

References

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We showed Dr McSherry's letter to a member of the Editorial Board, who writes:

The crux of our problem with Dr McSherry is that none of us has seen the references on which he bases his case. I understand that the journal he refers to is not held anywhere in this city and we have suspicions that it may, in fact, not be an English-language journal. I think it would be reasonable to ask Dr McSherry to send us photocopies of the papers he refers to to allow us the opportunity to judge whether the strength of his case is such that he should be given a further opportunity to put his point of view. On the whole I think all letters should be published as a matter of principle, as selection tends to create the impression that we are suppressing freedom of expression. If you were able to get hold of a photocopy of this article I would be delighted to read it and comment further on this debate.

We also showed Dr McSherry's letter to the writer of the editorial, who lives a long way from a university library and who replied:

I think Dr McSherry must be taking issue about the treatment of pneumonia, but I find his terminology confusing. In his letter the term 'acute respiratory illness' seems to relate to major chest infection, but in his *Journal* paper the term seems loosely applied to both pneumonia and simple respiratory illness. It is also paradoxical that in his paper he advocates tetracycline or erythromycin for adults, while the incidence of *Mycoplasma pneumoniae* is unquestionably more common in children.

In order to clarify woolly thinking:

1. *Simple respiratory illness in children* (i.e. upper respiratory illness or URTI). One GP saw 724 consecutive illnesses in 12 months and 66 developed bronchitis and four pneumonia, giving a 9.7 per cent incidence of chest infection. The need was acknowledged that sometimes antibiotics have to be given in the absence of chest signs if the cough is 'bad' or chesty (Everett, 1981).

Conclusion: no justification for routine antibiotic use on the basis of the incidence of complicating chest infection.

The commonest cause is surely viral, owing to the wide range of viruses in this type of illness shown by Blair and colleagues (1970), Hobson (1973), Wilks (1973) and Higgins (1974). *M. pneumoniae* was suggested as a common cause by Salinsky (1978), but he gave no proof. Fransen and colleagues (1969) did complement fixation tests (CFT) in 530 patients of all ages with "acute respiratory illness without pneumonia" and found 4 per cent with *M. pneumoniae*. Conclusion: *M. pneumoniae* is apparently not a common cause of simple respiratory illness.

But Foy and colleagues (1979) state that in epidemics of *M. pneumoniae*, many have relatively mild disease, e.g. cough and/or sore throat, and the 5-14-year-old age group particularly develop pneumonia. Conclusion: there could be justification during an epidemic of *M. pneumoniae* to give routine tetracycline or erythromycin to children and teenagers with colds and coughs, as a means of preventing pneumonia or treating early unsuspected pneumonia.

2. *Flu-like illness in adults* (equivalent to simple respiratory illness in children). One GP saw 280 consecutive illnesses in a two-year period: 143 had CFT, many viruses were identified and only one instance of *M. pneumoniae*. Antibiotics used selectively for respiratory complications (Everett, 1977). Conclusion: incidence of *M. pneumoniae* low. No evidence to support routine antibiotic use.

3. *Major chest infection* (pneumonia, acute bronchitis, pleurisy). I agree that the incidence of *M. pneumoniae* as a cause of pneumonia is about 20 per cent (quoted references, plus Fransen, 1969; Foy et al., 1970; White et al., 1981) and that the incidence is highest in children, teenagers and young adults, and that during an epidemic the incidence may be higher than 20 per cent. Conclusion: *M. pneumoniae* is the commonest identifiable cause by CFT, but not the commonest cause.

*Streptococcus pneumoniae* is believed to be the commonest cause (several references), and in the community Oseasohn and colleagues (1978) found that most instances of radiologically confirmed pneumonia were associated with pneumococci. Hence my advocacy of amoxycillin first. A change to tetracycline or erythromycin need not wait for serology, but can be made after a few days if response is poor (the brevity of the editorial precluded comment on such finer points of management).

The argument against the initial use of tetracycline is that *M. pneumoniae* pneumonia is indistinguishable clinically and radiologically, and it could be inadvisable to use tetracycline for what might be pneumococcal pneumonia owing to the known 13 per cent resistance rate (Ad hoc Study Group, 1977). But erythromycin could be used (no one would argue with that, since it is active against *Streptococcus pneumoniae* and *M. pneumoniae*). This point was made originally in the editorial but was lost in the interests of space).

I agree that sometimes treatment has to go ahead in the absence of physical signs (the editorial does say this), because in both children and adults with pneumonia, chest signs are occasionally absent.

I disagree with Dr McSherry's views on the severity of *M. pneumoniae* pneumonia. My own cases have not been severely ill and did not have a prolonged convalescence, and behaved like any other pneumonia. (Two received antibiotics which included neither tetracycline nor erythromycin, and got better before serological diagnosis—they presumably recovered spontaneously.)

References

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A week later the editorial writer sent a further note:

I now have photostats [Editor: from the College Library] of the two papers he referred to. Mardh and colleagues (1976) acknowledge that viruses are the commonest cause of simple (upper) respiratory illness, but wish to emphasize the unrecognized incidence of *M. pneumoniae*. They give a figure of 16 per cent, but this has to be taken with a