Letter from . . . Chicago

New epidemics

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This is a modern ailment for which no infectious agent has ever been found and no vaccine will ever be discovered. It was first described in this journal by Dr Heylings of Yorkshire as the "No Touching Epidemic—An English Disease."[1] Its symptoms or complications include a cold and distant manner, shyness, insecurity, introversion, loneliness, frigidity, prudery, intolerance, a lack of understanding for others, an inability to comfort, a fear of dead bodies of close relatives, horror at the sight of courting couples, an unhappy and discontented look, an inclination to visit doctors, and a need to be frequently examined.[1] The disease is widespread among the colder races of the North and less so on the continent of Europe and among Latins. It often affects doctors. It may be more common in the towers of academia than in town.

No touching goes against the oldest precepts of a healing profession that since the days of Hippocrates and Galen has prescribed massage and recommended the laying on of hands.[2] These precepts still echo through the modern literature. "There is something elemental, sensual, hopeful about touching another living creature," writes Dr Richard Lee in his "jaundiced eye series." reminding us that the more abstracted and remote doctors become the more they are feared and disliked.[3] "We stroke cats, pet horses, but deny this grace to human beings," wrote Dr Heylings in his original essay, emphasising that the older doctors did not interrogate their patients from the foot of the bed, but always touched them and shook their hand, "touching the spot that hurts and the belly that spasms."[1]

It now turns out that this epidemic can be prevented by education. Thus we read how in New Zealand Dr Julius Older teaches a popular five weeks' touch elective to medical students, also how he sent questionnaires to 169 deans and found out that the therapeutic usés of touching are taught in 12 other schools, mainly in North America and Australia, but also in Nottingham.[2] For younger age groups, however, such education may be unnecessary. At least it was so in the 'sixties, among some of the college students, who would take off their shoes and sit on the floor meditating, their soles touching, their souls drawn together by the magic flow of energy.

Kings who condescended to touch their scrofulous subjects must have transmitted the same kind of energy, perhaps as effectively as a six months' course of isoniazid and rifampin. Occasionally this approach works even in non-tuberculous states: I was once asked to see a young man, deeply comatose for one week from a non-dialysable poorly metabolised tranquiliser. A neurologist had said that he was brain dead and would not recover. The patient had suffered from recurrent amoebic dysentery and was supposed to have "pre-AIDS," which accounted for him being strictly isolated, his room surrounded by warning signs and bowls of disinfectants. The nurses made me wear a mask and gown and gloves, so that I would not catch pre-AIDS. Thus attired I went into the room and examined the unconscious man. There was clearly no point in dialysing somebody who had been in a coma for a whole week. But the magic touch must have worked, even through the rubber gloves, because the next day the patient woke up.

Conflicting priorities

So much for pre-AIDS. Full blown AIDS, however, has undoubtedly become a modern epidemic, as dreaded as the ancient ones. So far it has affected over 8000 people in the United States—73% of whom are homosexual or bisexual, and 18% drug abusers—but as its incubation period is now believed to be 27 months many more cases may surface within the next year. While promiscuity and frequent sexual contact with many different partners seems to be the main predisposing factor, many problems remain unresolved. How much money should society reasonably divert from other competing endeavours? Should hospitals set up AIDS wards, convenient, but likely to carry considerable stigma? Already we note that children with AIDS were refused admission into schools, that some airlines wanted to bar AIDS victims from planes, that in Florida two county workers were fired in order to protect the public and their fellow employees. Should we close the gays' public bathhouses and the addicts' shooting galleries? How can we reconcile public safety with safeguarding civil liberties? Should prostitutes with AIDS be quarantined like seventeenth century plague victims? If they are forbidden to work should they be given disability allowances? Somebody suggested jailing AIDS victims who knowingly had sexual relations with non-infected people. What about the federal rule requiring that blood donors be notified if their antibody test is positive? Will this information cause panic, lead to loss of employment, or will it result in homosexuals trying to donate blood in order to get the test free of charge?

Problems have also arisen with herpes simplex, which now affects some 500 000 Americans. Young children have been refused admission to schools, and have been shunned like lepers, and there has been considerable hysteria, even boycotts and lawsuits by parents and teachers. In Maryland a judge recently ruled that a 3 year old boy with herpes could attend school only if he wore a one piece suit to cover the lesions, if he was examined daily by the school nurse, and if he were to stay home when he had lesions on his hands. Other school boards are also struggling to come up with guidelines. Meanwhile public health officials everywhere are facing an unprecedented recrudescence of venereal diseases, two million cases of gonorrhoea in 1984 and twice as many chlamydia infections. Now the leading cause of non-gonococcal urethritis and epididymitis, it affects women by causing pelvic inflammation, often asymptomatic, but later resulting in sterility or ectopic pregnancy—as well as causing conjunctivitis and pneumonia in the newborn, proctitis in homosexuals, and perhaps Reiter's disease. "Chlamydia is not a flower," announces the drug company pamphlet with the orchid on its cover. It is "a major health menace" for which a diagnostic test is now available, "but is not part of the routine checkup and you have to ask for it." The text ends with the hope that someday medical science will come up with a vaccine against the disease.

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Increasing lawsuits

Meanwhile the conventional vaccines have fallen on troubled times. This winter a serious shortage of DPT (diphtheria, pertussis, tetanus vaccine) caused health officials to recommend postponing the booster doses generally given to older children. The shortage has been attributed to increased production costs and governmental competitive bidding practices driving down prices, this gradually eliminating all but one of the vaccine manufacturers from the market. The main problem, however, is the increasing number and cost of the suits brought against the manufacturers, culminating last year in a $10 million award against one particular company. At present the only remaining manufacturer in the field has 150 suits filed against it, largely because of entrepreneurial liability lawyers taking up cases on contingency, charging no fee, but expecting a share of the profits. Their technique is to file many suits in the hope of winning one and obtaining a big award, then getting the company to settle the other cases out of court.

Unfortunately, the use of DPT has always entailed a risk, not merely of collapse, shock, and high fever, but also a 1:100 000 chance of brain damage. Yet the benefits outweigh the risks, as shown by the reappearance of whooping cough epidemics in countries where vaccination had been temporarily stopped; and it is by no means clear how the present impasse can be solved. Suggestions have included ending government subsidies to civil courts (thus making it more expensive to sue), limiting lawyers' fees, defining negligence more clearly, restricting compensation awards, and eliminating punitive damages. Some groups want the federal government to compensate victims of vaccinations, which course the administration thinks would be too expensive, others also want to preserve the alternative option of going to court. Other proposals include tax benefits for manufacturers, support for research, importing vaccines from abroad or having the government make them, better reporting of adverse effects, and educating the doctors about the precautions to be observed in vaccinating children. Most likely, however, Congress will have to pass some form of legislation to solve the crisis.

Yet there are also other problems with vaccines, so much so that we read about an immunisation gap. While less than 20% of people at risk have taken the hepatitis-B vaccine, some 40% of adults lack immunity against tetanus, 30% against diphtheria, 10-15% of women against rubella. Influenza and pneumonia vaccines are also underutilised, and a chickenpox vaccine is near but may find no takers. Various factors are believed to contribute to this vaccination gap. Some vaccines are not being paid for by the government; doctors often do not encourage vaccination; there are fears about AIDS; and there are memories about the trouble with the swine flu vaccine.

Worst American epidemic

Another epidemic this April, the worst in United States history, occurred when the milk in a dairy processing plant in a suburb of Chicago became contaminated with *Salmonella typhimurium*. Over 9000 people, mainly in Illinois but also in adjoining states, developed fever, nausea, vomiting, and diarrhoea; and the infection caused or may have contributed to the deaths of several people. State authorities closed down the plant where the milk had been processed in 6000 gallon refrigerated tanks, and they virtually dismantled the dairy trying to find out how the contamination had occurred. In the midst of the epidemic the governor of Illinois fired the director of public health from his $65 000 a year job for "sneaking off" on a Mexican vacation instead of staying home to direct the investigation and ensure that all regulations were observed. Then the state environmental agency wanted to fine the company $100 000, complaining that it was illegally dumping tainted milk into sewers, and that milk was turning up in ponds and streams throughout the Chicago area.

Predictably, some 60 lawsuits were filed against the company within a few days, and several lawyers were advertising actively, promising to charge no fee unless they were successful. Then complaints about the adequacy of the inspection of dairy products led to an investigation of the health department by the state legislature. Regarding treatment, doctors were advised to relieve symptoms and replace fluid losses but avoid using ampicillin, which might promote the growth of the resistant salmonella by killing off the other bowel organisms. One patient, who died from septic shock two days after receiving penicillin for a tooth abscess, may well have been a victim of this phenomenon. And the emergence of what the press called the resistant "superbugs," once more prompted consumer groups to question the farmers' universal practice of adding antibiotics to animal feeds. But an inquisitive lady was amazed to read that the salmonella was named to commemorate a Dr Salmon. She had always assumed that the bacteria were fish shaped and resembled tiny salmons.

References

1 Heylings PNK. Personal view. *Br Med J* 1973;i:111.
2 Older J. Teaching touch at medical school. *JAMA* 1984;252:931-3.
3 Lee RV. The generalist: a jaundiced view. *Am J Med* 1982;73:617-8.

What treatment is advised for early morning sinusitis that worsens in the winter months?

Many of the symptoms of allergic rhinitis are called sinusitis by patients. The diagnosis of early morning sinusitis is not recognised by otolaryngologists. Nevertheless, the symptoms of nasal obstruction with or without sneezing and secretion and facial discomfort which tend to clear during the day are widely known. The effect of gravity on the haemodynamics of the nasal mucosa leads to congestion which accounts for nasal obstruction when in the prone position. Perennial nasal allergy—in particular, sensitivity to the house dust mite dermatophagoides)—accounts for the symptoms in many patients. Feather pillows and bedspreads are repositories of house dust mites and are allergenic in their own right. In autumn and winter in the United Kingdom the increased level of humidity and central heating is ideal for the multiplication of house dust mites; dust samples taken then show a higher antigenicity, as does dust taken from damp rather than dry houses. This seasonal variation in the numbers of house dust mites probably accounts for the apparent increase in the symptom of early morning nasal obstruction, which causes mucosal swelling of the ostia of the sinuses, thus giving rise to the symptoms of sinusitis. Other factors such as temperature and humidity variations in centrally heated environments may also influence the degree of vascular congestion of the nasal mucosa.

A full history of the symptoms should indicate the cause of the problem in most patients. If the only problem is postural vascular obstruction simple reassurance is all that is indicated. In the allergic group skin tests or radioallergosorbant testing for serum IgE antibodies may be necessary.

Elimination of the allergen by changing pillows and bedspreads to man made materials and improvement of the home environment are often the only measures needed to reduce the complaints to an acceptable minimum. Desensitisation to house dust mites has had some success in the control of symptoms. Oral sympathomimetics such as pseudoephedrine have a favourable effect on the symptoms, though they are mildly stimulating, and may be profitably combined with antihistamines. Nose drops containing sympathomimetics should not be prescribed as these may lead in the long term to rhinitis medicamentosa. Antihistamines antagonise the histamine released in the allergic response and inhibit the vascular phenomena caused by this mediator. Antihistamine drugs have several side effects including drowsiness and atropine like effects such as dry mouth. Sodium chromoglycate inhibits the release of histamine from the mast cells in the nasal mucosa and has proved to be of some benefit when given by insufflation into the nose. There are no major side effects. The anti-inflammatory properties of corticosteroids have a beneficial effect on allergic and non-allergic rhinitis. Intranasal beclomethasone dipropionate is an important advance in treating these conditions, and there is minimal risk of systemic side effects.—D C WILLIAMS, senior registrar in otolaryngology, London.

Ballantyne J, Groves J. *Scott Brown's diseases of ear nose and throat*. 4th ed. London: Butterworth, 1979.
Maram AGD, Stell PM. *Clinical otolaryngology*. Oxford: Blackwell Scientific Publications, 1979.