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LUNG ALERT

Many asthma deaths may be preventable

▲ Harrison B, Stephenson P, Mohan G, *et al.* An on-going confidential enquiry into asthma deaths in the Eastern region of the UK, 2001–2003. *Primary Care Respir J* 2005;**14**:303–13

All deaths under the age of 65 with asthma recorded in the first part of the death certificate were examined from a population of approximately 5.25 million people. Hospital and GP records were scrutinised and GPs were interviewed to ensure that asthma was the cause of death. Fifty seven of the original 95 reported deaths were due to asthma; the other 38 deaths were due to COPD (n = 13), cardiac disease (n = 11), pneumonia (n = 9), and other conditions.

Of the 57 confirmed asthma deaths, 19 patients had significant co-morbid diseases. 60% of the asthma fatalities were male, a reverse of the male/female ratio observed in severe asthma. 53% of patients were felt to have severe asthma according to BTS guidelines, 21% had moderately severe asthma, 16% mild asthma, and 11% not known. Eleven patients (19%, eight male, eight aged 20 years or less) suffered sudden death from acute severe asthma; 10 of these occurred between April and August suggesting that atopy may have had a role. The other 81% had more protracted courses of their final illness with potential opportunity for earlier intervention. The authors point out that the data were, by their nature, retrospective and occasionally incomplete.

Patient care was considered appropriate in only 33% of cases. Failings were present across primary and secondary care and included inadequate follow up (failures to refer to hospital at an appropriate time or to a respiratory specialist once in hospital) and inadequate prescription of inhaled or oral corticosteroids. 81% of patients had psychosocial or behavioural factors that were considered to be contributory to death. These included poor compliance/failure to attend (61%), but also significant smoking (46%), denial (37%), depression (20%), alcohol abuse (20%), and family disharmony (15%).

The authors endorse the production of an ''at risk'' register in primary care as advocated by the 2003 BTS/SIGN asthma guidelines and suggest criteria to guide the construction of such a register.

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