
**Drs. Cicardi and Banerji Reply:** On behalf of all the authors, we thank Giavina-Bianchi et al. for their consideration of our studies of new agents for hereditary angioedema, particularly in regard to concern surrounding the use of placebo rather than an established therapy as a comparison drug. Head-to-head comparative studies would certainly be of great interest. However, when our studies were performed, neither icatibant nor ecallantide was approved, and the efficacy of the C1 inhibitor concentrate Berinert P had not been fully established in properly designed controlled studies. Although it is a potentially weaker therapy, tranexamic acid (the active drug that was compared with icatibant in the For Angioedema Subcutaneous Treatment−2 trial) was an approved therapy that was accepted by the scientific community for the treatment of acute attacks of hereditary angioedema. Since our studies were performed in accordance with both the Declaration of Helsinki and expert consensus, we consider them ethically acceptable.

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Since publication of their articles, the authors report no further potential conflict of interest.


3. Adam D, Kasper S, Möller HJ, Singer EA. Placebo-controlled trials in major depression are necessary and ethically justifiable: how to improve the communication between researchers and ethical committees. Eur Arch Psychiatry Clin Neurosci 2005;255:258-60.

**THE EDITORIALIST REPLIES:** It is pleasing that my recent editorial reviewing therapies for hereditary angioedema has provoked debate.

Wuillemin notes 20 years of experience with self-administration in Switzerland. Indeed, Switzerland has led the way in this area, with excellent training and support for patients. Elsewhere in Europe, progress has been slower. Gompels and colleagues reviewed the situation in the United Kingdom and offered clear requirements for possession and self-administration of C1 inhibitor, including moderate-to-severe disease requiring C1 inhibitor infusion at least every 3 months, the availability of support from a partner when therapy is administered, successful completion of a comprehensive training program, good venous access, and agreement of the patient’s general practitioner. Many patients, including children, will be excluded by these sensible guidelines. Practitioners fear that drug use will escalate as patients treat minor swellings or false prodromes, increasing costs and perhaps also the risk of drug reactions. The Swiss experience might provide reassurance about these matters, and available data should be disseminated.

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Since publication of his article, the author reports no further potential conflict of interest.


**Determinants of Lung Function, COPD, and Asthma**

**TO THE EDITOR:** In a genomewide association study from the Cohorts for Heart and Aging Research in Genomic Epidemiology (CHARGE) consortium, we identified several loci as genetic determinants of spirometric measures of lung function in more than 20,000 adults from population-based cohorts. Moffatt et al. (Sept. 23 issue) attributed to us the statement that “genetic
determinants of lung function influence susceptibility to asthma” and indicated that their own data “do not support this hypothesis.” Because chronic obstructive pulmonary disease (COPD) is defined on the basis of the same spirometric measures of lung function, it is not surprising that some loci associated with measurements of lung function are also associated with COPD — for example, loci containing HHIP and FAM13A.1,3,4 We would not necessarily expect to observe associations between these same loci and asthma. We found that genetic associations with lung function were generally unchanged, despite the reduction in power brought about by excluding persons with asthma or COPD from the analysis.3 We interpreted this finding as evidence that many of the implicated loci are determinants of lung function in the general population.

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No potential conflict of interest relevant to this letter was reported.


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Smoke-free Legislation and Asthma

TO THE EDITOR: In their article on the observational study of changes in hospital admissions for asthma and the temporal relationship to the Scottish smoking ban, Mackay et al. (Sept. 16 issue)1 describe other reasons that could explain the observed reduction. On the basis of the crude numbers of admissions, there seems not to be any trend from 2000 to the end of 2008, but there does appear to be a decrease in the first 10 months of 2009. I add two further possible reasons for the decrease in hospital admissions for childhood asthma observed in the study. First, there was bias owing to exclusion of data from November and December 2009 — two important months for childhood asthma2 and the worst part of the H1N1 influenza pandemic in Scotland.3 The second reason is a possible reduction in the number of respiratory viral infections, a principal cause of asthma exacerbations in childhood,4 secondary to the special public health measures taken to reduce the transmission of pandemic influenza in 2009. For clarity, it would be helpful to have the data for all of 2009 and to observe the trend in the years thereafter.

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TO THE EDITOR: As in Scotland, the passage of smoke-free legislation in 2005 was associated with a reduction in the rate of hospitalizations for childhood asthma in the Lombardy region of Italy. We observed a decrease of 30.7% (95% confidence interval, 22.8 to 38.6) in the rate of admissions for asthma; a total of 15,042 children were hospitalized for asthma during the study period (Table 1). We speculate that the law may have had a positive influence on parental smoking, reducing in-home smoking and consequently passive exposure to tobacco smoke. However,

No potential conflict of interest relevant to this letter was reported.

4. Busse WW, Lemanske RF, Gern JE. Role of viral respiratory infections in asthma and asthma exacerbations. Lancet 2010;376:826-34.

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