In 1932, the *American Journal of Hygiene* again published 94 articles. Most were long, 18 pages on average, with a range of two pages (1) to 104 pages (2). Only 12 of the 94 articles had more than two authors. Women held their own in authorship. Of the 76 papers in which authors’ first names were given, 22 percent of the authors were women, and half of them were first authors. Volumes 15 and 16 in 1932 contained few papers of epidemiologic or general public health interest. Most dealt with bacteriology, protozoology, or entomology, and their authors made little or no effort to relate the results to human health.

A study of pneumococcal pneumonia in children was the only one to mention epidemiology in its title (3). Even so, it dealt almost entirely with the types and virulence of pneumococci isolated from cases and normal children and the duration of the carrier state. Fourteen types of pneumococci were recognized, although most of the analyses dealt only with types I, II, III, and all others, grouped as type IV. Among 86 family members of 21 children with pneumococcal pneumonia, only 12.7 percent had the same type of organism as the cases to which they had been exposed. Type I organisms were the most virulent, and the carrier state among convalescent cases lasted from 2 days to 152 days. Environmental conditions among the cases suggested that poor ventilation of their homes and undernutrition were risk factors; but without information on controls, these factors cannot be evaluated.

A study of the association of *Haemophilus influenzae* with upper respiratory infections was conducted among patients seen at a major Baltimore, Maryland, hospital between October 1926 and September 1930 (4). An epidemic of influenza occurred during the winter of 1928–1929. The following winter was “free from such an epidemic” (4, p. 64). Among 583 cases of acute upper respiratory disease, *H. influenzae* was not more common than among healthy persons of the same age, nor was it more common during the influenza epidemic than during the following influenza-free winter. Isolations of *H. influenzae* were most common in the age group 0–10 years and declined with age thereafter. Although the author did not say so, her findings strongly pointed to the conclusion that *H. influenzae* was not associated with upper respiratory disease, except as a possible secondary invader.

An effort to reduce the severity of symptoms due to the common cold by immunizing people against 15 common secondary invaders was made by W. E. Brown at the University of Cincinnati (5). Volunteers were recruited from the medical college. It appears that 80 volunteers chose to be in the group to be vaccinated and 82 chose to be unvaccinated controls. The group to be vaccinated had a history of more colds than the unvaccinated group. In the 6½ months after vaccination, nearly half of the vaccinees and only 5 percent of the unvaccinated group felt that they had been much better than usual with respect to cold symptoms, although the mean number and duration of recorded colds were only slightly and nonsignificantly lower among the vaccinees. As was mistakenly done in the tuberculosis field for many years, hypersensitivity to the bacterial antigen was used as an index of immunity. Because of the modest increase in bacterial hypersensitivity conferred by the vaccine and the slight
improvement in symptoms, the authors felt that a stronger dose of bacterial antigens might have provided more impressive protection.

“The man who has always had glazed windows to shelter him from a draught, whose feet have been warmed by hot applications renewed from time to time, whose dining halls have been tempered by hot air passing beneath the floor and circulating round the walls—this man will run great risk if he is brushed by a gentle breeze” (6, p. 233). This quotation from Seneca, the Roman sage, introduces Gafafer’s rebuttal of the complement of Seneca’s statement—namely, that sleeping in rooms with open windows and exercise in the open air in all seasons will prevent colds (6). Among adults aged 17–59 years, there were only trivial and nonsignificant differences in frequency or severity of colds or in types of cold symptoms associated with sleeping with wide-open windows, exercising for 8 or more hours in the open air in summer, or exercising for 4 or more hours in the open air in winter.

Few readers of the Journal who have spent their lives in the United States will remember the type of milk bottle routinely used in 1932 (7). The bottles were made of glass and capped with a circular cardboard disc that was approximately 3.5 cm in diameter. This disc could be snapped into a groove in the inner neck of the bottle and removed by a slight pull on an attached tab. In freezing weather, the milk, which was often left at the doorstep, would expand, and the cap would be found sitting on top of a frozen column of milk. Even when not exposed to the elements, the milk could be easily contaminated by material that had easy access to the depressed area of the cap. Dairies that cared about protecting their milk had begun to use a second cap which covered the entire top of the bottle. With funds from the Standard Cap and Seal Company of Chicago, Illinois, Isaacs and Zeiber (7) measured the bacterial contamination of milk delivered in single- and double-capped milk bottles. Care was taken that both types of bottles were handled similarly after capping. Bacterial counts were 38–64 percent higher in single-capped bottles, and Escherichia coli was found in the cream in bottles with single caps. Although double-capping did not prevent all contamination, it was clear that single-capped milk bottles were a hazard to health.

This report recalls an anecdote from my personal experience. A requirement of my third-year medical school course in preventive medicine was to conduct a sanitary survey of some town or county. As part of this assignment, I interviewed the owner of a small dairy that supplied almost all of the milk for the area. The name of the dairy and the type of milk in the bottle were printed on the caps. At that time, some people objected to pasteurization on the grounds that it spoiled the flavor of the milk and decreased the amount of usable cream. In spite of this belief, the dairy owner had decided to pasteurize all of his milk as a means of cutting costs. It was legal to label pasteurized milk as raw milk, but not the other way around. A short time before my interview, a new employee, knowing that all of the milk had been pasteurized, capped all bottles with caps that said “pasteurized.” The owner told me that as soon as the first bottles had been delivered, the telephone began to ring, with angry customers complaining that he (the owner) knew they couldn’t stand that awful pasteurized stuff! The delivery man was sent out to collect the bottles from the “raw milk” customers and return them to the dairy, where the caps were exchanged for those labeled “raw.” There were no further complaints.

REFERENCES