient clinic is given a peak flow meter. We teach families that they should identify their child’s best peak flow reading. We then give them a ‘danger’ figure (usually 60% of their best reading) and tell them to come to our accident and emergency department if the peak flow falls below that figure and does not improve promptly with bronchodilators. We find the asthma card supplied by the National Asthma Campaign to be useful. This card has separate sections for noting the child’s best and danger peak flow levels.

In a study of the value of home peak flow monitoring we have interviewed 58 families attending our clinic. Fifty four families knew their child’s best and danger peak flow levels to within 20% of the actual values and knew what to do about readings below the danger level. Four families either did not use the peak flow meter or had too poor a knowledge of their child’s best and danger peak flow readings for the meter to be useful.

Most families find the concepts of best and danger peak flow levels helpful. The proportion of asthmatic children attending a clinic who have a peak flow meter and whose families know their child’s best and danger peak flow levels is a useful performance indicator and can be audited.

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Beta glucuronidase and hyperbilirubinaemia in breast fed infants of diabetic mothers

Sir,—We read the paper of Sirota et al with interest.1 They suggest, after a study of 10 breast fed infants of diabetic mothers (IDM) and their mothers plus 10 infant and mother controls, that the high concentration of β-glucuronidase in breast milk of diabetic mothers is an additional important cause leading to hyperbilirubinaemia in their breast fed babies. We were concerned about problems that may limit successful breast feeding in our hospital, and identified exaggeration of physiological jaundice as a major problem. Following the work of Gourley and Arend,2 we aimed to determine if a relationship existed between the concentration of breast milk β-glucuronidase and the degree of early (first week) neonatal jaundice. Our study showed no relationship (r=0.12, p=0.4) between them in 55 healthy, full term infants who were breast feeding satisfactorily in baby and mother pairs on the third to sixth postnatal day.3 There were no IDM. Mean (SD) concentrations of breast milk β-glucuronidase and serum bilirubin were 387 (189) Sigma/units and 192 (108) μmol/l respectively. We felt that breast milk β-glucuronidase could not directly account for the exaggerated early neonatal jaundice seen in breast fed babies.

