TABLE III—COMPARATIVE TABLE OF TOTAL POSTOPERATIVE MORBIDITY AND MORTALITY

<table>
<thead>
<tr>
<th>ABDOMINAL CASES</th>
<th>ALL TYPES OF CASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slight bronchitis</td>
<td>5-9</td>
</tr>
<tr>
<td>Severe bronchitis</td>
<td>8-3</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1-1</td>
</tr>
<tr>
<td>Atelectasis</td>
<td>2-5</td>
</tr>
<tr>
<td>Total pul. morbidity</td>
<td>12-0</td>
</tr>
<tr>
<td>Total pul. mortality</td>
<td>1-1</td>
</tr>
</tbody>
</table>

* From tables published by Dawkins.

There were two deaths within three days, both in moribund patients.


vomiting at all; of these 6% vomited once, 5% twice, 4% thrice and 5% more than thrice; 3-5% patients after spinal anaesthesia recovered within an hour; the longest time was 5 hr. and the average 2 hr. 7 min. One of these patients could take fluids by mouth after 30 min.; 3 within an hour; the longest time was 1 hr. 35 min. and the average 3 hr. 40 min.

The immediate postoperative condition of the 1000 patients is summarised in table I. In the small Oxford Vaporiser series, where none of the patients was shocked or seriously ill before operation, the shortest time to recovery after anaesthesia was 15 min.; 6 of the 18 cases recovered within an hour; the longest time was 5 hr. and the average 2 hr. 7 min. One of these patients could take fluids by mouth after 30 min.; 3 within an hour; the longest time was 1 hr. 35 min. and the average 3 hr. 40 min.

The postoperative pulmonary complications are set out in table II, and the incidence is compared in table III with figures published by Dawkins from the Middlesex Hospital. In the 18 Oxford Vaporiser cases, though all had normal respiratory systems before operation, there was 1 case of slight bronchitis, 1 of interlobar empyema and 1 of bronchopneumonia.

SUMMARY

The patient's comfort and rapid convalescence, which should be the anaesthetist's major care after safety, have been largely neglected until lately. Many anaesthetists have thought that the only way to safety lies in adhering to the old and uncomfortable ways. Ether is so toxic and so liable to produce postoperative nausea and vomiting that it is unsound to judge their worth by the incidence of these complications. Many anaesthetists have thought that the only way to safety lies in adhering to the old and uncomfortable ways. Ether is so toxic and so liable to produce postoperative nausea and vomiting that it is unsound to judge their worth by the incidence of these complications.


41. Kahn, R. L. Brit. J. Med. 1940, i, 972; Courville, C. B. Anesthesiology, 1940, i, 261, and Untoward Effects of Nitrous Oxide Anaesthesia, California, 1939, p. 27.


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48. Thomas, G. J. Anesth. & Analges. 1940, 1, 261, and Untoward Effects of Nitrous Oxide Anaesthesia, California, 1939, p. 27.


57. Minnitt, R. J. Handbook of Anaesthetics, Edinburgh, 1940, p. 83.

58. Rand, E. L. Brit. J. Med. 1940, i, 972; Courville, C. B. Anesthesiology, 1940, i, 261, and Untoward Effects of Nitrous Oxide Anaesthesia, California, 1939, p. 27.


The disappearance of radiological signs, for the X-ray picture of hilar glands, which may persist for some time after the lungs have regained their translucency. The lung fields had largely disappeared by 21 days, and clinical recovery was seldom associated with a parallel disappearance of opacity in the lung. It was found that resolution of the pneumonic process, as judged by the radiological examination, carried out within twelve hours of admission and at weekly intervals thereafter. Before the beginning of treatment blood was obtained for culture and bacteriological examination, sputum was examined bacteriologically to confirm the predominance of pneumococci, and where possible the organism was typed. Only cases of true lobar pneumonia are included in this series. All cases of bronchopneumonia and atypical pneumococci, and cases showing a mixed flora on sputum examination, have been excluded.

The routine treatment in the case of all three drugs was essentially the same—administration of 4 g. of the drug, followed by 1 g. four-hourly. In the case of sulphamezathine and sulphadiazine the maximum total dose was 20–25 g. In the sulphapyridine cases a similar dosage was given, but a few cases received as much as 35 g. In addition to the usual symptomatic and nursing treatment, care was taken of sulphapyridine by treating in order of admission alternate cases with either of the drugs, and to contrast the results obtained with 354 cases treated with sulphapyridine.

The diagnosis of lobar pneumonia was based on the history of the illness and physical examination, and on radiological examination carried out within twelve hours of admission and at weekly intervals thereafter. Before the beginning of treatment blood was obtained for culture and bacteriological examination, sputum was examined bacteriologically to confirm the predominance of pneumococci, and where possible the organism was typed. Only cases of true lobar pneumonia are included in this series. All cases of bronchopneumonia and atypical pneumococci, and cases showing a mixed flora on sputum examination, have been excluded.

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As will be seen from the tables, there can be little doubt about the effectiveness of sulphamezathine in the treatment of lobar pneumonia. In the present series the death-rate was lower with sulphamezathine and sulphadiazine than with sulphapyridine. The difference in total numbers in the two series must be taken into account. It seems clear, however, that sulphamezathine is at least as effective as sulphadiazine and sulphapyridine. There was no very marked difference in the incidence of complications and sequelae, between the cases treated with the three drugs, except that the incidence of pleural effusion is higher in cases receiving sulphamezathine.

Twenty-one cases gave positive blood-cultures on admission, and one of these died. The average time required for the fever to subside was 29 hours.

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I, either of these substances is administered along with age of 40.

Two additional points of general clinical interest emerged. It was noted that in cases which recovered from pneumonia to develop empyema later, defervescence sulphadiazine to alter haemoglobin is less than that of so that, while the tendency of sulphamezathine and confection of sulphur, sulphaemoglobin will be formed; to produce clinically remarkable cyanosis. Further, if emerged. It was noted that in cases which recovered resolution, it was found that this had no relation to the incidence of this complication does however bear some relation to the age of the patient. Of 38 patients in which the pneumonia resolved slowly, 27 were over the age of 40.

SUMMARY

The results obtained by treating alternate members of a series of 137 cases of lobar pneumonia with sulphamezathine and sulphadiazine are compared with those in 354 cases treated seriatim with sulpha-

S O C I E T Y O F M E D I C A L O F F I C I E R S O F H E A LT H

The curative effect of sulphamethazine, as judged by case-mortality, is at least equal to that of sulphasulphadiazine, and both drugs compare favourably with sulphydrylprine.

In cases treated with sulphasasazine and sulpha-

REFERENCE


S O C I E T Y O F M E D I C A L O F F I C I E R S O F H E A LT H

The frequency of toxic effects in cases treated with sulphamezathine and sulpha-


S O C I E T Y O F M E D I C A L O F F I C I E R S O F H E A LT H

Hematology in the Infectious Diseases

At a meeting of the Fever Group on Nov. 19, with Dr. Andrew Topping in the chair, a discussion on

hematologic changes in children, was opened by Dr. G. W. Goodhart (LCC Pathological Service), who said that one of the difficulties in employing blood-counts in differential diagnosis is that the picture varies with the stage of the disease and this is often difficult to determine exactly. The prodromal stage of most fevers is characterised by a polymorph leucocytosis which persists into the eruptive stage in coccid diseases, whereas bacillary and viral infections tend at that stage to produce a leucopenia or a lymphocytic response. In scarlet fever a polymorph leucocytosis persists usually until the disease becomes acute, and under certain conditions, as in toxic cases is a bad prognostic sign. Eosinophilia, sometimes up to l0%, is characteristic. He would be chary of excluding scarlet fever even if there is no clear polymorph response. Prominent among the diseases marked by leucopenia with a relatively lymphocytosis is enteric fever. These changes occur quite early but their importance in diagnosis is overshadowed by the development of modern bacteriological methods. Nevertheless, leucopenia is a valuable adjunct to diagnosis particularly in clinically atypical cases, while a blood-count can sometimes negative a diagnosis of typhoid which seems clinically probable but lacks bacteriological proof. Insufficient attention is paid nowadays to the characteristic absence in exanthematous cases in the leucocyte counts of characteristic blood-counts in various fevers since many cases run a complete course without a greater change in the blood-picture than can be paralleled in healthy people. In convalescence anemia should be estimated by blood-counts rather than on clinical appearance, which may often mislead in children. The blood-picture in the common infectious diseases needs further investigation, but the knowledge to be gained from a count should be weighed against possible emotional trauma in small children. Facilities for these and other investigations are deficient in most fever hospitals at present but there will doubtless be improvement in the future. It is a delusion to assume that anyone can do a blood-count; it is only rarely acquired by careful training, attention to detail and constant practice.

Dr. IAN TAYLOR (LCC) pointed out the difficulty of interpreting minor changes in the blood-count in children in the absence of exact standards of normality for the various age-group.—Dr. R. F. L. Hewlett (LCC) had noted that in enteric fever with a respiratory onset there is sometimes a polymorph leucocytosis rather than a blood-count; often in acute cases demand it. Dr. Gooch of course that leucocytosis is more likely to be met in paratyphoid than in typhoid.—Dr. A. L. K. Rankin (Twickenham) felt that routine blood investigation in atypical throat infections would be more frequent as the angina type of glandular fever.—Dr. Robert Crouch-