

References

Krech, U., Price, P. C. & Jong, M. (1976). The laboratory diagnosis and epidemiology of *Mycoplasma pneumoniae* in Switzerland. *Infection*, **4**, 33-36.

McSherry, M. A. (1981). Why not prescribe antibiotics for 'heavy colds'? *Journal of the Royal College of General Practitioners*, **31**, 49.

Mardh, P. A., Hovelius, B. & Nordenfelt, E. (1976). Incidence and aetiology of respiratory tract infections in general practice. *Infection*, **4**, 40-48.

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

Ad hoc Study Group. (1977). *British Medical Journal*, **1**, 131-133.

Blair, W. et al. (1970). *Journal of the Royal College of General Practitioners*, **20**, 27-31.

Everett, M. T. (1977). *Practitioner*, **219**, 699-711.

Everett, M. T. (1981). *Practitioner*, **225**, 379-391.

Foy, H. M., et al. (1970). *Journal of the American Medical Association*, **214**, 1666-1672.

Foy, H. M. et al. (1979). *Journal of Infectious Diseases*, **139**, 681-687.

Fransen, H. et al. (1969). *Scandinavian Journal of Infectious Disease*, **1**, 91-98.

Higgins, P. G. (1974). *Journal of Hygiene (Cambridge)*, **72**, 255-264.

Hobson, D. (1973). *British Medical Journal*, **2**, 229-231.

Oseasohn, R. et al. (1978). *American Review of Respiratory Disease*, **117**, 1003-1009.

Salinsky, J. V. (1978). *Clinical Trials Journal*, **15**, 76-81.

White, R. J. et al. (1981). *Thorax*, **36**, 566-570.

Wilks, J. M. (1973). *Journal of the Royal College of General Practitioners*, **23**, 776-782.

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

pinch of salt, as cases were randomly selected (not consecutive), were aged over seven years, and in two thirds no cause at all was identified. Krech and colleagues (1976) report laboratory findings on 60,000 serum samples, and found a 23 per cent incidence of *M. pneumoniae* among 1,555 patients with "acute respiratory infection". They conclude, as Dr McSherry quoted, that "*M. pneumoniae* is the most frequent cause of acute infections of the respiratory tract", which is of course nonsense. It is only possible to conclude that, by the method used (serology), *M. pneumoniae* was the most commonly identified cause.

Secondly, it is curious the way things coincide. I am currently looking after a 10-year-old girl with pneumonia who, contrary to my previous experience, got steadily worse on amoxycillin and for 24 hours was quite worrying. She is now getting slowly better after a change to erythromycin at six days. Radiography excluded staph. pneumonia and she presumably has *M. pneumoniae* (too early for serological diagnosis).

It is often difficult and can take a long time to formulate a reasonable policy of management, but I think now, based on this case, previous experience and the literature, that in future I shall treat pneumonia in children with erythromycin as first choice to accommodate the known 20 per cent incidence of *M. pneumoniae*, but in adults will continue to use amoxycillin first.

And a further three weeks later he provided the final chapter:

On reflection, the conclusion to treat colds/coughs with erythromycin during an epidemic is possibly suspect, because how does one recognize an epidemic—by an outbreak of pneumonia in children perhaps? I have never consciously recognized one.

For completeness, the villain of the piece, the 10-year-old girl (now better), did indeed have mycoplasma pneumonia (titre 40, rising to 640).

Returning Questionnaires: Who Pays?

Sir,
I have this morning received a questionnaire concerning attitudes to postgraduate education from Dr Major of Northampton. This is the second or third questionnaire received in recent years which is accompanied by neither a stamped addressed envelope nor an explanation as to why not. I therefore do not intend to reply to this, or to similar questionnaires.

R. S. L. THOMAS

The Surgery
New Wokingham Road
Crowthorne RG11 6JL.

With both writers' permission, we asked Dr Major for his comments:

Dr Thomas is probably not the only GP whom I circularized with the question-

naire about postgraduate education in the Oxford Region to have been disgruntled at receiving it, but he is the only one to have written (by 1st class post) to inform me of the fact, without enclosing the completed questionnaire! All I can say in mitigation is that the Thames Valley Faculty Board allowed me to send the forms and bore the cost of printing and postage. One hundred and sixty 2nd class letters cost precisely £20. Double that sum and you have the reason why reply-paid envelopes were not included. Complaint is often made about increasing subscriptions to professional organizations—I've done it myself. I thought to try and keep costs down.

May I use your columns to thank those GPs who co-operated with my survey.

D. H. MAJOR

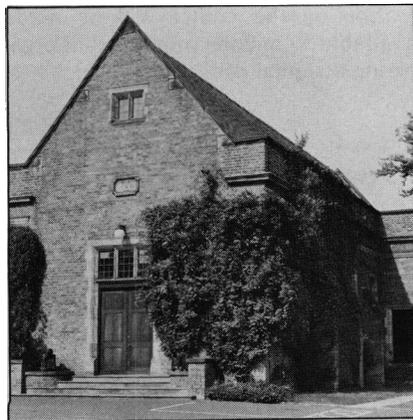
30 East Park Parade
Northampton NN1 4LD.

Correction

In Dr E. S. Hodgson's letter on occupational health (*July Journal*, page 451) the word 'not' was missed out of line 2 in the second paragraph. The sentence should have read "I am not sure that we continue to believe that they are of much value." Dr Hodgson assures us that one of the cornerstones of his practice is that he is almost totally opposed to pre-employment medical examinations as a case-finding exercise.

REPORT

Early Years in Practice



The conference centre at Alderley Park.

RECENTLY the College has been turning its mind to the increasing numbers of young doctors taking its examination, wondering what commitment these people feel they have to the College and what expectations they may have of it.

The Midland Faculty Board felt that young principals in general practice deserved special attention. Many seemed to disappear from the postgraduate educational scene, no doubt because of their new practice and other commitments. The problems and stresses of this stage of general practice were well remembered by Faculty Board members and it was therefore

proposed, in September 1981, that a course aimed at recent members of the College be organized.

A timely offer of the Alderley House Conference Centre at Macclesfield as a venue was made by ICI Pharmaceuticals as evidence of their interest in general practice education, and this was gratefully accepted. A programme for a two-day residential course was devised and entitled 'Early Years in Practice'.

Eligibility to attend was widened to include recent entrants to general practice, and Section 63 (zero rating) approval was obtained. The course took place on 4-6 March 1982, Thursday afternoon to Saturday lunch.

ICI Pharmaceuticals proved to be generous hosts and the programme opened up a tour of their research departments.

The main aims of the course were to provide members with an opportunity to examine their clinical activities, exchange opinions and views with their