A QJM legacy: medical research during both world wars

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11 November 1918 marked the end of the First World War or the original ‘Great War’. As we mark the centenary of this important day, we felt it appropriate to highlight published work in the QJM of clinical research undertaken during and after the First World War.

In January 1916, a seminal paper on ‘Some nervous affections produced by war’ by Dr Frederick Batten was published in which he described a series of serving soldiers from the frontline suffering from a variety of ‘nervous affections’. This paper was one of the first comprehensive descriptions of what we would call today post-traumatic stress disorder.1

In 1918, the definitive paper of that time was published from Dr Norman Keith and Dr William Thompson on 33 cases of ‘War Nephritis’ from a ‘Research Laboratory at a Base Hospital in France’.2 This was a significant problem in the First World War, accounting for over 5% of all medical admissions and 10% of total medical bed occupancy.

We have also published this year the excellent review by Prof Harbison of Trinity College Dublin on medical advances during World War 1 from the use of X-rays, advances in orthopaedic surgery, transfusion medicine and the use of oxygen supplementation.3

We continue this tradition in the current issue of the Journal with an authoritative commentary piece by Dr Geoff Gill of the Liverpool School of Tropical Medicine on lessons we can learn in modern tropical medicine from analysis of the diseases suffered by prisoners of war during the Second World War, particularly those imprisoned and involved in the construction of the Thai–Burma railway. These prisoners, over a period of three and a half years, were exposed to the harshest of conditions, suffered severe malnutrition and were vulnerable to a host of tropical diseases.4 It is a story worth telling, and has relevance and meaning for tropical medical practice today.

ECG abnormalities in the general population

An abnormal resting ECG is an independent predictor of enhanced risk and mortality from cardiovascular disease. So what is the prevalence of an abnormal resting ECG on symptom-free individuals walking down the High street? That study is now reported in the current issue of the Journal by Dr Ioannou and colleagues of St. Bartholomew’s Hospital London—and the answer is 31.8%.

The most common abnormalities are left ventricular hypertrophy, followed by first degree heart block and right bundle branch block. Atrial fibrillation and left bundle branch block was found in 1.65% of this asymptomatic population.

This study demonstrates that a sub-group of middle-aged men and women in the UK with no overt cardiac symptoms are at significant risk of having a cardiac conduction abnormality with potentially serious future complications. ECG offers the potential to identify these abnormalities and provide earlier intervention and treatment with the aim of improving cardiovascular outcome. The authors conclude that in view of the ready availability at a population level of this non-invasive, low cost investigation, ECG is well placed to be potentially included in future preventive strategies for early detection of sub-clinical cardiac abnormalities.

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References