INGLÊS MÉDICO

Atividade para avaliação da proficiência na leitura e interpretação de texto

OBJETIVOS:

Desenvolver as competências de leitura e interpretação em inglês médico, enfatizando a identificação de termos técnicos e suas aplicações.

ORIENTAÇÕES GERAIS:

- **Período de realização da atividade:** os alunos estarão liberado da aula de 24 de fevereiro para iniciar a atividades de avaliação e ainda terão o prazo até 09 de março para concluir a atividade individual.
- **Entrega**: O aluno deverá postar suas respostas (digitadas ou manuscritas escaneadas) em plataforma virtual no dia 10/03 antes do início da aula.

ETAPAS DA ATIVIDADE

LEITURA ATENTA DO CASO (EM INGLÊS)

- **Texto:** são 7.914 palavras – um aluno fluente em velocidade padrão de leitura demora em média 40 minutos. Um aluno sem fluência poderá necessitar de 1h40 a 2h para uma primeira leitura.
- **Tempo Estimado:** você terá 2 horas para leitura inicial e releitura, correspondendo ao período da aula do dia 24/02.
- **Objetivo:** Familiarizar-se com o enredo clínico, sublinhando informações essenciais.
- **Ação Prática:** Ler o texto integral pelo menos duas vezes. Na primeira, busque entender a história em linhas gerais. Na segunda, grife os pontos-chave (diagnósticos diferenciais, sintomas, achados laboratoriais, conclusões etc.).
- Anotar quaisquer expressões desconhecidas.

IDENTIFICAÇÃO E INTERPRETAÇÃO DE TERMOS TÉCNICOS

Lista de Termos:

- Durante a releitura, selecione **15 termos técnicos** em inglês.
- Para cada termo, faça uma breve definição em inglês (se possível) ou em português, deixando claro seu significado.
- Adicione uma frase de exemplo que demonstre o uso do termo em contexto (pode ser uma frase adaptada do próprio texto ou criada por você).

Distinção entre Termo Técnico e Coloquial:

- Escolha 3 termos que tenham equivalentes coloquiais ou formas mais simples de dizer (por exemplo, “to swallow” vs. “engolir” – e se há diferença entre um termo estritamente técnico e o coloquial; “fever” vs. “high temperature” etc.).
- Explique, em poucas linhas, qual seria o uso em linguagem coloquial e qual o uso em linguagem estritamente médica (fichas, prontuários, relatórios).
- **Produto Final:** Uma listagem (tabela ou texto) com 15 termos técnicos + definição + frase de exemplo; e 3 pares de termo técnico × termo coloquial com explicação das diferenças.

Questões de Interpretação do Texto

Responda, preferencialmente em inglês. Estas questões visam avaliar sua compreensão do caso clínico e a aplicação de vocabulário:

- What were the initial diagnostic suspicions or differential diagnoses for Mrs. Tate's condition?
- Which key clinical signs or laboratory findings suggested a viral infection?
- How did the autopsy findings confirm the definitive diagnosis, and why was this result surprising at first?
- Explain the role of Mr. Tate's testimony in clarifying the infection source.
- In your opinion, what public health measures are implied after a confirmed case of rabies in a patient?

Recomendações:

- Redigir as respostas empregando alguns dos termos técnicos previamente listados, mostrando conhecimento de seu sentido no contexto.

Reflexão Escrita (Curta)

Redija um parágrafo (60-80 palavras) em inglês refletindo sobre a importância de considerar fontes de infecção incomuns (como morcegos) no raciocínio clínico.

Responda:

- "Como a atenção a detalhes do histórico do paciente influencia a precisão do diagnóstico?"

Sugestões e Dicas

- **Gerencie seu Tempo:** divida a atividade em duas ou três sessões ao longo do período (24/02-09/03), não deixando tudo para a última hora.
- **Ferramentas de Apoio:** use dicionários médicos online (ex.: Merriam-Webster Medical Dictionary - https://www.merriam-webster.com/medical, MedlinePlus - https://medlineplus.gov/encyclopedia.html, The Free Dictionary - https://medical-dictionary.thefreedictionary.com/). Porém, evite tradutores automáticos para trechos grandes, pois prejudica o aprendizado ativo.
- **Qualidade x Quantidade:** concentre-se na qualidade das respostas, na precisão dos termos e na clareza de ideias.

ANNALS OF MEDICINE

THE INCURABLE WOUND

ON October 30, 1951, a woman I'll call Mabel Tate, the wife of a West Texas cotton planter, was admitted to the Parkland City-County Hospital, in Dallas, with a tentative diagnosis of bulbar poliomyelitis. The record also noted, as is usual in ambiguous cases, two possible variant readings. They were epidemic encephalitis and, at the suggestion of the Tate family doctor, influenza. The general nature of her trouble, however, was somewhat less uncertain. All major signs and symptoms reflected a virus invasion, and one of massive, if not overwhelming, proportions. Mrs. Tate was blazing with fever, she was wildly agitated, and she was unable to speak, unable to swallow, and unable to move her left arm. Four days later, she sank into a coma, and died. Something about the manner of her death prompted the attending physician to request a clarifying postmortem examination. The autopsy was done, with Mr. Tate's consent, early the following day. When the attending physician reached the hospital that morning, a report of the laboratory findings was on his desk. It began, "Encephalomyelitis with demonstrable Negri bodies in central motor neurons . . ." There was no need to read any further. That emphatically answered his question. Negri bodies are distinctive clusters of cellular substance whose presence in the brain has just one denotation. Mrs. Tate was a victim of rabies.

The attending physician once more sought out Mr. Tate. He told him what the pathologist had found and what the finding meant. That being the case, he went on to explain, two corollary conclusions were obvious. One was that Mrs. Tate had been attacked and bitten by a rabid animal. The other related to the approximate time of the attack. In view of the usual incubation period of rabies, he felt, it had probably taken place between two and six weeks earlier. The doctor spread his hands. All that remained was to establish the specific source of infection. It could have been a dog. It could have been a cat or a fox. It might even have been a skunk. There were numerous possibilities. Mr. Tate nodded. He appreciated the doctor's position. He doubted, though, if he could be of much help. It depended on what the doctor meant by an animal. His wife had been bitten, all right, and fairly recently, too. On October 9th, to be exact. But it wasn't a dog or a cat or any of those. It was a bat. His wife had come across it lying in the road near their house. She had thought it was dead, and stooped down to take a look. The next thing she knew, it had jumped up and given her a nasty nip on the left arm. Then it had flown away.

The doctor hesitated. Very curious, he said. And certainly a most curious coincidence. He shrugged, and rose. But, of course, that was all it could be. The only species of bat in which rabies had ever been demonstrated was the vampire, and its range was limited to tropical Latin America. He was forced to conclude that Mr. Tate was mistaken. There must have been another animal episode. It could have happened as much as a year before. Such cases were uncommon but possible. Either Mr. Tate had forgotten or his wife had neglected to tell him. The doctor returned to his office and took out the record of the case. He closed it with the notation "Rabies, source unknown."

OFFICIALLY, the animal responsible for the death of Mrs. Tate is still not known. There is little possibility now that its identity will ever be irrefutably established. The rules of scientific evidence are too rigid for that. Nevertheless, in the opinion of most interested epidemiologists, the case no longer presents much of a riddle. Several subsequent events, they feel, have rendered it to all practical purposes clear. The first of these occurred on a cattle ranch some thirty miles southeast of Tampa, Florida, on June 23, 1953. Around ten o'clock that morning, the stockman's son, a boy of seven whom I'll name David Bonner, was playing in the back yard when a bat burst out of a nearby clump of trees. He

"Oh, my God! A prologue and an epilogue?"

called to his father, who was at work a short distance away, and pointed. Mr. Bonner glanced up, and stared. It was odd enough to see a bat abroad in the full light of day, but the creature's behavior was even stranger. The bat, when Mr. Bonner first caught sight of it, was circling the house. An instant later, it turned and streaked straight for the woods. Then it was back again—flying high, low, and every which way. Suddenly, from almost directly overhead, it swooped. David screamed, and tried to run. But it was too late. The bat was already upon him. Mr. Bonner crossed the yard in a bound. He caught his son and swung him about. The bat was clinging to the boy's chest, its teeth sunk deep in his flesh, and blood was staining his shirt. Mr. Bonner broke its grip with a backhand swipe. It dropped, with a strangled hiss, to the ground. He gave it a kick, for good measure. Then he picked up his son and carried him into the house.

David was more frightened than hurt. While Mrs. Bonner held and comforted him, his father examined the bite. It was an ugly wound but a small one, and not, Mr. Bonner decided, in any sense serious. There seemed no need to call a doctor. He cleaned the bite with soap and water, dusted it with sulfanilamide, and covered it with a gauze dressing. That—for the moment, at least—appeared to be sufficient. It didn't, however, put his mind altogether at rest. The circumstances of the assault, he had to admit, were, if nothing else, uncomfortably queer. Mrs. Bonner agreed. They held a hurried conference and reached a prompt decision. Mr. Bonner fetched his jacket and a paper bag, and returned to the back yard. The bat was lying where he had kicked it. Its fur was sandy brown, with yellow overtones, and except for its saucer ears and its long, web-fingered forearms, it might have been a field mouse. It was also, he was relieved to find, dead. He scooped it into the bag, and went on to the garage and his car. Forty minutes later, he was in the Tampa office of the Florida State Board of Health, closeted with a staff epidemiologist.

Mr. Bonner began the interview with a brief account of the incident. He then produced the bat and stated the reason for his visit. He wanted to have the creature examined. It was his understanding, he said, that bats were capable of transmitting rabies. He remembered reading in a livestock journal that they had been linked to an outbreak of the disease among cattle somewhere in South America. That was true, the doctor replied. There had, in fact, been many such cases, and not only among cattle. Several human cases were also on record. Bat rabies, as it was awkwardly called, was endemic

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in several Latin-American countries. They included Brazil (where the phenomenon was first reported), Honduras, Mexico, Colombia, Venezuela, Surinam, and the island of Trinidad. But, he pointed out, the bats involved were not ordinary bats. They were bats of a kind unknown outside the tropics. They were true, or bloodsucking, vampires. The bat that Mr. Bonner had brought with him was a harmless Florida yellow, a member of the species *Dasypterus floridanus*. It subsisted, like all other bats in the United States, exclusively on insects. Those were the facts. They didn't, of course, explain the attack. He had no theory about that. It was his opinion, though, that the facts held no cause for alarm. The doctor paused. However, he added, it was impossible to deny that the bat had behaved very strangely, and he quite understood how Mr. Bonner felt. A certain amount of uneasiness was only natural. Consequently, in order to settle the matter, he would send the bat along to the board's local laboratory for a routine brain examination. The result, he was confident, would be completely reassuring.

Mr. Bonner left the Board of Health at a little past one. By the time he reached home, it was almost two. At three, he was called to the telephone. It was the epidemiologist in Tampa, and he sounded stunned. He was calling, he said, from the laboratory. A bacteriologist there had just finished a microscopic examination of the bat's brain, and Mr. Bonner, incredibly, was right. The findings were positive for rabies. Arrangements were now being made for the usual confirmatory tests. They involved the inoculation of laboratory mice with bat-brain material, and would be done at the main State Board of Health laboratory, in Jacksonville. But that was largely a formality. The microscopic evidence was in every essential conclusive. Mr. Bonner's son had been bitten by a rabid animal, and it was imperative that preventive measures be taken at once. Could he bring the boy in to the Tampa office that afternoon? Mr. Bonner could, and did. The Pasteur treatment, as the immunizing procedure against rabies is called (in commemoration of its creator), requires a subcutaneous injection of anti-rabies vaccine every day for two weeks. David completed the course, apparently with success, on July 7th, but because of the variable length of the incubation period in rabies, the summer was well over before it could be said that he was in all probability out of danger. That

BOTTLED AND PACKAGED IN FRANCE

he had been in danger was beyond dispute by then. The Jacksonville tests had confirmed the fact, and so had an even more elaborate investigation, conducted at the request of the Florida authorities by the United States Public Health Service, at its Virus and Rickettsia Laboratory, in Montgomery, Alabama. It was also certain by then that David's experience could not be dismissed as an isolated freak of misfortune. Late in September, while he was still under regular observation, a woman I'll call Frances Roberts suffered an almost identical attack, and that was closely followed by a third. The scene of both was eastern Pennsylvania.

THE second Pennsylvania episode, though the least unequivocal of the three cases, was by far the most unsettling in its implications. Unlike the others, it happened in a city, and indoors—in a tavern in the central business section of Harrisburg. Its victim was a used-car salesman I'll identify as Carl Dayton. Shortly after midnight on Saturday, November 28, 1953, Mr. Dayton was standing with a group of friends at the tavern bar. Something brushed his face. He stumbled back, looked up, and saw a bat. It was dodging from wall to wall, just below the ceiling, and was heading toward the rear of the room. There was an open window there, but the bat made no attempt to escape. Instead, it circled back to the bar, lower now and moving fast. The bartender tried to whip it down with a towel, and one of the customers swung his hat at it. Both of them missed. Another struck out with a rolled newspaper, and caught it a staggering blow. It fell to the floor at Mr. Dayton's feet. He squatted down for a look, then sprang up with a yell and began to pound on the bar. His friends stood frozen, and stared. The bat was fixed to the back of his hand, and before he could shake it off, it had bitten his thumb to the bone. The bartender was the first to recover. He slammed the bat across the room, and this released the others. They charged the bat and stomped it to death and threw it into the street. That, to the impairment of the subsequent investigation, was the last of the bat. Then, more sensibly, they inspected Mr. Dayton's wound. It was obvious that he needed medical attention, and after bandaging his thumb with a handkerchief, they fetched a cab and sent him off to Harrisburg Polyclinic Hospital. From the hospital, where an interne (either unimpressed

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or unconvinced by his explanation of the accident) was satisfied to merely clean, close, and properly dress the wound, Mr. Dayton went home to bed.

Mr. Dayton, like David Bonner, is still alive, and for much the same reason. In his case, too, chance decisively intervened. Within an hour after the accident, a reporter on the Harrisburg *Patriot*, the city's morning newspaper, emerged from his office, hailed a cab, and headed home. In the course of the trip, the driver began to talk. There was one thing about hacking, he said—anything could happen. Take tonight, for example. He had just come back from hauling a man to Polyclinic Hospital, and guess what was the matter with him. He'd been bitten on the thumb—by a bat! It was a mean-looking wound, too. His whole hand was covered with blood. But who ever heard of a bat attacking a man? He didn't know whether to believe it or not. Neither did the reporter, but it struck him that, if true, it was a possible story. The following day, on the way to work, he stopped by the hospital. A glance at the outpatient record established the facts of the matter. He then, with providential thoroughness, dropped around to the office of Ernest J. Witte, chief of the Division of Veterinary Public Health of the Pennsylvania Department of Health, and asked him what they meant. The case they described was news to Dr. Witte, but he answered without hesitation. They meant, he said, reaching for the telephone, that his division would investigate the incident at once. One phase of the inquiry would involve a search for the bat. Another, infinitely more urgent, would be concerned with Mr. Dayton. He must be found and returned to the hospital for immediate prophylactic treatment. The bat, in all probability, had been rabid.

Dr. Witte's hunch, though spontaneous, was anything but blind. He had good reason to associate belligerent bats with rabies. The relationship, indeed, was one with which he happened to be peculiarly familiar. His knowledge derived not only from the alerting example of the Bonner episode, a bulletin on which the Public Health Service had promptly dispatched to all state health officers, but also, more recently, from direct professional experience. That had been provided by the case of Frances Roberts. On the afternoon of September 29th, as Dr. Witte later reported to the Ameri-

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can Public Health Association, Mrs. Roberts, the wife of an amateur ornithologist of Boiling Springs, an upland resort about twenty miles west of Harrisburg, had accompanied her husband on a canoeing jaunt across a lake near their home. Toward six o'clock, deciding to stretch their legs before turning back, they beached their craft on a wooded shore, and Mr. Roberts wandered off to observe a flock of waterfowl.

Mrs. Roberts stayed by the canoe, and she was standing there, Dr. Witte noted in his report, when "a bat suddenly landed on [her] upper arm, and bit her without warning or provocation. The woman . . . was startled by the attack and could not immediately identify the object clinging to her arm. Because of her fright, she does not recall distinct biting sensations, although she was conscious of the creature's scratching. Still not knowing what the object was, she finally grabbed the bat with her other hand and threw it against a nearby fence, where it remained stunned by the blow. [Mr. Roberts] was attracted by the commotion and quickly identified the animal as a [hoary, or *Lasiurus cinereus*] bat. Being a naturalist, with considerable knowledge and background in wildlife, he quickly recognized the behavior of the bat to be abnormal. He had the presence of mind to act with swiftness and cleverly trapped the creature in a pail, which he had nearby, and covered it with a newspaper. In a matter of minutes, the party headed back by canoe . . . to their home. [Mrs. Roberts] proceeded immediately to the doctor for treatment. . . . The physician reported that the patient received attention within one hour after the biting episode. He scrubbed the wound thoroughly with surgical soap and cauterized the wound, using an electric cautery. There were three distinct tooth marks on the upper arm, between the elbow and shoulder. He then called the [State] Health Department for advice on the handling of this case. Motivated to a large degree by the reports of the Florida experience, we immediately recommended antirabies prophylaxis." At the same time, Mr. Roberts was asked to deliver the bat to the Harrisburg laboratory of the Department's Bureau of Animal Industry. He did so the following morning. "Touch preparations and, later, sections of the bat's brain revealed typical Negri bodies," Dr. Witte continued. "These were confirmed by the Director of Laboratories, Pennsylvania Department of Health, and by the Virus

and Rickettsia Laboratory of the U. S. Public Health Service. Two rabbits were injected intracranially with the bat-brain material. Both animals developed clinical symptoms of rabies and died [within] twenty-seven days. [Meanwhile], starting October 1st, [Mrs. Roberts] received fourteen injections of vaccine. [She] suffered no adverse reactions during the entire course of treatment. . . . As of this date [November 10, 1953], she remains in good health, but is still under her physician's care."

Although it was Dr. Witte who brought the attack on Mrs. Roberts to general medical attention, his report was not the first account of her misadventure. The first was a newspaper story, less comprehensive but equally stirring, that was widely published throughout the East within a day or two of the incident. Among those whom it particularly stirred was Frederick R. Taylor, an internist and professor of medical literature at the Bowman Gray School of Medicine of Wake Forest College, in Wake Forest, North Carolina. The news did not merely startle Dr. Taylor. It also inspired him to reflection, the nature of which he presently communicated to a colleague in Georgia. His letter, which has been preserved, began with a forceful summary of the Roberts case. This was followed by some lines to the effect that he had long been imperturbably aware of the existence of rabies in Latin-American vampires. "But," he then exclaimed, "an ordinary, insectivorous bat!!! What would happen if the Western bats that live literally by the millions in Carlsbad Caverns, New Mexico, got an epidemic started there? I have seen a high cloud of countless hordes of bats come out of the Caverns' mouth at dusk. Too horrible to contemplate!"

Dr. Taylor's letter was dated October 19, 1953. Little more than two years later, on February 1, 1956, a news story authorized by the New Mexico State Department of Public Health appeared in the Santa Fe *New Mexican* under a six-column headline reading, "CARLSBAD CAVE BATS INFECTED WITH RABIES." "Rabies," it began, "has been discovered among the millions of bats at Carlsbad Caverns. It was a rabies epidemic which caused the death of hundreds of the Cavern bats in August and September of last year." The account continued:

Last Aug. 20, officials of the National Park Service at Carlsbad noticed dead and dying bats in increasing numbers. They

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were found on the floor of the caverns and in its entrance. Ranchers in the area also found dead bats. At that time it was thought that extensive insecticide spraying might have caused the deaths during the 10 day epidemic. But tests by the U.S. Public Health Service found no evidence of this. Instead, tests were begun to see if rabies had caused the deaths.

Lt. Col. Kennet Burns, chief of the veterinary virus laboratory at Ft. Sam Houston, Tex., collected specimens of dead and dying bats for examination while the epidemic was going on. Virus examinations by Burns revealed the presence of rabies in more than 50 per cent of the specimens, the department said. In addition, blood samples from a large number of live bats collected in flight at the caverns after the epidemic showed the presence of antibodies against rabies, indicating that many of the bats had been exposed to the disease some time in the past. . . .

The story also stated that although no human being had ever been known to be bitten by a bat while visiting the caverns, the health authorities had warned people against touching any of the creatures they might find dead or dying there.

RABIES is one of around sixty human diseases now known, or confidently supposed, to be of viral origin. Its causative agent is thus a member of the most mysterious form of life on earth. About all that can be said of the viruses is that they are supremely small (some are only just within the reach of an electron microscope), infinitely numerous (not even the bacteria are more ubiquitous), and almost incomparably specialized. All viruses are obligate intracellular parasites. They share with the rickettsiae the otherwise unique distinction of being unable to grow or reproduce outside the protoplasmic tissue of a living host. In general, the severity of a viral invasion reflects the functional importance of the particular cells to which the invaders are drawn. The virus of rabies is a neurotropic virus. Like the viruses of poliomyelitis and the several encephalitides, it has a special affinity for the cells of the central nervous system. It has, however, little else in common with any other virus. Its range, for one thing, is extraordinarily wide. Unlike the great majority of viruses (including the agents of smallpox, measles, yellow fever, poliomyelitis, infectious hepatitis, and the common cold), which can find in nature fewer than half a dozen satisfactory habitats, it is able to exist comfortably and abundantly proliferate in any warm-blooded animal. Its means of transmission is also peculiarly its own. Most viruses insinuate themselves into a

host through either the respiratory passage or the gastro-intestinal tract. A few are conveyed by bloodsucking insects. The rabies virus enters by way of a bite contaminated with the saliva of one of its victims. In this respect, it might seem to resemble the various mosquito-borne viruses, but the resemblance is merely apparent. The latter are transmitted in the natural course of the carrier's search for food. There is nothing natural about the transfer of the rabies virus. It wrings collaboration from its carrier-hosts by torturing them into a homicidal fury. The incubation period of rabies (or the interval between the implantation of the organism and its establishment in the brain) is largely determined by the depth of the wound, its proximity to the brain, and the size of the original viral colony. This period, though disconcertingly variable, is seldom shorter than fifteen days and almost never longer than a year. But whether the virus reaches its destination in days or weeks or months, the result is inevitably the same. Rabies, in man, is a fatal disease. No recoveries are known.

The symptomatology of rabies is essentially the same in all susceptible animals. There are only superficial differences. The onset of the disease is generally mild and always indistinct. In man (and, insofar as can be determined, most comparably complicated animals), its earliest manifestations are those of any infection—a little fever, a dull headache, a scratchy throat, occasional nausea. This phase frequently lasts for two or three days, and sometimes even four, and is followed by a tingling pain at the site of the wound—the first diagnostically significant indication of rabies. Its grip, already fixed beyond release, then suddenly tightens. The muscles stiffen, the nerves tense, and the mind begins to fray with temper and apprehension. Anxiety quickens into fear. There is a vivid sense of approaching doom, a certainty of death. "A [rabid] patient weighed down with terror often becomes maniacal," D. L. Harris, medical director of the Pasteur Clinic in St. Louis, noted in a recent clinical study. "An excessive flow of thick tenacious saliva pours over his face and neck and becomes smeared on his hands and clothes and over the bedding and floor. These periods of rage are followed by moments of calm in which [he] usually shows anxiety for the safety of those around him and warns them of the approach of another crisis. Hyperesthesia of the skin to changes of temperature, and especially to currents of air, and in-

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creased sensitiveness to sound and light mark the progress of cerebral irritation. Convulsions are brought on by the least irritation and by the slightest current of air . . . the breath comes in spasms, dyspnea is extreme, and there are epileptiform seizures or tetanic rigidity. Hydrophobia is rarely absent. . . . When the patient [attempts to drink], there is an immediate viselike contraction of the muscles of deglutition with an excruciatingly painful spasm of the glottis and the pharynx. The body trembles with convulsive movements, the jaws are clenched, respiration is impossible. . . . After several attempts to drink, the pain is so terrible that despite intense thirst [the patient] cannot be induced to try to swallow liquids, and the sight of water or mention of the word brings on an attack. As a rule, death occurs after two or three days from cardiac or respiratory failure."

ALTHOUGH all highly developed animals are equally responsive to its gothic embrace, the rabies virus has its favored circle of hosts. It is naturally most inclined to frequent those best equipped to further its spread. This largely confines its normal range to the more prolific and short-tempered carnivores, a group that includes the fox, the wolf, the coyote, the jackal, the skunk, the mongoose, the cat, and the dog. Of these, the last, for reasons still obscure, has always been its most consistently conspicuous victim. The dog is also the animal in which its depredations were first recognized as those of a specific disease. Just when that occurred is uncertain. An allusion in the "Iliad" to "canine madness" has persuaded many medical historians that rabies may have been known to the Mediterranean world as early as the tenth century before Christ, and most believe, on the basis of rather stronger internal evidence, that the fifth-century Greek philosopher Democritus, who is chiefly remembered as a pioneer atomic theoretician and the teacher of Hippocrates, was probably conscious of its existence. The first explicit reference to rabies of which there is any record was set down by Aristotle, around 335 B.C., in his "Historia Animalium." "Dogs suffer from three diseases: lyssa, quinsy, and sore feet," he noted. "Lyssa drives the animal mad, and any animal whatever, excepting man, will take the disease if bitten by a dog so afflicted; the disease is fatal to the dog itself, and to any animal it may bite, man excepted." "Lyssa," a transliteration of "λύσσα," means "frenzy," and is the name by which

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rabies was originally known. The Romans gave the disease its modern name, which derives from "*rabere*," the Latin for "to rage," and has been in common usage since the first Christian century.

The Romans also modernized the Greek conception of rabies. A gifted encyclopedist of the early empire named Aulus Cornelius Celsus was among the first to raise his eyes from the pages of "Historia Animalium" and look squarely at the world around him. Having done so, he proceeded to challenge the first of Aristotle's comfortable exceptions as myopically veterinarian. All animals, he decided in his classic "De Medicina," were equally susceptible to rabies. Celsus was willing, however, to concede Aristotle's second exception. It was possible, his studies informed him, that the disease could be mastered in man. He then went on to propose a still valid preventive technique ("the wound . . . must be cauterized") and, less acutely, an antidote and a course of treatment. This consisted of thirty herbal ingredients (including poppy tears, Illyrian iris, Gallic nard, white pepper, male frankincense, and turpentine) mixed with honey and dissolved in a tumbler of wine. Its omission, he added, was risky. "When too little has been done for such a wound it usually gives rise to a fear of water," he wrote. "In these cases there is very little hope for the sufferer. But still there is just one remedy, to throw the patient unawares into a water tank which he has not seen beforehand. If he cannot swim, let him sink under and drink, then lift him out. If he can swim, push him under at intervals so that he drinks his fill of water even against his will. For so his thirst and dread of water are removed at the same time. Yet this procedure incurs a further danger, that a spasm of sinews, provoked by the cold water, may carry off a weakened body. Lest this should happen, he must be taken straight from the tank and plunged into a bath of hot oil."

Celsus's uneasy concession that rabies need not be fatal to man was accepted without recorded dispute for fifteen hundred years. So, except for certain pharmacological refinements, were his methods of breaking its hold. Pedanius Dioscorides, whose "De Materia Medica" was the standard pharmacopoeia throughout the Roman era, contented himself with offering two alternative antidotes. One was a draught of hippocampus, or sea-horse, ashes. The other had as its active principle the leaves of the bladder campion. "This, being

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beaten when it is green, with old swine's grease, is good for the mad-dog-bitten," he wrote. Rufus of Ephesus, a second-century physiologist, preferred a draught of "wormwood, aristolochia, Lycian thorn, decoction of river-crayfish, water-germander, rock-parsley, and the root called gentian." Even Galen, the most observant, as well as the most imaginative, medical investigator in the millennia between Hippocrates and the Renaissance, had nothing to add to Celsus but a polished definition: "[Rabies] is a disease that follows the bite of a mad dog and is accompanied by an aversion to drinking liquids, convulsions, and hiccups. Sometimes maniacal attacks supervene."

After Galen, and the subsequent canonization of Greco-Roman medicine, the illumination of rabies, like that of all disease, was considered complete, and the subject complacently closed. The first attempt to reopen it was made in the sixteenth century. A Veronese savant named Hieronymus Fracastorius is usually celebrated for this act of desecration. Rabies, he announced in 1546, in his precocious "Contagions, and Contagious Diseases and Their Treatment," was an infectious disease, always communicated by the injection of saliva into the blood, and, notwithstanding the protestations of pharmacy, always irremediably fatal. He also emphasized this novel conception of the disease in a dissertation on hunting dogs. "What particularly calls for the care of the skilled mind," he wrote, "is when, inflamed with rabies, [the dog] attacks now these, now those and, turning against the master himself, he inflicts the incurable wound." Fracastorius was a man of towering intellectual stature. In addition to being a notable physician, he was a poet (the term "syphilis" derives from his "A Poetical History of the French Disease"), a botanist, a geographer, a musician, a mathematician, and an astronomer, and his morbid view of rabies received a respectful hearing. It even, for a time, attracted a few admirers. But hope and habit were too strong, and within a generation the more congenial classic conception resumed its interrupted vogue.

Celsus's hydrotherapeutic regimen, adapted to the ducking stool, was commonly prescribed in cases of rabies throughout the sixteenth and seventeenth centuries, and at least on occasion (an essay by Oliver Goldsmith, written around 1765, refers to "a little boy bit in the leg, and gone down to be dipped in the salt water") during

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much of the eighteenth century. His pharmacological influence continued even longer. In 1806, the New York State Legislature passed, without recorded opposition, a bill entitled "An Act for Granting a Compensation to John M. Crous, for Discovering and Publishing a Cure for the Canine Madness." Crous's cure, for which he was granted a thousand dollars, was a tablet to be swallowed with water. Its components included the pulverized jawbone of a dog, the dried false-tongue of a newly foaled colt, and a pinch of corroded copper taken from an English penny minted in the reign of George I. Other American physicians of that time, perhaps less impressed by royalty, favored a remedy composed of bole armeniac, alum, chalk, elecampane, and black pepper. They also had confidence, as did many European doctors, in the curative powers of concretions, similar to kidney stones, that are sometimes found in the intestines of deer, goats, and other herbivorous animals and that, because they were used as a specific in the treatment of rabies, became known as madstones. Such concretions, being formed of mineral salts, are porous and somewhat absorbent. These qualities helped to support the belief that a madstone applied to a rabic wound would promptly extract the venom. "This afternoon called on by a man in Jeffersonville to apply the madstone to a little son bitten a day or two previous," an Indiana physician named John McCoy noted in his journal on June 9, 1848. "Rode thro' the rain and reached there about sunset. Induced to think the dog mad." In 1879, at an auction in Texas, a madstone brought two hundred and fifty dollars. That would be the equivalent of about a thousand dollars today.

THE supposition that rabies could be cured by some curious pill or poultice expired with the nineteenth century. The absolute lethality of the disease is now universally accepted. One reason for this abrupt resignation to reality is that the evidence assembled by modern medical science leaves no room for doubt. Another is that the truth is no longer unbearable. Since the eighteen-eighties, when Pasteur was inspired to adapt to rabies his epochal discovery that the pathogenic properties of a microorganism can be attenuated (by drying, or treatment with certain chemicals, and passage through a succession of laboratory animals) without affecting its capacity to generate protective antibodies, a reliable means of hobbling

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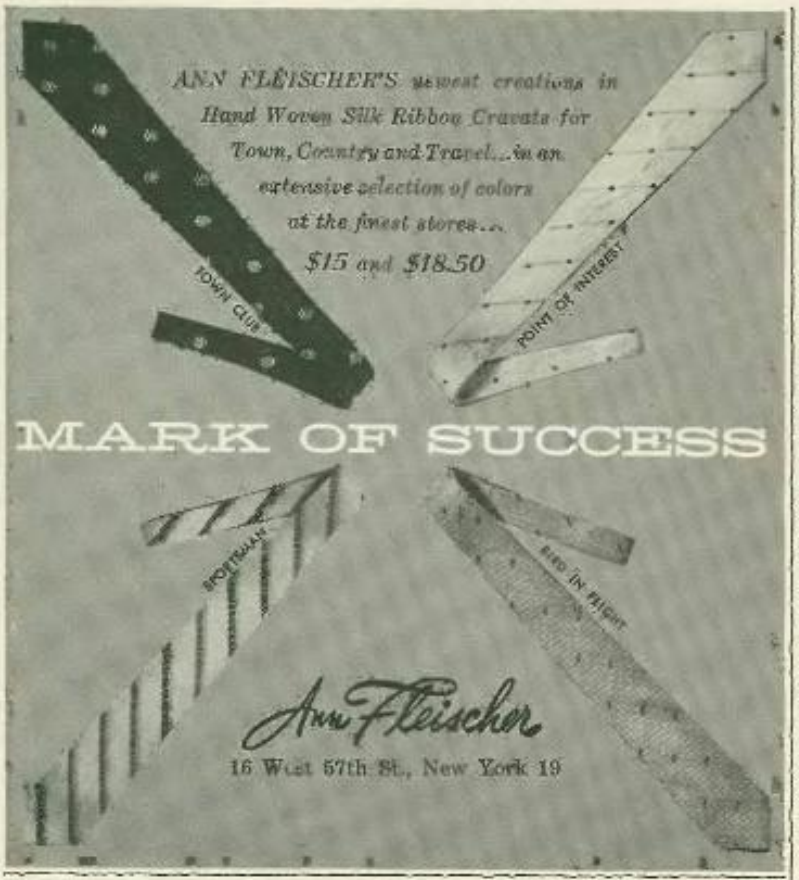
the disease has been everywhere at hand.

Pasteur conceived the idea of rabies prophylaxis in 1880. By the end of 1883, he and his associates at the Ecole Normale, in Paris, were able to produce a stable strain of suitably domesticated virus. This was followed by two series of experiments establishing beyond dispute that the strain was immunologically effective in dogs. The first of these was brought to a brilliant close in June, 1884, with a formal trial before a committee of scientists appointed by the French government. For this definitive test, Pasteur chose two previously vaccinated dogs, two untreated dogs, and two untreated rabbits. After being examined by the committee, the six animals were anesthetized and trephined. Each animal was then identically inoculated with a quantity of material drawn from the brain of a demonstrably rabid dog. When the operation was completed, the animals were separately confined, and all received the same post-operative care. Two weeks later, the four controls, or untreated animals, developed rabies, and died. The vaccinated dogs remained in normal health. The second series of experiments, though begun at about the same time, continued into the following year, and the results were equally emphatic. They showed that it was possible to immunize a dog against rabies not only before but, if the step was undertaken promptly, after exposure to the disease. Pasteur emerged from this revolutionary triumph with a vision of one even more revolutionary. "What I aspire to [now] is the possibility of treating a man after a bite with no fear of accidents," he wrote in the spring of 1885. ". . . I have not yet dared to treat human beings after bites from rabid dogs. But the time is not far off."

The time, as it turned out, was only a few weeks off. Pasteur treated his first human patient on July 6, 1885. This now famous pioneer was a nine-year-old Alsatian boy named Joseph Meister. Two days before, while walking on a country road near his home, he had been attacked by a plainly rabid dog, knocked down, and bitten fourteen times. When Pasteur saw him, at the request of a family doctor, the boy was more dead than alive. In fact, Pasteur later recalled, it was only the apparent hopelessness of the case that induced him to attempt its treatment. The procedure he used was a freehand adaptation of the one he had developed in his most recent experiments with dogs, and it took ten days. During that time,



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the boy received thirteen inoculations, of increasingly potent vaccine. His immediate reaction was encouraging, and it continued satisfactory throughout the treatment. At the end of a month, his wounds having healed, he seemed to be fully recovered. He was Joseph Meister lived to be sixty-four. He died in 1940, a suicide.

The rehabilitation of Joseph Meister, which Pasteur described in a paper entitled "Méthode pour Prévenir la Rage Après Morsure" and presented at a meeting of the Académie des Sciences on October 26, 1885, created an instant and appreciative stir throughout the medical world. "[Rabies], that dread disease against which all therapeutic measures had hitherto failed, has at last found a remedy," the formidable neuropathologist Edmé-Félix-Alfred Vulpian proclaimed. Assisted by this and other resounding testimonials, the Pasteur treatment, as the procedure came to be called, was in international use within a decade, and it has since been administered many thousands of times, with sufficient success to establish its worth as a reliable defensive tool. Or so it is generally assumed. To what extent the Pasteur treatment protects human beings against the development of rabies, however, is not known, and probably (in view of the natural scarcity of volunteers available for a series of controlled experiments) never will be. Its powers, in any event, are somewhat less than total. In a recent monograph, Harald N. Johnson, a staff member of the Rockefeller Foundation, observes, "On the basis of clinical evidence, there seems to be no doubt that rabies vaccine is effective in preventing the disease in the majority of the instances in which there is an expected incubation period of more than one month." But such an incubation period can only be expected in cases involving bites on the arms, legs, or torso. The chances that the Pasteur treatment will prevent the development of the disease when the victim is bitten severely on the head or neck are slight.

Only one more or less controlled test of rabies immunization in human beings has ever been made. That was conducted by a World Health Organization team in 1954, in Iran. Its purpose was to evaluate an anti-rabies serum developed that year by Hilary Koprowski, assistant director of viral and rickettsial research at the Lederle Laboratories of the American Cyanamid Company. Serum differs from vaccine in that it contains—rather than merely stimulates the body to pro-

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duce—the immunizing agents known as antibodies. A rabid wolf had burst into a mountain village, not far from the W.H.O. team's station, and bitten twenty-nine men, women, and children. As a matter of course, the Pasteur treatment was prescribed at once for all the victims. In addition, seventeen of the group, whose wounds included bites on the head or neck, were given immediate injections of serum. Eleven of them received one injection, the others two or more. The results were unmistakably clear. Twenty-five of the victims, including all who had received at least two injections of serum, survived. Of the four who died, three had been given only the Pasteur treatment, and the other a single serum inoculation. The limited efficacy of the Pasteur treatment is not, unfortunately, its only flaw. It has others. It is unpleasantly long (the present regimen, even when supplemented by serum, requires from fourteen to twenty-one days), it is usually expensive (the average injection costs about five dollars), and, above all, it is disturbingly dangerous. Reactions to anti-rabies treatment range from those common in allergic conditions—erythematous or urticarial rashes, edema, syncope—to one known as neuroparalytic accident. Neuroparalytic accident varies in degree from a polyneuritis to ascending encephalomyelitis. The latter, in an uncomfortable number of cases, is permanently incapacitating, and sometimes fatal.

The imperfections of the Pasteur treatment are not, of course, sufficient to deny it a place in the modern medical kit. There is, after all, nothing with which to replace it. In the opinion of most investigators, however, the imperfections are pronounced enough to discourage its use in any but cases of certain—or suspicious but unverifiable—exposure. It is also their urgent conviction that post-exposure prophylaxis is, at best, an indirect defense against the menace of rabies. "There can be no question that the ultimate solution to the rabies problem is predicated on the control and eventual elimination of the disease from animal populations," the *American Journal of Public Health* commented editorially in May, 1955. "This may be accomplished by the setting up of transmission barriers, such as animal immunization, elimination of stray dogs, and the reduction of excessive numbers of wildlife vectors." It has been accomplished in a considerable number of countries. Britain, where a system of controls, rigidly enforced by the Ministry of Agricul-

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San Antonio, and the second and third, in May and July, near Austin. The victims were a youth of twenty and two small children. Another was reported in October, 1955, in Madera, California, and involved a middle-aged man. Last year, two more attacks—one certain and the other probable—were added to the record. The victims of these were a soldier on maneuvers in Louisiana and a Texas State Health Department field epidemiologist named George C. Menzies. Dr. Menzies, at the time of his exposure, had been collecting specimens of cave-dwelling bats in central Texas to be examined for evidence of rabies infection. How and when he was exposed is not known. It is only known that he returned to his home, in Austin, on January 1st, and the following morning developed symptoms of rabies. Two days later he was dead. The five other victims received the Pasteur treatment, and survived.

Dr. Menzies' last assignment was one of a number of similar studies that have been undertaken in collaboration with the United States Public Health Service since the Bonner episode in 1953. The investigation, which was understandably intensified by the harrowing discovery at Carlsbad Caverns two years later, is expected to continue for at least another year. Some months will then be required to accurately assess its results. The preliminary findings, however, have been tentatively correlated by Ernest S. Tierkel, chief of Rabies Control Activities at the service's Communicable Disease Center, in Atlanta, and they are hardly reassuring. "During the last eighteen months or so, various field units have bagged in the neighborhood of ten thousand bats, in fifteen different states," Dr. Tierkel says. "About a hundred and fifty of them were positive for rabies. The group included four species of tree-living, or solitary, bats and eight species of cave-dwellers, or colonials. All, of course, insectivorous. Every state in which we've made a thorough study has yielded its quota of positives. The list, at the moment, is Alabama, California, Florida, Georgia, Louisiana, Michigan, Minnesota, Montana, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Texas, and Utah. Those are the facts that we have to work with. What they mean—their epidemiological significance—is what we hope to find out.

"In the early phases of our investigation, one possible conjecture was that what we were turning up wasn't really rabies. We thought it might be a new

virus disease of bats so closely related antigenically to the rabies virus that the two couldn't be differentiated by the usual laboratory tests. But a little more laboratory work disposed of that possibility. The disease is definitely rabies. Another basic question is whether the disease has always been present in the insectivorous bats of the United States and we have only just discovered it, or whether it represents a recent northward invasion into this country from the vampire-bat-rabies areas in Latin America. I'm inclined to suspect that the latter is the answer. We know, at any rate, that the Mexican free-tails of our Southwest migrate deep into the vampire country of Mexico. According to some authorities, the vampires and the free-tails even share the same winter caves. We hope that's all they share. If it turns out, as some preliminary findings have suggested, that our bats also share the vampires' resistance to rabies, we're up against an extremely difficult problem. Vampires—some of them, at least—are known to be capable of transmitting the disease for long periods of time without showing any signs of illness themselves. In other words, they're like Typhoid Mary. They're true carriers. If our bats have that capacity, if we find that they sometimes attack simply because they're frightened and not because they've been driven into a frenzy by the disease, and if we also find that the bat represents an important reservoir of rabies in the United States . . . Well, those are only possibilities, of course. We don't have the data yet to even hazard an answer. But what if they're shown to be facts? I think it would be a very good idea to tighten up our system of rabies controls." —BERTON ROUECHÉ

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MOST FASCINATING INTERVIEW OF THE WEEK

[The following item, reprinted in its entirety, is from the Herald Tribune]

Lord Beaverbrook, the British publisher, arrived at Idlewild Airport last night from a Caribbean vacation and said he would spend the night at the Waldorf-Astoria before returning to London today. Asked about his new book, reported to concern important personages in World War II, Lord Beaverbrook said, "Good show."

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Architect Marcel Breuer characteristically designed such interiors in the home of fabric printer George Neumann and his designing wife Vera (shown in black and white in our June 1956 issue).

—*Interiors.*

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