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## WHY NOT?

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# Why not prescribe antibiotics for 'heavy colds'?

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**N**OWADAYS, it is considered to be rather a disgrace to own up to prescribing antibiotics for Acute Respiratory Disease (ARD). I say "own up to prescribing" because we all do it and differ only in the way we rationalize our handling of this common management problem.

I would like to ask the question "Why not prescribe antibiotics for ARD?" I will immediately qualify this by endorsing the orthodox view, which is, of course, that prescribing of antibiotics in cases of apparently uncomplicated ARD is expensive, potentially harmful and often difficult to justify on scientific grounds.

My argument is this: if it can be shown that a sizeable proportion of ARD is due to an organism which is sensitive to nontoxic antibiotics, produces unpleasant illness which is infectious in closed communities, often leads to pneumonia, cannot readily be diagnosed except by laboratory testing and presents initial symptoms similar to those of a 'heavy cold' or a 'dose of the 'flu', then cannot prescription of antibiotics be justified, even on a wholesale basis, in cases of ARD?

I have recently become interested in the organism *Mycoplasma pneumoniae*. Studies in Switzerland (Krech *et al.*, 1976) have found *M. pneumoniae* to be the cause of 23 per cent of cases of ARD and conclude that this organism is the most frequent cause of this illness. Similar studies in Sweden on the aetiology of ARD (Mardh *et al.*, 1976) could establish a diagnosis in only 33 per cent of the total cases examined but found *M. pneumoniae* to be the largest single cause, accounting for 16 per cent of the identifiable cases.

An epidemiological survey in children (Foy *et al.*, 1979) has shown that *M. pneumoniae* infection, when measured in annual rates of seroconversion, is endemic. Although the majority of infections caused by *M. pneumoniae* in this study were essentially trivial, infection was more likely to result in pneumonia when the child was aged between five and nine years.

Studies of *M. pneumoniae* infection among navy recruits (Edwards *et al.*, 1976) show that seroconversion occurred in between 45 and 57 per cent in some of the recruit companies during the late summer peak in incidence. During the major peak season, *M. pneu-*

*moniae* was the known cause of pneumonia in 32 per cent of cases.

A report of an outbreak of *M. pneumoniae* infection among hospital personnel (Fisher *et al.*, 1978) found that the incidence of pneumonia was 21 per cent in those who contracted the infection.

All authors agree that the symptoms of infection are so nonspecific that the syndrome cannot readily be diagnosed on clinical grounds alone. Infection by *M. pneumoniae* may be proven by fourfold rise in CF antibody titre, or suspected if cold agglutinins are found in the blood of possible cases. Neither test is of much help in the early management of patients, as a rise in antibody titre may take seven days to develop and cold agglutinins may be present in only 50 per cent of cases. In my own experience an important part of the syndrome is the prolonged convalescence, with lassitude lasting for several weeks to months after the acute symptoms have subsided.

So: if *Mycoplasma* is the commonest cause of ARD, why not prescribe antibiotics more readily? *M. pneumoniae* is sensitive to tetracycline and erythromycin. What is so unscientific about using them?

My own somewhat arbitrary approach is to give serious consideration to prescribing a short course of tetracycline or erythromycin to any adult with ARD in whom fever of over 100°F continues for more than three days without subjective feeling of improvement, and especially if accompanied by profuse or yellow or green sputum. Is this so unreasonable?

## References

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