ROUTING OUT RHEUMATISM.

THE IMPORTANCE OF EARLY DIAGNOSIS. CENTRALISING THE TREATMENT CLINICS.

A complete scheme for the diagnosis and treatment of rheumatism, worked out with the approval of the Approved and Friendly Societies and endorsed unofficially by the Ministry of Health, was outlined recently by Dr. W. S. C. Copeman, M.B., M.R.C.P., Honorary Physician at the Red Cross Clinic for Rheumatism, in a lecture before the Royal Institute of Public Health. Sir Edward Stewart, Vice-Chairman of the Executive Committee of the British Red Cross Society, presided.

"The scheme I suggest," said Dr. Copeman, "is the outcome of my experience at the British Red Cross Society's Clinic for Rheumatism in Peto Place. Many of the points in it are already embodied in the organization of that Clinic, which, I hope, is only the first of many other similar institutions shortly to be established.

"Three factors have to be considered. First, prevention, which is predominantly a social question; secondly, detection, which is partly a social and partly a medical question; and, thirdly, treatment, which is predominantly a medical question.

"Under the first heading come such questions as exposure to extremes of heat and cold, draughty offices, the 'bun lunch' habit, housing, and the like.

"Under the second comes the importance of early diagnosis. Pains at first may be mild. 'Tingling' in the limbs and frequent sore throats are often symptoms. In industrial concerns the works doctor can help materially in early diagnosis. In our cities and towns I should like to see set up a Rheumatism Advisory Centre to which all might go for expert examination and advice.

"For treatment there should be local treatment centres in every city and town, which would supply physical treatment after working hours, so as to enable patients to remain at work during the day.

"The starting point of my scheme is the insurance doctor. Where treatment is necessary he refers his patient either to the Rheumatism Advisory Centre in his area, or direct to the Central Treatment Clinic, where he would receive, say, three courses of physical treatment, while still at work. If further treatment appeared desirable, the patient would then go on to the nearest Spa Hospital, where he could be treated for anything up to two or three months. One week's holiday at least is desirable, if it can be arranged, after his treatment at either place. The patient would then report back to his practitioner.

"The three units chiefly concerned in this scheme are the insurance practitioners, the town treatment clinics, and the Spa Hospitals, and possibly municipal hospitals where no spa is within reach. Their functions are to diagnose cases early, to cure or relieve, and, not least, to teach and investigate.

"Town treatment clinics would be run on voluntary hospital lines, but preferably not by municipal or purely local bodies. They should provide all forms of treatment that are not otherwise available in the area.

"Overlapping, of course, would have to be avoided. Public medical baths, for instance, are available in many industrial towns, and full use should be made of them. Specialists, too, whose opinions would often be wanted at the clinics, might consent to attend, say, once a week, to see patients. They would refer the patients who needed treatment to their own hospital departments.

"By centralising those clincs in large towns, rather than by setting up large numbers of small clinics, a bigger number of patients could be seen, more experience gained, and better results, in consequence, achieved. More reliable statistics would also become available.

"At present the insurance practitioner has no power to pass on rheumatic patients for Spa treatment, and although this is true of most diseases, he would be specially glad to do so in the case of a chronic disorder like rheumatism, for which he alone can do little.

"In the case of tuberculosis, which costs the country far less than rheumatism, the law provides for institutional treatment. Rheumatism needs this equally for its proper treatment.

"The argument against the establishment of clinics is expense. That, I hold, fails because of the enormous cost, no less than 20 million pounds annually, and the untold misery caused by the disease.

"A scheme such as I have outlined here could be put into operation in London at once, and its value worked out by the Approved Societies. It might then be copied in other towns if, as appears almost certain, they endorse its value.

"Is it too much to hope that the British Red Cross Society, which has done so much through its Rheumatism Clinic in Peto Place, to investigate the problem and to relieve the suffering it causes, will take the lead in a great campaign to stamp out the disease?"

In thanking Dr. Copeman for his address, Sir Edward Stewart said that the British Red Cross Society viewed the scheme for fighting rheumatism which he had outlined with great interest, and that it was whole-heartedly with him and those associated with him. It was prepared to support to the full any such scheme that might be put into operation.

SOME ASPECTS OF THE MORTALITY FROM WHOOPING COUGH.

In a paper read at a meeting of the Royal Statistical Society on February 21, Dr. Bradford Hill concluded that the history of whooping cough cannot with any certainty be traced beyond the middle of the sixteenth century, and not until the eighteenth century do accounts of epidemics become numerous. The absence of earlier reference is curious, but it does not seem likely that the lack of comment amongst ancient classical writers can have been due to a real absence of cases and deaths as a result of climatic differences, while in later centuries the tendency to leave its management to "old women and empirics" may have led, to some extent, to its relative neglect by medical writers. In modern times its mortality in England and Wales has shown a remarkable decline, the death rate in the years 1921-30 being only one-third of that recorded in 1861-70. In spite of this improvement it remains a very important cause of child mortality, more important than is perhaps always realised by the lay and medical public. In 1921-30 it was responsible in England and Wales for no less than 44,000 deaths, or nearly one per cent. of the total mortality of the population; this total represents slightly more deaths in the same period of years than those from measles, and more than those from scarlet fever and diphtheria put together. The mortality falls mainly upon the first two years of life, while, in 1921-30, over 90 per cent. of the deaths were concentrated on the first five years, a ratio which was equally true at the end of the eighteenth century. In view of this concentration upon very young children, steps to control it are earnestly to be desired.

One of the most curious anomalies of whooping-cough mortality, which has long been recognised, is the consistently heavier mortality of female children. From respiratory causes such as tuberculosis, pneumonia and bronchitis, the mortality rates of young female children in England and Wales are 15 to 20 per cent. below those of male children; from infectious diseases such as measles, scarlet fever and diphtheria they are 5 to 10 per cent. lower; from whooping

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