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THE TREATMENT OF ACUTE FAILURE OF THE HEART.

To the Editors of THE LANCET.

SIRS,—I read with much interest and pleasure Dr. C. Bolton's paper on this subject in THE LANCET of March 30th, p. 870, particularly that part of it concerning diphtheria. His attitude towards alcohol and strychnine and his insistence upon the importance of rest meet with my most cordial support, his views being substantially the same as those I have expressed elsewhere.[1] The paper, however, contains certain statements which should not, I think, be allowed to pass unchallenged. After rightly emphasising the importance of the early administration of antitoxin he says: "If antitoxin is administered on the first day of the disease, a circumstance only possible when the patient contracts the disease in a hospital, the mortality is only ½ per cent. ..... After the fifth day antitoxin is unable to produce any reduction of the mortality." Granted that diphtheria is often insidious in its onset, especially in children, in whom it may be mistaken for a cold or some other trifling affection, the prodromal symptoms are often sufficiently obtrusive to make the parents seek medical advice, especially if a recent case in the family or immediate neighbourhood has caused them to be on the alert.

[1] Practitioner, vol. ii., 1904, p. 798 et seq.

It is hardly fair to the general practitioner to suppose that he should always fail to recognise diphtheria on the first day, or that having formed a correct diagnosis he should not at once insure appropriate treatment, either by giving antitoxin himself or by sending the case at once to hospital. It is true that first-day cases form a comparatively small percentage of the total admissions to fever hospitals, but one has only to refer to the statistics of Dr. J. MacCombie[2] to see that during the last nine years as many as 214 cases have been admitted to the Brook Hospital on the first day of disease, all of which recovered. My own experience is corroborative. Out of 1200 consecutive cases that have been under my care in the course of the last four years, in 44 the clinical evidence confirmed the history of the disease having begun on the day of admission. No deaths occurred in these 44 cases, and in only three was there any paralysis, in each case of a mild character and short duration. In the remaining 1156 there were 268 paralysis cases, 98 of which were severe.[3]

In his remarks on the inefficiency of antitoxin after the fifth day of disease Dr. Bolton expresses an opinion which appears to be widespread, but which is, I think, erroneous, and if carried to its logical conclusion—viz., abstention from the administration of antitoxin in every case of diphtheria later than the fifth day—is highly pernicious. In my own cases no less than 169, or 14·08 per cent., were admitted after the fifth day of disease. With the exception of nine very mild cases, all in whom membrane was present received antitoxin. Of these 19 died, a mortality of 11·2 per cent. Would the death-rate have been so low

[2] Brit. Med. Jour., vol. ii., 1906, p. 1759. Cf. Metropolitan Asylums Board's Reports, 1898–1905.

[3] Cf. Practitioner, loc. cit., p. 612 et seq.

had antitoxin been withheld? Surely not. In the pre-antitoxin era,[4] even when the cases were brought under treatment at the very onset of the disease, the mortality was never less than 28·8 per cent., and not infrequently rose to 50 per cent. or more. Since age is an important factor in the prognosis of diphtheria it is well to say that the majority of my cases were children: 68 were between the ages of 0 and 5 years (14 deaths), 73 between 5 and 10 years (4 deaths), and 28 were 10 years old and over (1 death). The comparatively low death-rate cannot, therefore, be explained by saying that the patients were adults in whom the mortality of diphtheria is notoriously low. Nor can the low mortality be attributed to the mildness of the cases, as will be seen from the following classification: 17 were very severe (10 deaths); 51 were severe (9 deaths); among the remainder, which were classified respectively as "moderately severe" (17 cases), "moderate" (35), "mild" (40), and "very mild" (9), no deaths occurred. These figures also show that a late case is not synonymous with a severe case, every form of the disease being represented. It is important to realise that the evolution of diphtheria may be either rapid and malignant, so that even large doses of antitoxin given on the second day of the disease may not avert a fatal issue—the mortality among my second day cases was 3·08 per cent.—or comparatively slow and benign, so that the disease which may have been in progress for a week yields rapidly to a small dose of antitoxin, no subsequent complications ensuing. Though fully substantiating Dr. Bolton's remarks on the importance of the early administration of antitoxin, I

[4] Baginsky: Diphthérie, p. 312. Cf. Metropolitan Asylums Board's Reports prior to 1894.

would urge that we should be guided by clinical rather than chronological considerations in our treatment of diphtheria. The presence of membrane in the throat, however late the disease, is an indication for serotherapy. I have seen so many severe late cases, some of which I have recorded elsewhere,[5] in which my original gloomy prognosis has been happily falsified, as to feel inclined to say of diphtheria as Ricord did of syphilis: "As regards recovery everything is possible, sometimes even the impossible."

I am, Sirs, yours faithfully,

J. D. ROLLESTON.

Grove Fever Hospital, S.W., March 30th, 1907.

[5] Practitioner, loc. cit., pp. 808 and 821. Review of Neurology, 1905, p. 722. The British Journal of Children's Diseases, 1906, p. 541.

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