EDITORIAL
Dissemination of Knowledge to the Physician and Public in Tuberculosis Control

Tuberculosis is still a disease that people "catch" from one another. In the United States and a number of other countries, tuberculosis death rates have been reduced as much as 98 per cent since 1900. However, it still is the leading cause of death among infectious diseases caused by a single class of germ. The World Health Organization estimates that more than half the world's population has been infected by the tubercle bacillus, including 500 million children. Three million persons died last year and 15 million more were suffering from the disease.

The tuberculosis problem concerns all of us. We must recognize our responsibilities and lose our complacency.

With the introduction of effective chemotherapy in the 1940's came optimism that tuberculosis would be rapidly eliminated. This resulted in marked reduction in the number of beds for tuberculous patients and reduced numbers of tuberculosis residences and grants, despite a definite need for more physicians with knowledge about the treatment and supervision of tuberculous patients. In fact, many cities are unable to secure qualified physicians for their chest clinics to replace those retiring. A recent survey of practicing physicians in Massachusetts revealed that lack of knowledge and misinformation on the current concepts of tuberculosis existed among a number of physicians interviewed.

Present improved diagnostic and therapeutic modalities give the physician a better armamentarium with which to control and ultimately eradicate tuberculosis.

What shall we tell the public? For the past 10-20 years, we have prematurely advised that tuberculosis has been controlled and is being eradicated. Now they must be told the truth — every day — not only at Christmas Seal time — tuberculosis is still a real problem, locally, nationally and internationally.

It is essential that all old cases, treated and untreated, be followed indefinitely. This includes all contacts. Unfortunately, in many cities there are not sufficient health workers to follow even the active cases. It may be necessary to use lay personnel for proper follow-up of all active and "inactive" cases. All new or relapsing cases must be reported. If one inquires into case reports, there may be found inadequate, often inaccurate, or even unreported cases. In the past, we estimated the number of active tuberculous patients based upon deaths from tuberculosis. Today, this is no longer valid, making us more dependent upon initial and follow-up reports or postmortem findings. It has been suggested as a double check that pharmacists' records be checked for antituberculosis drug prescriptions. This might uncover a few previously unreported patients, but the improperly treated cases, those having poor or no follow-up supervision, the recalcitrant or the old "inocuous" grandparent would still not be properly treated. Today, the general practitioner, not the chest specialist, sees most of these patients so that he must assume responsibility for proper reporting and management, including follow-up care.

Medicine has made and is making great strides. Let us continue tuberculosis programs, including the tuberculin converters as well as clinically active cases and carry out the most effective methods of management, treatment and prevention. Only with such a regimen can we control and ultimately eradicate tuberculosis. A continued active program, not words, will mean success.

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