

In the series quoted by Professor Wynn there were 136 cases over the age of 10, and sixty-six of these were due to lobar pneumonia and seventy to bronchopneumonia. Our figures in 3,000 post-mortems were 113 of lobar pneumonia and 181 of bronchopneumonia; or if the atypical are combined with the lobar pneumonias, 146 and 181. In other words, fatal pneumonia in adults in the experience of the Adelaide Hospital is more often a bronchopneumonia than a lobar pneumonia.

In the last 1,000 post-mortems it is interesting to note the prevalence of the condition in males; twenty-three of the twenty-eight cases of lobar pneumonia were in males; thirty-seven of fifty cases of bronchopneumonia, excluding two influenzal cases; eleven of sixteen cases of atypical pneumonia; and thirty-nine of forty-nine examples of hypostatic pneumonia. As we hold post-mortem examinations on rather more than three men to two women, it will be seen that the above prevalence of males in our data is a real prevalence in this sex and is not merely the result of more post-mortems being held on them than on women. Evidently the male sex is distinctly more liable to all forms of pneumonia than are women.—I am, etc.,

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Adelaide, March 6th.

Treatment of Pneumonia

SIR,—I have read with interest the article on "The Treatment of Pneumonia" by Professor W. H. Wynn in the *British Medical Journal* of January 11th. It is obvious from this and from other articles which have appeared during the last year or so that we are on the eve of a great advance in the treatment of this disease. I have no wish to detract from the extremely valuable work done on vaccine and serum treatment, and I trust my remarks will not be interpreted in this way. However, there must still be many doctors in country districts at home, and many more abroad, who have not the facilities of a well-equipped general hospital, with laboratories, bacteriologists, oxygen apparatus, etc. To these colleagues I offer the following notes, which are the result of eleven years' experience in such places as the Assam tea gardens, Trinidad, Burma, and Iraq. The population of which I have been in control has varied in the different places from 2,000 to 13,000, so I may safely say that at least the normal number of pneumonia cases have come my way.

My procedure, which to some may seem heretical, has been to leave my patients alone as much as possible and merely hold a watching brief on their behalf.

On admission the patient is given a moderate purge, and thereafter the bowels are only moved, if necessary, by enemata. From the first he is not allowed to lift his head, but is fed by the feeding-cup. If the cough is dry he is given a simple expectorant for a day or two, which is stopped as soon as sputum is established, but from the first he is given this mixture: Tr. nuc. vom., $\text{m} 7\frac{1}{2}$; tr. digitalis, $\text{m} 7\frac{1}{2}$; spt. ammon. arom., $\text{m} 15$; aq. ad $\text{z} 4$, t.i.d.

On the day when the crisis is expected, or if symptoms of circulatory embarrassment appear, camphor in olive oil is injected. Camphor is preferred to other stimulants as its absorption in an oily medium is slow, and hence action is more prolonged. The principal drawback of other stimulants is that their action is too quickly over; they have their place in an emergency, but not in the routine case. The purpose of the mixture is the administration of a general tonic which will support the patient and allow as full play as possible to *vis medicatrix naturae*.

For pain I have found of the greatest benefit constant dry heat, such as can be obtained by the use of a small electric blanket, say 18 by 12 inches, laid under or on the affected side without embarrassing the respiratory move-

ments. These small blankets have usually a switch with three intensities of heat, and can be regulated to suit different needs of the same patient at different times. In the absence of electric power a kaolin plaster is next best. For insomnia or excitement I give one or two capsules, each containing 2 grains aspirin, 2 grains phenacetin, 2 grains pulv. ipecac. co., and 1 grain caffeine citrate; or bromide and chloral, or paraldehyde, according to the degree. There is nothing, of course, of more importance than good nursing.

The policy of non-interference, which by the way is quite different from that of *laissez-faire*, originated for me in the remark of an old clinical teacher of mine in Glasgow: that probably more pneumonia patients died through the interference of an enthusiastic doctor than from the disease. This, of course, was an overstatement in order to drive the point home, but I have often recalled it when I have seen a pneumonia patient being treated with this, that, and the next thing in rapid succession, when all he wanted was to be left to rest his weary body in peace and conserve his energy and resistance.

Omitting for the moment the undoubted possibilities of vaccine and serum treatment, I am convinced that the above policy affords the average pneumonia patient his best chance of recovery. My patients have been partly European, but were mostly natives, many of the latter being in a state of debility from other diseases, such as hookworm, malaria, or amoebiasis. The only figures which I have refer to the summer of 1934, when I was in charge of the medical side of a hospital in Burma. There were eleven cases with no deaths. This compared with twenty-six cases and seven deaths during the same period of 1933. These figures alone are too small to be conclusive, but the experience of other years bears them out. I have a great admiration for the excellent work recently done on vaccine and serum treatment, but I venture to suggest that, apart from larger towns and places where the patient can have all the resources of a well-equipped hospital at his command, the policy of a guarded non-interference is still the best one to adopt for those whose practices are in out-of-the-way places or whose lines are cast, as mine are, on the "fringes of civilization."—I am, etc.,

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Iraq, March 28th.

Ch.B., D.T.M.

Physiotherapy in Treatment

SIR,—I read with great interest Dr. E. B. M. Vance's article on physiotherapy in the treatment of injuries in general and orthopaedic practice (*Journal*, January 11th, p. 53). I think Dr. Vance raises an important point when he condemns the too common practice of referring injured persons to the massage department for "hot air and massage." This more or less traditional phrase should now be considered obsolete, and the more rational one, which Dr. Vance suggests, of "physiotherapy" should be substituted.

With his remarks on massage I am in full agreement, but feel that his rather sweeping condemnation of the use of electricity cannot be allowed to pass unchallenged. In the first place, Dr. Vance states that "in the ultra-violet lamp we have a method of employing heat"; this must at once make it fairly obvious that Dr. Vance's scientific knowledge of this branch of electrotherapy is fundamentally unsound, for the ultra-violet rays belong to the shorter side of the visible spectrum and contain a very small percentage of heat rays.

In a later paragraph he states that "after galvanism and faradism there was the 'static wave'" (why inverted commas?). To begin with, his history of electricity is very much at fault. Static electricity (of which the static wave is only one of many ways of applying this