

THE EFFECTS OF DRUGS ON THE COMMON COLD

P. D. MULKERN, M.R.C.S., L.R.C.P.

Navestockside

FIVE years ago I decided to study the natural history of some of the common ailments in general practice. To do this it was necessary to observe these episodes without treating them. The statement is starkly simple, but the procedure requires some discipline to initiate, and entails a great deal of worry and heart-searching at first until confidence and understanding develop. I decided to observe the following disorders:

Coryza: all non-specific upper respiratory tract catarrh and its sequelae were included.

Tonsillitis: peritonsillar abscess and cellulitis were excluded.

Otitis media: mastoiditis was excluded (but not encountered).

Bronchitis: asthmatic distress or failure to resolve in a few days indicated antibiotics.

Virus pneumonia: when systemic signs were mild and the disease ameliorated in three days.

These diseases are often treated with salicylic acid derivatives and phenacetin, or with sulphonamides or antibiotics. I substituted a placebo in all cases as follows:

Children: Mist. Sod. Bicarb. pro Inf. (*B.N.F.*) and Tab. Soda Mint.

Adults: Mist. Sod. Chlor. Co. (*B.N.F.*) and a capsule of Garlic oil.

Patients do not usually consult their doctor for coryza, but they may come for treatment of the unresolved catarrhal states when cold cures used at home have failed. I then used my placebo and advised them not to interfere with the next cold but to ask for advice if resolution did not occur naturally. In a few days the original head cold would reappear and the aches and pains or stomach upset or cough would disappear. During the past five years most of my patients have learnt the trick of leaving a cold alone; they will report for 'treat-

ment' if it fails to resolve in about five days. Figure 1 compares my prescribing rate with the average in this region. During the past three years the graph shows that my prescribing habit now differs from the average. Only one person in four has a prescription in this practice, compared with less than one in three for this area. This means about three hundred prescriptions less than the average in a year.

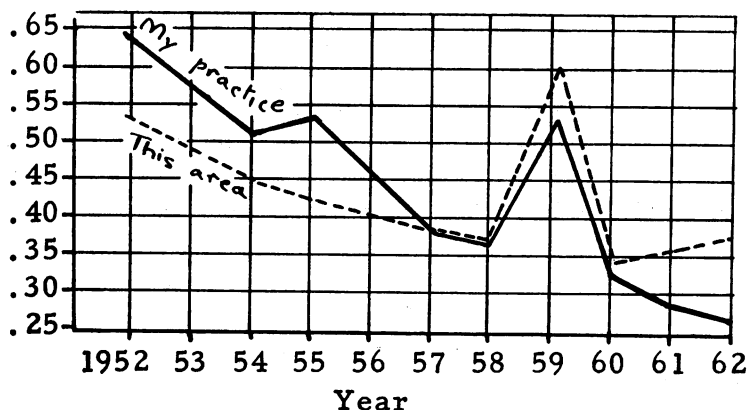


Figure 1

Average number of prescriptions per person on list.

The cost in pence per prescription is shown in figure 2. Since 1957 the prescribing costs in this practice have gone down to half the costs of the area. This means saving about £230 per annum.

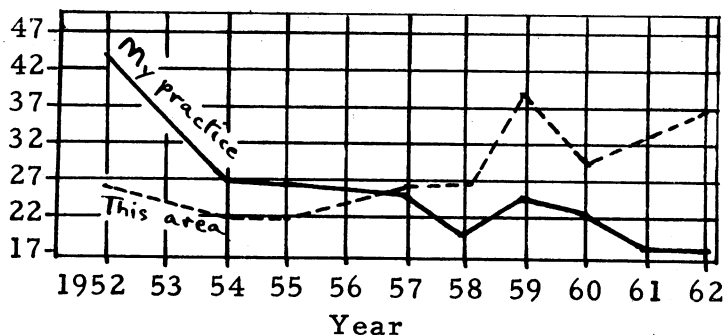


Figure 2

Cost in pence per person on list.

These observations are by the way and should not be regarded as

the aim of this study in general practice.

As time passed I became more confident and gave even fewer placebos. No complications occurred. Threatening diseases crackled and sparked for a day or two, but suddenly fizzled out. I began to be aware that the complications and sequelae of coryza appeared far less often in the consulting room and on the round. I thought that it would be interesting to compare the incidence of the diseases I had stopped treating with the national morbidity figures for this region. (Studies on Medical Population Subjects, No. 14. *Morbidity Statistics from General Practice*, volume I, Logan, W. P. D., Cushion, A. A., H.M. Stationery Office, London, 1958.)

From 1 November 1961, a morbidity survey was recorded on the lines laid down in *Morbidity Statistics from General Practice*. At the end of October 1962 one year's figures were harvested to compare with those relating to this region at the time of Logan's survey in 1955-1956. Figure 3 shows that the total consultation rate for all disease was closely comparable to the national figure for this region. But the patient consulting rate was higher in my practice. This means that more patients consulted me at least once for more illness episodes than would be the case in the average practice in this area.

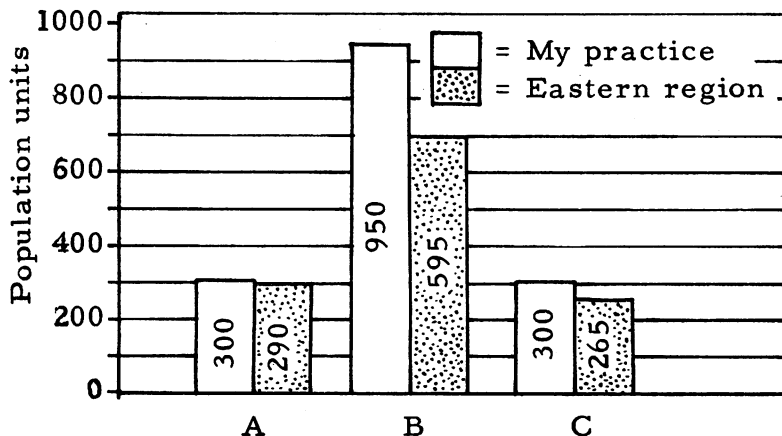


Figure 3

- A = Consultation rate per 1,000 of population.
- B = Patient consulting rate per 1,000 for all diseases.
- C = Patient consulting rate per 1,000 for respiratory diseases.

One possible explanation for this difference may be due to the different age group structure of my practice. Table I compares this

practice with the Eastern region of Logan's national survey; this practice has nearly twice as many 0-15 age group persons and less than half of 45 years and over persons.

TABLE I
CONSTITUTION OF PRACTICE ACCORDING TO AGE GROUPS

<i>Age</i>	<i>This practice</i>	<i>Region</i>
0 — 15 years	37.3 per cent	21.5 per cent
15 — 45 years	45.0 per cent	43.0 per cent
45 + years	18.0 per cent	37.6 per cent

The patient consulting rate per 1,000 for all respiratory disease is somewhat higher than the national figures for this region. This is probably due to the larger ratio of young children to adults in this practice.

Figure 4 compares the patient consulting rates for the common respiratory tract diseases in this practice and in this region. A suitable correction has been made to equate the age group structures of this practice with the average in this region in terms of each of these diseases. Tonsillitis incidence is more than halved, and otitis media (which includes all manifestations of middle ear infection and catarrh, such as eustachian tubitis) is reduced to one-third of the national average. Bronchitis is reduced by one-quarter. The pneumonias are exactly comparable with national figures and act as a control.

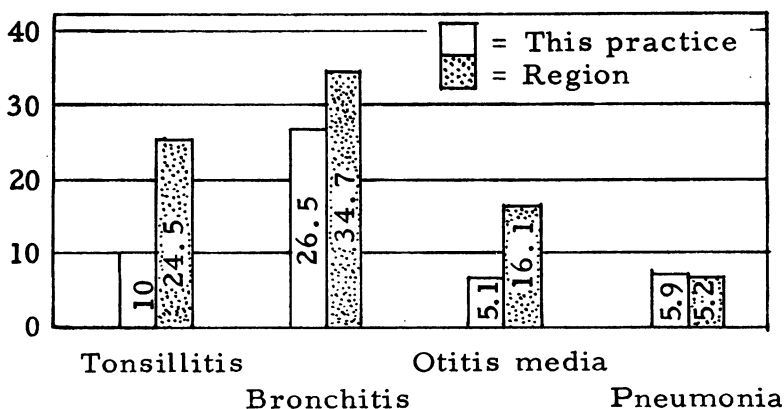


Figure 4
Patient consultation rates for U.R.T. diseases per 1,000 practice population.

As a further check on the accuracy of this record table II compares the patient consulting rates of some diseases chosen by chance, with the national figures.

TABLE II
COMPARISON BETWEEN THE CONSULTING RATES IN THIS PRACTICE WITH THE REGIONAL RATE FOR SELECTED DISEASES

<i>Disease</i>	<i>Patient consulting rates</i>	
	<i>This practice</i>	<i>Region</i>
Osteo-arthritis and rheumatoid arthritis	17.4	18.8
Duodenal ulcer	2.0	2.7
Appendicitis	4.2	4.0
Pneumonia	5.9	5.6

Conclusions

The writer has isolated an important section of morbidity seen in general practice in order to study the natural history of these diseases. The results prove that modern drug therapy is creating a marked increase in tonsillitis, otitis media, and, possibly, bronchitis. Personal attention of the physician and a rational exposition to the patient of the objects and aims of a natural cure take no more time, but much more initial effort for the doctor. But once the new approach is understood by an increasing number of patients and their families, the drudgery of prescribing and the menace of ever-increasing incidence of respiratory tract complications are abolished. The writer believes that this weaning of the patient away from the bottle can only be achieved when the doctor himself is confident that it is not necessary and also has a rational plan for the management of disease to propose to the patient. Patients soon learn to deal with chills and colds in a rational manner without calling the doctor and without resort to suppressive drugs. The incidence of time-consuming and worrying complications is steadily reduced, leaving the doctor more time to follow his real vocation as a physician or teacher.

Summary

During the year 1961-1962 a study of the natural history of respiratory disease revealed the probable iatrogenic origin of a large proportion of cases of tonsillitis and otitis media; and of a significant proportion of cases of bronchitis. Much time and money was saved by reduced prescribing. The total consultation rate did not increase above the national average for the area. This piece of research proves that natural cures are safe, complicating sequelae are materially reduced, the prescribing rate is much lower, and the cost to the National Health Service is about half the average for the area.