BIRTHDAY HONOURS

The names of the following members of the medical profession were included in a Birthday Honours List published in *Supplements* to the *London Gazette.*

Knighthood

JAMES DOUGLAS COOKE, F.R.C.S., M.P. for South Hammersmith since 1931. For political and public services.

SIDNEY VALENTINE SEWELL, M.D., F.R.C.P. Consulting Physician in the State of Victoria.

REGINALD WATSON WATSON-JONES, M.Ch., F.R.C.S. Civilian Consultant to the Royal Air Force.

C.B. (Military Division)

LEOPOLD THOMAS POOLE, D.S.O., *M.C.*, M.B., Ch.B. Major-Gen., late R.A.M.C.; Honorary Physician to the King. Director and Professor of Pathology, Royal Army Medical College.

C.M.G.

ALBERT VICTOR BERNARD, C.B.E., M.D., D.P.H. Late Chief Government Medical Officer, Malta.

GEORGE ERNEST HUGH LE FANU, M.D., Ch.M. Late Consulting Physician at Liverpool to the Colonial Office.

LUCIUS NICHOLLS, M.D. Director, Bacteriological Institute, Ceylon.

BENJAMIN STANLEY PLATT, M.Sc., Ph.D., M.B., Ch.B. Director, Human Nutrition Research Unit, Medical Research Council.

ALEXANDER MONTGOMERY WILSON RAE, M.D. Assistant Medical Adviser to the Secretary of State for the Colonies. Lately Deputy Director of Medical Service, Nigeria.

C.I.E.

KOMBAR RAMASWAMI KRISHNASWAMI IYENGAR, O.B.E., M.D., D.P.H. Lieut.-Col., I.M.S.(ret.). Late Director, Pasteur Institute of Southern India, Coonoor.

C.B.E. (Military Division)

WILLIAM INNES GERRARD, O.B.E., M.D., F.R.C.P. Acting Surg. Capt., R.N.(ret.).

THOMAS JAMES KELLY, *M.C.*, M.D. Acting Air Vice-Marshal, R.A.F.

D'ARCY POWER, *M.C.*, M.R.C.S., L.R.C.P. Acting Air Vice-Marshal, R.A.F.

ARTHUR EATON RICHMOND, O.B.E., M.R.C.S., L.R.C.P., D.T.M. Col. (Temp.), R.A.M.C.

C.B.E. (Civil Division)

Miss KATE FRASER, M.D., D.P.H. Commissioner, General Board of Control, Scotland.

BERNARD HART, M.D., F.R.C.P. Consultant Adviser in Psychiatry to the Ministry of Health.

JAMES RUSSELL, M.B., F.R.C.S.Ed., F.R.F.P.S. Surgical Director, Emergency Medical Service, Scotland.

ROBERT STANDISH-WHITE, O.B.E., F.R.C.S.I. For valuable services as honorary consulting surgeon, Rhodesian Air Training Group.

O.B.E. (Military Division)

ALGEO LLOYD ANDERSON, M.B. Surg. Capt., R.C.N.V.R.

JAMES MARTIN FLATTERY, M.B., Ch.M. Surg. Cmdr., R.A.N.

DAVID WALKER JOHNSTONE. Surg. Capt., R.C.N.V.R.

FREDERIC WILLIAM KEMP, *M.C.*, E.D., M.D. Lieut.-Col., N.Z.M.C.

WILLIAM PARSONS LAPPIN, M.B., Ch.B. Lieut.-Col. (Temp.), I.A.M.C.

CLARENCE LUCAN GRAY PRATT, M.D., M.Sc. Acting Temp. Surg. Cmdr., R.N.V.R.

JOHN ROWE, *M.C.*, M.B., B.Ch. Col., late R.A.M.C.

NORMAN LYON SHEPPERD, M.B., F.R.C.S. Lieut.-Col. (Temp.), R.A.M.C.

MALCOLM STODDART-SCOTT, *M.C.*, T.D., M.D. Lieut.-Col., R.A.M.C., T.A.

FREDERICK HAROLD VAN NOSTRAND, E.D., M.B. Col., R.C.A.M.C.

GORDON ABBOTT WINFIELD, M.D., C.M. Col., R.C.A.M.C.

O.B.E. (Civil Division)

AMAR NATH CHOPRA, M.B., B.S., D.P.H. Lieut.-Col., I.M.S. Inspector-General of Prisons and Director of Health, Orissa.

LAWRENCE WYLIE FITZMAURICE, M.D., C.M., F.A.C.S., Colonial Medical Service. Medical Officer and Bacteriologist, Bahamas.

NUTTING STUART FRASER, M.D., C.M. Consultant, St. John's General Hospital, Newfoundland. For public services.

ALISTAIR ROBERTSON GRANT, M.D. Medical Superintendent, Emergency Hospital, Whittingham, Preston.

HARRY HASTINGS, M.B., Ch.B. For medical and missionary services in Nigeria.

WILLIAM MALCOLM MCALISTER, M.B., Ch.B., F.R.C.P.Ed. Medical Superintendent, Bangour Emergency Hospital, West Lothian.

PETER JOHN MACLEOD, M.B., J.P. Medical Superintendent, Glen-eagles Hospital and Fitness Centre. For services to civil defence. Capt., R.A.M.C.

Miss ALICE DEIRDRE KINGSNORTH PETERS, B.M., B.Ch. Senior Medical Officer, Royal Ordnance Factory, Chorley.

MOSES SENDAK, M.D., D.P.H. Lieut.-Col., I.M.S. Superintendent, Special Prison, Ahmednagar Fort, Bombay.

CHARLES MILLIKEN SMITH, M.D., D.P.H. Medical Officer of Health, Northamptonshire County Council. For services to civil defence.

Mrs. CLARA STEWART, M.B., B.S. Honorary Secretary and Organizer, Emergency Committee for Nurses, Leeds.

HERBERT WATT TORRANCE, *M.C.*, M.D. For medical services in Palestine.

M.B.E. (Military Division)

CHARLES BERNARD BALL, L.M.S.S.A. Major (Temp.), R.A.M.C.

JAMES MENZIES CLOW, A.M. (Gold), F.R.C.S.Ed. Major (Temp.), R.A.M.C.

WILLIAM ROBERT DUNLOP. Major, R.C.A.M.C.

CHARLES VINCENT SCOTT, M.B. Major, R.C.A.M.C.

M.B.E. (Civil Division)

Miss DEV PRIYA BALI, M.R.C.S., L.R.C.P., Women's Medical Service. Deputy Inspector-General of Civil Hospitals (Women), United Provinces.

PROBHAT KUMAR BISWAS. Civil Assistant Surgeon, Bengal.

Miss ALVA ADELINE DANIELL, M.B., B.S. Civil Assistant Surgeon, Civil Medical Department, Government of Burma.

DANIEL GEORGE SHIELDS, M.B., B.Ch. Area Air-raid Precautions Medical Officer, Norfolk.

JOHN EDWARD WRIGHT, F.R.C.S.Ed., F.A.C.S. Colonial Medical Service. Surgeon-Specialist, Holbarton Hospital, Antigua, Leeward Islands.

Kaisar-i-Hind Gold Medal

BRUCE LYMAN CARRUTHERS, M.D., C.M., F.A.C.P. Director, Medical Centre, Miraj.

Miss JESSIE FINDLAY, M.D. Principal and Professor of Surgery, Women's Medical College, Vellore, North Arcot District, Madras.

THE MEDICAL STUDENTS AT BELSEN

At a Press conference in London Dr. A. P. Meiklejohn, member of the Rockefeller Foundation Health Commission, who has been seconded to the Nutrition Section of the European Regional Office of U.N.R.R.A., described the work of the ninety-six London medical students whom he had the privilege of supervising at the horror camp at Belsen. He said that the first batch of students arrived on the last day of April, and the primary task allotted to them was the distribution of food for the starving. Until then the small number of British troops garrisoning the camp, which had been liberated on April 16, could do no more than deliver food from the cook-houses to the doors of the huts, where it was taken over by internees. The result of such a method was that, in the moral collapse which prevailed in the camp, those who were able to walk took all the food they could get and became desperately ill from overfeeding, while those who were too weak to leave their huts died because there was nobody to feed them.

How they tackled the Job

Each student took responsibility for one or more huts, comprising from 100 to 150 patients, together with about twice that number of internees at least well enough to feed themselves. The students saw to it that the food was fairly distributed. The students also set up a dispensary and started medical treatment. The daily death rate among the sick, which had remained at about 4% until May 1, fell in one week to half that figure, and in the second week to half again, and at the same time a new spirit was plainly discernible among the internees. One special body of 25 students created within the camp a hospital area in which the most seriously sick could be cared for under hospital conditions, pending removal. They showed the same vigour in the business of cleaning out filthy, verminous huts, "creosoting" the floors, and dusting it with anti-louse powder, as others showed in their more strictly medical occupations. So excellent was their initiative that within two weeks 1,200 patients had been washed, disinfected, reclothed, and returned to the renovated huts, where they were cared for entirely by the students and by volunteer nurses from among the more active internees. "It was a joy to see the change which took place in the patients," said Dr. Meiklejohn, "when they found themselves under proper ward conditions with adequate medical attention. There can be no doubt that the large majority of the patients in this students' hospital owed their lives to this achievement."

The last of the infamous huts was burned five weeks after the arrival of the first British troops in the area. For the remainder of the month the students were employed in medical work in hospital areas which now held the 12,000 surviving sick. "It is my personal belief that no other body of men

could have successfully accomplished the job which the students carried out." He spoke in appreciation of the help which the students received throughout their stay from the R.A.M.C. and the camp garrison, particularly from Lieut.-Col. J. A. D. Johnston, the senior medical officer, and Brig. Glyn Hughes, D.D.M.S., Second Army.

[Dr. W. F. Collis's preliminary report on conditions at Belsen Camp and the medical problems that arose was published in the *Journal* of June 9, page 814, and a letter by Brigadier Hughes, paying tribute to the medical students, on June 16, page 857.]

Correspondence

Determination of Age Incidence of Disease

SIR,—The *Journal* of June 9 (p. 797) contains an article on civilian dyspepsia by Drs. F. Avery Jones and H. Pollak recording *inter alia* what they refer to as "age and sex incidence" of peptic ulcers, accompanied by a chart. This, they say, "shows the maximum incidence for gastric ulcer between 40 and 60, but duodenal ulcer has an earlier peak at 35 to 39."

Surely it is time to insist that clinicians should use the term "incidence" as used in vital statistics to signify the ratio of observed cases to the appropriate population at risk. So defined, the age incidence of a disease is a true measure of liability to contract it at a given age. The figures cited by the authors of this article, like those cited in so many articles still published in medical journals, show nothing of the sort. The chart referred to simply exhibits the numbers of cases observed in each age group unrelated to the age composition of the population from which they were drawn. As such they merely indicate the risk that a patient will come under the observation of the observers at a given age if (*a*) the observers remain at the same hospital; (*b*) the population from which the hospital draws its patients maintains the same age composition.

The assessment of the age-strength distribution of the effective population of a hospital might be undertaken if a hospital had at its disposal an expert demographer with a thorough grasp of the social differentials involved in population structure. To the best of my knowledge no British hospital employs one. Within the framework of private practice any valid information about liability to disease in the civilian population at a given age is therefore confined to a handful of conditions which are either notifiable or quickly fatal.

On the other hand we have the necessary data for the Army population, because the Army population has an all-in system of social medicine. With the assistance of my colleague, Jun. Cmdr. M. M. Johnstone, M.A., I have recently made an exhaustive analysis of the true age incidence of some fifty major diseases, including peptic ulcers. The results would have been available for publication if the disclosure of basic data were not, for the present, subject to security regulations. The conclusion that the age distributions of gastric and duodenal ulcer are different, and that the latter has its peak at an earlier age, is correct; and this is not surprising since the effective population reservoir was presumably the same for both sets of cases. The peak ages of risk cited by the authors are not in agreement with the results of our analysis and can carry no weight as such for the reasons given above.—I am, etc.,

LANCELOT HOGBEN,
Deputy Director,
Medical (Statistical) Research, War Office.

Primary Atypical Pneumonia

SIR,—I feel some comment is necessary on the leading article on primary atypical pneumonia (April 7, p. 487), for such an article has wide publicity and influence, and it appears to me to leave a false impression of the disease. I would like to make the following observations based on a series of about 300 cases which have passed through my Division, situated in Italy during the past 18 months—cases which have been analysed with considerable precision.

1. Primary atypical pneumonia is not characterized by an influenzal onset; on the contrary, upper respiratory tract symptoms are absent. Cases giving a history of a cold followed by much coughing, expectoration, and central tracheal pain are descending infections of pyogenic or virus aetiology, and may cause bronchopneumonia or patchy collapse which is usually basal in situation, or influenzal pneumonia may so develop. Such cases are immediately distinguishable from atypical pneumonia by this very history.

2. To say that the disease may last from 3 to 5 weeks and that recovery is the rule is very misleading. The average duration of fever is 8.8 days, the mean range 7 to 10 days, with extremes between 5 and 15 days. Following subsidence of the fever convalescence is rapid and patients feel fit within a week thereof. Recovery is much more than the rule: there have been no deaths in this series, and such an outcome is extremely rare. Complications are equally unusual.

3. Cough is not invariable, but is entirely absent throughout the whole course of the disease in 12 to 15%. It is often mild, dry, and disturbs the patient but little, being quite different from the hacking distressing paroxysms of pyogenic bronchopneumonia. The sputum is not mucopurulent but characteristically mucoid. Purulence develops late in a minority which becomes secondarily infected, or it may appear early in patients who are already the subjects of chronic bronchitis. Conspicuous staining with blood occurs in 30 to 35%; it commonly appears between the 5th and the 7th days and may last from a few days to a week or so.

4. Symptoms referable to the chest are often absent apart from the cough mentioned: pleural pain occurs in about 20%; dyspnoea and cyanosis are rare; the respiratory rate is commonly within normal limits. These points are in contrast to the respiratory features of pyogenic pneumonias.

5. While it is true that there may be no physical signs in the chest, a careful physician will detect the tell-tale patch of crepitations in 80% of cases. These crepitations commonly appear first on about the 4th day and become obvious on the 5th day; they usually last a week or so. Dullness to percussion and bronchial breathing are rare, the former being noted in 10% of cases and the latter in but 6%. While it is true that the *x*-ray appearances are not diagnostic, they are nevertheless highly suspicious. As stated in the article under criticism, they are either diffuse homogeneous shadows or localized flocculent opacities, the two types being sometimes mixed. The situation of the lesion, however, is suggestive; it is segmental, occurs as often in the upper as in the lower lobes, and is not infrequent in the middle lobe or in its counterpart on the left side. Multiple lesions occurred in 12%; clinical lesions with negative skiagrams in 7%. The exact figures for distribution in my series were as follows:

	%	%
Upper lobe:		
Apical segment	2	42
Pectoral "	20	
Axillary "	20	
Middle lobe	16	16
Lower lobe:		
Dorsal segments	10	42
Basal "	32	

6. General symptoms are like those of any other high fever, with the emphasis mostly on headache and least on limb and back pains. Unlike the febrile stage of jaundice, abdominal pain is absent, but anorexia is not uncommon, and there is sometimes nausea or vomiting. Meningismus is very rare even in cases with gross headache, and the cerebrospinal fluid is normal. The spleen is sometimes enlarged, but this is of doubtful significance in a malarial country. The actual figure in this series was 15%.

7. The temperature chart was characteristic in 63% of the cases, showing a high irregular fever to about 104° F., with odd sharp swings of several degrees, sometimes occurring twice within 24 hours. The temperature had a tendency to keep returning to the same maximum figure. The end was rather sudden in 39% or it was by lysis. The fever was sustained in 13% and quotidian in another 13%. It was short-term in 7%, low-grade in 3.5%. Relapses, usually very short, occurred in 2%.

8. The white count is of course normal. The highest total in my series was 13,500, and only 7% were above 10,000; the maximum differential polymorph count was 80%, but the great majority lay between 50 and 75, only 8% being between 75 and 80. The erythrocyte sedimentation rate rises early and may measure 25 to 50 millimetres in one hour by the 3rd or 4th day. It may reach a maximum level of 40 to 70 during the second week, and then falls away to reach normality in about the 4th week. Cold agglutination tests were done on about 20 cases with entirely negative results. Both penicillin and sulphonamides have no influence on the course of the disease.

While it is agreed that atypical pneumonia may differ in its characteristics in various parts of the world in different epidemics, I doubt very much if the type seen in Italy, which has been so widespread among British troops and so uniform in its manifestations, is materially different from that seen at home in the last two years.—I am, etc.,

PAUL WOOD,
Lieut.-Col., R.A.M.C.

C.M.F.