BRITISH PÆDIATRIC ASSOCIATION

PROCEEDINGS OF THE SIXTH ANNUAL GENERAL MEETING

The Sixth Annual General Meeting was held at the Old England Lake Hotel, Windermere, on Friday and Saturday, the 5th and 6th May, 1933.

FIRST SESSION (MAY 5TH, 10 A.M.)

Business Proceedings: The President, Dr. Dingwall Fordyce (Liverpool), was in the Chair, and there were present 45 members.

The minutes of the last meeting were read and approved.

The following Officers, Honorary and Ordinary Members were elected.

President: 1933-34, Dr. Eric Pritchard (London).

Secretary: Dr. Donald Paterson (re-elected).

Treasurer: Dr. Morley Fletcher (re-elected).

Representative for Ireland: Dr. F. M. B. Allen in place of Dr. Brian Crichton (resigned).

Representatives for London: Dr. Alan Moncrieff and Dr. A. E. Maitland-Jones.

Honorary Members: Dr. H. Morley Fletcher, Dr. Robert Hutchison and Dr. F. John Poynton (all Past Presidents).

Ordinary Members: Dr. G. W. Bray, of London, Dr. R. W. B. Ellis, of London, Dr. W. F. Gaisford, of Liverpool, Dr. J. V. C. Braithwaite, of Leicester, and Dr. F. J. Ford, of Glasgow.

Next Meeting: The selection of the next place of meeting was left to the Executive Committee.

The Treasurer’s report was received and adopted.

Dr. Morley Fletcher asked for the approval of the meeting to the suggestion by the Executive Committee that a sum not exceeding £50 should be utilized for the purpose of the Third International Pædiatric Congress. The meeting approved this.

Dr. Alan Moncrieff suggested that, in view of the recent persecution of the Jewish pediatricians in Germany that members should, as far as possible, find temporary posts for some of them in this country until things became more settled there.

1. DR. D. NABARRO (London): ‘The incidence of congenital syphilis.’ He said that it was impossible to form an accurate estimate of the incidence of congenital syphilis amongst the general population. There is no doubt that race plays a part. For example, in the United states the disease is more prevalent amongst negroes than amongst whites; and probably the world over, the disease is much more prevalent amongst the hospital class than amongst those of a higher social status. Figures varying between 0.6 and 10 per cent., or more, have been given by different observers, for the incidence of congenital syphilis amongst hospital patients. During
the 17 years 1916-32 the author had studied 737 cases, including 32 parents. The average number of cases seen per year is 48, so that the disease can hardly be regarded as negligible. Undoubtedly more cases would be detected by a wider application of the Wassermann and flocculation tests. He was of opinion that untreated congenital syphilis, more particularly in a woman, may be transmitted to the offspring ("third generation syphilis").

2. DR. A. V. NEALE (Birmingham): 'Some observations on 300 fatal cases of tuberculosis in children.' Observations on the exact necropsy findings in 300 fatal cases of tuberculosis in infants and young children were reported. Practically all had died of miliary tuberculosis and tuberculous meningitis. Detection of the primary route of infection was determined by careful search for the primary focus—intrathoracic (Ghon tubercles and hilar glands) or abdominal (alimentary). The results were:—(a) primary thoracic (aerogenous infection) 215 or 71.6 per cent., (b) primary abdominal (ingestion infection) 46 or 15.3 per cent.; and (c) no primary focus detectable 39 or 13.0 per cent. In the last group, although no primary focus could be detected, it was almost certain that there had been a rapid generalization after aerogenous infection. In cases under 3 years of age, the numbers in the three groups were 141, 30 and 33 respectively.

66 fatal cases in breast-fed babies under nine months of age, showed that 64 had been initially infected by inhalation on contact with open tuberculosis in an adult—usually parental or in the family circle. Contacts had been traced in many of these cases and a predominance of tuberculous fathers was found. The extreme danger to a baby of exposure to tuberculous adults was emphasized.

3. DR. C. MCNEIL (Edinburgh): 'Pyo-pneumothorax.' He said that pyo-pneumothorax, although rarely mentioned in text-books and periodical literature, was not a rare condition. It was nearly always the result of perforation of the pleure with the formation of a broncho-pleural fistula. It occurred under various pathological conditions:—in multiple sub-pleural abscesses; in bronchiectasis; in encysted or interlobar empyema, and after surgical operations for empyema; as a result of chronic sub-pleural focal lesions of the lung; and in pulmonary tuberculosis. Where there was a large amount of air in the pleura its clinical recognition was easy, but in the majority of cases the amount of air was small and in those cases it easily escaped recognition. It was frequently associated with staphylococcal or mixed infections of the pleura. Where the lesion in the lung was not serious or extensive prognosis in pyo-pneumothorax was at least no worse than in simple empyema, and in many cases was better.

4. DR. L. THATCHER (Edinburgh): 'Intra-peritoneal therapy.' He regarded the following as the essential points to be observed for the safe administration of fluids into the peritoneal sac—(1) The nature of the fluid used; 6 per cent. solution of glucose in normal saline is the most satisfactory. (2) This fluid must be injected slowly, at least 45 minutes for the volume used; this being 6-7 ounces as a general rule. (3) The fluid must be kept at or about body temperature all the time; a simple apparatus for maintaining it during the process of administration was described. Charts were shown to demonstrate the value of this therapy in the starvation of acute congenital hypertrophy of the pylorus; in acute infections of the alimentary tract; and in severe dyspepsia, especially that associated with intolerance for carbohydrates.

5. DR. J. C. SPENCE (Newcastle): 'Familial periodic paralysis.' Dr. Spence described cases of familial periodic paralysis in a family of which four successive generations had been affected. At the ages of 3 or 4 the affected members of the family began first to be liable to the attacks, which diminished in intensity and frequency after adolescence. Investigation showed that abstinence from food played no part in precipitating the attacks. In many of the cases there was a tendency for the paralysis to appear on a Sunday morning, or on other days when they lay in bed to an unusually late hour. Recognizing this they combated the attacks by
BRITISH PÆDIATRIC ASSOCIATION

rising immediately on feeling the first sensations of muscular weakness, and by exercising freely. This often resulted in aborting the attack. In its severest form the period of paralysis might be 6 or 8 days, during which time the patients were too weak to sit or turn in bed, and had to be fed.

6. DR. ERIC PRITCHARD (London): ‘The medical treatment of obstetric fractures in the new-born.’ Dr. Pritchard exhibited a number of X-ray photographs illustrating the possibility of treating obstetric and other fractures in the new-born without splints, bandages, extension apparatus, or other appliances commonly used by surgeons. Some of the films demonstrated the failure of surgical means to improve the position of the fractured bones. Others showed the astonishing reparative power of unaided nature to reduce deformities and restore the axis and alignment of the bones by throwing out an enormous quantity of provisional callus, and subsequently so moulding it and shaping it that the original form and shape of the bone is ultimately attained. In most unpromising cases, with extensive overlapping and deformity, the bones are restored to their original shape within a few months with no shortening or other evidence of the original fracture.

7. DR. J. H. THURSFIELD (London): ‘Remarks on splenomegaly.’ Dr. Thursfield gave a short communication pleading for the reconsideration of the pathology of splenomegaly, and of the rationale of splenectomy. He pointed out that the original ideas which had prompted the advocacy of splenectomy in such diseases as acholuric jaundice and haemorrhagic purpura had with fuller experience proved to be based on a false pathology, and that especially in the latter disease the doctrine that the removal of the spleen cured the condition by causing a flooding of the circulation with platelets was not wholly in accordance with the facts. All that we were entitled to infer from our experience of splenectomy in a variety of conditions was that the spleen played an important part in the evolution and the well-being of the constituents of the blood, and that in diseased conditions of haemopoiesis the removal of the organ in diverse circumstances appeared to break a vicious circle. If this view were correct it would be proper to extend the operation of splenectomy to the treatment of other anemias, and especially to the severer cases of purpura associated with high platelet counts.

8. A. HAYES SMITH (Bradford): ‘Case of staphylococcal septicaemia in a girl of 10 years with orbital metastasis.’ He related an example of this condition due to staphylococcus aureus, secondary to a furuncle on the forearm. Recovery ensued. The treatment comprised concentrated antitoxic antistaphylococcal serum, intramuscular liver liquid, and drainage of the orbit. He considered the absence of eosinophils from the blood picture a valuable sign of septicaemia, their reappearance an indication of improvement. The practical uselessness of blood culture was stressed; and attention was drawn to the early evidence of toxic collapse afforded by the difference between the rectal temperature and that of the dried axilla, a difference of 8° suggesting a guarded prognosis and 5° a very grave one.

At 7 p.m. the Association Dinner took place.

SECOND SESSION (MAY 5TH, 8.30 P.M.)

9. DR. J. C. SPENCE opened a discussion on ‘The prevention of ward infections’ and this was followed by some remarks by Doctors Pritchard, Parsons, and Lapage.

10. DR. K. D. WILKINSON (Birmingham) showed cinematograph pictures of interesting medical cases.

THIRD SESSION (MAY 6TH, 10 A.M.)

11. DOCTORS S. G. GRAHAM AND N. MORRIS (Glasgow): ‘The effect of sterilization of milk on the retention of minerals, nitrogen and fat.’ Comparisons were made of
ARCHIVES OF DISEASE IN CHILDHOOD

the retentions of calcium, phosphorus, fat and nitrogen in each of two healthy infants. The periods were of seven days' duration and the milk throughout came from the same source: prior to and during one period the milk was given raw while before and during the other it was boiled. The retentions of calcium, phosphorus and nitrogen were greater during the boiled milk periods while the retention of fat showed no significant difference on the two types of feeding. It is concluded that during short-term experiments the utilization of minerals, protein and fat is not decreased by sterilization of milk.

12. DR. A. G. OGILVIE (Newcastle): 'Hereditary hæmorrhagic disease.' The careful and accurate work of Bulloch and Fildes cannot be criticized, but the occurrence of female bleeders and transmission by males deserves further consideration than they gave it. Accumulating reports of inherited purpura with very definite hæmophilic characteristics, together with the occurrence of hæmophilia and bleeding purpura in one and the same family, gives added weight to this view. It is time to extend the restricted view of Bulloch and Fildes, and to take a broader view of the inherited tendency to bleed. Pedigrees illustrating this point abound in the literature, and especially in the monograph of Bulloch and Fildes. Examples of such pedigrees were shown and described.

13. DOCTORS R. LIGHTWOOD AND J. C. HAWKESLEY (London): 'Icterus gravis neonatorum.' This condition is coming to be regarded as a clinical sub-variety of erythroblastosis foetalis, and the group of clinical states with a foetal erythroblastic background may be classified as follows:—1. Intra-uterine: (a) with universal oedema (=hydrops foetalis), (b) without oedema; and 2. Neonatal: (c) with severe jaundice and anaemia (=icterus gravis neonatorum), (d) with severe anaemia and little or no jaundice (=anæmia hæmolytica neonatorum).

The grave familial jaundice of the new-born is the most widely recognized of this group of diseases, but icterus gravis is not always familial, isolated cases occurring not infrequently. The main clinical and pathological features of foetal erythroblastosis are: anæmia, icterus, enlargement of liver and spleen, a large excess of nucleated erythrocytes in the blood, and extensive extra medullary hæmatopoiésis.

An histological study of 12 fatal cases of icterus gravis neonatorum showed important pathological changes in the liver, spleen, kidney, suprarenals, deeper layers of the skin, bone-marrow and brain. In the main the findings confirmed those reported by Clifford and Hertig, and by Blackfan and Diamond, with some additional observations: a sequence of pathological changes was traced in the livers of subjects dying at varying periods after birth. The importance of destructive hepatic changes and the origin of hepatic fibrosis was demonstrated. Icterus gravis neonatorum, by virtue of the selective staining of the basal nuclei, occurring in a small proportion of cases (kernicterus), and by virtue of the hepatic changes now demonstrated may prove to be the common aetiological basis for the hepato-ileutaric degeneration of Wilson and the pseudo-sclerosis of Westphal. The possible causal relation of foetal erythroblastosis with some cases of idiopathic juvenile cirrhosis, splenic anæmia, and anæmias of the von Jaksch's type require investigation.

The following changes in the blood were noted in cases under personal observation:—1. Severe hæmolysis, with marked regenerative activity of erythron. 2. All types of immature erythrocyte occur, with high reticulocytesis. 3. If hæmolysis stops recovery from anæmia ensues; the colour index remains high. 4. Subsidiary changes occur in the white cells and thrombocytes. 5. The mean diameter of the erythrocytes, at first increased, diminishes more rapidly than in normal or premature infants.
BRITISH PÆDIATRIC ASSOCIATION

Icterus gravis neonatorum has a high mortality rate and a high incidence of sequelæ, particularly from damage to the brain. Repeated transfusions of whole-blood (50 to 70 c.c.) has been the most effective treatment. The transfusions do not appear to arrest haemolysis but rather to tide the infant over a period of severe anaemia until the haemolytic process ceases spontaneously.

14. DR. F. M. B. ALLEN (Belfast): 'Toxic polyneuritis in two brothers.' He said that the ages of the two brothers were 10 and 12 years, and the children were noticed to be drowsy and heavy six weeks before admission to hospital and four weeks later were staggering. There was gradual loss of power of the limbs, and one complained of sensation of pins and needles. Temperature was normal, the deep reflexes absent, superficial present. Cranial nerves normal, no other ocular changes. Wassermann and Mantoux negative. C.S.F. normal. No evidence of post-diphtheritic infection or poisoning by chemicals. Complete recovery ensued in both cases.

15. DR. GEORGE BRAY (London): 'The symptomatology of migraine in childhood.' In studying 100 cases (males 56, females 44) he had found that the first symptom noticed was—vomiting attacks in 38, fits in 2, feverish attacks in 10, abdominal pain in 7, headaches in 59, fainting turns in 5, and eye trouble in 4. In 12 of the cases the first symptom had appeared during the third year, in 2 during the fourth, in 19 during the fifth, and in 16 during the sixth. 76 cases complained of headache (bilateral 58 per cent., unilateral 42 per cent.), 62 of nausea or vomiting, 60 of constipation, 44 of fever, 18 of abdominal pain, 16 of fainting, 10 of dizziness, 9 of eye trouble. Some other allergic manifestation was present in 56 cases. In 82 per cent. of families there were other members showing allergic symptoms, in 60 per cent. unilateral, in 18 per cent. bilateral. Skin tests were positive in 78:-inhalants 25, foods 60 (pork 35, milk 19, beef 11, egg 6, wheat, potato, beans and peas, cocoa, fish 2, banana, tomato, oats 1). A fractional test meal showed achlorhydria in 11 and hypochlorhydria in 59. In cases with migraine alone the white blood count showed 163 eosinophils per c.cm. (1.5 per cent), whilst in cases with other allergic manifestation there were 700 (5 per cent.). In practically all cases the fasting blood sugar was normal.

16. DR. N. B. CAPON (Liverpool): 'Nervousness in childhood.' Dr. Capon gave a communication based upon a series of nervous children seen in private practice and emphasized the importance of studying the child as a whole. He pointed out that insufficient attention seemed to be paid to the mental, intellectual and spiritual aspects of childhood; paediatric physicians held a privileged position which should enable them to take a broad view. Careful physical examination must come first, and this should include accurate determination of minor defects in sense organs. The key to the trouble was frequently found, however, when the child's environment was investigated, and the paediatric physician should have valuable observations to make upon important social problems such as birth control, parental discord, divorce, educational methods and so forth.

17. DR. F. J. FORD (Glasgow): 'The metabolism of healing rickets in coeliac disease.' This communication is published in the present number of the 'Archives of Disease in Childhood.'

18. DR. J. D'Ewart (Manchester): 'The treatment of rhinitis due to the Klebs-Loeffler bacillus.' Dr. D'Ewart reported thirty-one cases of nasal virulent K.L.B. treated by a weekly X-ray dose of one-third pastille. An aurist reported few cases as clinical diphtheria, several showed inflammatory conditions. The majority gave no ocular evidence. Twelve patients were cured by one treatment, nine by two. Three required six, and one eight. Where discharge was present X-ray cleared it speedily. Attention was drawn to the variation in obtaining negative swabs at weekly intervals. Even after five or six negatives further positives were obtained. It was suggested the K.L.B. persisted in the accessory sinuses. Only three references to X-ray treatment could be found in the literature.