LETTER TO THE EDITOR

Dear Sir,

May I congratulate you on the improving standard of the Bahrain Medical Bulletin, as shown in Volume 1 No. 2. I appreciate what hard work must take place to produce a Bulletin of this class.

Under "Recent Advances" on P. 35, you show a young lady blowing a Wright's Mini Peak Flow Meter, without any caption other than an unobtrusive arrow to the heading, "Tapes could lead to Breakthrough in Hypertensive Treatment". There is at the end a semi-paragraph, "And an inexpensive device to measure the peak lung expiratory flow."

As important a physician's aid as this merits fuller description for the benefit of those not initiated in it and its parent instrument.

As Dr. Harry Morrow Brown, Director of Research at the Midlands Asthma And Allergy Research Association, U.K. has written :-

"Many Hospital Physicians, as well as family practioners, will treat asthma without measuring even the peak flow rate. But who would treat hypertension without measuring the blood pressure, or diabetes without a blood sugar estimation ? Everyone should have some method of measuring the airway, because the chronic asthmatic has no idea what a normal airway feels like and often adapts his life around his asthma to avoid exertion."

The instrument giving the fullest information is the Vitelograph. The drawback is that it is expensive, so that we can only afford to plan for one for each Health Centre. It is cumbersome, so that one has to take the patient to the Machine rather than the machine to the patient. It has the big advantage of giving a specific record on paper.

The very practical alternative, which I have found invaluable, over years in Family Practice, is the Wright Peak Flow Meter. It is easily portable, easy to use, needs practically no maintenance and is priced in the range BD. 100. It measures, as its title suggests, the peak expiratory flow, which for practical purposes is a measure of Bronchospasm.

The merits of it are fourfold :-

1. If one suspects Bronchospasm to be present it can confirm or refute this suspicion.

2. It gives a statistical assessment of how bad any asthmatic patient is at a particular attendance.

3. If it is used on the patient's arrival and the patient is then given a Ventolin Aerosol to use and tried on the Peak Flow Meter again 20 minutes later it gives a measurement as to how reversible the bronchial constriction is. It can be used to assess the benefit of other forms of treatment, such as a Becotide Aerosol, Salbutomol Tabs., Oral Cortisone, or A.C.T.H. over longer periods. With all these treatments and their potential risks and costs, it is important that we do not continue with them unless we can show specific benefit.

4. It amplifies the wheeze in a patient during forced expiration, which is often surprising when the use of the stethoscope has not revealed any spasm. Not only does this add another dimension to the physician in his examination, but the audible wheeze produced often impresses the patient so much that they are more willing to deny themselves the pleasures of inhaling nicotine.

Such a measurement is very important because, in a clinical trial in Derby, U.K., it was shown that on a 10 point scale that the patient's estimate of the severity of their asthma by the patient and the physician in almost all cases grossly underestimated the situation, so that the asthmatic was almost always worse than he imagined, the reverse of what is usually thought.

The problem with the Vitelog-

raph and the Wright Peak Flow Meter is that they can only be used normally by the physician possessing them. On the other hand, the patient will often report that their Bronchospasm is worse at 11.00 p.m. or 4.00 a.m. It is very helpful to have some measurement of the severity of the Bronchospasm at that time and a measurement of the response to treatment suggested. For this reason there is the mini Wrights Peak Flow Meter, which was available in U.K. 12 months ago at a cost of £ 8. The patient can be taught to use this, taking it home with them and producing readings on his next attendance for his physician. It is not such a robust or accurate instrument as its parent instrument, but nevertheless extremely useful. It does not amplify the wheeze, which, in practice, I have found useful.

The Mini Peak Flow Meter has been in use now in Isa Town and A'Ali Health Centres for many months. A Peak Flow Meter will be available shortly at Ibn Sinna, Jidhafs & Sh. Salman Health Centres and in the Equipment of all Health Centres from now there will be a Vitelograph as a base instrument, with Peak Flow Meters for each Consulting Room and Mini Peak Flow Meters to use appropriately. I would be pleased to show the use of the Peak Flow Meter to anyone interested who contacted me and to show them the appropriate literature. Incidentally, Dr. Wright is a charming old man, who has shown a particular interest in developing simple forms of measurement for common medical problems. He would maintain that one can measure expiratory flow satisfactorily by testing a patient's ability to blow out a match or a candle, using a ruler to measure the distance at which a patient can achieve this. I have found this a difficult exercise in which the physician is liable to burn his fingers on the match !

I am sure these well tried and comparatively inexpensive instruments will be very beneficial to the patients in Bahrain, suffering from reversible obstructive airway disease.

Yours sincerely,

Dr. E. Cotter □□