**LETTERS TO THE EDITOR**

### Omega-3s and childhood asthma

In their study, Haby and colleagues found a high intake of dietary polyunsaturated fats to be a risk factor for asthma in preschool children. They suggest that reducing the consumption of these fats represents an intervention that has great potential for lowering asthma rates. However, this may be too much of a conclusion as it is not the total content of polyunsaturated fats in the diet but their composition that is likely to be causing adverse health effects. The problem most probably stems from the imbalance of n-6 to n-3 fatty acids.

It is estimated that, throughout much of human existence, we ate diets that contained ratios of n-6 to n-3 fatty acids of approximately 1:1 to 2:1. However, today in the US the ratio is estimated to be greater than 10:1, and some have estimated that it is actually more like 20:1 to 30:1. Could it be that the increased intake of polyunsaturated fats seen in preschool asthmatics by Haby et al is actually just a marker for an even greater imbalance in this ratio?

In Japan the n-6:n-3 ratio in the typical diet is about 4:1, several times better than in the US. One epidemiological study found that the rate of childhood asthma in Tokyo is 0.7% and some have estimated that it is actually zero. However, this may be a risk factor for asthma in preschool children: prevalence and risk factors. Thorax 2001; 56: 589–95.


### Mechanical insufflation

We read with interest the recent paper by Sivasothy et al on the effect of manually assisted cough and mechanical insufflation on cough flows of normal subjects, patients with chronic obstructive pulmonary disease (COPD), and patients with respiratory muscle weakness. Thorax 2001; 56: 438–44.


### Diagnosing TB

While not wishing to diminish Professor Partridge’s argument that respiratory medicine needs a higher profile, there are some notable disparities between disease profiles within respiratory medicine. The year 2001 saw a remarkable number of outbreaks of tuberculosis including the largest since chemotherapy became available. In at least two of these outbreaks the doctor attending the index patient diagnosed asthma not tuberculosis for several months. Part of the reason is that “Doctors don’t think of tuberculosis because there isn’t a (pharmaceutical) company producing goods saying ‘think of TB’.”

There is a point of view which would wish to move tuberculosis into the province of infectious disease. Yet chest physicians manage 85% of cases and, as the most common symptom of tuberculosis is a cough, it is likely this will remain so.

As chest physicians we have a duty to all respiratory patients, not just those who happen to have a pharmaceutically fashionable disease.

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**Mechanical insufflation**

When cattle are allowed to graze freely in the warmer months, as historically they have always done, their fatty acid composition is favourably enhanced. While improving the fatty acid profile of the meat supply may not fully compensate for the many shortcomings of the modern western diet, it would certainly be a step in the right direction. Since it is estimated that a fourfold increase in fish consumption would be required to bring n-3 fatty acid consumption up to recommended levels, improvements in any other food sources would be of great value.

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### References


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**Diagnosing TB**

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**References**


Inhaled sodium cromoglycate in children with asthma

We note with interest the further correspondence concerning the systematic review of inhaled sodium cromoglycate as maintenance therapy in children with asthma from Professor M Silverman and Dr G Laszlo.

Professor Silverman asked the authors to carry out separate calculations of the size of the treatment effect between inhaled sodium cromoglycate and placebo for school children and pre-school children. The results of these calculations show that the mean difference between inhaled sodium cromoglycate and placebo for school children (cough 0.26, wheeze 0.29) than for pre-school children (cough 0.12, wheeze 0.08). In both age groups these differences are significant and in favour of sodium cromoglycate. In fig 1 we illustrate these differences and the comparison with all children taken from the original review.

These results support our own conclusion that the drug is either less effective in pre-school children or the apparent lesser effect is related to the difficulties in trials in younger children. In their reply to Silverman the authors dismiss his suggestion that sodium cromoglycate is more effective in schoolchildren by stating that results from early trials in older children were likely to be unreliable by implying that the trials were flawed. Why then did they include them in their reply? This hardly seems a valid argument. Tasche et al state that the finding that the 95% CI tolerance interval for cough (not wheeze as in their reply) in school children includes zero also supports the view that this conclusion should be dismissed. We have already pointed out that we believe that their interpretation of the tolerance interval is incorrect and misleading.

Systematic reviews of treatments for important diseases are likely to be used in the development of treatment guidelines for doctors. In such reviews the conclusions of the authors of the review are likely to be taken into consideration. In this case the authors concluded that “there is insufficient evidence for a beneficial effect of sodium Cromoglycate as a maintenance treatment in children with asthma”. This conclusion was not supported by their original review and, in the case of school children, is certainly not supported by the new calculations as requested by Silverman. In their review of the 12 trials conducted in children aged 5–17 years, they classified 11 as positive and one as positive/equal. In the pooled placebo groups the reported mean daily symptom score was 0.8 and the size of the treatment effects, particularly in school children, is certainly beneficial and of clinical importance. In the light of both the statistical and clinical benefits seen with sodium cromoglycate, we would therefore suggest that the authors be asked to reconsider their conclusions.

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References
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