Physicians continue to prescribe stilbestrol for prophylaxis of abortion even though controlled studies have shown that this “therapy” is useless. Repeated investigations have revealed Sippy-style warm milk diets are unnecessary in the treatment of peptic ulcer; nevertheless, some clinicians still inflict these rigid dietary restrictions upon their patients. Decades have passed since it was demonstrated that patients with acute hepatitis need not be at absolute bed rest, but this message has not reached many segments of the medical profession. Dr. Thomas C. Chalmers recently described these examples of how physicians may ignore the conclusions of well controlled studies. What is the connection between chicken soup “therapy” and these pharmacologic and dietary errors? The rationale for linking the delightful satire “Chicken Soup Rebound and Relapse of Pneumonia” (page 215) to the prescribing habits of physicians lies in Dr. Chalmers explanation of why some practitioners ignore the therapeutic imperatives in recent research. He suggests that many physicians are influenced as much by bad studies as by excellent research. The corollary of such a conclusion is that far too many doctors have an astonishingly inadequate understanding of the discipline of clinical research.

Systematic medical research is largely a post World War II development; the controlled clinical trial was virtually unknown before 1945. Unfortunately, research is one of the few specialties in medicine for which specific training programs have not been developed. Thus, it is not surprising that so many graduates of fine medical schools and excellent postgraduate programs are not critical readers. It is ludicrously easy to spot the scientific deficiencies in the delectable spoof by Caroline and Schwarz (page 215). The hypothesis and conclusions are grossly exaggerated for the purposes of humor. The authors observed that the patient’s fever diminished after chicken soup was ingested. One may infer only one thing from this clinical observation and that is that there was a coincidental occurrence of a certain clinical response associated with the administration of a therapeutic agent. It did not prove a cause and effect relationship. Surely all physician readers will identify the fallacies in this “case report,” but it is shocking how often authors and readers neglect fundamental aspects of investigational techniques when only slightly more sophisticated principles are involved. The ability to understand the enormous difference between clinical observations and a controlled clinical trial should be a prerequisite for every reader of medical periodicals. Rational scientific treatment (rather than empirical therapy) became possible when studies changed from anecdotal documentation to prospective randomized controlled double blind studies. These guidelines for clinical research must be understood not only by editors, consultants, and investigators, but also by practitioners. The clinician who places as much credence in unsophisticated studies as excellent ones may be responsible for the perpetuation of therapeutic myths.

There will continue to be a place in medical literature for simple clinical observations, but the editor must request that the limitations of this approach be clearly identified in the published reports. In addition, there will always be a constructive role for studies which lack elements of the “ideal protocol.” However, the investigator should understand the restrictions of his methodology. Recently, several authors submitted a manuscript to Chest with the comments, “We realize that this is not a controlled trial, but we believe that the data may be very valuable within the limitations of this particular study.” The consultant who reviewed the manuscript noted, “The authors indicate that their study lacks the scientific excellence of a planned experiment. The types of problems they are studying cannot ever hope to achieve the scientific excellence of a planned experiment.
experiment, but often retrospective clinical data can be usable. However, they must follow the scientific rules for retrospective clinical studies and unfortunately these rules have not been observed."

This is a rather ponderous and sober introduction to the satire which follows. It is difficult, however, for an editor to be other than somber when he contemplates the international drug and surgical fads which characterized the first half of this century. The discretionary reader remains the medical profession's strongest bulwark against repetition of these clinical mishaps.

**Reference**

1 Schoolman HM: Medical research: A profession peopled by amateurs. Clin Res 14:9, 1966

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**Chicken Soup Rebound and Relapse of Pneumonia: Report of a Case**

*Nancy L. Caroline, M.D.,* and *Harold Schwartz, M.D.*

A case is reported in which a previously healthy individual, having received an inadequate course of chicken soup in treatment of mild pneumococcal pneumonia, experienced a severe relapse, refractory to all medical treatment and eventually requiring thoracotomy. The pharmacology of chicken soup is reviewed and the dangers of abrupt termination of therapy are stressed.

Chicken soup has long been recognized to possess unusual therapeutic potency against a wide variety of viral and bacterial agents. Indeed, as early as the twelfth century, the theologian, philosopher and physician, Moses Maimonides wrote, "Chicken soup...is recommended as an excellent food as well as medication." Previous anecdotal reports regarding the therapeutic efficacy of this agent, however, have failed to provide details regarding the appropriate length of therapy. What follows is a case report in which abrupt withdrawal of chicken soup led to severe relapse of pneumonia.

**Case Report**

The patient is a 47-year-old male physician who had been in excellent health until 8 days prior to admission, when he experienced the sudden onset of rigors followed by fever to 105°F (40.5°C), breathing shallowly 60 times per minute, with a pulse of 140. Physical findings were again chiefly limited to the chest, where bilateral pleural friction rubs, bibasilar rales and egophony over the right middle lobe were heard. Chest x-ray examination showed consolidation of the right middle lobe, infiltrates at both bases and a questionable right pleural effusion. White cell count was 7700 without a shift to the left. Electrolytes were within normal limits. Arterial blood gases on 8 liters/min of nasal oxygen were pH=7.51, Pco2=20 torr and Po2=50 torr. Gram stain of the sputum showed swarming diplococci, and multiple cultures of sputum and blood subsequently grew out type 4 pneumococcus.

Chicken soup being unavailable, the patient was started on one million units q 6 hours of intravenous penicillin. Failure to respond led to increases of the dose up to 30 million units daily. Nonetheless, the patient remained febrile and his chest x-ray film showed progressive effusion and infiltration. On the twelfth hospital day he was taken to the operating room for a right thoracotomy. He thereafter made an uneventful recovery, maintained on 30 million units of penicillin daily during his postoperative course, and was discharged on the 25th hospital day.

**Discussion**

The therapeutic efficacy of chicken soup was first discovered several thousand years ago when an epidemic highly fatal to young Egyptian males seemed not to affect an ethnic minority residing in the same area. Contemporary epidemiologic inquiry revealed