A HUNDRED YEARS AGO

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INFLUENZA AND PUBLIC HEALTH

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IN JANUARY 1907, I contributed an article to the Special Influenza Number of *The Practitioner*. In 1919 it must be admitted that for actual control over influenza we are practically no further advanced than in 1907.

Nor are we much further advanced in our knowledge of the bacteriology of influenza. We have no knowledge whether the pandemics of the past mean the excitation in microbes always with us, or increased pathogenicity and greater striking-power, or the introduction of an equally mysterious virus from some unknown centre or centres.

In regard to this disease, we are more absolutely ignorant than of the causes of epidemic cycles in the group of autumnal communicable diseases.

1918 London epidemic

Influenza, as a rule, is a winter or early spring disease. Last year was a remarkable exception. Taking London as an example, towards the end of June the metropolitan death returns showed few deaths from influenza. The course of the very exceptional outbreak which culminated in July and of the later epidemic of last year is shown by the figures below.

There has been no previous example, that I can find, of two successive epidemics of influenza affecting not only one community, but almost the whole world at an interval as short as that between the epidemic in London in July and in October of last year. This is so, whether the epidemics compared are measured from peak to peak, or from any other point. Measured from peak to peak, the recent interval was only 16 weeks. The nearest approach to this in the Metropolis, in respect of approximation of epidemic peaks, being 35 weeks between the epidemic peaks in 1891 and 1892.

Week of Year.	Deaths in London from Influenza.
25th	16
26th	67
27th	218
28th	287
29th	192
30th	86
31st	38
32nd	21
33rd	20
34th	12
35th	12
36th	12
37th	14
38th	9
39th	17
40th	80
41st	371
42nd	1,256
43rd	2,458
44th	2,433
45th	1,665
46th	1,178
47th	942

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Difficulties of controlling influenza

Passing to the possibilities of control of influenza, it must be admitted that the prospect is not very hopeful, unless further advances in knowledge add to our present means of attacking, or defending ourselves against, this disease.

Vaccine: We have not, so far, an effective prophylactic vaccine against influenza, and until the bacteriology of the disease is further elucidated, it is unlikely that such a vaccine will be forthcoming. Nor are we furnished with sufficient vaccines to prevent or mitigate the damage produced by secondary streptococcal or pneumococcal invasion.

Secondary steptococcal infection: The fairly close analogy between measles and influenza may be noted. In both diseases, secondary streptococcal infection is, perhaps, the most frequent cause of death; in measles, it is probable that septic conditions of the naso-pharynx are the source of lung infection, and sanitary authorities are taking action on a wide scale in many districts to secure irrigation of mouth and naso-pharynx with antiseptic and weak saline solutions, and thus diminish the death-rate from measles. Similar action in influenza may reduce pulmonary complications.

Notification: General compulsory notification of cases of influenza has at various times been proposed.

Consideration of the rapid, lightning-like, rate of progression of the disease renders it unlikely that any intervention of sanitary officials following on notification of cases would influence its course.

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