

BMJ 1995;311:1510 (2 December)

Little yellow cold pills

Treating the common cold can be a messy affair because patients expect to be cured when they come to see you and eye you suspiciously when you fail to cure them, wondering if you might be incompetent, uncaring, or spending your weekends fishing instead of taking refresher courses. You could of course get them off your back with a shot of penicillin, which borders on malpractice, or order computed tomography, an idiotic but interesting approach because over 70% have variable occlusion, pneumatization, or thickening of the mucosa of the upper nasal airways and sinuses [N Engl J Med 330:25]. You could also routinely measure nasal mucociliary clearance and airway resistance by single-nostril active anterior rhinometry, which will get you in the newspapers if you bill Medicare or into a lunatic asylum if your friends and relatives get wind of it. You could draw a picture of the virus, with the unintended result that the patient will move irrevocably to the doctor down the road.

You could also try evidence based medicine and explain that in 68 subjects studied there was no difference between those who inhaled heated vapor for 60 minutes and those who got regular air [JAMA 271:1109]; or indicate that anticholinergics, antitussives, expectorants, and decongestants are useless [JAMA 269:2258], as are combinations and antihistamines, studies showing benefits being "rife with methodological problems" [JAMA 270:1812]. Tea with lemon and honey, chicken soup, or hot broth might possibly be effective [JAMA 272:1063], but more studies are needed. So tell patients to come back in a few years when special DNA probes and hybridization techniques will identify the offending virus and allow prompt intranasal treatment with specific antisense oligonucleotides.

Alternatively, you might try giving patients the famous little yellow cold pills, so powerful that they must not exceed four in a day. You could legitimately charge for the service but I prefer giving them away for free, as I buy them generically by mail order for less than one cent per tablet. Results are spectacular and everybody recovers. Last year a patient was cured instantaneously, almost as in olden days; and riots have broken out when I have been out of town and nobody could get at the magic pills. Chlorpheniramine pills are said to cause sedation, but so far nobody has driven into a lamp post after taking 4 mg or had to take time off from working for their Nobel prize on their account.

Imagine then my indignation when I read about a professor testifying before congress that Americans spend \$1 billion each year on antihistamines that hurt rather than help and that they "should be removed from all non-prescription products promoted for the relief of cough and cold symptoms." Mercifully a spokesman for the drug industry countered that "people wouldn't be using these products if they didn't work."

Since then an algorithmic sequential approach to chronic cough and postnasal drip syndrome caused by rhinitis has also recommended first trying an antihistamine-decongestant [Ann Int Med 119:977]. But the professor has remained unreconciled. He even said that a popular cold remedy worked only because it contained 25% alcohol. In a competitive managed care environment this could indeed pose a threat to the magic yellow pills and even promote the more cost effective two hat cure: hang a hat on a bed post; get under the blankets with a bottle of whisky; and keep drinking until you see two hats.