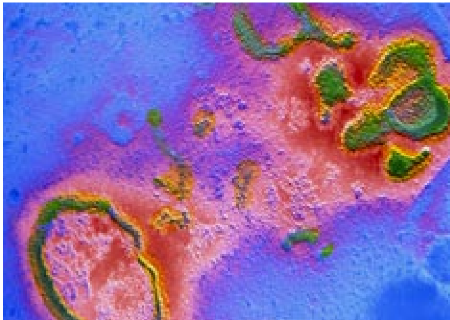
We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS


CNRI/SPL

ACUTE BRONCHIOLITIS

Risk of hyponatraemia

Bush and Thomson stated that electrolytes should be determined only in infants with bronchiolitis who are dehydrated.[1] However hyponatraemia is seen in up to 33% of children in hospital with this disease.[2] It is unrelated to dehydration and has been associated with administration of intravenous fluids together with increased antidiuretic hormone values.[3 4]

It can cause generalised tonic-clonic seizures,[2] which may be refractory to anticonvulsants. The National Patient Safety Agency has issued an alert aimed at reducing the risk of hyponatraemia in children – electrolytes should be determined before starting intravenous fluids and at least daily afterwards.[5]

Fluids should be restricted in children with hyponatraemia who are receiving intravenous 0.9% saline (with 5% dextrose) and who have high antidiuretic hormone concentrations.

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Competing interests: None declared.

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There may be a treatment

Although the track record for successful treatment interventions for acute bronchiolitis has so far been unimpressive,[1] a recent trial using nebulised hypertonic saline holds promise.[2] This study involved 96 infants with a mean age of 4.7 months admitted to hospital for acute bronchiolitis, who were double blindly randomised to receive nebulised 3% saline or 0.9% saline. The infants in the hypertonic saline group had a clinically significant 26% reduction in length of hospital stay (2.6 *v* 3.5 days). Treatment was well tolerated with no observed adverse side effects.

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Competing interests: None declared.

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COMMUNITY ACQUIRED PNEUMONIA

Antibiotic coverage is atypical: evidence from randomised trials

Bjerre quotes an observational study to support the addition of antibiotics that cover atypical pathogens to the treatment of patients with community acquired pneumonia.[1] The results of randomised controlled trials dealing with this question were amassed in two recent systematic reviews and meta-analyses (one published in the *BMJ*), which were not quoted in the editorial.[2 3] Our systematic review included 24 trials, which randomised 5015 patients.[3] Mortality was no different in the arm that provided atypical coverage and the arm that did not (relative risk 1.13, 95% confidence interval 0.82 to 1.54). Regimens that covered atypical pathogens showed a trend towards clinical success and a significant advantage to bacteriological eradication. Both disappeared when evaluating methodologically high quality studies alone. Nearly all studies compared a β lactam with a single quinolone or macrolide.

A randomised clinical trial comparing treatment with a β lactam to a combination of a β lactam and a macrolide is needed.

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ASYLUM SEEKERS' ACCESS TO CARE

Document is worrying

The Home Office document mentioned in Mooney's news report contains some rather worrying features.[1 2] It talks about NHS trusts sharing information with the immigration authority regarding failed asylum seekers, without any mention of confidentiality.

It also confidently states that new technology will help assess the age of claimants who say that they are minors. Is anyone aware of a new technological advance that has suddenly resolved the difficult problem of age assessments? Or is the government placing too much faith in a fix that could result in vulnerable children being wrongly treated as adults?

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Competing interests: PRM previously worked as a general practitioner in special services for asylum seekers, and has prepared medicolegal reports relating to asylum claims.

1 Mooney H. Charity warns of proposed restrictions to asylum seekers' access to primary care. *BMJ* 2007;335:1012-3. (17 November.)
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COLECTOMY AND IBD

Does surgery improve survival?

The study by Roberts et al of mortality among patients in hospital for inflammatory bowel disease (IBD) has several limitations.[1]

Firstly, the observation that patients with IBD undergoing elective colectomy had lower mortality than those treated medically or needing emergency

colectomy is not "strong evidence suggesting that the threshold for elective colectomy is too high." Patients who electively undergo colectomy usually have chronic relapsing disease or risk of malignancy, whereas those admitted to hospital for medical management or emergency colectomy are usually far sicker with severe acute or fulminant disease.[2] These subgroups of patients have entirely different indications for colectomy, so lowering the threshold for elective surgery would not necessarily reduce numbers being admitted with severe acute disease.

Secondly, the authors' method of risk adjustment for comorbidity is flawed given the poor accuracy and completeness of secondary medical diagnostic coding in the hospital episode statistics database.[3] Furthermore, their risk model did not include well established predictors of the need for colectomy, such as extent of IBD and race,[4 5] or take the severity of comorbid disease into account. It therefore assumed that patients with mild and severe comorbid disease have the same risk of mortality. Patients treated medically may have been high risk surgical candidates with poor prognosis who were appropriately not offered surgery. This contention is supported by the authors' observation that patients managed conservatively during their index hospital admission had high mortality irrespective of whether they subsequently underwent colectomy.

No evidence exists to change the current practice of consigning surgery in IBD to the treatment of last resort.[2]

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Competing interests: None declared.

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FOREIGN DOCTORS' VICTORY

British benevolence and betrayal

As a qualified clinical epidemiologist, I had an excellent position abroad but migrated to the UK in 2002 under the highly skilled migrant programme (HSMP)[1] because of various ties with the UK. I declared the UK my main home and invested my life savings in the country. I was welcomed with open arms by NHS colleagues. When my application was approved, government documents and communications led me to believe that I could apply for indefinite leave to remain (ILR) after four years.

When the first highly skilled migrants were close to applying for ILR, the government retrospectively lengthened the qualifying period to five years. I had to pay an extra £15 000 (€20 900; $31 000) in university fees for three years. Fees for many applications to the Home Office increased steeply. Travel continued to be expensive and difficult as visas were needed for mainland Europe.

A joint parliamentary committee concluded that these changes were "not compatible with the right to respect for home and family life under Article 8 ECHR and contrary to basic notions of fairness." It recommended that the changes should apply prospectively, and that those already granted leave to remain under HSMP should be treated according to the previous rules.[2]

On behalf of thousands of highly skilled migrants who have made the UK their home and who perform their civic duties, I appeal to the UK government to be fair and not to cause enormous misery and hardship by changing the rules of the game midway.

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Competing interests: I have been both personally and financially severely disadvantaged due to the changes introduced midway through the scheme while I was on the HSMP visa.

1 Dyer C. Foreign doctors win High Court challenge over training places. *BMJ* 2007;335:1009. (17 November.)
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CLIMATE CHANGE AND HEALTH

We must all act now

See also Editorial by Stott et al and News by Watson

Almost everyone agrees that human production of greenhouse gases is driving global warming—more quickly than anticipated.[1] The latest summary of the scientific evidence by the Intergovernmental Panel on Climate Change (IPCC) suggests that by 2030 the earth will warm by 2.0°C—the tipping point at which warming may lead to more warming.[2] Temperatures may rise by 6.4°C this century.

In Bali next week, world leaders will try to agree how to limit this rise. It is imperative that they do. The IPCC predicts increased death and injury due to heatwaves, floods, storms, fires, and droughts. Cardiorespiratory disease will increase because of higher ozone concentrations. Freshwater and saltwater flooding will increase the spread of diarrhoea.[3] By 2100, the number of people exposed to malaria prone temperatures may increase by a third. Water availability will suffer. Subsistence agriculture will fail through changes to the climate and ecosystem collapse. Hunger, migration, and war may also be driven by economic collapse similar in scale to that associated with world wars.[4]

As doctors we urge the leaders to consider the health implications of climate change and act now to prevent it. The most vulnerable people will be affected first. Around 175 million children are predicted to be afflicted each year over the next decade by disasters caused by climate change; by 2010, 50 million people may be displaced, mostly women and children.[5]

We consider this to be the greatest public health disaster facing us today and one that requires action at all levels. We call on all health professionals to urge their colleagues, employers, and institutions to reduce their carbon footprint and to set an example in their personal lives. We intend to make our colleges carbon neutral as soon as possible. Above all, we call on the world's leaders to take radical action to reduce CO_2 emissions as a matter of extreme urgency. Only by firm and decisive action now, can we, as a global community, hope to avert or mitigate an impending public health catastrophe of immense proportions.

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Competing interests: None declared.

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