TREATMENT IN GENERAL PRACTICE

This article is one of a series on the management of some of the major medical disorders met with in general practice

THE TREATMENT OF INFLUENZA

BY

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Preventive Treatment

Against epidemic waves of incidence of the disease we have as yet no remedy. Nor have we any means of lowering the susceptibility of the individual against being attacked. It is commonly held that to maintain a high standard of general health is a safeguard, but in the epidemic of 1918-19 the incidence of the disease was higher in young adults and adults than in children and the elderly, as also was the mortality; nor did persons of apparently poor physique seem to suffer so much as the apparently robust. The virus of influenza, in other words, unlike tubercle and the more chronic pyogenic infections, does not attack only, or even chiefly, persons of low general resistance.

Specific measures of inoculation, or of passive immunization, are not available as yet. By analogy with other virus infections the serum of convalescent patients may possibly be of protective help, but efforts in this direction lie with future epidemics. The only form of prophylaxis so far available is inoculation against the secondary infections of the disease. These are, however, of great importance, and such inoculation is to be recommended. Of the various formulae used, one which is made up in the proportions 2:1:1:1 for *B. pfeiffer*, pneumococcus, streptococcus, and *M. catarrhalis* respectively, is perhaps the best; but the composition of a vaccine of this kind should be adapted to the prevailing epidemic. From 25 to 1,000 millions of such a vaccine may be given, in graduated doses, at intervals of three clear days.

Curative Treatment

Immediately the diagnosis is made—or even before this, because the sudden onset of fever, with or without respiratory symptoms, is unlikely to carry diagnostic conviction during the first two or three days, unless an epidemic be prevalent—the patient is confined to bed. The room should be as airy as possible and, by preference, warmed by a coal fire. A free current of air is probably the most important single point in the whole treatment. If both ventilation and warmth cannot be obtained at the same time, then give preference to ventilation. The bed should be placed as near the centre of the room as possible, and all articles of furniture that are not required for nursing, and all bric-à-brac, should be removed from the room.

The bedclothes demand special attention. The amount of them is to be determined by the height of the thermometer, not by the patient's sensations. This is a cardinal point, and nurses scarcely ever understand it unless it is explained to them. Quilts and bed-covers are disallowed. If the pyrexia is persistently high the cradle method of control, formerly so useful in typhoid fever, is excellent. Frequent sponging is also of help in reducing fever; it adds considerably to the patient's comfort and tends to induce sleep. The temperature of the water used is to be adjusted to the height of the fever.

Diet and Drugs

The diet should be restricted to warm liquids, given every two hours by day and every four hours by night if the patient is awake. The total intake of liquid should not be less than four pints in twenty-four hours. The drinking of plain water, cold if preferred, is to be encouraged. "Feeding up" is to be deprecated. In most cases alcohol is unnecessary. The bowels are opened by a double dose of the patient's customary aperient; if there be none, give calomel in 1/4 grain doses hourly for four or six doses, and follow this by a saline draught.

There is no specific drug. Aspirin and Dover's powder, given in doses of 5 grains of each and repeated at intervals of six hours, for four to six doses, help to control the fever and allay the headache and general discomfort. (Alternatives are ammoniated tincture of quinine in half-ounce doses or salicin in 20-grain doses, at the same intervals.) If the headache is severe and is not relieved by these measures give a mixture of phenacetin, caffeine, and antipyrine, 3 grains of each, every three hours for four doses. In the case of all drugs a draught or a powder should be ordered, not tablets. When gastric symptoms are troublesome a mixture of sod. bicarb., sod. sulphocarb., and bismuth oxycarb., 5 grains of each, with glycerin of carbolic acid 10 minims, in peppermint water, may be ordered four- or six-hourly. If vomiting is present reduce feeds to a minimum, giving rectal salines with glucose 10 per cent., and order 1 minim of tinct. iodi in a teaspoonful of water hourly for six or eight doses.

In the majority of severe cases respiratory symptoms are present. Treatment is then as for acute bronchitis: temperature of room not below 60° F.; a lightly made "pneumonia jacket"; an evaporating liniment such as lin. camph. et terebinth. equal parts; and a "sedative expectorant," such as ammon. chlor. 5 grains, vin. ipecac. 5 minims, tinct. scillae 5 minims, tinct. camph. co. 10 minims, syr. pruni virg. 20 minims in water, six-hourly. For the cough, if this be persistent and exhausting, as is not seldom the case, order an inhalation of tinct. benzoni co., and spray the upper air passages with 2 per cent. each of chlorotone and menthol in paraffin, adding cocaine 1/2 per cent. if necessary. A linctus, such as syr. cocillanae co., or syr. codeinae, or tinct. terpheroi, may also be tried. Failing these measures—and the cough may be very intractable—order a mixture of ammon. brom. 20 grains with syr. chloral 20 minims and bromoform 1 minim in aq. glycyrrhizae every two hours for four doses.

Sleeplessness calls for a revision of the general measures (v.s.): ventilation, hydrotherapy, diet, etc. Alcohol may now be useful, especially in elderly subjects. Try first a draught of ammon. brom. 20 grains with one drachm of syrup of chloral. If still troublesome, order paraldehyde in one-drachm doses, with tinct. quillaiae and tinct. aurantii 20 minims of each to cover the taste. Or give a hypodermic of 1/4 grain morphine with 1/120 grain atropine. The barbiturates are better avoided.

If heart failure threatens alcohol is indicated, and is best given as brandy, in half-ounce doses every four hours in water. It is better not to mix it with the feeds. Supplement this by strychnine 1/60 grain twice during the day and coramine (synthetic camphor) 1 c.cm. twice during the night. Suprarenal solution (1 in 1,000) 0.5 c.cm.

may be substituted for either of these. If the condition remains serious give an intravenous injection of strophanthin 1/250 grain in 15 minims of sterile saline solution with an ordinary hypodermic syringe, and repeat this in six to eight hours' time.

Convalescence

Convalescence must be watched with care in all cases, even in those which do not give much concern during the active stage of the disease. The patient must not be allowed out of bed until the pyrexia has ceased for at least four days. In cases of longer duration than a week this period of recumbent rest after the fall of the temperature should be extended. The state of the heart and the pulse rate must be carefully noted, and any failure to respond satisfactorily to the initial trial of physical effort must be met by further rest. The diet may be now increased, and mild tonics and haematinics may be ordered, but strong stimulants, whether cardiac or nervous, are usually contraindicated.

A complete overhaul, especially in regard to the heart, lungs, and nervous system, should be undertaken a week after the patient gets up, and again a month later. By these means, and by appropriate measures of treatment if any disturbing feature be brought to light by the examination, many of the tiresome sequelae of the disease may be avoided.

OBSTETRICS IN INDIA

BY

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CHIEF MEDICAL OFFICER TO HIS LATE HIGHNESS MAHARAJAH JAMSAHEB OF NAWANAGAR

Much has already been written on the subject of obstetrics in India. The mortality rate, both among mothers and among newborn children, always finds a place in every census report, and that these rates are very high is well known. Attempts are invariably made to reduce them to percentages, but such statistics are at best only approximate, for several reasons. Stringent rules as to the proper notification of the cause of death are the exception rather than the rule. There is no legal necessity for a medical certificate. Thousands of deaths occur annually without the attendance of a medical practitioner. The supply of doctors is grossly inadequate to the population, medical advice being therefore the exception. Even where such advice has been available, no certificate is asked. Cremation or burial takes place as soon as possible, and no question arises unless there are suspicious circumstances, which might often escape notice. In most instances death is notified by a relative, who makes his own diagnosis, or the cause is inferred from his statement. Such haphazard methods render all statistics unreliable.

Take the case of a woman who dies of puerperal fever ten days after her confinement. Her husband would say she died of fever, and make no reference to the confinement at all: the body will have already been cremated, and the ashes scattered to the four winds or thrown into the river. Post-mortem examinations are extremely rare, and are undertaken chiefly by police request in cases of suspected foul play. I often tried to obtain permission for a post-mortem, but never succeeded once in six years. It was looked upon as a desecration of the dead. The cause of death mattered nothing, and the interests of science still less. During my six years in Jamnagar, the deaths regularly exceeded the births to judge by the notifications, and yet at the census the population was found to have increased by many thousands. Obviously this could not have been entirely due to immigration. Exact figures are therefore an impossibility. Those available must be looked upon as erring on the low side. Comparisons between different parts of India are equally impossible. All one can do is to accept the statement that maternal and infant mortality reach limits which can only be described as colossal.

Hospital Facilities

In this paper I propose to give a short résumé of the conditions as I saw them in a State the population of which was roughly 450,000 and the area 3,500 square miles. During the last four years it had a women's hospital, into which many labour cases were admitted from all parts of the State. During the first twelve months the female hospital was not open, and confinements were only rarely admitted, and then into the male hospital. This fact, together with a complete absence of any nursing staff, is quite sufficient to account for the small number of female admissions. The following year, 1928, I opened and equipped the female hospital, engaged the services of a very able and painstaking lady doctor, a graduate of Bombay University, and began to collect a staff of nurses, the nucleus being four Indian women with Bombay Presidency Nursing Association certificates.

I had, six months before, started a women's clinic, spending three mornings a week there myself. Up to this time I knew it was an almost unheard-of thing for Indian women to permit examination by a male doctor, and I was prepared to encounter great difficulty in this respect. I found, however, that with a little persuasion most of them were quite sensible, and the clinic rapidly became popular. After a while, refusal of an examination became a rarity. The number of women attending was often thirty to forty, which proved the necessity of the clinic. Naturally, when the lady doctor took over, the numbers rose rapidly, so that two years later I had to engage a second lady doctor.

It might be thought that in Jamnagar, with a women's hospital ready to receive labour cases at any hour, and an ambulance service which I had organized about the same time at the disposal of the public at a moment's notice, no woman should be in labour for more than a day or two without receiving assistance. This was actually far from being the case. It was many months before the public would take advantage of the hospital to any extent at all. I often admitted women whose confinements had been in progress for three or four days but whose homes were within a mile or two of the hospital. The first year the women's hospital was open the total confinements amounted to about twenty-five. Most of these were cases of delayed labour brought in by ambulance from neighbouring villages. The number from Jamnagar itself was very small. The next three years saw considerable improvement, and over 150 cases were admitted in 1932-3.

There was obviously some very strong influence at work, preventing the women from taking advantage of the facilities offered. All food, dressings, drugs, and accommodation were free, and there was a full and properly trained staff. And yet there was this great unwillingness to come into hospital. For the first year or so cases came in only as a last resource. I concluded there were three main reasons for this. First came the purdah system, with its ingrained mistrust and dislike of allowing women to leave the shelter of their own homes. It mattered not at all that these homes were often squalid and insanitary in the extreme, and that the hospital was a palace in comparison. The purdah system also precluded the attendance of a male doctor on the unfortunate woman, so that she was from first to last in the hands of that menace to the pregnant woman in India—the "dhai," or native midwife. And the dhai was the second reason why women were so long availing themselves of their opportunities. The third was a fatal apathy on the part of the people themselves, by whom I mean the relatives. Life is cheap in India, and wives, I suppose, easily come by.

Native Midwives

The part played by the dhais needs more consideration. These women are responsible for most of the sepsis and suffering borne by the women of India. Members of the lowest class, outcaste and unclean, they are ignorant of all knowledge of midwifery, and dirty in the extreme. A woman in labour is considered in India to be unclean, and so, by a process of perverted reasoning, must only be attended by another unclean woman. For the same reason all clothes used for the confinement are the dirty