of one of the tetracyclines is probably the treatment of choice, since *Haemophilus influenzae* often predominates in producing secondary infection. Tetracycline itself, chlortetracycline, or oxytetracycline are the most suitable drugs; the dose in each case being 250 mg. four times daily.

Analgesics

Aspirin is an excellent drug for relieving malaise and reducing fever. The indiscriminate swallowing of whole aspirin tablets is to be deprecated, since it is a cause of severe gastro-intestinal bleeding. Soluble aspirin is preferable, one to three 5-gr. (320-mg.) tablets being dissolved in water before swallowing. This dose may be repeated six-hourly. Aspirin, combined with Dover's powder (tab. acid. acetylsalicyl. et opii co. *B.N.F.*) is a more powerful diaphoretic and analgesic than aspirin alone. Up to four tablets may be taken at a time. There is no experimental evidence that alcohol is beneficial, but tradition justifies the use of hot whisky and lemon, if so desired, as a "night cap."

Inhalations

Steam inhalations are of inestimable value in relieving nasal and laryngeal congestion in the early stages of a cold. Benzoin and menthol, either alone or in combination, are the most popular preparations. Their action is partly due to the inhalation of steam, and they should not be used immediately before going into the cold air. Proprietary pocket inhalers containing aromatic vasoconstrictors have achieved some popularity. Amphetamine is no longer used in inhalers, since it was found that many patients became addicted to its use. Inhalers containing propylhexedrine are available. This drug has a less vasoconstricting action than amphetamine, but it is not habit-forming. Apart from convenience, these pocket inhalers have no advantages. Their use should be discouraged on the grounds that a patient whose cold is severe enough to require repeated inhalations is ill enough to be at home having adequate treatment and infectious enough to stay away from work.

Nasal drops and sprays should be used with care. In no circumstances should oily solutions be administered. Not only do these preparations impede the helpful ciliary action of the nasal mucosa, but there is a risk of their being inhaled into the lungs, where they may cause extensive and severe lipid pneumonia. Drops containing sulphonamide and antibiotics are of limited value and open to the dangers referred to earlier. After using nasal sprays, patients tend to clear the nose by vigorous blowing, but this may help to spread infection into the paranasal sinuses and middle ear.

Vasoconstriction by means of a 1% solution of ephedrine in saline (narist. ephed. *B.N.F.*) alleviates nasal congestion and is the simplest and safest of the many popular preparations. A simple alkaline douche such as solv. nasal. alk. *B.N.F.* is helpful in clearing the nose at a later stage; again, the patients should be warned against enthusiastic nose-blowing after use.

Gargles

Gargles have been used extensively in the past for the treatment of the pharyngitis accompanying upper respiratory infections. Although they are possibly beneficial when the tonsils are enlarged, it is difficult to see how they can benefit the patient with pharyngitis, since the fluid does not get beyond the anterior faucial

pillars during the act of gargling. To be effective, the preparation should be swallowed after gargling. Garg. ferr. perchlor. *B.N.F.* or glycer. thymol. co. *B.N.F.* can be used in this way. If relief from painful swallowing is needed, lozenges are probably preferable. Troch. benzocain. co. *B.N.F.*, containing benzocaine and menthol, acts as a pleasant local anaesthetic, but has the slight disadvantage of anaesthetizing the tongue and spoiling taste at the same time. Incorporating antibiotics in gargles and lozenges is valueless and possibly dangerous in the treatment of patients with coryza.

Antihistamines

Antihistaminic drugs have been widely advocated in the treatment of coryza, but without justification. Although highly effective in controlling rhinorrhoea in hay fever and, to a less extent, in perennial vasomotor rhinitis, antihistaminics are useless in the treatment of the common cold.

General Aims

Until successful prophylactic measures are discovered, the common winter upper respiratory infection will continue to be a burden to the community and the practitioner. At present there are no effective means of control and treatment is largely palliative. The doctor's aims are to ease the patient's symptoms, to avoid accepting the diagnosis of coryza too readily in febrile illness in the winter, to try to persuade the patient to keep the infection to himself, to give effective antibiotic treatment in occasional cases, and finally to refrain from exposing the patient to risks of treatment which might be more formidable than the disease.

OBSTETRIC PROBLEMS OF THE GENERAL PRACTITIONER AS SEEN BY A CONSULTANT

BY

S. BENDER, M.D., F.R.C.S.Ed., M.R.C.O.G.

Obstetrician and Gynaecologist, Chester

The problems of the general practitioner in domiciliary obstetrics are quite different from those of his specialist colleague working in hospital. For example, a sharp ante-partum haemorrhage or a severe toxæmia may tax the skill and resource of the obstetrician in an institution, but to the general practitioner such a case poses no real problem; the disposal of the patient is obvious—after appropriate first-aid treatment she must be transferred to hospital.

The real problems of the general practitioner obstetrician are shown by the three sets of circumstances in which he calls in a consultant to see the patient outside hospital. First, the specialist may be summoned to help in an acute emergency, most often in labour, such as delay in the second or third stage. Secondly, the family doctor may call in the consultant as a reinforcement, where he himself has strongly advised the patient to enter hospital but she has refused. In three cases in this series the patient rejected such advice from both general practitioner and specialist. Thirdly, and by far most commonly in my experience, the consultant is

called because the family doctor feels that with some specialist help and advice he himself could retain clinical control of the particular case, without transfer of the patient to hospital and without added risk to mother or baby.

In an attempt to define these problems a review is made of 244 consecutive consultations outside hospital in connexion with women 28 or more weeks pregnant. The period of review was the three and a half years ending on June 30, 1958. The cases fell naturally into three groups—namely, ante-partum, 158 cases; intra-partum, 63 cases; and post-partum 23 cases. The first group out-numbered almost by two to one the other two groups combined. Of the 244 women, 123 (50%) were transferred to hospital sooner or later.

The complications in each group for which consultations were sought are shown in Tables I, IV, and V. In regard to the most common, the questions asked by the general practitioners are given, together with the courses of action taken and the results obtained. If the standards of antenatal care and intra-partum management by the family doctors were not always of the highest, the judgment and technique of the specialist was not always faultless. And naturally the views and practice of the consultant, whose previous experience had been largely confined to hospital obstetrics, underwent some change as his experience of domiciliary midwifery increased.

Ante-partum Consultations

Ante-partum consultations were requested for no fewer than 14 different conditions (Table I), but two complications of pregnancy accounted for almost 60% of the total cases in this group. These were post-maturity and toxæmia; they, together with spontaneous premature rupture of the membranes, are discussed further.

TABLE I.—*Ante-partum Consultations (158 Cases)*

Post-maturity	47	Rh-immunization	4
Toxæmia	46	Thrombophlebitis	3
Mild ante-partum hæmorrhage ..	16	Depressive state	3
Malpresentation	10	Intrauterine death	2
Premature rupture of membranes	9	Disproportion	2
Abdominal pain	9	Acute vulvovaginitis	2
Vomiting	4	Hypotension	1

Post-maturity

General practitioners were perplexed because they knew that some obstetricians regarded post-maturity as a serious and not uncommon problem, while others thought it of little or no account. The questions the family doctors asked me could be summarized as, "Action or inaction?" and, "If action, where, when, and how?" The two conditions in which the family doctor is most often subjected to pressure and agitation by the patient and her relatives are prolongation of pregnancy and delay in labour.

Statistics can be produced from different hospitals showing that good results and bad results have attended policies both of intervention and of non-intervention for post-maturity. But conditions in different hospitals, or in the same hospital at different times, are not always strictly comparable, and ideally the best test would be to try both policies in the same hospital at the same time. This was done by Racker *et al.* (1953), and their figures showed that a lower perinatal loss accrued from a policy of intervention. It is probably also significant that when an obstetrician has changed his views it has nearly always been from complacency to concern. In

this series, generally but not routinely, action was advocated; the decision to induce or not being made on the sum total of all the evidence, including the age and previous obstetrical history of the patient.

The method of induction most often employed was tapping of the hindwaters, reinforced in some of the earlier cases by the injection of 1 unit of oxytocin intramuscularly half-hourly up to a maximum of six doses. The Drew Smythe catheter has certain advantages in these cases. The amount of liquor amnii in the forewaters is small in most cases of true post-maturity, especially when the head is deeply engaged; rupture of the forewaters is therefore less likely to be followed by the rapid onset of labour. Tapping the hindwaters allows a greater amount of liquor to be released and also permits a better assessment of the quality as well as the quantity of fluid in the amniotic sac. This is important because if the amount of liquor is very small, or if the fluid resembles thick pea-soup, or both, the foetus is probably already suffering from a serious degree of hypoxia and should be delivered quickly, even if this necessitates caesarean section.

The results in the 47 cases were satisfactory in that there was no perinatal mortality (Table II). However, three of the babies had birth weights of less than 5½ lb. (2,500 g.), which may indicate either errors of judgment or evidence that even in prolonged pregnancy the foetus

TABLE II.—*Results in 47 Cases of Post-maturity*

Active treatment at home	32	No active treatment at home	15
Delivered at home	25	Delivered at home	12
Delivered in hospital	7	Delivered in hospital	3
Failed induction	4 (1 C.S.)	Breech presentation	2
Scanty thick liquor	2 (1 C.S.)	Elderly primigravida	1
Prolonged labour	1		

Perinatal mortality, nil. Premature babies, 3.

may be technically "premature." Only 10 of the 47 women were transferred to hospital. In 12 of the remainder the presumptive diagnosis of post-maturity was not considered correct; in the absence of other complications no active measures were taken, and all 12 later started in labour spontaneously and were delivered uneventfully at home.

Toxæmia

Here the question asked was, in effect, "Which cases of toxæmia can be safely supervised at home?" The general practitioner appreciated that severer degrees of toxæmia required treatment in a specialist-staffed hospital, but he would have preferred to supervise the milder cases at home. In this series the advice given was that only those women with a mild uncomplicated essential hypertension in pregnancy were suitable for supervision outside hospital, and even these patients were best booked for delivery in a specialist-staffed maternity unit and admitted there two weeks before the expected date of labour.

In all other types and degrees of toxæmia the march of the condition was considered so unpredictable that the constant supervision obtainable only in an institution was desirable. And it was pointed out that the woman with a mild hypertension allowed to remain at home must be closely watched against the supervention of pre-eclampsia. Such supervention, indicated by a rise in blood pressure and by the appearance of albuminuria, necessitated the immediate transfer of the patient to hospital because it added so greatly to the hazards for both mother and baby.

Spontaneous Premature Rupture of Membranes

The family doctor found the disposal of patients with this complication difficult to decide. The questions asked were, in effect, "Action or inaction?" "Home or hospital?" and "Antibiotics or not?" In answering these questions the figures quoted by Eastman (1956) were heeded, a distinction being made between the mature and the premature baby. Eastman drew the dividing line at 2,500 g. (5½ lb.) birth weight, but as this cannot be ascertained before delivery the distinction was here made arbitrarily at 37 weeks' gestation.

Eastman's figures (Table III) showed that the perinatal mortality in *mature* babies was quadrupled if more than 48 hours elapsed between spontaneous rupture of the membranes and onset of labour. The perinatal loss in *premature* babies was largely determined by the degree of prematurity.

TABLE III.—*Perinatal Mortality in Spontaneous Premature Rupture of Membranes (after Eastman, 1956)*

	Labour Started	Perinatal Mortality
2,615 mature babies	In 80% within 24 hours	1.7% when interval less than 48 hours
	" 90% " 48 "	6.8% when interval more than 48 hours
540 premature babies	" 50% " 24 "	Determined largely by degree of prematurity
	" 70% " 48 "	

If, therefore, the baby was adjudged *mature*, and excluding any additional complication—for example, malpresentation, cord prolapse—the onset of labour was expedited. Initially, measures were taken to this end in the patient's own home, 1 unit of oxytocin being injected intramuscularly every half-hour to a maximum of six doses. This was done on the understanding that if labour did not start within six hours of the last injection the patient would be transferred to hospital for an oxytocin drip. Antibiotics were not given while the patient was at home, but after admission to hospital they were administered in the interests of both mother and baby (Smith *et al.*, 1956; Bound *et al.*, 1956).

If, however, the foetus was adjudged *premature*, active measures were not taken, because here prematurity was the outstanding cause of perinatal loss. But admission to hospital was urged so that the facilities of the premature-baby nursery would be immediately available if required. Antibiotics were regarded as necessary because of the low resistance of the premature baby to infection and because the mother was in a strange bacterial environment. If labour did not start within 72 hours of admission and liquor was no longer draining, the antibiotic therapy was discontinued and the patient was allowed home the next day. The perplexing cases were those in which liquor continued to drain in quantity for weeks or even months. The pathology of this condition has been discussed by Burnett (1957). "Masterly inactivity" is probably the best policy, but there is a somewhat greater than average incidence of foetal abnormality in these pregnancies.

Of the nine cases of spontaneous premature rupture of the membranes in this series two babies were lost, both being instances in which the principles laid down above were not closely followed. A mature baby died *in utero*; the patient had not been transferred to hospital when active measures outside failed to initiate labour. A premature baby died from septicaemia 72 hours after delivery in hospital; the mother had not been given antibiotics in labour.

Intra-partum Consultations

Almost two-thirds of the 63 calls during labour were on account of delay (Table IV). Prolongation of each of the three stages of labour is discussed further.

In none of the 10 parturients in whom possible disproportion was the indication for consultation was this complication present; all were delivered at home

TABLE IV.—*Intra-partum Consultations (63 Cases)*

Delay in labour	39	Malpresentation	9
First stage	17	Breech	8
Second stage	14	Shoulder	1
Third stage	8	Post-partum haemorrhage ..	4
? Disproportion	10	Bucket-handle tear of cervix ..	1

without foetal loss. Of the nine cases of malpresentation, one was a transverse lie in the late first stage of a strong labour in a multipara; the lie was easily corrected by external version, and the membranes were then ruptured to fix the head in the pelvis. Only one of the eight breech presentations was seen in the first stage; this patient was transferred to hospital, where she was safely delivered. Two of the others were complicated by prolapse of the cord, but both babies were extracted alive. One breech baby was stillborn but was known to have died before labour. Another was born alive but showed evidence of brain damage; it weighed over 13 lb. (5,900 g.). In most of the breech cases the malpresentation had not been diagnosed antenatally, but in at least three the general practitioner had undertaken to conduct a breech delivery at home, a policy with which I do not agree.

Delay in First Stage

This was sometimes difficult to evaluate because it was impossible to ascertain exactly when labour had started. The cases in this group fell into three categories: the slow starters, those with true primary uterine inertia, and those with incoordinate uterine action. The slow starters were so termed because they had been a long time apparently in labour, but by the time I saw them they were having strong pains and making progress, and required no treatment other than analgesia. Two of the six in this class were indeed already in the second stage by the time I examined them.

Primary uterine inertia was considered to be present when the pains were of average or below average strength and infrequent. The slow progress of labour, as evidenced by the slow dilatation of the cervix, was therefore not unexpected. These cases were either transferred to hospital at once or treated initially at home, according to the presence or absence of other complications (such as malpresentation, malposition, doubtful disproportion), the general condition of the patient, and the length of time she was said to have been in labour. In favourable cases reassurance and mild sedation were followed at home by the active measures of enema and rupture of the membranes, reinforced in some of the earlier cases by the injection of 1 unit of oxytocin intramuscularly every half-hour to a maximum of six doses. But these measures were taken on the understanding that if they were not effective in stimulating normal uterine action in four to six hours the patient was to be sent to hospital. It was regarded as an important point in management to sustain the morale of the patient and her relatives. Three of the five women in this category were transferred to hospital, where one of them was eventually delivered by caesarean section.

Incoordinate uterine action, a form of uterine inefficiency largely confined to primigravidae, was regarded as a more serious condition, warranting the transfer of the parturient to hospital in every case. The diagnosis was made on the typical clinical picture of frequent painful contractions, which tended to be confined to the sacral region or hypogastrium, with lack of progressive dilatation of the os. The reversal of the normal time relationship between pain felt by the patient and contraction palpated by the attendant, with the pain preceding and outlasting the contraction (Jeffcoate, 1955), was a most useful diagnostic sign. In three of the six cases the foetal head was in the occipito-posterior position. Three of the women were eventually delivered abdominally.

Delay in Second Stage

This worried the general practitioner more because he regarded the foetus as being in greater jeopardy now than when the first stage was prolonged. The most common cause of delay in this group was a diminution in the strength of the contractions. In 7 of the 14 women this was the only impediment to normal progress, but the doctor forbore from applying forceps because of the traditional fear of subsequent atonic post-partum haemorrhage. It was demonstrated that such fear could be obviated by giving 0.5 mg. of ergometrine intravenously at the close of the second stage, supplemented by an equal dose given intramuscularly after delivery of the placenta. The substitution of local analgesia by pudendal block for general anaesthesia afforded a further safeguard, and several general practitioners expressed their regret that they had not previously been taught, before or after qualification, the technique of pudendal block. A recent report on general-practitioner obstetrics (College of General Practitioners, 1957) declared that there was much scope for the more frequent use of local analgesia and of "prophylactic" ergometrine in domiciliary obstetrics. The latter procedure, however, necessitates the presence of two doctors at delivery so long as midwives are forbidden to give intravenous injections.

In four cases the delay in the second stage was associated with transverse arrest of the head, while in a fifth the position was occipito-sacral. All were delivered safely outside hospital. Only 2 of the 14 patients with delay in the second stage were transferred to hospital. Both were primigravidae—one with a brow presentation and the other with a breech impacted in a hitherto undiagnosed small android pelvis. Both were delivered abdominally.

Delay in Third Stage

When the third stage was prolonged and the placenta was retained, the general practitioner asked regarding its removal, "When?" "Where?" and "Under which anaesthetic?" Following a review by Sheehan (1948) of the factors operative in fatal cases of shock in obstetrics, it has become general practice not to allow the duration of the third stage to exceed one hour; and if the placenta is to be delivered within the hour preparations must be initiated within 40 minutes of the end of the second stage.

In this series the principle was followed that if the baby was born at home the placenta was best delivered at home, for fear of shock or haemorrhage or both starting in the no-man's-land of the ambulance. This is good policy also when there is third-stage bleeding, the general condition of the patient being sustained

meanwhile by infusion or transfusion by the doctor or the summoned flying-squad. General practitioners were therefore encouraged to carry among their midwifery equipment a giving set and a bottle of blood substitute.

As the anaesthetic for manual removal of the placenta in the patient's home, where there was usually a large open fire in the room of confinement, chloroform was found most useful. However, it was not used if the pregnancy had been complicated by toxæmia, or if the labour had lasted more than 24 hours, or if the drug had already been administered for the delivery. The safe use of this anaesthetic should still be taught to medical students.

Post-partum Consultations

This group (Table V) was, not unexpectedly, the smallest. Only one case of an acute depressive state was seen post partum, probably because the services of the psychiatrist were sought rather than those of the obstetrician. Three cases were seen antenatally (Table I). It was considered that a woman with a depressive state or with a history of such an episode in relation to previous child-bearing was best booked for delivery at home if there were no other contraindications to domiciliary confinement. This was because the woman was thought to be less subject to additional stresses at home than in the unfamiliar surroundings of a hospital, and because her own relatives at home would appreciate those warning minor changes of mood more quickly than would the hospital attendants who knew her less well.

TABLE V.—Post-partum Consultations (23 Cases)

Venous complications	7	Depressive state	1
Puerperal sepsis	4	Uterovaginal prolapse	1
Secondary P.P.H.	3	Rectal prolapse	1
Broken-down perineal repair	2	Anaemia	1
Breast infection	2	Vomiting	1

Venous Complications

Venous complications in the legs were the commonest indication for post-partum consultation. The questions asked by the family doctor were, in effect, "Home or hospital?" and, "Anticoagulants or not?" In answering these, a distinction was made between superficial and deep thrombosis. In the former, which usually occurred in veins previously varicose, anticoagulants were not advised and the patient was allowed to continue her lying-in period at home. In deep thrombosis, however, anticoagulants were necessary to reduce both morbidity and mortality; and as this therapy required strict laboratory control the patient was transferred to hospital.

Three cases of thrombophlebitis were seen antenatally (Table I) to which the same principles were applied. Foetal death after antenatal anticoagulant therapy has been reported in this country (Gordon and Dean, 1955), but in a series of nearly 500 similar cases treated on the Continent no untoward effect on the foetus was noted (König *et al.*, 1954).

Summary and Conclusions

Problems in general-practice obstetrics, as seen by a consultant, have been reviewed and some guidance has been offered on when the family doctor might safely continue to treat the patient outside hospital. Both consultant and general practitioner should appreciate that the latter works under at least one notable disadvantage—namely, that he is liable to pressure and agitation from the patient and her relatives to a degree against which

the hospital obstetrician is largely insulated by distance and the intervention of nursing staff. This is particularly true when pregnancy is prolonged or labour protracted.

Although a large volume of opinion in Britain favours the abolition of domiciliary midwifery, the practice is likely to continue for many more years for at least two reasons: first, many women still insist on being delivered at home; and, secondly, there are not enough hospital maternity beds to cope with all labours, especially while the parturient is expected to spend 10 days in hospital after delivery. The medical student, who is more likely to be destined for general practice than for any other branch of medicine, should therefore be taught undergraduate obstetrics in a perspective that will enable him to realize the scope and the limitations of domiciliary midwifery. This perspective should be maintained during the resident postgraduate training that he should be required to undertake before acting as a general-practitioner obstetrician. It follows that full-time university teachers of obstetrics should be allowed, and encouraged, to participate as consultants in domiciliary midwifery; otherwise the major part of the training of future general-practitioner obstetricians may be received at the hands of those who have never seen or attended a pregnant woman in her own home.

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INFLUENZA

REPORTS FROM GENERAL PRACTITIONERS

We are much indebted to the general practitioners whose names appear below for their reports on the outbreak of influenza.

Sudden Onset

Drs. R. J. F. H. PINSENT, L. A. PIKE, and R. H. MORGAN (Birmingham) write: The diagnosis "influenza" began to appear on case sheets in the practice during the third week in January, increasing in frequency and replacing "coryza" almost completely during the following weeks. At first young adults were affected, and cases occurred in groups in different localities, but later the load was spread evenly by districts and age groups. Of the first 300 consecutive consultations and visits by one partner in February, 92 (31%) were on account of influenza. No children under the age of 5 have been affected so far.

Symptoms.—The character of the illness differs little from that of previous epidemics. The onset is sudden, with headache, muscle pains in limbs and back, sweating—sometimes profuse—shivering, and weakness. Pyrexia of 101–102° F. (38–39° C.) may last for 48 hours. Vomiting is common, sometimes diarrhoea, and in patients thus affected the raised temperature persists longer. Vertigo, with maintained pyrexia, occurs when patients get up too soon.

Moist sounds may occur in the lungs of older patients and those known to have previously had bronchitis. The signs usually subsided with the fever, unless bacterial

infection followed, with a change to purulent sputum. In about half the cases there was a boiled-ham-coloured hyperaemia of the palate and fauces, with swollen lymphoid follicles on the posterior pharyngeal wall.

The course of the disease was mild in the young adult, but debility sometimes lasted up to 10 days. Relapse has occurred in two patients so far, bronchopneumonia in three others. No patients have died to date.

Specimens for serological investigation were collected during the first week of the epidemic, but no results are yet through. One has the impression that the people seen now are those who escaped infection in the epidemic last year, though no confirmatory evidence has been sought.

Treatment.—This has been symptomatic, with sufficient rest in bed, fluids, and tinct. benz. co. steam inhalants. Tab. codein. co. has been prescribed by two partners, paracetamol by one. Impressions of clinical effectiveness will be compared. Pholcodine linctus has been used for troublesome coughs. Antibiotics have been given only when there was clear evidence of superadded bacterial infection, tetracycline being prescribed for the patients with pneumonia.

Few Cases

Dr. KEITH HODGKIN (Redcar, Yorks) writes: In Redcar so far there has been little evidence of influenza, although reports suggest that West Hartlepool, only 12 miles away, may have been hit by the epidemic 14 days ago. Since the end of the serologically proved second wave of Asian influenza in March, 1958, there has been little clinical and no serological evidence of influenza in this practice. Fourteen days ago we had an outbreak in a single household of an illness which satisfied the three main clinical criteria for influenza—high household attack rates, known fever, and cough—but there have been no further suggestive cases.*

The Table on page 502 shows that the weekly attack rates for the main respiratory diseases in this practice are about average.

My thanks are due to my partner, Dr. Philip Edmundson, who helped collect the information on which this report is based.

Short Illnesses Called "Flu"

Dr. C. A. H. WATTS (Ibstock, Leics) writes: January to March inclusive are generally accepted as being the busiest months of the year for the general practitioner. The work this season has been patchy. In rural districts, except in the rare pandemic, it is most unusual for all the villages to be affected at the same time. Thus, while one part of the practice has been very busy, other parts have been comparatively quiet for the time of the year. The measles epidemic is just beginning to crop in two widely separated areas. There have been a number of short febrile illnesses which the patients delight to call "flu," but there has been nothing like the outbreak of Asian influenza which occurred in the fall of 1957. Most of these cases are back at work in four or five days, but a few are complicated by sinusitis and otitis media.

There has been more fog in this part of the world this season than for many years, but it has never become smog. The winter has been colder and more sunless than usual, and the old folk have suffered in consequence. There has been some bronchopneumonia among them and among the chronic bronchitics, but with antibiotic treatment these illnesses have been well controlled. One death from bronchopneumonia occurred in an aged person in early February, but that has been the only chest fatality in the practice during the entire twelve-month period. Indeed, considering the weather the patients liable to chest disease have fared rather better than one would have expected.

Among children there have been some cases of acute chest disease and wheezy bronchitis. A few have had a very trying and persistent cough for many weeks. It is possible

*STOP PRESS.—Laboratory examination shows that this family had influenza A (Asian). The only member not to succumb was a girl who had influenza during the epidemic last year, when the others escaped it.