THE AETIOLOGY, PREVENTION AND TREATMENT OF CHRONIC BRONCHITIS*

BY

NEVILLE SOUTHWELL

From Guy's Hospital

No one can pretend that the treatment of chronic bronchitis at the present time is anything but profoundly unsatisfactory. No attempts are made at prevention, whilst treatment of the established case depends to a large extent upon the depth of the patient’s purse, and consists of a bottle of cough mixture for the poor patient, and advice to winter in South Africa for his wealthier fellow-sufferer.

It is therefore quite clear that a reconsideration of the whole problem is urgently indicated, especially as this disease is well known to be an extremely common condition in England, and one of great economic importance, extending in most cases over many years of the patient’s working life, and rendering him year by year progressively less capable of following his occupation. The final result is likely to be a state of miserable invalidism, the patient himself crippled by prohibitive shortness of breath, and both he and his family irritated beyond endurance by his constant ineffectual coughing.

Aetiology

Chronic bronchitis is essentially an inflammatory condition, and to bear this constantly in mind is of cardinal importance in the understanding of the problem under discussion. In all acute and chronic inflammatory disorders the nature, severity, and duration of the disease are determined by a balance between the virulence and numbers of the causative agent on the one hand, and the local and general resistance of the patient on the other. Chronic bronchitis is no exception. The organisms are known. They are bacterial, and include micrococci, catarrhalis, pneumococci, various forms of streptococci, both haemolytic and non-haemolytic, especially strep-tococcus viridans, together with Friedlander’s bacillus, and staphylococci. The organisms are almost always mixed, and it is not possible to say that any of the above predominates in the majority of cases. The resistance of the patient depends upon a number of factors. It is probable that first and foremost amongst these is the natural inherited resistance of the individual. Some persons, indeed some whole families, are unduly prone to respiratory infection both of the upper and lower respiratory tract. Lowering of their general and local resistance to respiratory infection is brought about in these susceptible persons by a combination of causes; these include the obvious ones of chill, damp, fatigue, under-nutrition, and debility from a recent illness of some kind or other. No less important are the local factors: mouth breathing, excessive cigarette smoking, and any real focus of infection in the naso-pharynx. In addition, it is well known that workers in certain occupations are particularly likely to develop chronic bronchitis, and naturally these occupations are those involving the inhalation of dusts and fumes, especially those of silica, iron, steel, asbestos, carbon and kaolin; less commonly, the fumes of chlorine, ether, ammonia, nitric acid and, strange to relate, also in a few apparently innocuous trades, such as hairdressing.

There is an additional group of cases, in which an essential underlying feature is the presence of a permanent, infective focus in the lung, usually bronchiectatic, often with fibrosis, and not uncommonly to be found in stout, thick-chested subjects with a poor respiratory movement. In this minority upper respiratory infection is of less importance in producing chronicity, but is responsible for repeated symptomatic exacerbations.

Clinical Course

It is almost invariable to find that a patient with chronic bronchitis gives a history of recurrent acute or subacute attacks in the past. In many cases the bronchial mucosa is first damaged in childhood during one or other of the acute specific fevers, most often measles or whooping cough, especially if complicated by bronchopneumonia. At that time the bronchitis clears up quickly, but probably another attack will occur the next winter, after an upper respiratory infection, and on this occasion prove more stubborn, and when the same sort of thing happens the following winter, it lingers on for many weeks, and finally, in succeeding years, tends to drag on in a mild form throughout the whole winter. The ultimate result is a permanently damaged and denuded bronchial epithelium, which reacts violently to the slightest inhaled irritant, so that the sufferer is never really free from symptoms the whole year round. Nor is this all, for owing to the obstructive element, sooner or later in most cases will appear the twin bogies of chronic bronchitis: bronchitic asthma and emphysema.

Preventive Treatment

Any attempts at prevention must be made before the chronic inflammatory changes in the bronchial tree are finally established, i.e. at a fairly early stage, when the patient is still giving a history of recurrent autumnal or winter exacerbations, but is well during the rest of the year. Every effort must then be made to protect these susceptible individuals from upper respiratory infection and its effects. This might be accomplished in various ways, and from every point of view, not least the assessment of results, the measures to be suggested could best be applied to large groups of persons rather than individuals. These measures will consist of:

1. Attempts at diminishing the frequency of upper respiratory infection in those prone to develop bronchitis.
2. Attempts at protecting the individual from the effects upon his bronchial mucosa of an upper respiratory infection, should he contract one.

It is accepted that upper respiratory infections occur either by direct droplet spread from individual to individual, or by inhalation of airborne pathogens spread in the atmosphere from a more distant source. Although

* A paper read before the London group of the Association of Industrial Medical Officers in September 1945.
the former is probably the more common way of contracting an upper respiratory infection, the latter also accounts for a considerable number of cases, and its importance may well have been somewhat underestimated in the past.

Measures aimed at diminishing direct droplet infection have quite properly attracted a great deal of attention for a number of years past. The damage is done, not by coughs and sneezes, but by droplets of mucus containing respiratory organisms which can be avoided only with difficulty by most persons, especially the public transport vehicles. However, widespread propaganda against indiscriminate coughing and sneezing is obviously of great value, and it is evident that warning notices should be posted in all crowded places in public and industrial premises, and elsewhere. Bronchitic subjects might be well advised to walk or cycle to work if they can, or if travel is unavoidable, a bus is probably a better choice than the underground. In workrooms, proper spacing of workers is naturally essential and the erection of glass screens between opposite benches has much to recommend it. It is a wise course to send home anybody who arrives at work in the morning with a streaming head cold.

Measures aimed at controlling distant airborne droplet spread are important. Droplets are disseminated by sneezing and coughing and, having travelled some distance, however, may be beyond the range of efficient hygiene. Comparative coughing at least 15 feet, and they remain airborne for a considerable time. It has been found possible to recover influenza virus from various parts of a large room one hour after it has been sneezed by someone in the room. The passage of respiratory infection from these airborne droplets, the concentration of pathogens in the atmosphere must obviously be kept as low as possible. This might be achieved in various ways:

(i) Improved ventilation in indoor premises. Although most large buildings are equipped with some form of mechanical ventilation, natural ventilation can usually be made satisfactory by attention to various elementary points. Natural ventilation depends upon wind pressure and gravity, air being driven in through windows on the windward side and out on the leeward. Gravity effects are due to temperature differences, warm air being drawn upwards through the chimney, especially with a fire burning. If there is no chimney, roof cliffs are valuable, their action being supplemented by the force of the wind itself. Windows should be adequate, the usual allocation is said to be 5 square feet of window space for every 100 square feet of floor area. Mechanical ventilation is usually of propulsion type in large premises, but extraction ventilation is quite satisfactory providing that mind is made for air to be drawn in through cracks and under doors, producing draughts. It is also important to remember that windows should be closed in the near vicinity of the extractor, to prevent short circuiting of fresh air. Actual air conditioning does not seem to confer any additional benefit from the point of view of ventilation. The whole subject of ventilation is admirably dealt with in a detailed article by Bedford (1944).

(ii) Bacterial mists. Much laboratory work has been published on the use of bacterial mists, and has shown quite definitely that the dissemination of certain mists in the atmosphere of the laboratory in small concentrations is sufficient to infect the laboratory workers. It remains to put this method to the test of a full-scale field trial from the clinical point of view.

The essential requisite of a bactericidal mist is that it should be bactericidal. It should sterilize the air. In addition, it should be quite harmless, not unpleasant in the atmosphere, non-injurious to clothing or industrial products, non-irritant to the nares, non-corrosive to metals, cheap and easy to control. Various agents have been tried, using ultraviolet light, or hydrogen peroxide, or steam, but none of them has been satisfactory as they did not fulfil the above criteria; ozone, propylene glycol and resorcinol have been used, and naturally the practicality of using a bactericidal mist is a matter to mind. In addition, it should be quite harmless, not unpleasant in the atmosphere, non-injurious to clothing or industrial products, non-irritant to the nares, non-corrosive to metals, cheap and easy to control. 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test of time, and the clinical impression of many very experienced physicians is that cod liver oil has some value in building up resistance to winter colds.

Some observers have stated that no expectorant mixture is of any value at all, and have sought to prove that after administration of expectorants there is no increase in the amount of sputum produced. Whatever may be the laboratory evidence, however, all bronchitic sufferers will testify that the act of expectoration is facilitated by certain mixtures, and the distress of coughing much relieved. Not all expectorants are of equal value in this respect, and it is the strong conviction of the writer that the two of greatest worth, dextrose and iodiode and ammonium carbonate. The former especially has a notable effect on the sputum, liquefying it and relieving bronchospasm to some extent. It should be given indefinitely in small doses throughout the winter months to these patients. To be of any use, ammonium carbonate, although unpleasant, must be given in large doses. In addition to the above drugs, the Brompton hot water mixture is often a great help in the mornings, and consists of sodium chloride, sodium bicarbonate, spirit of chloroform and anised water, and is given in an ounce of hot water. One other small point is the advisability of the common routine addition of stramonium or belladonna to these mixtures, because of their action in drying up secretions.

For the treatment of emphysema it is permissible to emphasize the surprising success of physiotherapy in some of the most unfavourable cases. Relaxation, deflation of the lungs and added mobility to the thorax, together with improved inspiratory breathing power, and an increase in the vital capacity itself, can all be achieved by patient tuition in a well organized clinic, providing the subject is allowed the necessary time to attend, for it is usually many months before the maximum benefit is attained. The use of a belt to hold in the abdomen and elevate the diaphragm, so that the amount of residual air in the lungs, has been advised and is theoretically sound, but patients themselves dislike the sense of constriction round the waist and are loath to adopt the rigours of this treatment.

Ephedrine is of great value, even in the absence of any obvious bronchospasm which, however, always exists to a certain extent in these cases. It should be given in full doses at regular intervals for an indefinite period. Some patients will complain of its side effects, such as palpitation, and it may then be found that administration as a mixture instead of as the usual tablet overcomes this drawback. It is also worth while bearing in mind that elderly bronchitics may complain of the difficulty in passing water after taking ephedrine.

Conclusion

The writer has been much impressed by the constancy of the infective factor in the great majority of cases of recurrent bronchitis. As it appears impossible at the present time to do more than ameliorate the symptoms of the chronic case, it is felt that attention should be directed towards the prevention of the preceding recurrent infective episodes. There seems to be sufficient laboratory evidence to justify the experimental use of bacfericidal mixtures and inhalations on patients themselves.

It is suggested that it would be profitable to undertake a field trial of these methods in industry, or wherever there are large numbers of persons under continued supervision, especially where they have properly documented past medical histories.

References

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Neville Southwell

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