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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

A confidence trick

SIR,—Mrs Barbara Castle, when Secretary of State for Health and Social Security, promised the British public that closure of private wards in NHS hospitals would release 4000 beds—"the equivalent of four 1000-bedded district hospitals" as she put it—for public use. She also promised that this move would help abolish the enormous national waiting list for hospital admission.

On 20 May of this year 10 beds on the private ward at the Gordon Hospital, a part of our hospital group, were due to be closed down. These beds will lie empty and gradually collect a veneer of dust. There is no question at all of their being used for NHS patients and to help reduce our rapidly lengthening waiting list. Inquiries among my surgical colleagues throughout Britain have failed to reveal any example where the closure of a private ward has released a single bed for an NHS patient.

I am therefore forced to conclude that these closures are being made on purely political grounds and without any possibility of their being used to improve NHS facilities. The whole thing has been a confidence trick by the Government. I believe that the people of this country deserve to know that, yet again, they have been deceived by our masters.

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Deaths from asthma in children on aerosol corticosteroids

SIR,—Your leading article on this subject (30 April, p 1117) and another (25 December 1976, p 1523) entitled "Intranasal beclomethasone: wonder drug or hazard?" seem to show a change of view when compared with a previous leading article as recently as February 1975,[1] which began: "Steroid aerosols have revolutionised the treatment of severely asthmatic children." Such vacillation of editorial opinion could certainly cause confusion, doubt, and anxiety in the minds of those who care for the asthmatic child.

The 1975[1] article is a model of clarity with which I am in complete agreement except that reference to our pioneer publications[2 3] was overlooked. Having already expressed my views regarding the intranasal use of beclomethasone,[4] I must again seek the courtesy of your correspondence columns because some attempt to assess this treatment in balanced perspective should be made. It is unfortunate that our review of 5½ years of experience with 600 asthmatics of all ages [5] and five years' experience of 223 cases of perennial allergic rhinitis[6] cannot be published in the *BMJ* because of lack of space, as our long-term findings may help in establishing the place of this treatment in modern therapeutics.

Steroid aerosols for asthma and rhinitis are now accepted in many countries as an important advance without significant side effects. Properly administered and carefully monitored, such treatment offers release from steroid bondage. In contrast, what would be the fate of corticosteroid drugs if recently discovered and submitted to the Committee on Safety of Medicines or the Food and Drug Administration?

The report of Mellis and Phelan,[7] to which you refer in your most recent leading article, is well detailed and I agree with their conclusion that timely and adequate corticosteroid treatment might have prevented the three deaths, in two of which there were clear warning signals. It is disturbing that two children had "normal" tetracosactrin adrenal function tests and that satisfactory but occasional pulmonary function tests were also misleading. Maybe self-monitoring of the peak flow rate would have provided an early warning, but the absence of mucus plugging at post-mortem suggests other causes of death than asthma.

You state in that article that aerosol corticosteroids were first introduced in 1968, but I am aware of only one centre where beclomethasone dipropionate was on trial at that time and was found ineffective,[8 9] very nearly discouraging the makers from proceeding further.

At the start of our trial in mid-1970 and in our first publication in 1972[10] enthusiasm caused us to withdraw steroids too quickly, but much slower withdrawal has been practised since and clearly published.[11] Good clinical judgment and monitoring at this crucial period is the best guide, some requiring considerably slower withdrawal than others. We have had no tragedies in 241 ex-steroid-dependent patients treated for up to 5½ years, but have repeatedly emphasised the risks in this group. In contrast, there were three deaths from asthma in the 359 non-steroid-dependent patients in our long-term studies.[5 6]

The method adopted in Derby to avoid disaster has been to supply corticosteroid

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