BRITISH PAEDIATRIC ASSOCIATION

PROCEEDINGS OF THE SEVENTEENTH ANNUAL GENERAL MEETING

The Seventeenth Annual Meeting of the British Paediatric Association was held at Rugby School, by kind permission of the headmaster, P. H. B. Lyon, Esq., M.A., on August 2nd and 3rd, 1946.

Business Proceedings: The President, Prof. G. B. Fleming, was in the Chair and the following members were present:—


There were also 35 Guests, including the following visitors from abroad:—

Prof. P. F. Armand-Delille (corresponding member) (France).
Prof. S. Clausen (U.S.A.).
Prof. H. Eckstein (Turkey).
Dr. Doxiades (Greece).
Dr. J. A. Molhuyse (Holland).
Dr. G. M. H. Veeneiklaas (Holland).

The Minutes of the last Annual General Meeting were approved. The President welcomed the guests, especially those from abroad, and congratulated Sir Leonard Parsons, past President, on his Knighthood. He referred to the death of Dr. George Bray and to the illness of Dr. K. D. Wilkinson, to whom it was decided to send the best wishes of the Association.

Election of Officers: The following were unanimously elected by ballot for the year 1946–47:—

President: Prof. C. W. Vining, Leeds.
Treasurer: Dr. Donald Paterson, London.
Secretary: Prof. Alan Moncrieff, London.
Executive Committee (to replace those retiring).
Representative for the Provinces: Dr. J. M. Smellie (Birmingham). (To replace Prof. C. W. Vining.)
Representative for Ireland: Dr. R. Marshall (Belfast). (To replace Dr. F. M. B. Allen.)

Election of New Members: The following were elected by ballot to the membership of the Association:—

(a) Honorary Members:
Prof. G. B. Fleming, Glasgow.
Dr. Lewis Thatcher, Edinburgh.
Dr. T. Y. Finlay, Edinburgh.
(b) Corresponding Members:
Dr. R. Debret, Paris.
Dr. L. Exchaquet, Lausanne.

(c) Ordinary Members:
Dr. Cecil Asher, London.
Dr. W. S. Craig, Leeds.
Dr. R. H. Dobbs, London.
Dr. N. M. Jacoby, London.
Dr. H. W. Everley Jones, Wolverhampton.
Dr. Agnes MacGregor, Edinburgh.
Dr. F. J. W. Miller, Newcastle-on-Tyne.
Dr. Ursula Shelley, London.
Dr. Mary Wilmers, London.

The Treasurer’s Report was received and approved.

The Joint Secretaries’ Report

Mr. President, Ladies and Gentlemen,

Since our last General Meeting held on the 2nd and 3rd August, 1945, in Rugby, your Executive Committee has met on five occasions. In the following report we have attempted to give a brief résumé of their activities:

1. National Health Service: Since details of the proposed Service have now been made known, we feel that some definite pronouncement on matters of policy in this connexion should, and must, be formulated by such a body as the British Paediatric Association to guide the Executive and their representative for the future. It is obvious that the Association will require to take an active part in all deliberations if paediatrics is to attain its rightful place of importance in the proposed Service.

2. Hospital Architecture and the Part it Plays in the Prevention of Cross Infection in Children’s Hospitals, etc.: The policy of your Executive has been to suggest that the Sub-Committee on this subject, under the able Chairmanship of Dr. A. G. Watkins should publish an interim report on this subject; a copy of this appeared in the B.M.J., and you have all received one of these. This report was published over the signatures of the Sub-Committee as no unanimity of opinion could be obtained. The long-term policy of the Association is to obtain facts over the next year or two, and this is now in progress in various parts of the country.

3. Child Psychology: You will all have received an excellent report prepared by your Sub-Committee under the Chairmanship of Dr. W. G. Wyllie, with the help of Dr. Charles Harris and with Dr. C. T. Potter acting as Secretary. Their terms of reference were 'To examine and interpret into the existing facilities, for the diagnosis and treatment of psychological problems in childhood, and the character of the work undertaken in such places as are provided.'

4. Neonatal Mortality: The Joint Committee comprising representatives of your Association and the Royal College of Obstetricians and Gynaecologists has met on three occasions, under the Chairmanship of Mr. Eardley...
Holland. A synopsis of the original draft report was prepared by Dr. W. Gaisford for the Royal Commission on Population; this has been approved by your Executive Committee, and representatives of the R.C.O.G. serving on the Joint Committee. Meanwhile, much additional valuable material prepared by Professors Norman Capon and T. N. A. Jeffcoate has been considered by the Joint Committee and it is hoped that this report will be in your hands in the near future.

5. CHAIRS OF CHILD HEALTH: Members of the Association will be pleased to recall that a Chair of Child Health in the University of London, based on the Hospital for Sick Children, Great Ormond Street, came into being on January 1, 1946. Dr. Alan Moncrieff was appointed as the first Professor. Members will also learn with pleasure that Dr. W. S. Craig, who has recently attended the Joint Committee as the Observer for the Ministry of Health, has been appointed Professor of Child Health at Leeds.

6. FUTURE CONVALESCENT HOME ACCOMMODATION: Your Sub-Committee on this subject has met on several occasions, along with representatives of the I.C.A.A., and Hospital Almoners' Association, and are in process of compiling a brochure of 'approved' convalescent homes, for the use of yourselves. All sections of the British Isles were circulated in our questionnaire in an effort to make the brochure comprehensive. It is hoped that this brochure will be of great use to members. Dr. W. Sheldon, Chairman of your Sub-Committee is to be congratulated on bringing this brochure into being.

7. PAEDIATRIC COMMITTEE OF THE ROYAL COLLEGE OF PHYSICIANS: Members will recall that they received, nearly a year ago, a copy of the interim report of this committee, dealing with the first part of the 'terms of reference,' namely, 'to inquire into the education of those post-graduates and post-graduates in the subject of Infant Hygiene and Diseases of Children. The second part of the terms of reference 'to make recommendations covering this branch of medical practice in the future' has been considered by the Committee. Your Executive prepared a Memorandum covering the latter part of the terms of reference. This was drawn up by Dr. R. Lightwood for your Executive Committee, and approved after revision. The Deputy Chairman of the Paediatric Committee of the Royal College of Physicians, Sir Leonard Parsons, and the Secretary Prof. Alan Moncrieff. It is hoped that the report will be published in October.

8. POST-WAR PLANNING FOR HOSPITALS: It will be of interest to members of the Association to recall that sub-committees of your Association have visited Wolverhampton, Worcester, Exeter, Bristol, Leicester, and Chester, to advise on the paediatric service in each area. Confidential reports have been approved by the Executive Committee on each occasion. We feel these are of great value and have added to the reputation of the British Paediatric Association. In addition, our advice on the terms attaching to the appointment of paediatricians has been asked for from Plymouth. An invitation to visit Norwich has also been received.

9. TERMS OF FUTURE APPOINTMENTS OF CONSULTANT PAEDIATRICIANS: Your Executive has felt that this is of such vital importance, that a Sub-Committee consisting of Drs. Gaisford, Moncrieff, Sheldon, Paterson, Ellis, and Harris, has been drawn up. The report has been circulated for your information. It will be noted from the report that emphasis has been placed on the great importance of the status, facilities for assistants, and scope, rather than salary which is later to be determined.

10. OBITUARY: The Executive has noted with profound regret the death of Prof. Jundell of Stockholm, and of our first Ordinary Member, Dr. George Bray. Dr. Bray endowed the George Frederic Still Memorial Lecture given in alternate years to your Association.

11. CONTINENTAL CHILD RELIEF: Your Executive has been approached in an advisory capacity, regarding various problems arising in this connexion: Dr. R. Lightwood has acted as your representative and dealt with such matters.

12. DIPLOMA IN CHILD HEALTH: Correspondence between your Executive Committee and the Secretary of the Examination Board regarding the Diploma in Child Health has had as its object to secure that a longer period shall elapse between qualification and the right to sit for the D.C.H. Examination and also that during such a period a good basic training in paediatrics is obtained.

13. BRITISH ASSOCIATION OF OTOLARYNGOLOGISTS: A letter from this Association was received suggesting that the B.P.A. might like to consider their report on 'Conditions and Terms of Service for E.N.T. Specialists' and make any suggestions they wished. The report was considered, and it was resolved that the Secretary reply on behalf of the Association suggesting that there is need for very much more co-operation between Paediatricians and E.N.T. Surgeons than appears to be envisaged in their report, e.g., an E.N.T. unit for children should be part of any Paediatric Department and primarily the responsibility of the Paediatrician.

14. JOINT TUBERCULOSIS COMMITTEE: The representative appointed by the Association, Dr. W. Sheldon, has been a member of a special Sub-Committee on notification and other matters, a report of which has appeared in the medical press.

15. TRAINING OF HEALTH VISITORS: Your Executive Committee was asked to consider a confidential document on this subject in relation to a proposed new syllabus. Its criticisms were conveyed to the Ministry of Health.

16. CARE OF CHILDREN COMMITTEE: The Association was asked to appoint a member of a special committee of the British Medical Association preparing evidence for the Curtis Committee. Dr. Gaisford was appointed and his report, together with the B.P.A.'s memorandum of evidence has been circulated to all members.

17. VITAMIN TAKE-UP: The questionnaire answered by members of the Association provided a large amount of interesting material which was summarized by Dr. W. S. Craig and approved by your Executive Committee before submission to the Ministry of Health.

18. ARCHIVES OF DISEASE IN CHILDHOOD: Prof. Alan Moncrieff intimated that he wished to resign as editor. Your Committee recommended to the appropriate committee of the British Medical Association that Dr. R. W. B. Ellis be appointed editor and that in view of the provision of a permanent sub-editor for all the special journals there was no necessity to appoint an assistant editor at present. Mr. R. C. Brock and Dr. L. Findlay retired by rotation from the editorial board and Prof. Moncrieff and Dr. Franklin were elected to take their places. These appointments were made jointly by the B.M.A., and the B.P.A.

19. LONDON TEACHING HOSPITALS: In view of special problems likely to arise as regards paediatric teaching at the London teaching hospitals, your Executive Committee has appointed a committee to deal with the matter, consisting of Dr. R. W. B. Ellis (Chairman), Drs. C. Harris R. Lightwood, and W. Sheldon.

20. SWISS PAEDIATRIC SOCIETY: An invitation was received that the Association should send delegations to attend the annual meeting of this society. You all received a circular on this subject and as a result Dr. R. W. B. Ellis, Dr. A. W. Franklin, and Mr. D. Browne attended a most successful meeting in Berne on June 1st and 2nd. The President of the Swiss Paediatric Society, Prof. L. Exchaquett, has been recommended as a Corresponding Member of the B.P.A.

21. HONOUR FOR PROF. PARSONS: Your Executive Committee learned with great pleasure at its June meeting
of the Knighthood conferred upon Prof. L. G. Parsons and sent him the affectionate congratulations of the Association.

DONALD PATERSON and ALAN MONCRIEFF.

Communications

1. DR. W. SHELDON (London): 'The Work of a Tuberculosis Diagnostic Clinic.' An analysis was given of some aspects of the work of the Tuberculosis Diagnostic Unit at the Hospital for Sick Children, Great Ormond Street. The unit, consisting of ten beds, came into being in 1943 in co-operation with the London County Council. Arranging admissions by age-groups, it was disappointing that the group under one year should be so small, since that is the age when childhood tuberculosis is both common and dangerous to life. Suspicion of tuberculosis was most frequently entertained in the six-year-old, but the incidence of false alarms was also found to be greatest in this group.

Analysis of tuberculin skin tests showed the order of reliability to be (i) Mantoux 1 in 1,000; (ii) Jelly test; (iii) Mantoux 1 in 10,000; (iv) Patch test. Because of these findings, the speaker had discarded the Patch test in favour of the Jelly test. Correlation of physical signs with X-ray findings confirmed the correctness of the teaching that a negative physical examination alone could not be held to exclude intrathoracic tuberculosis. Thus, physical signs were lacking in 40 per cent. of cases judged positive by X-ray examination. Of physical signs, percussion had been found more often positive than auscultation, but was also more apt to be misleading.

The source of infection had been discovered in 70 per cent. of cases to which a history of a child's home. One or other parent was the most common source, and of other relatives aunts were most frequently involved.

Although co-operation with the Tuberculosis Authority had been close and cordial, persistent difficulty arose from the shortage of beds for treatment to which children, after diagnosis, could be transferred. As a result many children had to wait in the diagnostic unit for two or three months, with a consequent slowing down of the work of the ward; and in a hospital with responsibility for teaching students and training nurses it was felt that the ward could be put to better use, particularly as the work of the ward could be as efficiently carried out in an out-patient Tuberculosis Diagnostic Clinic.

2. MR. JAMES CROOKS (London): 'Bronchoscopy in Pulmonary Tuberculosis in Childhood.' Tuberculous infection of the lungs in children often leads to obstruction of the main bronchi from involvement of the peribronchial mediastinal glands. The obstruction is due either to compression of the bronchus from outside by an enlarged gland, or to ulceration of the gland into the lumen of the bronchus which becomes blocked by granulations and caseous matter. If the obstruction is complete on inspiration and expiration the corresponding area of lung collapses. If the obstruction is sufficient to block the small expiratory lumen, but not the larger inspiratory lumen of the bronchus, emphysema results. Sometimes the same granulation causes collapse of one lobe of a lung, and emphysema of another. Granulations and caseous matter can be removed through the bronchoscope, and such a procedure is of value because collapse or emphysema may be relieved by this means. There appears to be no danger of stirring up more active disease by doing this, but no attempt has been made to operate upon enlarged glands, causing compression, through an intact mucosa. Twenty-five examples of this condition were mentioned, and X-ray films shown of five children.

3. DR. BREND A MORRISON (Newcastle-on-Tyne). (Introduced by Prof. E. Spence): 'Some Clinical Observations on the Burnt Child.' During the past three years a clinical study was made of thirty cases of burns and scalds in children, hoping to clarify the clinical picture and to assist rational treatment.

The picture may be separated, chronologically and etiologically, into four phases, in each of which the child may die. These are


(2) Haemocoagulation. Immediate onset. Height six to twenty-four hours according to severity. Duration thirty to forty hours. This may cause death from circulatory failure. Relieved by intravenous fluids—up to seven times total plasma volume may be required.

(3) Toxaemia. Onset towards end of first twenty-four hours. Duration—four to six weeks.

(a) Sustained pyrexia.

(b) Moderate hypertension.

(c) Drowsiness and signs of increased intracranial pressure.

(4) Secondary infection and wasting. These are very important in lesions of over 20 per cent. extent.

An interesting feature of the constitutional disturbance was the hypotension. This was present during the first forty-eight hours in twenty-one out of twenty-seven cases in whom readings were available, and in the majority appeared as a reaction to plasma or serum therapy. But in fourteen of these twenty-one cases it persisted for varying periods (up to several weeks) after the resuscitation period. Although most marked in cases with much sloughing, it was not directly related to this, and there was a definite individual variation in the liability to hypotension with a given lesion.

4. DR. B. SCHLESINGER (London): 'Results of Gold Therapy in Still's Disease.' Dr. Bernard Schlesinger related his experiences in regard to gold therapy. A small series of 14 cases had been followed up from five to eleven years following this treatment which, in the majority, had been administered in early childhood and within two years after the onset of the disease. When last examined most of the cases had reached adolescence or adult life. The results were certainly not encouraging. Out of the 14, only 3 could be claimed to have been cured and one of these was no longer traceable; 4 were improved but still had arthritis; 2 had relapsed and were in hospital again; 3 were hopeless arthritic cripples and 2 had died.

Solganol B, neo-solganol, aurotoxid and myocryn were all tried, up to six courses being given at adequate intervals and in doses which were in vogue at that time but which to-day would be considered rather high. Quite promising responses were obtained at the outset of the treatment but the ultimate results were disappointing. The general and acute phase of the disease, such as fever, splenomegaly, arthritis, wasting and in certain instances subcutaneous nodules and bursitis subsided. Serum B.S.R. was raised but the arthritis progressed with gradual loss of cartilage, osteo-articular changes and a tendency to ankylosis. In other words, the infection appeared ultimately to burn itself out, leaving considerable destruction in its wake and the gold seemed powerless to prevent this process.

 Certain toxic reactions were mentioned, particularly nephritis and hepatitis, which could be serious and occurred in children who were resistant to this heavy metal and, therefore, after a relatively small total dosage. Myocryn was found to be the safest gold preparation in this respect.

The importance of following a disease of this nature into adult life before assessing the value of any special form of therapy was stressed.

5. DR. R. PUGH (London) (introduced by Dr. D. Paterson): 'Staphylococcal Infection of the Respiratory Tract.' The subject was reviewed to illustrate the increasing importance of staphylococcal infection of the lower respiratory tract after the advent of sulphonamide therapy, and to suggest that the prognosis, which was previously grave, might be greatly improved with penicillin therapy. In the past three years of established staphylococcal pneumonia, all with empyema, were recorded, and two with tension pneumothoraces, all of which recovered completely.
The incidence of staphylococcal pneumonia in the pre-
chemotherapeutic era was inferred from three sources
compiled from the available literature:

<table>
<thead>
<tr>
<th>Source</th>
<th>No. of cases</th>
<th>Staphylococcal (per cent.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Post-mortem culture</td>
<td>702</td>
<td>7-2</td>
</tr>
<tr>
<td>b. Empyemata</td>
<td>1914</td>
<td>9-1</td>
</tr>
<tr>
<td>c. Lung puncture...</td>
<td>414</td>
<td>11-0</td>
</tr>
</tbody>
</table>

Accurate information regarding the bacteriology of
pneumonias which are neither fatal nor develop empy-
emata is very scanty.

The predilection of staphylococcal pneumonia for the
twelve first months was illustrated, and the figure of
67 per cent. of all empyemata under three months of age
(Hochberg Steiner, 1940) quoted.

Post-sulphonamide incidence: this has been stated to
have tripled at the Babies' Hospital, New York, while in
seven pneumonias quoted at autopsy at the
Hospital for Sick Children, Great Ormond Street (Jan.,
1944 to June, 1946) in patients under two years, 31
(64-5 per cent.) gave a pure culture of Staphylococcus
haemolyticus. Among these 31 cases were 12 with
major lesions in other systems including 5 cases of
fibrocystic disease of the pancreas, while 26 of these
cases were under six months of age.


6. Dr. R. E. STEEN (Dublin): 'Cyclical Diseases.'
Under this heading are included a variety of conditions
which display a peculiar periodicity, for example, cyclical
vomiting, recurrent mucous colitis (cyclical diarrhoea)
recurrent of pale stools, migraine, asthma, and
many others. The importance of the psychological
factor in such illness is suggested.

The term 'acidosis' used by itself is criticized as being
only a symptom and it is emphasized that in any case the
term 'ketosis' is preferable. On the other hand, it
is pointed out that many cases of cyclical vomiting have
at times attacks unassociated with vomiting in which the
child suffers perhaps nausea, nausea, and
a marked ketosis since these children appear to have an
unusually sensitive carbohydrate: fat balance. Since
the term cyclical vomiting obviously cannot be applied
to these attacks it is suggested that the term cyclical ketosis
should be used. It is admitted that the ketosis in such
cases, though a striking symptom, has probably no direct
etiological significance, any more than the vomiting when
this is present. Certain, e.g., abdominal pain, may,
however, be due to the ketosis, e.g., the diabetic
acute abdomen, or on the other hand, the pain may
simply be the equivalent of nervous dyspepsia in the
adult.

The etiology of the condition is similar to that of
cyclical vomiting. Simple psychological disturbances,
such as jealousy on the part of the elder child when a
further arrival into the family occurs, emotional strain
at school, and the like, are often major factors in creating
the state of psychological ill-health which is the basic
factor at work. Sporadic attacks are often excited by
some simple emotional disturbance such as a birthday
party, a first visit to the theatre, the shock of some trivial
accident or some slight infection, such as a cold, which
in another child (or the same child at another period)
may cause practically no upset at all.

The diagnosis, like all neuroses, must only be made by
a most careful exclusion of an organic cause. It may be
suspected if the attacks occur in a cyclical manner or if
the attack is associated with some emotional upset
immediately before it. Associated psychological symp-
toms, e.g., yawning, are also very suggestive.

The treatment is similar to the treatment of cyclical
vomiting. The importance of psychological treatment is
stressed. This in the large majority of cases is of a very
simple nature and can be carried out by any doctor with-
out special psychiatric experience. Unnecessary opera-
tions should be avoided though they often effect the
psychological symptomatology. The part which a
fat-reduced diet plays is discussed.

7. Dr. CHARLES HARRIS (London): 'Pseudo-Hermaphroditism and Sudden Death.' A report was given of three infants with pseudo-hermaphroditism who were admitted to hospital with symptoms resembling those of
genital hyperpertrophic pyloric stenosis, but without
palpable tumours. Their ages on admission were 28
days, 42 days, and 28 days. In addition, all had attacks
of pallor, sweating and unconsciousness similar to syn-
copal attacks in older patients. The infants survived
for periods varying from twelve days to two and a half
months in hospital. They did not thrive. The attacks
continued and proved fatal in every case.

At autopsy the internal genitalia proved to be female.
Suprarenals in all were enlarged, sometimes more on
one side than another, the total weight in each case being
approximately three times that of normal. In one case
the thymus was observed to be unusually small—3-9
grammes. On section, the suprarenals showed a normal
medulla. The cortex was hyperplastic and thrown into
nodules, like the surface of the cerebrum, to acco-
modate the extra material. To ordinary staining
methods, the cortex showed nothing, but with special
staining by Vines' carbolfuchsian method the cells of the
cortex were found to be loaded with fuchsinophil
granaules. Compared with a normal suprarenal from a patient
of the same age this staining reaction was striking.

8. Mr. DENIS BROWN (London): 'The Ectopic Anus.' The subject of this paper is the congenital deformation usually described as recto-vaginal or recto-
urethral fistula. It is suggested that this name is a bad
one, being not only inaccurate but leading to bad treat-
ment regarding the use of false analogies with true fistulae
between the rectum and other organs.
Pathology: A. In the Female. First-degree deformity
consists in the moving forward of the anus so that its
orifice is right against the opening of the vagina, without
the interposition of the usual strip of skin. It might be
called the 'shot-gun perineum' from its resemblance to
the muzzle of a double-barrelled gun.
Second-degree deformity is the low vaginal anus.
In this the opening is forwards, just inside the vaginal
cavity, and in consequence there is a sharp bend at
the lower end of the rectum. This, together with the narrow-
ing which is invariably present, causes constipation, often
very severe.

Third-degree deformity is the high vaginal anus.
In this the constipation is usually less severe, owing to
the absence of the angulation of the bowel.
B. In the Male. First-degree deformity is the bulbar
anus. In this the opening lies over the bulb of the
urethra, and is usually minute.
Second-degree deformity is the urethral anus, in
which the opening is into the urethral tube, not on to the
surface. It may be accompanied by hypospadias of
varying degrees.

TREATMENT: This consists in recognizing that the
abnormal opening, however small and displaced, carries
with it its normal sphincter mechanism.
This avoids the common mistake of trying to
make an opening in the correct position, and to close
or ignore the displaced one.
The second consideration in treatment is the grave
risk of irreparable disaster if an attempt to transplant
the abnormal opening is made. Fixation of a flimsy
structure in a septic area is extremely dangerous, and if it
fails the opening retracts into a mass of scar tissue.
The correct principle is suggested to be to make the opening
work where it is found, by dilatation preceded if necessary
by incision backwards.

9. Prof. N. B. CAPON (Liverpool): 'Anaemia in Renal
Insufficiency.' Three cases were described in which gross
congenital abnormality of the kidneys and ureters,
accompanied by infection, gave rise to uraemia with anaemia as the chief clinical sign. The difficulties of diagnosis were commented upon and reference was made to types of bone-marrow reaction in disturbances of the kidneys. An autopsy was performed on each case.

10. Dr. P. MacArthur (Glasgow) (introduced by Prof. G. B. Fleming): 'The Plasma Volume in Nephritis.' It was shown that in acute haemorrhagic nephritis there is a temporary rise in the red cell count during diuresis and diminishing oedema, while during this stage in patients with nephrotic nephritis the red cell count falls markedly.

Forty-two plasma volume estimations were done by the dye method at various stages in the two diseases, and these revealed that during the stage of diuresis and diminishing oedema in acute haemorrhagic nephritis the plasma volume is considerably reduced, but returns to its previous level when oedema and diuresis have passed off.

The findings in nephrotic nephritis were quite different. During the stage of diuresis the plasma volume was greatly increased and later, when water balance was re-established, it returned to a normal volume. The correlation shown between the red cell counts and the plasma volumes was consistent with the view that the changes in the cell count were due to both diseases to variations in plasma volume. The contrasting effects of these changes in plasma volume in the two diseases were explained and the necessity for taking them into account in assessing the presence of anaemia was emphasized. It was suggested that in acute nephritis the kidneys are the primary agents in producing the changes in plasma volume, while in the nephrotic disease they play a purely secondary rôle in this respect.

11. Dr. D. Gairdner (Newcastle-on-Tyne) (introduced by Prof. J. C. Spence): 'Some Observations on Anaphylactoid Purpura.' It is suggested that the Henoch-Schönlein syndrome should be grouped with acute nephritis, rheumatic fever, and polyarthritis nodosa, and that all four diseases form a single family unit by (a) the frequent coexistence of one member of the group with another, (b) the similar pattern of relationship which each of these conditions has to the haemolytic streptococcus (bacterial allergy).

This hypothesis is supported by the results of the study of ten cases of the Henoch-Schönlein syndrome in children. Upper respiratory tract streptococcal infections were common in the series and often appeared to initiate the first attack or to provoke a relapse. Biopsy of the skin lesion in five cases showed that this consisted of a non-inflammatory reaction, compatible with an allergic process.

The incidence of nephritis was high and this nephritis did not usually clear up completely. In one fatal case autopsy showed a subacute nephritis and necrotizing arteritis in the brain.

The common factor in the four conditions which seem to be closely related is, it is suggested, an antigen-antibody reaction which takes place in the Henoch-Schönlein syndrome around the capillaries of the skin and gut and in acute nephritis around the capillaries of the glomeruli, and in rheumatic fever in connective tissue.

12. Dr. A. Barlow (London) (introduced by Dr. D. Paterson): 'Oedema of the Neonatal Period.' Infection was found to be the commonest cause of oedema in a series of 22 infants under six weeks of age admitted to the Hospital for Sick Children, Great Ormond Street, with oedema as one of the major symptoms. Their final diagnoses were:

**Infection:**
- Septicaemia .... 4
- Pneumonia .... 2
- Mastoiditis with Sclerema Neonatorum .... 3
- Congenital Syphilis .... 3
- Icterus Gravis .... 3

**Congenital heart** .... 2
**Hyproproteinaemia in a premature infant** .... 1
**unexplained** .... 1
**No cause found for oedema** .... 2
**Polycystic kidneys** .... 1

The oedema can be explained in some of these cases by one or more of the factors: plasma osmotic pressure, corrected blood pressure, capillary permeability; in others the rôle of the infant's kidney with its decreased electrolyte clearance must be considered important.

In the cases of infection, increased capillary permeability and low plasma protein levels were thought to be the most important factors.

13. Dr. R. R. Gordon (Glasgow) (introduced by Dr. S. Graham): 'Haemolytic Disease of the Newborn.' (To be published subsequently.)

14. Dr. M. Bodian (London) (introduced by Dr. D. Paterson): 'Fibrotic Disease of the Pancreas.' This condition was diagnosed at the Hospital for Sick Children, Great Ormond Street, in 30 cases during three years, 1943 to 46. The diagnosis was made clinically in all but 7 instances. The incidence was 3.4 per cent. in a survey of 500 autopsies.

 Usually histological evidence was obtained of a puri-glandular disease affecting pancreas, salivary glands, anterior mesenteric glands lining the upper respiratory tract, intestinal tract, uterus, and vaginal mucosa. Secretion inspissates in pancreatic acini and ducts followed by atrophy and fibrosis of secretory tissue. Bronchi and bronchioles are blocked with abnormal secretion. Subsequent infection leads to bronchiolitis and bronchial abscesses with bronchopneumonia.

Mechanical blockage and infection account for bronchiolitis, emphysema and collapse.

Of all investigations, estimation of trypsin in duodenal content was most reliable in differentiating this condition from other nutritional disturbances.

The 30 cases under review fell clinically into three groups: neonatal intestinal obstruction, pneumonia in infancy, and coeliac syndrome.

First group: 3 cases, 1 atresia of small intestine, 2 meconium ileus.

Second group: 13 infants under 1 year; large frequent stools from birth, chest infections from less than three months, leading to death in all but 2 cases. Diagnosed during life in 8 instances.

Third group: 14 cases from 1 to 8½ years. Two cases of chronic bronchiectasis, the other coeliac syndrome. Later chest complications, in 50 per cent. after the first year accounting for longer survival. All but 1 diagnosed during life; 8 still alive.

Ten cases are under dietetic and substitution treatment, with encouraging results. Principles: high protein, casein hydrolysate, moderate fat, low starch, high glucose diet. Pancreatin 60 to 90 grains daily. Large doses vitamin A.

### Report of Child Psychology Sub-Committee

In commenting on the above report (which was published in *Arch. Dis. Childh.*, 21, 57), the Secretary of the Provisional National Council for Mental Health draws attention to a change which has been effected in the scheme of training outlined in *Arch. Dis. Childh.* 59. The present arrangements are summarized as follows:

The usual course of training covers one year and is half-time. In certain circumstances a two years' training, half-time, may be considered necessary. A special six months' full-time course for ex-service men and women only can be arranged as an emergency measure. A fee of £60 is charged. Lots up to £100 can be made to assist fellows during training. In exceptional circumstances grants up to £150 may be given to suitable candidates requiring financial assistance, plus a fee of £60, but funds for this purpose are limited.