CURRENT MEDICAL LITERATURE

INFLUENZA.

Observations of approximately 500 cases in the Michael Reese Hospital and in private practice during the recent influenza epidemic are contributed to *The Journal A. M. A.*, Nov. 9, 1918, by Solomon Strouse and Leon Bloch, Chicago. They divide the cases according to the character of the onset into three groups, the first beginning with more or less severe coryza; the second with varying degrees of prostration, backache, chilly sensations and elevated temperature, and the third with a feeling indefinite discomfort, no fever at first, but a few hours later a definite rise of temperature. Careful examination at the beginning usually revealed few signs except slight reddening of the anterior pillars of the pharynx and often an intense conjunctival congestion. Many coughing patients showed no signs of bronchial involvement, the cough being probably due to tracheal congestion. In a large percentage, however, careful examination at the onset revealed a more or less circumscribed area with râles or dulness or changes of breath sounds in the chest. All these cases, the authors think, should be considered pneumonia. One of the most important lessons of the epidemic is the potential danger shown by these pulmonary signs, even with normal temperature. A very slight condition of this kind, after careless exposuse, developed into severe pneumonia. The pneumonia symptoms occur either after a complete defervescence following fever of one or two days or after a slight drop of temperature, not to normal, or with no reduction but an elevation on the third or fourth day. Persistence or a rise in temperature on the third day, the authors believe, indicates bronchopneumonia. The patient may not appear ill in the beginning, but later the symptoms appear. At times the uncanny combination of absence of radial pulse with sweating and cyanosis, but retention of mental faculties, is a pretty sure sign of coming death. The low pulse rate, characteristic of the disease, is of no definite value. Patients seen early with a pulse rate above 100, provoked suspicion of some complicating disease, although occasionally an increased pulse rate may have been caused by too large doses of acetylsalicylic acid. Late in the disease, with an increase in the severity of the condition, a rapid pulse is present. A rather striking feature was the inverted type of temperature. Perhaps the most common site of pneumonic trouble was in the left lower lung posteriorly, but this was not general, as any or all parts might be involved. Respiratory rate was, as a rule, slow, and an increased rate indicated not only more pulmonary involvement but greater toxemia, and was generally an unfavorable sign. Cough was a prominent and troublesome sequel, and actual pleuritic pain occurred in a small percentage. There