they "rarely" had difficulty. The different experience may reflect a difference between elective or semi-elective postoperative admissions versus acute medical admissions. Perceived or actual experience in intensive care could be another factor; 48% of respiratory specialist registrars had experience of intensive care medicine at the SHO level compared with 100% of anaesthetic trainees, and all the anaesthetic trainees had experience at the registrar level compared with 52% of the respiratory specialist registrars. Both groups underestimated the duration of critical care experience of each other.

Critical care leads considered that the "quality" of referral was better from specialist registrars in anaesthesia than medicine. They strongly supported the need for physicians to receive more training in how to make effective referrals and in achieving a more "realistic" understanding of potential benefit from ICU admission.

Our survey confirms the common perception that medical teams have more difficulty than anaesthetic colleagues in gaining acceptance of their patients to intensive care. Furthermore, this may relate to the perception that they are less able to judge need or prognosis because they have less ICU experience. Critical care training is soon to be integrated into acute care common stem,[2] but additional experience for all medical specialties is probably needed together with an expansion of dual accreditation by medical specialists in intensive care medicine.

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Breathing techniques in the management of asthma

We welcome the study by Slader *et al*[1] recently published in *Thorax* as the current state of our knowledge on breathing techniques for asthma is deplorable,[2] although such techniques are frequently used by physiotherapists when treating patients with asthma.[3]

Several aspects in this study may have influenced the results and need to be discussed.

First, the absence of evidence that upper body exercises, used as a comparator in this study, have an impact on lung function should not be confused with evidence that such an effect is absent. The two studies identified in the Cochrane review on breathing exercises for asthma,[2] that included forced vital capacity or forced expiratory volume in 1 s as an outcome, had only 8–12 patients in each group. If upper body exercises are in fact effective, the contrast between the two interventions may have been insufficient.

Second, we believe that more attention is needed for the hypothesis that the subjects recruited in this study were a special group. The patients were recruited using a database of volunteers and advertising in the lay press. In our view this may jeopardise the generalisability of the results to patients who consult a doctor for asthma.

Finally, the possibility that the two breathing routines provided a non-specific deferral strategy for reliever use needs further testing by, for example, comparing a breathing exercise with other (non-physical) deferral strategies.

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NICE guidance for screening for malnutrition: implications for lung cancer services

The National Institute for Health and Clinical Excellence (NICE) guidelines on nutrition support in adults recommends screening all outpatients at their first clinic appointment to identify those who have malnutrition or are at risk of malnutrition.[1] A recent study of inpatients with cancer also suggests outpatient screening to improve the early identification of patients who may benefit from nutritional support.[2] In response to this, we have examined the potential impact of introducing routine screening for malnutrition into the two Combined Lung Oncology Clinics held weekly at the Nottingham University Hospitals NHS Trust. Neither clinic routinely screens for malnutrition, and referrals to a dietician are made—relatively infrequently—on an ad hoc basis. The malnutrition universal screening tool (MUST)[3] was completed in 50 consecutive patients with lung cancer at their first or second outpatient attendance following their histological diagnosis. Using either the NICE or MUST guideline recommendations, about one third of patients had or were at high risk of malnutrition (table 1).[1 3]

Table 1 Screening for malnutrition in 50 outpatients with lung cancer

Mean (SD) age (years)	69 (10)
M:F	28:22
NSCLC:SCLC	39:11
Performance status (East Coast Oncology Group)	
0–1	37
⩾2	7
Unknown	6
Mean (SD) BMI (kg/m^2)	24 (5)
NICE recommends nutritional support is considered for any of the following:	
BMI <18.5 kg/m^2; weight loss >10% or	
BMI <20 kg/m^2 and weight loss >5%	
Total meeting one of the above criteria	15 (30%)
MUST score, n (%)	
0 (routine clinical care)	20 (40%)
1 (medium risk, observe)	12 (24%)
⩾2 (high risk, needs nutritional treatment)	18 (36%)

NSCLC, non-small cell lung cancer; SCLC, small cell lung cancer; BMI, body mass index.

The introduction of routine screening for malnutrition into lung cancer clinics is therefore likely to identify a large number of patients at the time of their diagnosis who should be considered for nutrition support. The challenge locally is to identify how screening can be implemented routinely and how the dietetic input required can be funded, at a time when financial constraints are limiting service development. The generally nihilistic view of nutritional support will also need to be addressed. Progress cannot be made unless such patients are identified, receive high quality support and have the opportunity to take part in trials that aim to improve outcomes.

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