YESTERDAY, TODAY AND TOMORROW

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Nothing shows the change in medicine in the last 35 years more than contrasting the medical wards of Addington Hospital in 1925, as I first knew them, with the wards at present under my care.

Typhoid

At that time typhoid fever was perhaps the greatest challenge to nursing. It was exceptional to have no case of typhoid in the male or female wards. More often than not more than one case would be in any medical ward. During the last year we have had only *two* cases of typhoid—a mother and daughter infected from the same source.

Dysenteries

Dysenteries (bacillary and amoebic) were common. It was exciting in those days to define the frequency of amoebic dysentery, which was found to be much more common than had been formerly believed. Amoebic liver abscess accounted almost invariably for at least one bed in a ward at any time. It was instructive to find that intramuscular injections of emetine hydrochloride, combined with aspiration of the abscess, gave better results than open operation which had been formerly practised. It became appreciated that adherence to the dictum 'where there is pus, let it out', was followed by secondary infection in a large number of cases with open drainage.

A time was to come when the diagnosis of amoebic dysentery became too facile, and many of the multitudinous symptoms put down to it were to be evaluated more accurately and judiciously as being due to functional or other causes. In the last few months we have had only *one* proved case of amoebic dysentery. Bacillary dysenteries were common in summer. They were treated by a process of attrition; sodium sulphate and acid sulph dil. being given in small frequent doses until the stools slowly became normal.

Pneumonia

Pneumonia, second only to typhoid, was an illness calling for skilled nursing. In those days there were many more frank lobar pneumonias than we see today, with abrupt onset, fastigium, and sudden crisis, often associated with collapse. Today, with the exception of cases due to Friedländer's bacillus or a penicillin-resistant staphylococcus, most cases of pneumonia may almost be regarded as minor illnesses, provided the suitable antibiotic is available.

Malaria

Malaria, mainly subtertian, was very common. No case of pyrexia was investigated without the search for malaria parasites, and often a patient with a doubtful PUO was given quinine empirically, so as to be sure that one was not caught out. Today months go by without one case of malaria in the wards, and then it is usually a patient off a ship, or one who has travelled in other parts of Africa. What a wonderful triumph has been achieved by public-health measures in our lifetime! Blackwater fever was a dreaded and not uncommon complication. We have not had a case of blackwater fever for years. Almost every patient with a difficult diagnosis had perforce to have a blood Wassermann reaction done, for many clinical problems, in almost every field of medicine, were only solved by including specific disease in the differential diagnosis. Today, in Europeans, a positive reaction is the exception rather than the rule, and one's skill in giving intravenous NAB has become rusty owing to the easier, shorter, and more effective treatment by means of intramuscular penicillin.

Peptic Ulcer

Peptic ulcer was common then as it is common today. But if one's memory does not play one false, there seemed then to be proportionally more gastric ulcers. Today, there are immeasurably more duodenal ulcers. In those days the peptic ulcer patient was conscientiously and strictly kept in bed on milk and alkalis, to the exclusion of almost everything else. It was disconcerting to find that the milk-alkali syndrome not very infrequently occurred in one's most meticulous and law-abiding patients. Partial gastrectomy was then less commonly and less easily called upon to cut the Gordian knot of chronicity.

Rest in Bed

Rest in bed was more strictly insisted upon for many diseases and, although phlebothrombosis and pulmonary embolism were not unrecognized, I cannot but feel that they did not occur as often as they do today. Perhaps they did, but were not diagnosed as such, and only the more serious cases were recognized.

Cardiac Disease

Cardiac disease was ever with us. The most common causes of congestive failure were rheumatic heart disease and hypertension, with specific aortitis as a runner-up. Coronary thrombosis was beginning to impress itself as an alternative cause, but known coronary occlusions were comparatively uncommon. How different is the present position when recently, out of a male ward of 30 beds, 13 were occupied by men with coronary occlusion! Angina pectoris occurred of course, but one wonders how many cases of this nature would today have been diagnosed as coronary thrombosis. Peripheral vascular disease today seems to be more common, and it appears to occur at a younger age.

Other Conditions

Functional disease then, as now, was all too common, but the cases one remembers showed signs of gross hysteria rather than symptoms of anxiety states, as is seen so often today.

The wards were full of cases of tuberculosis before the King George V Hospital relieved the situation. Only a few suitable cases were sent to Nelspoort Sanatorium, and artificial pneumothorax was yet to become a common method of treatment. Rest in bed was the most effective treatment that we could offer.

Malignant disease has probably changed less than anything else from the diagnostic and therapeutic points of view.

With what enthusiasm did we start to feed patients with pernicious anaemia on whole liver (to be followed soon by intramuscular injections of crude extract), and to realize that we had something to counteract the hitherto fatal effects of a megalocytic anaemia.

A streptococcal septicaemia was then the most dreaded of infective illnesses, for which nothing effective could be done. Almost the same could be said for meningococcal infections, for which repeated lumbar punctures were about all that could be offered.

CONCLUSION

The good old days? By no means. There is almost nothing that today is not better done or more easily and safely performed. It is a privilege to have lived, in the course of one working life, through a time so full of change for the better.

But what of the future? It is probable that the present tendencies towards increased specialization and the fragmentation of medicine will continue, that efficiency will increase and that the laboratory and machine will play a greater and greater part in the new sixteen-storey building which is rising from the ashes of the old Addington Hospital.

In the welter of specializations, however, one hopes that the general physician will remain to act as coordinator, interpreter, general confidant, and friend of the patient. Without such a pilot and the study of the patient as a whole, whatever the technical advances, colossal errors of judgment are bound to occur; and the patient will be left starving in a land of plenty.