




# BRONCHITIS III

THIRD INTERNATIONAL SYMPOSIUM

EDITED BY N. G. M. ORIE, M.D.  
AND R. VAN DER LENDE, M.D.



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# BRONCHITIS III

PROCEEDINGS OF THE  
THIRD INTERNATIONAL SYMPOSIUM  
ON BRONCHITIS  
AT GRONINGEN, THE NETHERLANDS,  
23-26 SEPTEMBER 1969

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We want to congratulate Messrs. VanGorcum, who also published the first two volumes, with the fine presentation of this third book.

N.G.M.O.

R.v.d.L.

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# Opening Address

N. G. M. ORIE<sup>1</sup>

It is a great pleasure to welcome you on behalf of the organising committee, on behalf of our staff and, I am sure, on behalf of the whole department of medicine, in which we fight a brave – but I am afraid fruitless battle – to keep internal medicine an integrated field of study and medical practice.

I welcome those who were here before; and I am sure nobody will feel hurt when I address a special word of welcome to our British guests. Britain was the first country with the wisdom to recognise the enormous impact, medically and socially, of asthma – although they called it bronchitis. The famous triumvirate Stuart-Harris, Fletcher, and Reid have been the pacemakers in the field of clinical medicine and epidemiology. A very sincere welcome also to those who are here for the first time. I hope they will feel at home and enjoy the ambience.

In my introduction to the booklet with the summaries I wrote: "Does this third conference serve a useful purpose" and I answered in the affirmative. When Tom Okker, our all time leading tennis player, entered the final stage at the 1969 Wimbledon tournament, one of our leading journals – delighted with his achievements but apparently distressed with his health – wrote: "so luckily the bright sunshine cured his hayfever", not realising that this weather type was most favourable for the pollen dispersion. I don't think that such a statement could have been written by one of the participants of this Symposium. Even in our own group, however, considerable semantic differences and divergent opinions in other fields still exist. These can be solved only by contact and discussion.

"Bronchitis" has still as many meanings as has "asthma". And although meant to solve the problem, the famous statement of the American Thoracic Society, issued in 1962 in the American Review of Respiratory Disease (at that time still the American Review of Tuberculosis) has given a solid base to the confusion.

The expression: "No effect of bronchodilators" still refers mainly to the ab-

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sence of a response to sympathomimetics. This is quite misleading. "Bronchitis" still induces the reflex administration of antibiotics, when – even when a bacterial inflammation complicates the bronchial obstruction – release of the bronchial narrowing should be the first goal. Who would pour penicillin down the occluded sink in the kitchen? "Floep" (which acts by chemical elimination of the obstruction) is the „drug“ of choice. As a rather lonely voice in the desert I am pleased to quote May from his recent monograph: "Even so the use of antibacterial drugs in this disease (chronic bronchitis) is at best a stopgap".

"Bronchial infection" still remains a vague concept. However meaningless and misleading this expression is, even the most sophisticated journal hardly ever strikes the expression "common bronchial flora" or "no pathogens" from the description of a sputum sample in the manuscripts they accept for publication. Attitudes may have changed during the last few years but are still open for improvement.

Recently I saw a patient from abroad and certainly not from an underdeveloped country. He was 52 years old and complained of dyspnoea increasing during the last few years. He had been examined, rather thoroughly, and been given an allergic skin test. He was told he had emphysema and got the advice to take a desensitisation course and see a psychiatrist. Instead, after some hesitation, being of Dutch extraction – he saw us. His lung function test became practically normal (VC and FEV<sub>1</sub> both circa 100% of predicted values) after treatment with what we consider a proper combination of drugs, including prednisolone. The improvement was considerable and there was certainly no irreversible bronchial obstruction. But what is more important was what happened when he came back in his country. He saw his physician who expressed his pleasure about the good condition of the patient but added he did not like prednisolone. There was, however, not more to say for him when the patient's wife answered: "But doctor you have given me prednisolone for three years already for my rheumatism". This lack of communication, this irrational approach on many sides, included probably on our own side, has maybe been one of the strongest stimuli in arranging this third meeting.

The Symposium has three main topics.

The relation between respiratory symptoms and signs on the one hand and endogenous and exogenous factors on the other – as epidemiology teaches us – is the first. Anatomical changes of the lung and their functional expression is the second; and the mechanism of reaction of the bronchial tree to irritation and the drugs useful in preventing it is the third.

We hope that by making a selection the base of our program kept within the realm of clinical problems – is not too small. On the other hand we do hope that the scope will also not be too broad, just touching the subject and disregarding the difficulties unsolved.

Acknowledgements are usually made at the end. In articles this is sensible, because the small print at the end is probably often read first. But during the last hour of a conference – however interesting it has been – everybody looks

forward to lunch, the journey home, or just to the end. Therefore, I think those who deserve special mentioning should be given homage now. They are: The "Stichting Jan Kornelis de Cock" and The Netherland Asthma Fund, whose joint efforts made this conference possible. Several pharmaceutical firms mentioned in the program and especially Fisons who have given a substantial contribution. But it is clear that it would never have reached this stage without the help of the organising committee and our staff. I think I can thank them now – the success of the further part is up to you – the firm basis has been laid. I most sincerely want to thank Dr. H. Booij-Noord, Dr. J. van Haeringen and especially Dr. R. van der Lende for their work in the organising committee. The same holds for the efforts of Dr. A. M. van der Wal and Dr. L. E. van Bork, for the work to give everybody a good night's sleep. The results of the work of Dr. K. de Vries and Dr. A. Polman in arranging the exhibition will be seen on the walls of our meeting rooms. Dr. C. Hilvering took over a large part of the clinical tasks of those who were engaged in the organisation. No fruitful work during the last five years could have been done without the help of Dr. H. J. Sluiter, Dr. K. de Vries, and Dr. G. J. Tammeling. Finally, I have to mention the whole team. Notwithstanding increasing clinical burden, an increasing teaching load, and shortness of personnel, they have managed to keep the clinic going and still find the time to help with the organisation of this symposium.

# Introduction

C. H. STUART-HARRIS<sup>1</sup>

*Professor Orie, Professor Reid, Ladies and Gentlemen,*

It is again my privilege to open the proceedings of a Bronchitis Symposium in Groningen. On this, the occasion of the third Symposium, I shall be very brief because we have a full programme of papers and discussion ahead of us. It is, however, my duty not only to thank Professor Orie and his friends and colleagues in the Netherlands for calling us once more together but to remind you of the deliberations of the previous symposia which form the background to the current programme.

In 1960, when some of us here today assembled for the first time in Groningen, we found that the exchange of our ideas was handicapped by a lack of understanding of the precise meaning of words. Worse, we found that we were often using the same words in different senses so that the immediate task was to agree upon definitions of these words. This lesson was well-learned and when we assembled together for the second Conference in 1964, we began with an agreed terminology. This meant that our communications were more precise than in the first Conference and it was possible to discuss not only physiological and pharmacological problems, but also to explore the possible causes of chronic non-specific lung disease, enlightened by the epidemiological method. This new Conference which I have the greatest pleasure in inaugurating, is to take up the subject of the epidemiology of chronic non-specific lung disease in an intensive manner. The papers which we are about to hear will deal with the complex interplay of personal factors stemming from the constitution and of the environment in its widest meaning. Perhaps there will be much new information to guide us in our halting steps towards prevention, particularly because of the emphasis upon children. Tomorrow we will learn of investigations of the physiological mechanism of airways obstruction – that mystic concept which seems to have become established in our minds as the major cause of disablement from CNSLD (CARA). Finally, on the third day, we shall hear of pharmacological matters in relation to bronchial obstruction and

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## INTRODUCTION

perhaps will learn of the possibility of influencing through drugs, the devastation wreaked upon the function of the lungs by the complex causative factors. Thus we shall be led during our discussions from the beginnings of disease to its major source of disablement and to the pre-occupation of the clinician in the latter's therapy.

This is a strenuous programme. Let me wish us all well in the understanding of what has been prepared. I shall now hand over to Professor Reid once more.

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# I

## Epidemiology of chronic non-specific lung disease (CNSLD)

*Morning Session*

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