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Adventitia

It is a matter of conjecture whether my spell at the Army chest centre in 1957–8 helped to shape my future career. It was certainly time well spent. I was posted from an army unit to the Connaught Hospital, near Hindhead, Surrey, as the first epidemic of the "Asian" 'flu was waning. The effects of the epidemic had been quite dramatic and we had been very busy, with barrack rooms doubling as sick bays where the few not affected and those convalescing from the acute phase of the illness helped to care for those laid low by the virus. It was as much as a regimental medical officer could do to get round the unit to examine any soldier whose illness or progress was out of the ordinary, and thus it was that one picked up the patients with staphylococcal pneumonia. My experience with this disease and its complications was soon to be consolidated at the Army chest centre, where we saw many cases, and the lessons learned stood one in good stead for years to come.

The striking opportunism of the staphylococcus as a cause of pneumonia during influenza epidemics is less evident today, and indeed in recent years staphylococcal pneumonia has presented itself as a sporadic and infrequent event. Now we seem to be much more concerned with *Pneumocystis carinii* pneumonia and other infections that are also opportunistic, but for different reasons. It surprised me 35 years ago, and still does, that a necrotising pneumonia that so often led to the formation of multiple cavities within the lung was not more often a cause of life threatening haemorrhage. Although I have seen this happen it has been a rare event. I recall one patient, an extremely ill young woman, whose haemoptysis ceased when the blood throughout her left bronchial tree clotted to form a perfect bronchial cast, resulting in the collapse of that lung. The bronchial thrombus could be removed only by piecemeal extraction at bronchoscopy. I remember also that she went on to suffer widespread staphylococcal osteitis but eventually made a complete recovery.

As at any chest unit in the 1950s, tuberculosis was a major item. Primary pulmonary tuberculosis and pleural effusions were commonplace and there was a wealth of experience with post-primary disease, which was often extensive at the time of diagnosis. Happily, treatment regimens were well established and effective. Resectional surgery was still in vogue for selected patients in whom gross residual disease persisted after adequate chemotherapy, in case the disease was quiescent but not cured and might later relapse. Besides the surgery that was offered to regular British soldiers there was in progress a programme of such treatment for Gurkhas, who were transferred from Malaya for operation after completing their medical care at the British Military Hospital in Kinrara. The presence of these cheerful men was a notable feature of life in the hospital at that time. It was rumoured that while being prepared for their proposed operation some of the Gurkhas had been given to understand that this was needed in the fight against their enemy within, and that the resulting chest wound would represent an honourable battle scar and a successful outcome. Although this is no doubt apocryphal it does illustrate the paternalism that pervaded our profession at that time.

We were fortunate to see a wide variety of chest diseases, some of them uncommon, such as pulmonary arteriovenous aneurysms, sequestrated segments, and the Hamman-Rich syndrome (as it was then called, still "in its infancy" and apparently rare). Competence was gained in the investigative techniques of the day and in interpretation of chest radiographs, tomograms, and bronchograms. We became quite adept at bronchography, and it was surprising how often underlying bronchiectasis was identified in our population of patients, who until their recent acute illness had been "fighting fit" and gave no previous history of lung disease.

A sense of humour prevailed. On the occasion of the arrival of a new commanding officer an addendum mysteriously appeared overnight in large block capitals beneath the name of the hospital on the signboard facing the main road:

UNDER NEW MANAGEMENT,
OLD BOY!

I know of no instance where any of the recently appointed NHS trust hospital managers has been similarly greeted. Such was the spirit of the times.—T B STRETTON