showed increased AChE activity. 7 patients ultimately proved to be cases of Hirschsprung's disease; all but one of the rectal biopsies showed an increased AChE activity in the mucosa, and all biopsies showed an increased activity in the submucosa.

From the investigation of resected bowel segments it was shown that the strongest activity occurred in the most distal part of the aganglionic bowel and that the proximal extension of the enhanced activity into the aganglionic segment increased with age. Rectal suction biopsies stained for AChE activity therefore seem to be a valuable diagnostic aid for investigation of constipation. False negative results are possible in young infants, but can be avoided by taking the biopsy immediately proximal to the pectinate line.

Large-scale investigation of 2 phenylketonuria screening methods and factors affecting blood phenylalanine levels in the newborn. J. B. Holton. Department of Pathology, Southmead Hospital, Bristol BS10 5NB.

Bloods taken from 22,365 babies between the 5th and 20th day of life were analysed for phenylalanine by the Guthrie inhibition assay and by an automated fluorimetric method (Hill et al., 1965). 6 phenylketonurics were found and both methods were equally effective in detecting the disease. The fluorimetric method showed a more consistent pattern of rising phenylalanine levels before treatment. Using an acceptable upper limit of mean +2 SDs, the fluorimetric method gave more 'false positive' results. Two-thirds of these high levels were shown by a thin layer chromatogram to be associated with tyrosinaemia. The distribution of blood phenylalanine by both methods was non-Gaussian, and a small shift in the accepted upper limit would eliminate many 'false positives' without significantly altering the detection of phenylketonuria.

An attempt has been made to identify in normal infants some factors which influence blood phenylalanine in the newborn period. The level is raised at day 5 then remains constant up to day 12. After the 6th day of life the phenylalanine level of boys tends to be higher than girls. Babies with a birthweight below 2.5 kg have significantly higher phenylalanine levels than heavier babies, presumably due to immaturity of liver enzymes. However, very low birthweight babies do not show as high levels as those between 2.0 to 2.5 kg, perhaps because of poorer feeding. A big difference was observed between babies born in rural areas and those from urban districts. The reason for the lower phenylalanine level in rural areas is unknown.

REFERENCE

Quantitative study of vesical ganglia in children with neurospinal dysraphism. M. Forbes. The Congenital Anomalies Research Unit, University of Sheffield, Thornbury Annex, Sheffield 10. This project was undertaken to determine if neurogenic dysfunc-

of the bladder in children with spina bifida and meningomyelecele was in any way related to the population of vesical neurones present.

Two quantitative histological studies were performed. In the first, 10 whole bladders (3 normal and 7 spina bifida) were serially sectioned at 10 μ. Every 50th section was counted and the total number of ganglion cells calculated per block of bladder from the fundus to the urethra. The results showed an overall reduction in the number of ganglion cells in the bladders of spina bifida children, but there was a particularly striking depletion in the region of the trigone.

In the second study, a single midtrigone block was taken from 100 bladders (50 normal and 50 spina bifida) and again the total number of ganglion cells estimated per block. The mean values for ganglion cell counts related to age showed a marked reduction in the spina bifida cases as compared with the controls.

The possible pathogenesis of these findings was discussed.

Brain swelling in the newborn: artefact, development, or pathology? J. Fryse-Davies. Bernhard Baron Memorial Research Laboratories, Queen Charlotte's Maternity Hospital, Goldhawk Road, London W.6.

Brain swelling was studied prospectively in 183 perinatal deaths of 20 to 42 weeks' gestation. Cerebral flattening in 67 babies obviously correlated with maturity, a factor difficult to exclude in any other analysis; there was also an apparent association with birth asphyxia and intrauterine growth retardation.

Macroscopically there was a progressive series of findings to suggest genuine brain compression. Cerebellar herniation of varying degree was found in 22 cases and slight herniation of uncal gyri in 30; both features occurred in 16 brains. Such herniation phenomena were only found in association with cerebral flattening, which was not always marked. Reduced cisternal CSF in 46 cases and skull moulding in 21 usually correlated with other features of cerebral compression, but also occurred without brain swelling; 18 swollen brains showed no confirmatory evidence of compression. Prolonged body storage and survival time were probably related to an increased incidence of cerebral flattening but not to herniation phenomena.

Babies showing cerebellar herniation have been described in detail, as this was considered the main indication of pathological brain swelling. This finding was associated with death before (3 cases), during (10), and after labour (9). Apart from gross trauma or a softened macerated skull, moulding alone was thought unlikely to initiate herniation. However, constriction of a swollen brain during intrapartum hypoxia might increase the lethal potential of compression and exaggerate the appearances in the dead fetus. In 9 babies cerebellar coning was probably unrelated to skull pressure and due to hypoxia or intracranial bleeding occurring after delivery.

Histological evidence of nerve cell damage showed no consistent relation to brain swelling. Purkinje cell

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changes were greater in the mature brain but this appeared to be due to difficulties of recognizing degeneration in the immature cerebellum rather than to any correlation with brain swelling. Necropsy delay was also related to an increased incidence of Purkinje cell degeneration.

Brain water content showed an inverse relation to maturity and brain swelling: it was highest in a case of overhydration and possibly in hydropic fetuses, but lowest in cases with herniation phenomena and small-fordates babies. No consistent relation was recognized between high brain water levels and histological evidence of oedema. Gyral flattening was, however, associated with an unexplained vacculated inner cerebral cortical picture, but such changes were related to a wide range of brain water content.

The main histological feature related to maturity and low water levels appeared to be vascular congestion. Dehydration of cord blood specimens showed that fetal blood contained twice the solid content of whole brain. It is suggested that perinatal brain swelling is basically due to increased blood volume. Vascular congestion is a marked feature of an asphyxial fetal death and this may be part of a vicious circle involving hypoxia, acidosis, vascular dilatation, and brain swelling with raised intracranial pressure. This may be lethal or, in survivors, may play a part in the development of the early stages of cerebral birth injury.


Familial lymphohistiocytosis—20 cases in three family groups. A. J. Barson. University Department of Pathology, Williamson Building, Brunswick Street, Manchester 13.


Premature rabbit fetuses (gestational age 28 days) were tracheostomized immediately after delivery, the respiratory movements of the fetuses being prevented by compression of the thorax during operation. Consequently, the fetuses had to take their first breath through a tracheal cannula, which in 20 experimental animals contained 50 μl of a concentrated suspension of pulmonary surfactant, prepared by centrifugation of alveolar wash from adult rabbit for 1 hour at 1000 × g and 4 °C. In 20 control fetuses, the tracheal tubing contained an equal amount of saline, or it was empty. 13 of the surfactant-treated fetuses survived the operation by 3 to 40 hours, whereas all but one of the control fetuses died within 45 minutes after tracheostomy (P < 0.001). The unopened thorax of the fetuses was fixed by immersion in formalin, and the air expansion of the lungs was evaluated histologically. Alveolar air expansion, varying in degree from slight to prominent, was apparent in all surfactant-treated fetuses. Among controls, slight alveolar air expansion was observed in 3 cases, whereas in 17 fetuses the lungs were unexpanded. Our findings thus suggest that tracheal deposition of surfactant increases the survival time of the fetuses by enhancing the air expansion of the lungs. Possibly a modification of this treatment might be adopted as a prophylactic measure against neonatal respiratory distress due to prematurity.

Relation of bronchopulmonary dysplasia to oxygen and ventilator therapy in the newborn. J. S. Wigglesworth. Nuffield Neonatal Research Unit, Institute of Child Health, Hammersmith Hospital, Du Cane Road, London W.12.


The trachea in infants with respiratory distress and stridor, especially during prolonged cannulation, was examined by biplane cineradiography. The examination was performed without any contrast medium in the trachea. In some cases intrapleural and intratracheal pressure was recorded together with respiratory flow and lung volume. When no pressure measurements were made, thoracic impedence was registered so that each single frame could be timed to the respiratory phase.

In cases with increased mobility of the tracheal walls there was a marked increase of inspiratory widening and expiratory narrowing of the intrathoracic trachea or part of it. The tracheal collapse was considerably more marked in the lateral than in the anteroposterior projection, indicating the major role of the membranous part of the trachea. Causes of an increased weakness of the tracheal wall and the significance of the tracheal cross-sectional shape in increased collapsibility were discussed.

Intrathoracic tracheal collapse—a pathophysiological study. O. Hjalmarson. Department of Paediatrics, The Children's Hospital, Barnsjukhuset, Göteborg, Sweden.

It can be shown that pronounced expiratory narrowing or collapse of the intrathoracic trachea can be seen as a normal phenomenon at very high flow rates or in pathological conditions in forced expiration if the static lung pressure or the stability of the tracheal wall is reduced, or if the resistance 'upstream' to the collapsing site is increased.

Eight infants, 2 to 25 months of age, all with a history of tracheal cannulation of long duration, and on clinical grounds believed to have tracheomalacia, were examined with simultaneous cineradiography of the trachea and measurements of tracheal and oesophageal pressures, tidal flows, and volumes. 'Upstream' resistance, lung