Don't rely on Munthe's autobiography

EDITOR,—As I trained at the Salpêtrière, I appreciated the article by Raymond Hierons about Charcot and his visits to Britain.[1]

Charcot's links with Britain were also reviewed in a paper presented at the Salpêtrière on the centenary of Charcot's death.[2] Despite his reservations, Hierons gives too much weight to *The Story of San Michele* by Axel Munthe. Nothing indicates that Munthe knew Charcot closely, although Charcot was a jury member when Munthe presented his doctorate in 1880. The French edition of Munthe's book omits the chapters relating to the Salpêtrière and to Charcot.[3]

Léon Daudet, a lucid observer of Charcot, was never engaged to Jeanne Charcot. Edmond de Goncourt's diary describes the fury of the Charcots at the marriage of Léon Daudet to Jeanne Hugo, granddaughter of Victor Hugo.[3]

This broken friendship has other causes,[4] principally Léon Daudet's failure at the Concours de L'Internat, a highly competitive examination, critical for a hospital and university future. The Daudets attributed Léon's failure to Charcot. In fact, Léon Daudet had neglected his work for Jeanne Hugo, whom he married several weeks later. It was not a happy marriage. They separated in 1894. Jeanne then married Jean Charcot, and they separated in 1906. Léon Daudet never saw Charcot again. He denounced Charcot's autocracy and *Cesarisme de Faculté* but remained fascinated by him.

Charcot last travelled to England in June 1893. Accompanied by Brouardel, professor of forensic pathology, he examined Cornelius Herz, one of the main people accused in the Panama scandal, in Bournemouth. The medical experts declared Herz unfit for extradition to France, creating a furore of press and public opinion. New medical evidence was sought. On 4 November, Brouardel and Dieulafoy (who had replaced Charcot on Charcot's death on 16 August) concluded: "what was not possible four months ago is possible today."[5] Yet Herz was not extradited, as Hierons explains. He died in England on 6 July 1898.

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1 Hierons R. Charcot and his visits to Britain. *BMJ* 1993;307: 1589-91. (18-25 December.)
2 Gelfand T. Charcot international. *Rev Neurol (Paris)* (in press).
3 Goetz CG, Bonduelle M, Gelfand T. *Constructing neurology: Jean-Martin Charcot, 1825-1893.* Oxford: Oxford University Press, 1994.
4 Bonduelle M. Charcot et les Daudet. *Presse Med* 1993;22:1641-8.
5 L'incident Cornelius Herz. *Le Progrès Médical* 1893 Nov 18:383.

Community acquired lower respiratory tract infection

Bacterial infection not uncommon

EDITOR,—The unreferenced statements by Harold S R Hosker and colleagues that viruses account for most cases of acute bronchitis and that in otherwise healthy people acute bronchitis is usually associated with a speedy recovery and few sequelae[1] are not supported by our prospective study of the aetiology and outcome of lower respiratory tract infections in 480 adults in the community.[2] Evidence of bacterial infection was found in 91 of 206 patients studied in detail and was commoner in those with underlying disease or in those aged over 60, but nearly a quarter of those in previously good health and under the age of 60 had evidence of pneumococcal infection. This latter group also included five of the 16 patients with *Haemophilus influenzae* infection and all four infected with *Moraxella catarrhalis*. "Atypical" infections were remarkably uncommon at all ages. There was no relation between the presence of focal signs on chest examination (found in 76 of 315), radiographic changes consistent with acute infection (21 of 180), and the identification of a bacterial pathogen. Another study also found that the identification of an infection likely to respond to antibiotics correlated poorly with radiographic changes.[3] A quarter of the patients we studied returned for a second consultation with their general practitioner, usually because of unsatisfactory clinical progress; two thirds of these patients had previously been in good health. Similar results have been found in a further, continuing study of over 400 adults.

We agree with Hosker and colleagues that there is confusion about definitions of lower respiratory tract infections, but, using specific criteria for definition,[2] we conclude that, even in previously well and younger adults, bacteria are important in the aetiology of lower respiratory tract infections in the community and recovery is not rapid in all cases.

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1 Hosker HSR, Jones GM, Hawkey P. Management of community acquired lower respiratory tract infection. *BMJ* 1994;308: 701-5. (12 March.)
2 Macfarlane JT, Colville A, Guion A, Macfarlane RM, Rose DH. Prospective study of aetiology and outcome of adult lower-respiratory tract infections in the community. *Lancet* 1993; 341:511-4.
3 Melbye H, Berdal BP, Straume B, Russell H, Vorland L, Thacker WL. Pneumonia—a clinical or radiographic diagnosis? *Scand J Infect Dis* 1992;24:647-55.

Refer to the guidelines

EDITOR,—The British Thoracic Society has recently published guidelines for the management of adults with community acquired pneumonia admitted to hospital.[1] We are concerned that the article by Hosker and collegues on the management of community acquired lower respiratory tract infection[2] did not refer to these guidelines. Analyses of patients with community acquired pneumonia who were admitted to intensive care units[3,4] and of deaths in young adults from community acquired pneumonia[5] have indicated that in some cases the severity of pneumonia has been inadequately assessed, which has led to delayed transfer to the intensive care unit or death on a general medical ward. The primary aim of management in community acquired pneumonia must be the prevention of death; this can only be achieved by early recognition of severely ill patients.

The British Thoracic Society's guidelines emphasise the importance of assessing the severity of illness in individual patients and tailoring the management accordingly. The article by Hosker and colleagues gives no guidance about the management of severely ill patients; this is a serious omission.

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1 British Thoracic Society. Guidelines for the management of community-acquired pneumonia in adults admitted to hospital. *Br J Hosp Med* 1993;49:346-50.
2 Hosker HSR, Jones GM, Hawkey P. Management of community acquired lower respiratory tract infection. *BMJ* 1994;308:701-5. (12 March.)
3 Woodhead MA, Macfarlane JT, Rodgers FG, Laverick A, Pilkington R, Macrae AD. Aetiology and outcome of severe community-acquired pneumonia. *J Infect* 1985;10:204-10.
4 British Thoracic Society. The aetiology, management and outcome of severe community-acquired pneumonia on the intensive care unit. *Resp Med* 1992;86:7-13.
5 Tang CM, Macfarlane JT. Early management of younger adults dying of community acquired pneumonia. *Resp Med* 1993;87: 289-94.

Policy on drug misuse

EDITOR,—Michael Farrell and colleagues highlight the enormous variations between theory and practice in treatment of drug misusers and the dearth of information or analysis.[1] This scenario is present on a much smaller scale on my own doorstep.

Within walking distance of the surgery where I work there are a number of professionals, including myself, doing their own thing in relation to drug users. We probably all firmly believe our method is the right one, and some of us have facts and figures to back this up. But can we all be right? And if we are, why is the problem increasing rather then decreasing?

To cite just a few examples: I use a flexible regimen, with a range of options from maintenance to abstinence, paying more attention to reducing criminal behaviour and stabilising lifestyle than to stopping drugs. The GP down the road believes in giving users all the drug they want, in the belief that this will reduce the black market; others believe that this only feeds the drug market. The local drug dependency unit has a fairly strict reducing regimen of a very small number of drugs and offers no help to users of multiple drugs; recently it has opened a low threshold clinic, and we await the results of this experiment. A private clinic expounds the "Minnesota method"; it seems to have some reasonable results but is accessible only to those with a healthy bank balance.

Can anyone think of another "medical" problem for which there is so little agreement on treatment? Does this raise other questions? Is drug use in truth not a medical problem? Should we be dealing only with the complications like deep vein thrombosis, subacute endocarditis, HIV, and hepatitis?

I questioned 20 under 16s I saw at the surgery—10 had smoked cigarettes, 18 had taken alcohol, and 12 had used some other mood altering drug—mainly cannabis, but four had used ecstasy, two cocaine, two benzodiazepine, and one heroin.

This problem is not going to go away. Perhaps more open discussion, better information, and more proactive research may help us through this sea of uncertainty.

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1 Farrell M, Strang J, Neeleman J, Reuter P. Policy on drug misuse in Europe. *BMJ* 1994;308:609-10. (5 March.)

Deterioration of the NHS

EDITOR,—We have recently expressed our concern in the national press about the deteriorating state of the health service.[1-4] We have highlighted several important issues.

Firstly, appreciable problems in the handling of patients with acute medical problems, due to lack of beds and the diminishing number of hours worked by doctors, have led to long delays in accident and emergency departments and admissions wards and dangerous clinical care. This