BRITISH PÆDIATRIC ASSOCIATION.

PROCEEDINGS OF THE SECOND
ANNUAL GENERAL MEETING.

The Second Annual General Meeting was held at The Palace Hotel, Buxton, on Friday and Saturday, April 26th and 27th, 1929.

FIRST SESSION (APRIL 26TH, 10 A.M.).

Business Proceedings: The President, Dr. Edmund Cautley, was in the Chair, and there were present 43 members and 7 guests.

President: Dr. H. Morley Fletcher was elected President for 1929-30, and the election of Officers, Honorary and Ordinary Members followed, as recommended by the Executive Committee.

Secretary: Dr. Donald Paterson (re-elected).
Treasurer: Dr. H. Morley Fletcher (re-elected).
Representative for London: Dr. Robert Hutchison.
Representative for Scotland: Dr. Charles McNeil.
Honorary Members: Dr. A. Blackader of Montreal and Dr. George Sutherland of London.
Ordinary Members: Drs. J. Murray Bligh (Liverpool), R. D. Clarkson (Larbert), C. F. Harris (London), W. P. H. Sheldon (London) and Kenneth Tallerman (London).

Next Meeting: The place of next year’s meeting was discussed and it was decided that it should be held at Harrogate, Blackpool or Scarborough.

Treasurer’s Report: Dr. Morley Fletcher presented the Treasurer’s Annual Report, which was adopted. This showed a balance of £13 14s. 3d.

Scientific Business.

1. Dr. Lewis H. F. Thatcher (Edinburgh): "Acid Milk Feeding." He discussed the use of acidified skimmed milk in the treatment of feeble infants, and in conditions of dyspepsia where the tolerance for food was low. He had found that whole acidified milk, as originally advocated by Marriott, was very often not tolerated where failure had followed the feeding of ordinary milk mixtures, and he preferred to begin with diluted acidified skimmed milk, working up to undiluted, before adding any extra carbohydrate, usually in the form of dextrimaltose. The milk is allowed to stand for six hours before being skimmed, and is then acidified with B.P. lactic acid, in the proportion of sixty drops to the pint, without being boiled; fat content was found to be round about 1.5%. In this way a fresh food was given with a full protein and a low fat content; moreover, the casein was altered to a fine precipitate of casein lactate, and the food was of a reasonable buffer value, both conditions that ought to render peptic digestion of the essential protein easier.

2. Dr. C. Paget Lapage (Manchester): "Recurrent attacks of butyric acidity (sour-sickness in babies) in pyloric spasm and pyloric stenosis." He drew attention to the periodic occurrence of spells of sour-sickness in babies with pyloric delay, either from pyloric spasm or pyloric stenosis. X-ray findings had confirmed this delay. In a spell of sour-sickness the baby was not necessarily very ill, but became languid and tired, lost appetite, and either posseted or vomited very sour smelling fluid. The smell was due to butyric acid. Overfeeding, especially on fats, might predispose, but the attacks might occur on any food. He said that precautions should be taken to guard against these attacks by giving grey powder or rhubarb and soda, and by limiting the fats.

3. Dr. H. T. Ashby (Manchester): "Acute anaphylaxis to cow’s milk protein in the infant and its treatment." He described a breast-fed infant, who, when given a feed of cow’s milk for the first time, had an acute anaphylactic shock. There was swelling of the face, lips and mouth. The infant was much distressed and nearly died. Various skin tests proved that the infant was extremely sensitive to milk of all kinds, egg albumen, soups made from meat, malt, etc. The infant was very gradually desensitized by giving at first minute doses of cow’s milk each day and then slowly increasing the amount of milk.
4. Dr. Eric Pritchard (London): "The treatment of pyloric stenosis." He gave a short account of a clinical method for estimating the degree of alkalosis in infants from whom only a small amount of blood could be obtained. The method employed was Payne's modification of Van Slyke, Stillman and Cullen's, requiring only 0.05 c. cm. of blood plasma. No other reliable method was at present available. He said it was thought that the sudden collapses which occurred in pyloric cases might in some way be dependent on high degrees of alkalosis. The investigation showed that varying degrees of alkalosis always existed in cases of pyloric obstruction, and that the indication for treatment was the administration of sodium, ammonium, or calcium chloride, and that there was danger in increasing the alkalosis by giving bicarbonate of soda.

5. Dr. Thursfield (London): "Chronic haematuria ending in uraemia." He related the case of a boy who suffered from intermittent painless haematuria from the age of 3½ years. For several years there were no other symptoms, and at an operation done for suspected stone in the right kidney in 1922 the kidney was reported normal. From 1925 onwards his blood pressure was above the normal, but he enjoyed good health and was fully up to the average in weight and development, playing all school games up to within a week of his death from uraemia. The kidneys were finely granular, and showed microscopically diffuse interstitial and glomerular changes.

6. Dr. Robert Hutchison (London): "Paroxysmal sneezing in whooping cough." He described a case in which the patient, a girl of 4, was admitted for extensive broncho-pneumonia. Five weeks previously she had begun to whoop, but after three weeks the paroxysms of cough had given place to paroxysmal sneezing. The attacks were very striking and recurred from 8 to 10 times in the 24 hours. They consisted in a succession of violent sneezes—perhaps 6 or 7—during which the child became black in the face and after which she was rather collapsed for a time. During the sneezing a very large quantity of thick muco-purulent material was discharged from the nose and this was found to contain Bordet's bacillus. After the child had been a fortnight in hospital the sneezing became less frequent and was partly replaced by the usual paroxysms of cough.

7. Dr. D. N. Nabarro (London): "The present incidence of dysentery in this country." He said that at Great Ormond Street, in the year 1928, there were 13 cases of bacteriological dysentery (that is, cases in which one or other of the typical dysentery bacilli was isolated); 13 of these were due to the Sonne bacillus and 2 to the Flexner. There were two deaths, one with each bacillus. During the first four months of 1929 there had been in all 13 cases, with 5 deaths; of these 9 were due to the Sonne bacillus, with 4 deaths, and 4 to the Flexner bacillus with one death. Several points of interest were brought out by recent small outbreaks: (1) that the Sonne bacillus might be the cause of a fatal dysentery (this was not a new observation, but was often not realised); (2) that some of the very young children died very quickly, within 24 hours of being affected; and (3) post mortem the lesions found in the intestine might be either very slight ulceration or sometimes even only a general reddening of the bowel wall.

8. Dr. E. Bellingham Smith (London): "An attack of dysentery of unusual type." He commented on a recent epidemic of dysentery at the Queen's Hospital for Children, various names having been given to the organism. He thought ulcerative colitis in older people was probably chronic dysentery.

9. Dr. Robert Marshall (Belfast): "Brachydactyly in a child, its mother and aunt." He described a child aged one year, whose mother, aunt, uncle, and, it was said, maternal grandmother and great-grandmother were similarly affected. The condition was interesting in view of Bateson's statement that it was the first condition in man found to obey Mendelian laws of heredity. The brachydactyly was of the type in which there is apparent absence of the middle phalaxis in both fingers and toes. Photographs and radiograms were shown.

SECOND SESSION (April 26th, 8.30 p.m.).

10. Dr. Bernard Schlesinger (London): "The treatment of chorea by nirvanol." He stated that this drug, phenylethylhydantoin, had received an extensive trial in Germany, but had not as yet been used in this country. He had treated four cases of chorea by this method with such favourable results that he proposed to extend the use of the drug to other types of
He gave clinical notes in four cases of that had occasionally charts illustrating was prevalent. and cylindrical photographs. In all there was a fairly good state of general health, associated with typical clinical features. Two showed a limited bilateral bronchiectasis, of saccular type in one instance, and cylindrical in the other. The remaining two were examples of extensive unilateral bronchiectasis combined with fibroid contraction of the lung.

11. Dr. Charles McNeil (Edinburgh): “Different types of bronchiectasis in children.” He gave clinical notes in four cases of bronchiectasis in children, illustrated by lipiodol X-ray photographs. In all there was a fairly good state of general health, associated with typical clinical features. Two showed a limited bilateral bronchiectasis, of saccular type in one instance, and cylindrical in the other. The remaining two were examples of extensive unilateral bronchiectasis combined with fibroid contraction of the lung.

12. Dr. C. Wilfred Vinzing (Leeds): “Some remarks concerning pneumonia of infancy, with special reference to the subcutaneous administration of oxygen.” He referred to a series of 147 cases with a mortality of 47%. 48 of the cases were admitted from households where influenza was prevalent. Oxygen had been given subcutaneously in all the cases, approximately 60 c.c.m. being administered into the soft tissues of the thigh twice daily. While in no case in his experience had it done harm locally or generally, yet he had seen nothing in the results to justify him in believing that anything was gained by giving oxygen in this way. He recorded his opinion that the alkaloids of belladonna were definitely useful, especially in the generalized type of case with cyanosis, but no massive consolidation. He also expressed the opinion that lobar pneumonia did occur during the first three years of life, although he agreed that its differentiation from broncho-pneumonia was not always possible by the physical signs alone.

13. Dr. W. A. Alexander (Edinburgh): “Remarks on slowly-resolving pneumonia in children.” He referred to a group of 45 cases (under the charge of Dr. McNeil) in which a localized pneumonia, after persisting for weeks or months, had eventually cleared up with little or no evidence of permanent damage to lung structure. The incidence in a large pneumonia series was 7%, and the age in more than half was 3 years or over. No case in which pus had been detected had been included, but it was the opinion of many that delayed resolution simply meant an undiscovered empyema. None of the cases seemed to fit in with the conception of epituberculosis. In a few hypothyroidism was evident. The initial pneumonia seemed usually to be of lobar type, but it was likely that the inflammatory process had affected the pulmonary stroma to a degree unusual in lobar pneumonia, and that recovery was seldom so complete as it seemed.


15. Dr. H. Morley Fletcher (London): “Subcutaneous emphysema in children.” He related a case of subcutaneous emphysema in a healthy boy of three. On January 11th, he had a slight cough. At 3 p.m. he vomited, his temperature was 100°, he had a short dry cough and his lungs were natural. At 7 p.m. his neck was swollen and he had subcutaneous emphysema. On January 12th, the temperature was 101°, and the emphysema had extended over the face and the whole of the trunk and upper arms. The child presented an extraordinary blow-out appearance, the eyes being completely closed. The breath sounds were inaudible owing to the subcutaneous emphysema. The temperature fell in a few days and the emphysema gradually subsided, the child making a complete recovery. The chief feature of the case was the rapid onset without dyspnea or definite signs of broncho-pneumonia. This suggested rupture of a tuberculous gland in the bronchus, but the favourable termination negatived this diagnosis.

16. Dr. Hector Cameron (London): “Trismus neonatorum.” He said that the so-called tetanus neonatorum was not due to the specific tetanus bacillus, but was a manifestation of a generalized sepsis. Formerly the disease had been extremely common in the country under the name of “eight-day fits” or trismus or tetanus neonatorum. Up to 1780 17% of the infants born in the Rotunda succumbed. With improved hygiene the death rate rapidly declined, persisting only in the most primitive parts of the country, as in St. Kilda. To-day it was still rife in India and in the West Indies. In 1884 a few months before the discovery of the tetanus bacillus, Hartigan published a careful post-mortem study of 23 cases, in most of which there was evidence of the extravasation of lymph or serum around the spinal cord. With the discovery of the tetanus bacillus it was assumed that trismus was due to tetanus. Photographs of cases of trismus were shown, in which search for the tetanus bacillus had proved negative, but from
which cerebro-spinal fluid had been removed, showing a high protein content and a great increase of cells. The spasm of the jaw in trismus was generally less persistent than the spasm of hands and feet. In one case after death infective endocarditis was found.

17. DR. J. S. Y. ROEGIS (Dundee): "A case of diaphragmatic hernia." He described a child aged 7 months, suffering from broncho-pneumonia. The bulk of the liver seemed in the left side, the heart was in a normal position, the spleen on the left side, low down in the pelvis. It was diagnosed as congenital diaphragmatic hernia. The X-ray was difficult to read but an abnormal shadow in left chest was suggestive of diaphragmatic hernia of the liver. No barium was seen in the chest after a barium meal. Post mortem a hernia of the liver through the left sterno-costal hiatus, where the superior epigastric vessels perforate the diaphragm, was seen. The sac had a peritoneal covering and was therefore a true hernia. The liver was altered in shape and was embryonic in type in that both halves were equal and were lobulated. There was also a groove where the liver was constricted by the neck of the sac. The hernia was at an uncommon site and contained the liver only, the liver alone being a rare hernial content. Of other abnormalities present, the left kidney was congenitally absent, the left suprarenal was present with a vein running direct into the inferior vena cava, the ductus venous was patent and opened into the right auricle and the spleen was displaced into the pelvis.

THIRD SESSION (APRIL 27TH, 10 A.M.).

18. DR. C. W. VINING, with DR. H. H. MOLL (Leeds): "The Pink Disease with special reference to the neurological findings in a series of fatal cases." These findings are to be published in full at an early date.

19. DR. NORMAN CAPON (Liverpool): "Idiopathic hypertrophy of the heart." He described an example of cardiac hypertrophy and dilatation in a male child four months old. The infant was extremely ill when first seen and the clinical findings were suggestive of left-sided pericarditis, with pericardial effusion. Autopsy showed a heart more than three times the normal size; the left coronary artery was found to arise from the pulmonary artery and there was possibly a slight grade of infantile coarctation. The blood supply of the myocardium under these abnormal conditions was discussed, and references were made to somewhat similar cases reported in the literature.

20. DR. E. W. NEILL HOBHOUSE (London): "A case of spinal birth injury." He described the case of a child 4 months old when first seen, who was said to be unable to use the right arm. The confinement was difficult and prolonged, breech presentation. During the first weeks neither arm was moved, but during the second and third months the left arm developed movements and then the right hand. When first seen there were movements in the right hand and forearm, but flaccid paralysis of the deltoid, shoulder girdle and triceps. There was slight rigidity in the legs, and sensation was somewhat diminished. The arm was splinted in abduction; active movement developed first in the triceps and then in all the other muscles. The case was in all probability one of haematomyelia occasioned by traction on the breacl, similar to the cases described by Crothers and Putnam in their monograph on spinal birth injuries.

21. DR. E. BELLINGHAM SMITH (London): "Three cases of thallium acetate poisoning." He described a boy aged 9, a girl aged 7 and a boy aged 4, who had been given thallium acetate for ringworm. By some mistake they were given three doses instead of the usual one. The elder boy, who had had two doses, got severe pains in his legs, but after showing great weakness, recovered in one week. The younger boy, who had had three doses, but had vomited the last, was weaker and could not stand. He recovered in six weeks. The girl, who retained all her three doses, was unconscious and had flaccid paralysis remaining so for 3 days, then became conscious and developed movement, with groaning, mental irritation, screaming and blindness. About a month after the reflexes appeared, but she was still blind and incontinent. A fortnight later she had tremors of the face and jaw and hands with hyperaesthesia. She was given nasal feeds and subcutaneous salines. She had insomnia and a rapid pulse. This continued for a further three months, then she began to improve, to speak and to hear and see. Five months later she could just stand alone, and after another two months walked and talked intelligently. She was at present intelligent, but could not see well. She could read but still had a very ataxic gait. The speaker suggested that the children had an acute encephalitis, like lead poisoning.
ARCHIVES OF DISEASE IN CHILDHOOD

22. DR. L. G. PARSONS with DR. K. D. WILKINSON (Birmingham): "Osteosclerosis Fragilis (Albers-Schomberg disease)."

23. DR. L. G. PARSONS (Birmingham): "Three cases of pellagra in one family." He described a family of four daughters, of respectable parents, living 12 miles from Birmingham 300 feet above a river. The eldest girl of 12 was quite well. All the children were breastfed until nine months old. The second child had a rash on her legs at 16 months and died. The third child became ill at 10 months old, had diarrhoea and vomiting, spasmodic movements and spastic legs. At 2 years and 5 months she was admitted to Hospital, but died 24 hours after. The face was expressionless, there was no rash, but there were fine tremors of the hands. The lumbar puncture was normal, and nothing was found post mortem. The fourth child came under observation at 2 years with a rash. Six months later she came into hospital with a rash, desquamation and incipient convulsions and spasticity. Vitamin B was given, and she improved greatly and at present seemed a normal child.

24. DR. F. J. POYNTON (London): "A case of (?) Renal Teratoma." This case was described by Dr. Moncrieff in the absence of Dr. Poynton. A girl aged one year and six months was noticed to have a swelling in the left side of her abdomen since the age of six months, with no urinary or other symptoms except some abdominal tenderness of a week's duration. On examination there was a cystic swelling in the position of the left kidney and a ureteric catheter would not pass up the left ureter. Operations showed a large mass attached to the left kidney which was completely removed. The mass proved to be a cyst containing warty growths. Microscopic examination showed that this was an adeno-sarcoma of the kidney. The child made a good recovery after operation.


26. DR. WILKIE SCOTT (Nottingham): "Cases of pneumococcal peritonitis." He described some cases recently under his care. One was an infant of 21 days with purulent peritonitis, in whom there was also pneumonic consolidation of the lungs. He suggested that some cases of so-called primary peritonitis were really cases of pneumococcal septicaemia with concurrent infection of the lungs and peritoneum. He emphasized the difficulty in diagnosis of those cases of primary peritonitis where the early symptoms were diarrhoea and vomiting without abdominal pain or rigidity and asked for suggestions as to the best course to adopt where, with these symptoms, there might be a suspicion of pneumococcal peritonitis.