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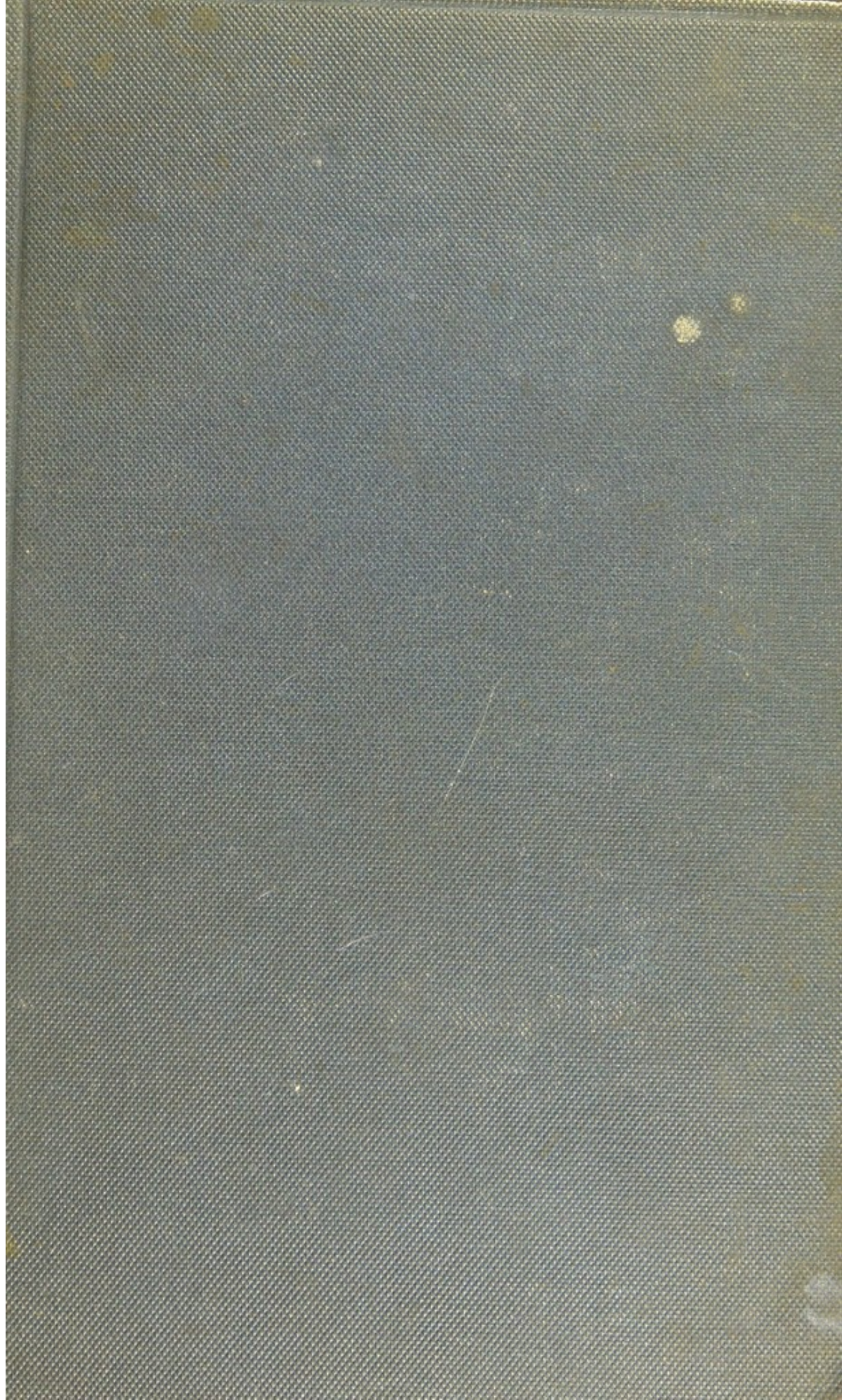
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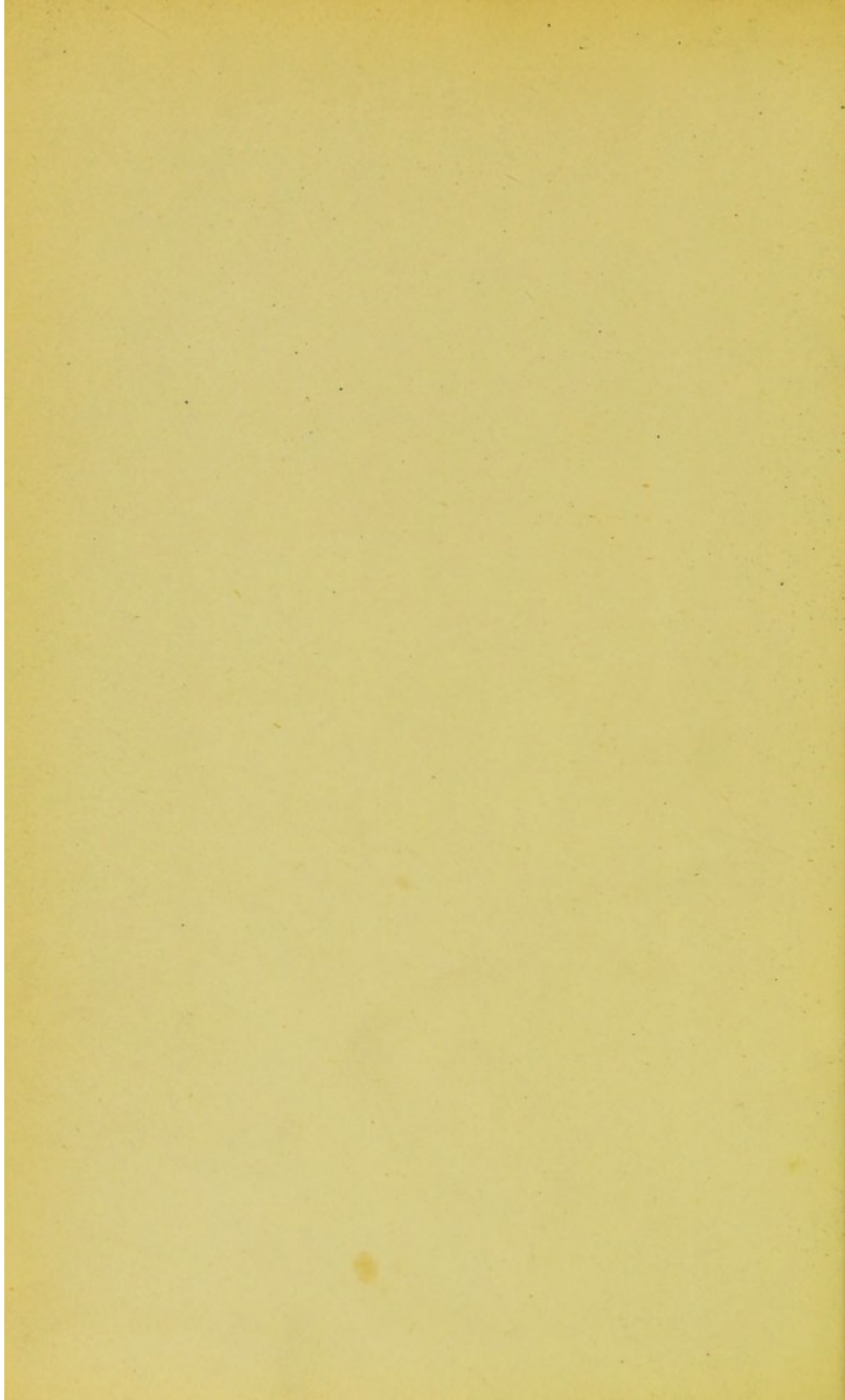
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THE  
DISEASES OF CHILDREN

*BY THE SAME AUTHORS.*

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THE  
DISEASES OF CHILDREN

MEDICAL AND SURGICAL

BY

HENRY ASHBY, M.D. LOND., M.R.C.P.

PHYSICIAN TO THE GENERAL HOSPITAL FOR SICK CHILDREN, MANCHESTER  
LECTURER AND EXAMINER IN DISEASES OF CHILDREN IN THE VICTORIA UNIVERSITY  
FORMERLY LECTURER ON PHYSIOLOGY IN THE OWENS COLLEGE  
AND IN THE LIVERPOOL SCHOOL OF MEDICINE

AND

G. A. WRIGHT, B.A., M.B. OXON., F.R.C.S. ENG.

ASSISTANT SURGEON TO THE MANCHESTER ROYAL INFIRMARY  
AND SURGEON TO THE CHILDREN'S HOSPITAL

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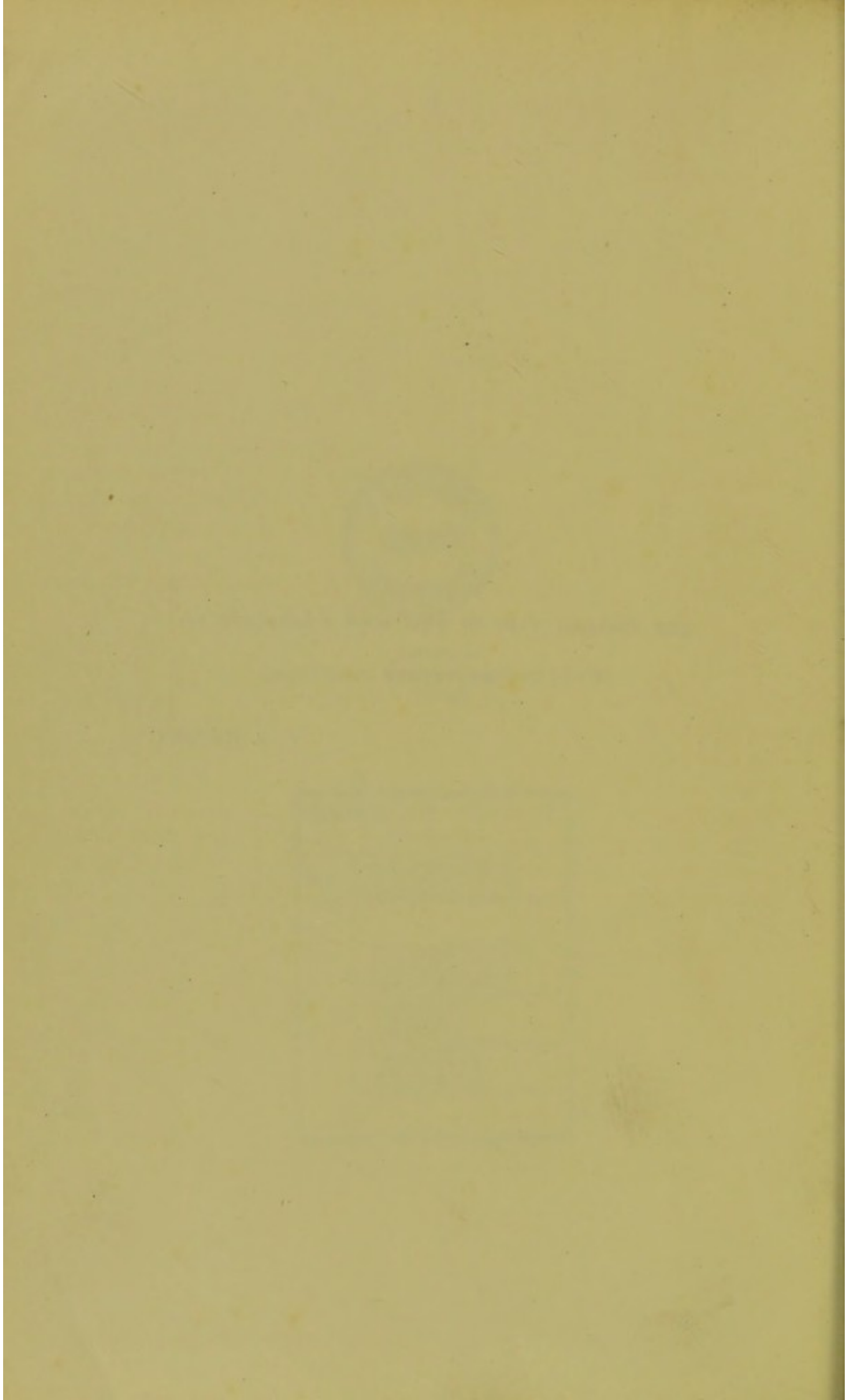


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THE SURGICAL PART OF THIS BOOK I DEDICATE TO  
MY FATHER

*G. A. WRIGHT*



# PREFACE

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THE PRESENT WORK is intended to give to senior students and junior medical practitioners a fairly complete, though necessarily condensed, account of the various morbid conditions peculiar to, or chiefly found during infancy and childhood. Those diseases which are neither special to children nor modified by their occurrence in early life are either omitted altogether or only briefly considered.

The book is written from a practical point of view, and but little pathological detail will be found in it.

The basis of our work is our experience at the General Hospital for Sick Children, Manchester, an institution at which some 1,200 in-patients and some 10,000 out-patients are annually treated. Our observations have extended over nearly ten years, and during the whole of that time we have been collecting material both at the Children's Hospital and at the Royal Infirmary for this purpose.

The original feature of this book is that it is written conjointly by a physician and a surgeon ; it is hoped that it presents, therefore, a fairly complete account of disease in children. Though we are well aware that the book is not an exhaustive treatise, we think it will be found practical, and it is at least based on experience and is not a mere compilation.

The illustrations are almost entirely taken from photographs of cases that have been under our own care ; where this is not so, their source is acknowledged.

We have to tender our cordial thanks to our friends and colleagues, both at the Children's Hospital and at the Royal Infirmary, for the

help. Our thanks are also due to successive generations of house surgeons who have kept the records of our cases.

To our colleague, Dr. Hutton, for allowing us without stint the use of his cases, as well as for much help and advice in correcting our proofs, our especial thanks are due : also to Messrs. Southam and Collier, our colleagues at the Royal Infirmary and the Children's Hospital, for their care and kindness in proof-reading. To Mr. Wilson we owe our chapter on Anæsthetics, which is made especially valuable by his large experience in the administration of these agents both at the Children's Hospital and the Royal Infirmary. To Drs. Humphreys and Massiah, our former colleagues, we are also indebted for the use of their notes of cases.

We must also acknowledge the help rendered to us by Messrs. Paine and Benger in connexion with the formulæ for medicines and external applications given in this work.

We cannot take leave of our work without further acknowledging our indebtedness to the Board of Governors of the Children's Hospital for their generous treatment of us in many ways, and especially for enabling us to publish our annual abstracts of cases treated at the Hospital. We also desire to express our appreciation of the value of the work of our sisters and nurses in making observations of cases, and in the preparation of temperature charts.

To Messrs. Longmans, our publishers, we are much indebted for their liberality in allowing us to borrow woodcuts from their published works, and for their help in many ways ; we desire also to acknowledge the great pains and skill shown by Mr. Pearson in engraving our photographs.

HENRY ASHBY,  
G. A. WRIGHT.

MANCHESTER : *May* 1889.

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# DISEASES OF CHILDREN.

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## CHAPTER I.

### THE PHYSIOLOGY OF INFANCY AND CHILDHOOD.

**The Periods of Early Life.**—The life of man is naturally divided into three great epochs—viz. a period of *Growth and Development*, of *Maturity*, and of *Decline*.

The first division includes the periods of early life, when those series of operations are in progress by which the ovum or primitive germ is transformed into the complete organism; it may be subdivided into *Intra-uterine Life, Infancy, Childhood, Youth and Adolescence*.

**Intra-uterine Life.**—During this epoch the embryo depends entirely upon its parent for all its wants. The maternal blood supplies it with material for constructive purposes, carries away its waste products, and renders unnecessary the maintenance of an independent temperature. It is clearly a time of great importance to the future being, and it is necessary that this development should take place under healthy conditions, inasmuch as it is physiologically impossible for an unhealthy or weakly mother to supply the wants of the embryo, and any failure in the nutritive powers of the maternal blood is certain to leave its stamp on the future development of the child. An infant may come into the world fairly well developed and plump, from the presence of more or less stored-up fat, in spite of the weakly state of the mother's health, but it is almost certain sooner or later to exhibit tendencies to disease in the direction of the stock from whence it springs. Not only may the embryo owe a weakly building up of its tissues to its mother, but it may actually share maternal disease. The fœtus may suffer from endocarditis originating in a rheumatic state of its parent, and this lesion, affecting as it usually does the right side of the heart, may lead to malformations, which early cut short its career. From its parents also the fœtus may receive the virus of syphilis, from which it may suffer during its embryonic life or in after years. It may receive an inheritance of tuberculosis or epilepsy, or a tendency to gout or rheumatism. During fœtal life many anomalies may arise from arrested development or an overgrowth in certain directions; cleft palate and hare lip are instances of the former, and supernumerary fingers and nævoid growths of the latter.

**Infancy.**—The Romans used the word *infans* in its widest sense, and though, as its derivation implies, it was originally applied to those who could not speak, it came to be employed by them for children of much older years. The term *infancy*, *première enfance*, or *Säuglingsperiode*, is most usually applied to the first seven or eight months of life, the time during which the infant is nursed at the breast and before the eruption of the milk-teeth. It is, however, used by some writers to include the whole of the first year. Within the first week or two of life the infant has often to contend with conditions which are peculiar to this period, inasmuch as they depend in one way or another on the act of birth. It may be born asphyxiated in consequence of strangulation by the cord, or pressure on the head, or various injuries producing hæmatomas may take place; or there may be septic infection in connection with the umbilical cord. The change from placental alimentation to the digestion of food in the infant's stomach is a time of peculiar danger, especially if artificial food is given, and the mortality of infants is much greater during the first week of life than at any other period.

During the first few months of infancy life is not so purely vegetative as it is during the intra-uterine period, yet the mental faculties are in abeyance and the movements mostly involuntary or reflex.

One consequence of the undeveloped condition of the higher or inhibitory centres is that the reflex centres are less under control than in later years, so that disorderly reflex movements in the form of convulsions are liable to take place on the slightest provocation. Growth at this period is extremely rapid, the weight more than doubling itself during the first six months of life, and a great strain is thus thrown on the alimentary system; the lymphatic and blood-forming organs are also exceedingly active. It is not surprising therefore that the diseases which are most common and fatal at this period are those connected with digestion and absorption. The infant requires much rest, and indeed divides its time for the most part between feeding and sleeping. It is during this period that 'wasting,' 'marasmus,' or 'atrophy' is so common, a result of chronic catarrh of the intestinal tract and a consequent impairment of the digestive organs.

**Childhood.**—The eruption of the milk-teeth marks an epoch in early life, the term *childhood* being applied to the period commencing with the first dentition and ending with the commencement of the second, at the sixth or seventh year. The terms *seconde enfance* or *Kindersalter* are used in a similar sense. Growth at this period continues to be active, though not proceeding at the same rate as during infancy, but disturbances of the alimentary system are common and the children quickly waste if digestion and absorption are interfered with.

The osseous and muscular systems are developing so that by the end of the first year the child can crawl or even walk with help. It is at the commencement of this period that rickets, a disease so intimately associated with malnutrition, often makes its appearance. The mental faculties are opening out as the brain develops, and the infant begins to recognise its friends and call them by name. During the period of dentition nervous disturbances are common, and the lesions giving rise to infantile paralysis are apt to take place.

**Youth.**—The term *youth*, *jeunesse* or *Knabensalter*, is generally applied to the period commencing at the second dentition and ending at puberty or about the fourteenth year. The milk-teeth are replaced by the permanent set, the bones become more solid and the muscles better developed, while the mental faculties are exceedingly acute and the mind readily acquires knowledge. As puberty approaches the voice becomes deeper and the sexual organs undergo a marked increase of development. During this period, in which scholastic education is carried on, the memory is exceedingly retentive, perhaps more so than at any other time. Children at this period easily 'outgrow their strength,' the nervous system is readily upset, as is evidenced by the frequency of chorea, and the alimentary canal is apt to suffer from chronic catarrh.

**Respiration.**—During intra-uterine life the respiration of the foetus is carried on by means of the placenta. The needs of the foetus as far as oxygen is concerned are supplied in a far more imperfect manner through the maternal blood than when, after birth, the oxygen is taken direct from the air into the vesicles of the lungs. The oxidation processes of the foetus, with its life of continual sleep and without the necessity of maintaining an independent temperature, are feeble and its wants are easily supplied. This condition of things induces a tolerance of oxygen-starvation, much greater than in adults, that frequently stands it in good stead during the act of birth, when the placental circulation is perhaps cut off, or the nervous centres in the medulla are subjected to great pressure. Newly-born infants are often in a condition of asphyxia, especially after severe labours, and have been known to survive without either placental or pulmonary respiration for 10 to 15 minutes. Infants may live for many hours, or even days, with the greater part of their lungs in an unexpanded state. The same tolerance of a venous condition of blood occurs in other newly-born animals; thus Brown-Séquard has shown that a newly-born mouse will recover after 10 minutes', and a newly-born guinea-pig after 12 minutes' immersion in water, while an immersion of 3 to 3½ minutes is fatal to the adult animals.

In the newly-born the respirations amount to about 44 per minute; during the early months of life they vary from 35 to 40 per minute; at the end of the first year and commencement of the second they have fallen to about 28; during the third and fourth years they are about 25; by the fifteenth year they have fallen to 20; in the adult they vary from 16 to 20. Infants and children, as might be expected, give off absolutely less carbonic acid than do adults, but relatively more.

The absorption of oxygen is also relatively greater in childhood than in adult life, and indeed the tissues in childhood seem to store away more oxygen than they give out carbonic acid as compared with later years.

In the infant and during the first three years of life the type of respiration is the abdominal, the diaphragm being the chief muscle used in tranquil respiration, the abdomen rising and falling, and the ribs moving but little. Later the costo-inferior type is present, respiration takes place both by the raising of the upper seven ribs by the intercostals, and also by means of the diaphragm, the chest expands and the abdomen moves slightly.

In girls towards puberty the costo-superior type is present, the upper part of the chest moves freely, the lower part and the abdomen hardly at all.

The vital cubic capacity of the lungs is smaller in proportion to their height in children than in adults. This is due in part to the relative smallness of their lungs and to the greater elasticity and flexibility of their chest-walls.

According to Schnepf and Wintrich the vital cubic capacity at different ages is shown by the following table:—

3 to 4 years . . . about	450 c.c.	11 to 12 years . . . about	1800 c.c.
5 " 7 " . . . "	900 c.c.	13 " 14 " . . . "	2200 c.c.
8 " 10 " . . . "	1300 c.c.	In adults (average) "	3300 c.c.

**Changes in the Circulation after Birth.**—The cessation of the placental circulation, the inflation of the lungs with air, and consequently the increased amount of blood passing through the pulmonary artery, lead to a gradual shrinking and obliteration of the various foetal passages, viz. the vessels of the cord, the ductus venosus, ductus arteriosus, and foramen ovale. These changes commence after the first few respirations have been taken, and within a week or ten days these passages are occluded. Not infrequently, however, one or other of them remains open for a much longer period, this being especially true of the foramen ovale. In 62 cases under two years of age noted by Parrot, it was only completely obliterated in 4; and of 52 cases between 2 and 9 years, in 26 only was it completely closed.

With regard to the ductus arteriosus, Parrot found that of 187 cases of 1 month to 3 years, in 46 it was open, in 18 it was partially closed, and in 119 it was obliterated. The ductus venosus is mostly obliterated within three days; according to Quincke its remaining partially open gives rise to icterus.

**Amount of Blood in Body.**—In the newly-born infant the amount of blood in the body is relatively less than in the adult, viz.  $\frac{1}{19}$  of the body-weight, while in the adult it is  $\frac{1}{13}$ .

The blood of the infant contains a greater proportion of white to red corpuscles, viz. 1 to 130 (Demme), than does that of the adult. According to Hayem the blood of the foetus contains more red corpuscles per cubic mill. than does adult blood. This observation has also been confirmed by spectrum analysis, Leichtenstern showing that foetal blood contains more hæmoglobin than in adults. The fibrin is less and coagulation occurs less completely. According to the same authority, during the first fourteen days of life remarkable changes take place in the red corpuscles in size, and also in the number of granules present, apparently from the destruction of the corpuscles.

**Pulse.**—At the end of foetal life the number of cardiac contractions per minute is about 132 in boys and 140 in girls; in the newly-born infant it has fallen to 130 to 133. According to some observations, the pulse-rate falls notably immediately after the ligature of the cord, to regain its normal number an hour or two later. During the week succeeding birth it varies from 120 to 140, crying immediately increasing the number some 10 to 30 beats. By the second year it has fallen to 110, by the fifth to 100, by the eighth year to 90, and by the twelfth to 80.

During sleep the pulse-rate is diminished, especially in infants, sometimes by as much as 10 or 20 beats. The pulse is more often irregular in

infancy and childhood than in adults, and this apart from the influence of disease.

According to Soltmann the inhibitory action of the vagus is less marked in newly-born animals than in adults. The circulation of the blood in infants and children is carried on more rapidly than in adults, and consequently the tissues are supplied with a superabundance of arterial blood.

According to Vierordt a complete circulation takes

In newly-born infants	12 seconds	(134 pulse rate)
At two years . . . .	15 „	(107 „ )
At fourteen years . .	18.6 „	( 87 „ )
In adults . . . . .	22 „	( 72 „ )

On account of the proneness of the pulse to be influenced by excitement during infancy, it is of less value in diagnosis at this period than in later years.

**Alimentary Canal.**—For the first six to eight weeks of life there is very slight secretion of saliva, only sufficient being formed to render the mouth moist. In the third and fourth months the secretion is much more free, so that infants about this period begin to dribble; the amount of secretion becomes still larger as the period of dentition approaches. By the third or fourth month the saliva contains ptyalin and readily converts cooked starch into maltose. The stomach of the newly-born infant is small, its capacity being under two fluid ounces, by the end of the fourth week from three to four ounces, at three months, about five ounces, and at the end of the first year, ten ounces. The gastric juice has at first but imperfect digestive powers, and the stomach is in consequence quickly exhausted; the peristaltic action of the walls of the stomach is often very vigorous, and gives rise to the regurgitation of the food swallowed. For the first few months the digestive powers of the pancreatic and intestinal juices are exceedingly feeble, so that starches and portions of curd of cow's milk will pass through the whole of the intestines unchanged. The secretion of bile begins at an early period of foetal life, probably about the third month; the bile accumulates in the small intestines and is passed as the meconium during the first few days after birth. It forms dark brown or greenish masses, viscous and tenacious, and of a feeble acid reaction, and consists of mucus holding in suspension fatty matters, epithelial cells, biliary pigments and cholesterine, but no bile-acids. Three or four days after birth the meconium is succeeded by the golden yellow semi-liquid stools characteristic of the healthy infant. This yellow colour is due to the bili-rubin of the bile; the green colour sometimes seen in intestinal catarrh depends upon the oxidation of the bili-rubin and formation of bili-verdin. Under normal circumstances newly-born infants have two or three stools daily. Their character gradually changes as the infants get older, becoming more and more like the stools of adults.

**Urine.**—The newly-born infant generally passes water within 24 hours of its birth and continues to do so some 10 or 12 times daily, passing about 1 oz. at a time, or about 10 ozs. in 24 hours. The first urine passed is cloudy from the presence of uric acid and epithelial cells, and is of specific gravity 1003–1006; later it becomes clear and of a light straw colour. It contains more uric acid and less urea (about .5 per cent.) than does that of adults.

During the whole of childhood the urine is of a paler colour and lower specific gravity than during adult life ; smaller quantities are also passed, but on account of the difficulty of collecting the total quantity the amounts have not been accurately determined. The following figures may be taken as approximative :—

Between 2-5 yrs.	about 15-25 ozs.,	containing	5-14 grammes of urea	(in 24 hrs.)
„ 5-9 „	„ 25-35 „	„	14-19 „	„ „ „
„ 9-14 „	„ 35-40 „	„	19-22 „	„ „ „
Adults	„ 50 „	„	30 „	„ „ „

**Temperature.**—The temperature of an infant at birth taken in the rectum is about 100° F. (37·75 C. Roger, Sommer). A few minutes after birth it sinks to 97°, or in weakly infants still lower ; in the course of a few hours it again rises and remains at about 98·8° F. This temperature or a fraction of a degree higher—98·8-99° F.—may be taken as the normal rectal temperature during childhood and youth. For young children, if exact observations are required, the rectum is the best place to insert the thermometer, as it is difficult to keep the infant quiet with a thermometer in its axilla. It is important to remember that the rectal temperature exceeds that of the axilla by about ·7° F. For most clinical observations the fold of the groin or the axilla may be taken. What is of more importance than whether the temperature is taken in the axilla or rectum, is the time at which it is taken. According to the careful researches of Finlayson, the diurnal range of temperature amounts to about 2° F., the maximum being at 5 to 6 P.M. and the minimum in the small hours of the morning ; the range of temperature in adults being somewhat less.

According to Reitz, the lowest temperature is between 4 and 5 A.M., increasing to 11 A.M., falling to 2 P.M., then rising to its diurnal maximum at 6 P.M.

The most recent observations upon the temperature of children in health have been made by Dr. O. Sturges. The most interesting of these were made upon two sturdy children living in the country, aged respectively 1 year and 2 years. The temperatures were taken at various hours from 10 A.M. to midnight, the usual range being 97·4 to 98·6. The highest temperature was after breakfast, when the child was most lively and eager for play.

The heat of the body is maintained with greater difficulty during infancy than in later life, a result due not only to the relatively larger surface, but also to the much greater vascularity of an infant's skin. Infants and children are much more liable to suffer from cold extremities than are adults.

**Nervous System.**—The closure of the anterior fontanelle takes place towards the end of the second year in strong and vigorous children, in immature and rickety children it may be delayed till the third year, or it may be later.

The cubic capacity of the skull in newly-born infants is about one-third that of adults, viz. 500 c.c. ; by the second year it is about 1000 c.c., while in the adult it is about 1500 c.c. The brain of a newly-born infant forms about 14 per cent. of its body weight, while in the adult it is only 2·37 per cent. The brain doubles its weight during the first year of life (14 oz. to

28 oz.); by the seventh year it has reached 38 oz.; by the fourteenth or fifteenth year 42 oz. to 45 oz.; the average brain weight of an adult (male) being about 50 oz.

The cerebellum after birth develops more quickly than other parts of the brain, the frontal lobes more slowly till six years of age, when they develop more rapidly. If the brain of a newly-born infant be examined, it will be noted that its consistence is much less firm than is that of an adult's. If placed on a plate it spreads itself out or moulds itself into any shape more readily than an adult's. The pia mater is exceedingly delicate and very easily dissected off with a pair of forceps. In colour the brain is light grey, often yellowish from jaundice; there is no well-marked difference between the 'grey' and 'white' substance as in adult brain, and the convolutions are less distinctly marked. The multipolar cells in the grey matter on the surface are ill developed, as also are the pyramidal bundle of nerves which connect them with the basal ganglia and internal capsule; on the contrary, the nerve elements of the cord and spinal nerves are well developed.

From the above researches it is clear that while the excito-motor centres in the spinal cord and medulla are well developed at birth, the higher centres on the surface of the brain are imperfect, and so also are the strands or nerve-paths which connect the higher and lower centres. This agrees also with the experiments of Soltmann, who has shown experimentally that the application of some form of irritation, as the induced current, to the surface of the brains of newly-born animals does not evoke movements in the face and limbs as it does in adults. The actions of infants—sucking—crying—swallowing—breathing—are reflex, and inasmuch as they are uncontrolled by the inhibitory influence of the higher centres, are apt to be excessive and violent. The reflex actions displayed by a brainless frog are more violent and vigorous than those displayed when the brain is intact. As the higher centres develop changes come over the mental character of the infant, and the reflex actions become more and more under control and dominated by the psychical centres.

**Sight.**—In the first week after birth the infant apparently cannot distinguish objects, but can light from darkness. According to Preyer's examinations, the movements of the eyes are not co-ordinated at first. Konigstein, from an examination of 300 newly-born infants, states that they were all hypermetropic. The colour of the iris is bluish-grey or green, but one finds also shades of light grey and brown. The same investigator has also noted blood-extravasations in the retina which disappear in a few days. The pupils are very large in the newly-born and sensitive to light; in later childhood they can endure strong light better than can adults. Of the colours, children learn first to distinguish white from black; in the second year they learn to distinguish other colours, first red and yellow, later green and blue.

**Hearing.**—In the newly-born the mucous membrane of the tympanum is swollen so that no cavity is present, consequently they are not very sensitive to sounds, but shrill and strong sounds make impression, the infants waking with cries. In the first months children hear better high and sharp sounds than deep. Older children can hear very weak and high sounds which make no impression on adults.

**Taste.**—Newly-born infants can distinguish sweet, bitter, sour, and salt tastes.

**Psychical Phenomena.**—In the second month an infant learns to hold up its head and make voluntary movements and to distinguish the voice of its friends. At the 3rd to 4th week it can laugh and smiles when caressed. In the 3rd to 4th month the infant notices its toys or anything it can hold in its hands, mostly putting them to its mouth. At 7 to 9 months the child can sit up, and 3 or 4 months later tries to walk; when a year old well-developed children can walk. From this time the child begins to talk first syllables, such as *tá-tá*, *dá-dá*, *bē-bē*; then words are learnt, and by the end of the second year most children can string a few words together.

**Sleep.**—The newly-born infant sleeps all day except when it wakes up for food. At a year old the infant sleeps fifteen to sixteen hours; from 2 to 3 years, twelve to thirteen hours; from 4 to 5 years, no sleep in the day, from ten to eleven hours at night; from 12 to 13 years, eight to nine hours. Infants sleep lightly and are easily awakened; at 4 to 5 years of age they are generally heavy sleepers.

**Body weight.**—An infant born at full term weighs from  $6\frac{1}{2}$  to  $7\frac{1}{2}$  lb., 7 lb. being an average weight. For the first two or three days of life there is a loss of 4 oz. to 7 oz., then a regular gain, so that by the 8th to 9th day the initial loss has been made good. According to Gregory, the following figures express the average daily loss and gain during the first six days of life:—

1st day	.	.	loss of 139 grammes or nearly 5 oz.		
2nd "	.	.	" 64	"	" $2\frac{1}{4}$ "
3rd "	.	.	gain of 33	"	about 1 "
4th "	.	.	" 50	"	" $1\frac{3}{4}$ "
5th "	.	.	" 50	"	" $1\frac{3}{4}$ "
6th "	.	.	" 36	"	" $1\frac{1}{4}$ "

That these figures are by no means universally correct is clear from the difference in weight noted by different observers; thus, according to Lewis Smith, in 170 infants born in the New York infant asylum (89 male and 81 female), the average weight of the boys was 7 lb. 11 oz. and the girls 7 lb. 4 oz. Fifty of these were wet-nursed, and weighed when one week old with the following result:—

Increase of weight in	.	.	.	.	32 cases
Loss	.	.	.	.	13 "
Average gain	.	.	.	.	4.8 oz.
" loss	.	.	.	.	3.3 "
Greatest gain	.	.	.	.	12 "
" loss	.	.	.	.	6 "

Growth during the first year, more especially during the first six months, is extremely rapid, the infant doubling its weight in the first six months and trebling it during the first year. Many observations have been made on the weights of children during the first year; the following table exhibits the monthly gains, being the average of nine infants observed by Pfeiffer, who were nursed at the breast at first, and later this was supplemented with cow's milk:—

Age.	Monthly gain.		Weight at end of the months.	
	oz.		lb.	oz.
1st month . . .	13 $\frac{1}{4}$	.	8	5 $\frac{1}{2}$
2nd „ . . .	30 $\frac{1}{2}$	.	10	4
3rd „ . . .	26 $\frac{1}{2}$	.	11	15
4th „ . . .	26	.	13	9 $\frac{1}{4}$
5th „ . . .	21	.	14	14 $\frac{1}{4}$
6th „ . . .	21	.	16	3 $\frac{1}{2}$
7th „ . . .	17	.	17	5
8th „ . . .	21	.	18	10
9th „ . . .	23	.	20	1
10th „ . . .	20 $\frac{1}{4}$	.	21	5 $\frac{1}{4}$
11th „ . . .	11	.	22	0
12th „ . . .	7	.	22	7

Growth after the end of the first year is slower, so that the weight is not again doubled till the end of the sixth year, and doubled again by the end of the fourteenth.

**Length.**—The average length of a newly-born infant is 19 inches ; it has doubled its length by the end of the fourth year.

Much interest and importance is attached to the increase of weight and height during infancy and childhood : weekly weighings, especially during the early months of life, give very valuable information with regard to diet. It must, however, always be borne in mind that increase in weight, especially if it be due to an accumulation of fat, does not always indicate strength, or that the food being taken is a suitable one. During childhood, undergrowth or loss of weight must be looked upon as an indication of danger and as evidence of malnutrition. On the other hand, overgrowth without a proportionate increase in weight should always be taken as indicative of weakness.

For further information on this subject, the reader is referred to the ‘ Life History Album ’ by Francis Galton.

The following is a proportionate table of height and weight :—

Height	Weight	Height	Weight	Height	Weight
in.	lb.	in.	lb.	in.	lb.
24	18	37	38	49	62 $\frac{1}{2}$
25	19 $\frac{1}{2}$	38	40	50	65
26	21	39	42	51	67 $\frac{1}{2}$
27	22 $\frac{1}{2}$	40	44	52	70
28	24	41	46	53	72 $\frac{1}{2}$
29	25 $\frac{1}{2}$	42	48	54	75
30	27	43	50	55	77 $\frac{1}{2}$
31	28 $\frac{1}{2}$	44	52	56	80
32	30	45	54	57	82 $\frac{1}{2}$
33	31 $\frac{1}{2}$	46	56	58	85
34	33	47	58	59	87 $\frac{1}{2}$
35	34 $\frac{1}{2}$	48	60	60	90
36	36				

It is not only of interest, but it is important, to both weigh and measure children at frequent intervals. Periods of under or over growth are periods of danger, as indicating either malnutrition or an overtaxing of the strength. There should also be maintained a close relation of height to weight.

**Dentition.**—At birth the jaw contains the dental sacs with the already calcified crowns of the temporary teeth. Besides the temporary teeth, there is the calcified crown of one of the permanent set, the first molar, which is situated immediately behind the last temporary molar. (See fig. 1.)

During the interval which elapses between birth and their eruption, the teeth are undergoing further development; the sacs become enlarged, so that they are readily felt through the gum as rounded swellings, the edges of the teeth become sharper, and the fangs are developed. As the fangs elongate, the edge of the tooth comes nearer to the surface of the gum, the latter swells,

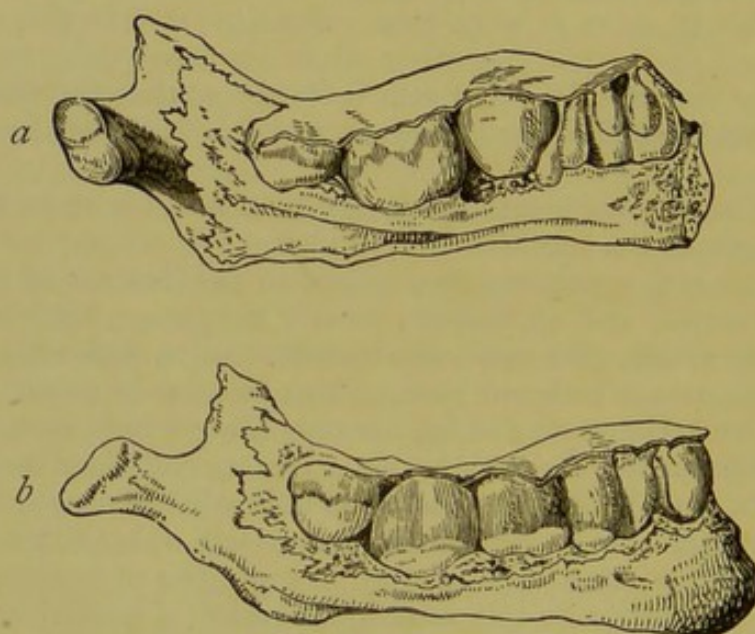


Fig. 1.—Jaw of a Child at Birth, showing the Dental Sacs (Quain's 'Anatomy'). *a*, the left half seen from the inner side, *b*, the right half seen from the outer side; the bone has in part been removed to expose the dental sacs. *b* shows the sacs of the temporary set and the sac of the first permanent molar behind the posterior molar of the milk set. *a* shows the same, and also the sacs of the permanent incisors and canine.

and becomes more vascular, the edge of the tooth appears as a line or point beneath the membrane, which finally becomes perforated, and the tooth is cut.

The temporary set appear for the most part in groups in the following order. **First group**—The lower two central incisors appear from 6th–8th month, followed by a pause of from three to six weeks. **Second group**—The four upper incisors are cut at intervals of a week or two, from the 8th–10th month, followed by an interval of one to three months. **Third group**—The lower lateral incisors, the upper front molars, the lower front molars appear at intervals from the 12th–14th months, followed by a pause of two to three months. **Fourth group**—The canines appear, the upper ones usually being first, from the 18th–20th month. **Fifth group**—The posterior molars mostly appear at the age of 2–2½ years.

The following formula exhibits the relation between the temporary and permanent set :—

Temporary set	{	Upper	mo.		ca.	in.	in.	ca.	mo.	} 20	
			2		1	2	2	1	2 = 10		
	Lower	2		1	2	2	1	2 = 10			
Permanent set	{	Upper	mo.	bi.	ca.	in.	in.	ca.	bi.	mo.	} 32
			3	2	1	2	2	1	2	3 = 16	
	Lower	3	2	1	2	2	1	2	3 = 16		

The milk set, when complete, remain unchanged for several years, though the permanent set are gradually becoming developed in their sacs, ready to replace the earlier set.

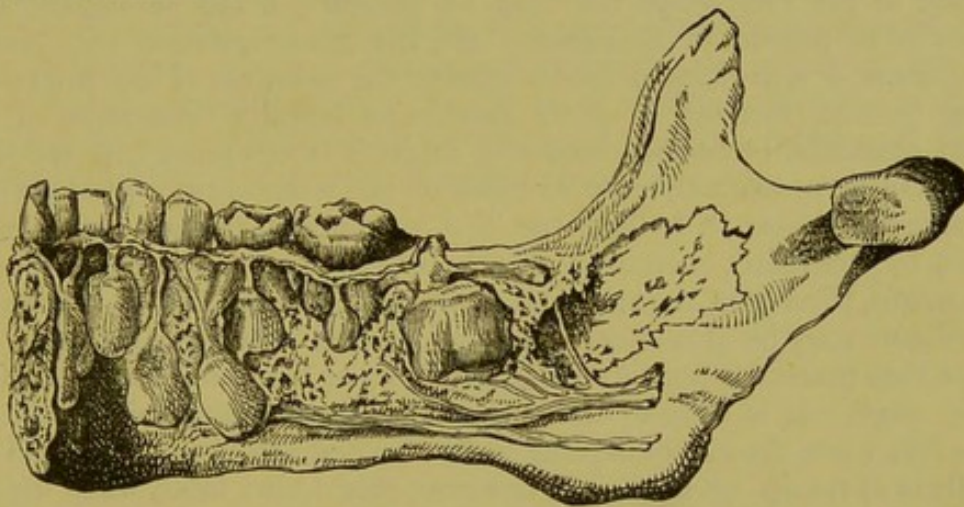


Fig. 2.—Lower Jaw of Child of about three years, showing the relation of the temporary and permanent teeth. The milk-teeth of the right side and incisors of the left are shown, and also the sacs of the permanent set, except the wisdom-tooth, which is not yet formed. The large sac near the ramus of the jaw is that of the first permanent molar, and above and behind it is the rudiment of the second molar. (Quain's 'Anatomy'.)

At six years of age there are a greater number of teeth in the jaws than at any age, there being the milk set and all the permanent set except the wisdom-teeth.

The permanent teeth are cut in the following order :—

Molar, first	.	.	.	.	.	6 years of age
Incisors, central	.	.	.	.	.	7 " "
" lateral	.	.	.	.	.	8 " "
Bicuspid, anterior	.	.	.	.	.	9 " "
" posterior	.	.	.	.	.	10 " "
Canines	.	.	.	.	.	11-12 " "
Molars, second	.	.	.	.	.	12-13 " "
" third	.	.	.	.	.	17-25 " "

It is to be particularly noted that during this period a marked increase takes place in the length of the jaw to provide room for the three molars of the permanent set, which make their appearance posteriorly to the milk set; the bicuspid replace the temporary molars (see fig. 2).

While the above account represents the state of things which obtains under normal conditions, yet important deviations both as to the time of the appearance of the teeth through the gum and the condition of the teeth themselves frequently take place as the result of disease or enfeebled nutrition. It is well known that rickets is the most common cause of delayed dentition, and not only are the teeth cut later than usual, but the defective nutrition which exists in this state frequently interferes with the development of the teeth; they are in consequence dwarfed or provided with a thin or partially deficient layer of enamel, so that they quickly become carious after being cut. Mr. Hutchinson has pointed out the effect of hereditary syphilis upon certain of the permanent set, the most characteristic effect being a dwarfing and notching of the upper central incisors, the result of malnutrition during the manifestations of syphilis in the first few months of life, just at the time when the 'cap of dentine' of the permanent set of incisors is in process of formation. He has also suggested that just as a local eczema or a prolonged illness affects the nutrition of the finger-nails, leaving behind furrows or other marks, so infantile stomatitis or some general condition of malnutrition will, through interference with the formation of dentine or enamel, leave its mark on the temporary or permanent set.

There is reason to believe the first permanent molars are especially affected by stomatitis, mercurial or otherwise, the enamel being deficient at their crowns, producing rugosities on their upper surface (*érosion en mamelon*). The incisors may be also affected, having either a transverse furrow or a pitting, or they present a honeycomb appearance or notch in the centre of their cutting edge. It is easy to understand that if a condition of malnutrition occurs just when the cap of dentine is first formed, the future tooth will show the effects at its tip or edge. If, however, this occurs later, when the germ is of some size, the future tooth will show a groove or mark at some distance from the tip.

**Mortality in Infancy and Childhood.**—In this country out of every 1,000 children born, on an average 149 die before the end of their first year of life and 263 before the age of 5 years. During the next five years, from 5 to 10 years of age, 35 die, and 18 more between the ages of 10 and 15 years. So that out of the original 1,000, 684 will be alive on their fifteenth birthday and 316 will be dead. From these figures it is clear that the mortality is the greatest during the first year, and that it rapidly declines as childhood advances. Indeed the mortality is the greatest during the first day and succeeding days after birth; thus Körösi, in analysing the ages of infants at death, found, out of 26,623 infants born in Pesth during the years 1874 and 1875, that out of every 1,000 born, 13 died within 24 hours; 5.7 on the second day; 34.2 during the first week; 26.3 during the second week; and 92 during the first month. The mortality of infants under one year differs enormously, according to the amount of care which has been taken in their feeding and the care bestowed upon them, as well as upon the health of their parents. This difference is shown very strikingly in the mortality in illegitimate children as compared with those born under more favoured circumstances. Wolf, basing his observations on the mortality returns of Erfurt during the years 1849-68, found that for every 1,000 illegitimate children born, 352 died before the end of the first year, while out of the

same number in other classes of life, among the working classes 305, among middle classes 173, and among the higher classes only 89.

The same difference may be seen in the statistical returns of English cities; thus, quoting from Dr. John Tatham's health report of Salford for 1884, the death-rate of illegitimate children under one year was 39·1 per cent., while in Regent Road and Greengate, districts which are mostly occupied by a working-class population, the death-rate at the same age was 20 and 19·4 per cent. respectively; in the suburb of Broughton, largely occupied by a well-to-do class, it was 14·2.

Infant mortality should not be calculated, as is sometimes done, by comparing infant deaths with deaths at all ages, or with the number of persons living, inasmuch as in a given population there may be many or few children or few old people, but it should be calculated on the infant population, or the number of children living at that age. Thus the number of deaths in infants under a year old should be compared with the number of infants living at the time, which is usually calculated as the mean of the births in that and the preceding year. In the same way the mortality of children under five years is calculated by comparing the deaths in the year with the number of children living under five years of age.

## CHAPTER II.

## THE DISEASES INCIDENT TO BIRTH.

THERE are certain lesions which are apt to take place only once in a lifetime, inasmuch as they owe their origin to the act of birth, or to those important changes which occur in the life conditions of the infant, when it exchanges the quiet dependence of intra-uterine life for the greater activity of an independent existence. Though many of these morbid conditions differ from one another in various ways, yet they are so intimately associated in their pathology and etiology that it is most convenient to discuss them together, rather than to relegate them, as is often done, to their respective places in the ordinary classification of disease. The act of birth brings its own special dangers to the infant as well as to the mother, and it is hardly surprising to find that many perish on the threshold of life, and that the mortality during the first few days after birth is greater than that of any other period. It must also be borne in mind that parturition is not only responsible for many infant deaths, but damage may be done to the nervous centres by pressure or hæmorrhage, which may be irreparable, and the infant lives to be paralysed for life or a hopeless imbecile. These diseases which are connected with parturition are also of much interest and importance, in that there are many of them eminently preventable, and are often the result of the ignorance of the friends or neighbours, who, in the absence of a medical practitioner or trained midwife, preside in the lying-in room. However this may be, many a life is lost and various morbid conditions arise for want of assistance during the later stages of labour, or to the want of care and cleanliness, or exposure to contagion during the first few days which succeed birth. We will first consider the effects of asphyxia, so common in newly-born infants.

**Asphyxia neonatorum.**—(a) The infant may die from this cause before birth, or it may be born asphyxiated; (b) asphyxia may supervene after birth through failure of the pulmonary respiration. It is hardly to be expected that the transition from placental to pulmonary respiration should be accomplished without some risk of the cessation of the one before the commencement of the other. Fortunately for the infant, its nervous centres and tissues generally are far more tolerant of a venous condition of blood than they are in after life, for during intra-uterine life the aeration of the blood is far less perfectly performed by the placenta than it is afterwards by the lungs; and, moreover, there is a mixture of the placental blood with the venous blood of the inferior vena cava before it is distributed to the body. Brown-Séquard has shown by direct experiment that newly-born guinea-

pigs will survive ten to twelve minutes' immersion in water, provided no water enters their air-passages, whilst less than three minutes is fatal to an adult animal under similar circumstances ; and, in the same way, one is frequently astonished to find the large amount of unexpanded lung present in infants who have survived their births some hours, or even days. This tolerance of venous blood stands the infant in good stead during the last stages of labour, when long delayed, and the placental respiration interfered with or the funis compressed, or when after birth only an imperfect expansion of lung takes place.

(a) Asphyxia before birth may be caused by the death or faintness of the mother, detachment of or interference with the placental circulation, compression of the cord, or possibly pressure on the brain. Asphyxia of the foetus may be suspected if the foetal heart becomes faint, the pulsation of the cord ceases or is weak, or by the passage of meconium. In infants born asphyxiated the symptoms will vary according to the degree of asphyxia present ; when slight, the lips are of a bluish tint, the skin dusky, the conjunctivæ injected, the limbs are motionless, but the muscular tonus is present, the heart's action is slow and mostly visible, the movements of respiration are separated by long intervals, or no attempts are made unless some strong reflex irritation is applied. In the deeper stages of asphyxia the face and lips are pallid, the extremities blue, the muscles of the limbs and neck have lost their tonus, no attempts are made at respiratory movements, or only a few inspiratory efforts accompanied by indrawing of the ribs and epigastrium, but without any effect in expanding the lungs. Infants in this condition quickly die unless relieved. The *post-mortem* examination in such cases shows some foreign body in the air-passages, such as mucus, liq. amnii or meconium, or if respiration has taken place, the lungs may be partially expanded with air ; the blood is dark and fluid, no clotting having taken place. Minute hæmorrhages may have taken place on the surfaces of the lungs or brain ; the right heart is distended with blood ; the stomach may contain meconium or air ; the large intestines may be partially empty, the meconium having been expelled.

(b) Asphyxia may be due to causes which operate after birth. In some of these cases long-continued pressure on the brain may have damaged the nervous centres ; or asphyxia before birth may have given rise to hæmorrhage, which has paralysed the respiratory centres. The commonest cause, however, is weakness or immaturity on the part of the infant, its ribs being wanting in rigidity and its inspiratory forces feeble, so that it fails to draw in air with sufficient power to inflate the lungs, and the latter remain to the greater part of their extent in the foetal or unexpanded state, a condition to which the term of 'atelectasis' is applied. Among the rare causes, asphyxia may be due to an imperfect development of the diaphragm, double pleuritic effusion, syphilitic infiltration of the lungs, and pressure on the trachea from enlarged glands. Those infants who have some complete physical obstruction to the entrance of air into the lungs necessarily only survive their birth a few minutes, either making no attempt at respiration or inspiratory efforts are accompanied by recession of the chest-walls, without any air entering the chest. Premature or weakly infants may survive for many hours or even days with a large portion of their lungs in an unexpanded

state. They are extremely feeble, their cry is weak and whimpering, their lips and limbs are dusky blue, and their temperature below normal. These respiratory movements are confined to slight movements of the diaphragm, sometimes accompanied by indrawing of the walls of the chest; they have hardly strength to suck; they are drowsy, or in a semi-comatose condition. They frequently suffer from local twitchings, less often general convulsions. If they live over forty-eight hours they become jaundiced and the limbs œdematous. An examination of the bodies of such infants reveals the usual signs of death from asphyxia: the blood is dark and fluid; the right heart and veins distended; the sinuses and membranes of the brain congested; and very often meningeal hæmorrhage is present. The lungs will be found in a condition of atelectasis. Thus in a case which we recently examined in which the infant died six hours after birth, both lungs sank in water, were solid everywhere except at the anterior edges, where there were clusters of air-containing lobules and also similar expanded vesicles of a light red colour, scattered over the surfaces of the upper lobe. The cut sections displayed purple solid lung without a trace of expanded lobules. In another case, where the infant lived three days, the lungs and heart together just floated in water, but the lungs everywhere had a solid feel, crepitating very slightly; the surfaces of both lobes were covered with distended lobules, while the central parts were solid. As a rule, the upper lobes are more often expanded than the bases, and the anterior and inferior edges and surfaces more than the central parts. Care must be taken not to confound atelectasis of the lung with pneumonic consolidation; the latter condition is rare in the newly-born.

*Treatment.*—1. Remove any mucus or fluid from the fauces and air-passages by means of the finger or by suction with a soft indiarubber catheter.

2. Attempt to excite respiration by some form of irritation applied to the skin. This perhaps is most effectually done by placing the infant in warm water (100° F.), and then dashing cold water over it by means of a sponge or the hand, or by slapping it with the wetted corner of a towel, or if the Faradic current is at hand, a feeble current may be applied to the diaphragm or other inspiratory muscles.

3. If these methods fail, no time should be lost in practising artificial respiration by Sylvester's or Schultz's method, which is to be continued as long as the cardiac sounds can be heard.

Active treatment will less often be required in those cases of asphyxia supervening after birth from non-expansion of the lungs. Gentle measures may be undertaken to excite more active respiratory effects, and to combat the somnolence by means of hot and cold water, or of the application from time to time of stimulating liniments to the chest. Such infants, however, but feebly respond to our efforts, and over-treatment in this direction may easily do more harm than good; our efforts will mainly have to be directed to placing the infant under the most favourable conditions for gaining strength and gradually bringing about expansion of the lungs. One of the most important indications is to maintain its heat. As soon as possible it should be surrounded by cotton-wool and placed before the fire; if too feeble to take the breast, milk should be drawn from the breast and given the infant by a spoon or small feeding-bottle. It may even be necessary to feed it by pass-

ing a No. 12 or No. 14 soft indiarubber catheter (Jacques's patent) into the stomach, and thus introducing, by means of a syringe or funnel, half an ounce of milk; the catheter must be quickly withdrawn to prevent reflux of the fluid. In the care and nurture of these weakly infants various means have been adopted; for instance, placing them in cradles or cots in small chambers where the temperature is maintained by artificial means. The best known of these is the 'Couverse' of Auvard, which consists of a box, in which the basket containing the infant is placed, and maintained at a temperature of 100° Fah. by means of a reservoir of warm water heated by a special arrangement; a glass lid covers in the box, and ventilation is secured by a current of air which has passed over the warm-water reservoir.

**Apoplexia neonatorum.**—Cerebral hæmorrhage, occurring in early life, is hardly ever the result of a ruptured artery, but almost invariably is caused

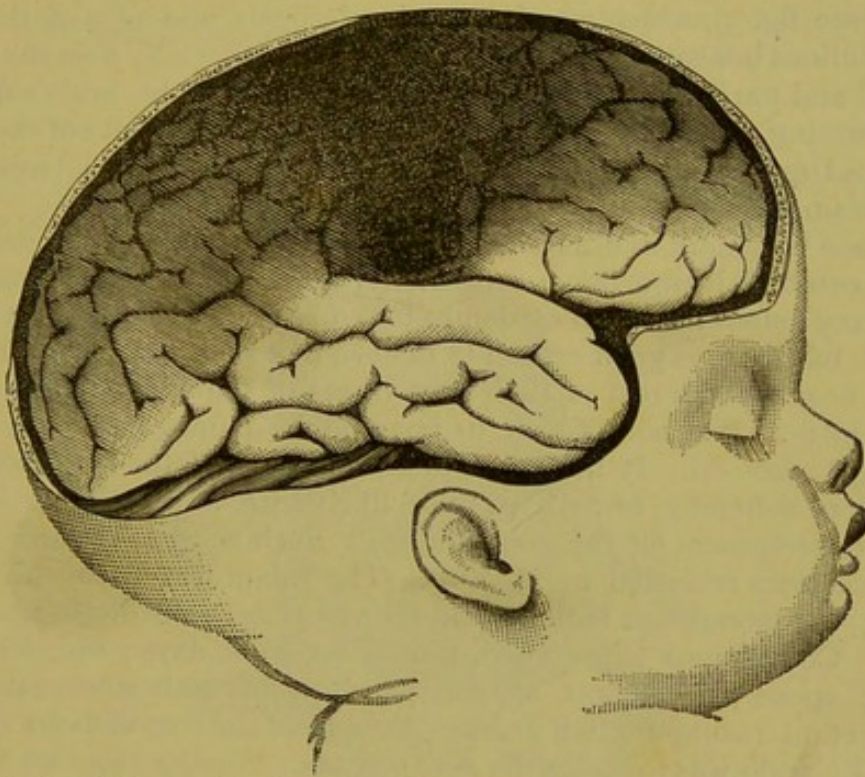


Fig. 3.—Meningeal Hæmorrhage in an Infant; death on the twenty-second day (*after McNutt*).

by a venous congestion, and takes place from the capillary vessels of the pia mater or choroid plexuses. The arteries of the young are not liable to suffer from atheroma, but retain their elasticity, and, moreover, are not likely to have to submit to any unusual strain from a hypertrophied heart. On the other hand, the pia mater in early infancy is exceedingly delicate, and its capillaries fragile, as can be readily demonstrated by noticing how easily it is stripped from the brain by means of forceps, and how loose is its connection with the soft brain substance beneath it. Further, we have already alluded to the fact that the cerebral sinuses and veins become distended with blood in asphyxia from various causes—a rupture of the capillary vessels of the pia mater takes place, and blood is effused into the sub-arachnoid space. This effusion, in consequence of the loose connections of the pia with the brain, may extend over

a large surface, or burst into the sub-dural space. The blood clot may compress or lacerate the brain substance, and if the infant lives for a few days it may be followed by softening. The hæmorrhage may take place during birth, from compression of the umbilical cord, producing asphyxia, and is consequently especially common in breech presentations; or a hæmorrhage may occur in an infant born weakly or premature, it suffers from atelectasis, lives a few days, its small stock of expanded lung becomes choked, and it dies asphyxiated, and a meningeal hæmorrhage of greater or less extent is found, which probably took place shortly before death. Or the infant may live some days after the hæmorrhage has taken place, as in a case recorded by McNutt; the labour, which was a breech presentation, was easy; the breathing became irregular on the day of birth; later it suffered from convulsions, difficulty of swallowing, left hemiplegia, and emaciation. It died on the twenty-second day. At the *post-mortem* the right hemisphere was covered by a clot (see fig. 3), which was firm and gelatinous, and of a dark colour, the convolutions beneath it were in part destroyed, especially so in the ascending frontal and parietal regions. The clot also invaded the brain substance, actually forming part of the roof of the ventricle, whilst the site of the corpus striatum and optic thalamus was occupied by a reddish-brown clot mixed with softened brain tissue.

This case is remarkable as showing how long an infant may survive an extensive cerebral hæmorrhage and the further damage by the secondary inflammatory softening which evidently took place. These are instances of fatal cases, but there is good reason to believe that such cases frequently survive, and bear for the rest of their lives traces of the damage done to their brains at birth. It is not difficult to imagine the damage which a surface hæmorrhage may do. It may lead to compression of the convolutions, or meningitis, or softening, or perhaps more likely lead to atrophy, or interfere with the development of the convolutions. Such a case, verified by *post-mortem*, has been recorded by McNutt. The infant was born with the feet presenting, the labour was tedious, and there was delay in disengagement of the head. Convulsions supervened, lasting for some days; the child never walked or spoke; there was spastic paralysis of both sides, except the face; it died at two and a half years. Atrophy of the convolutions about the fissure of Rolando was found at the *post-mortem*. Similar cases are tolerably common; there is a history of a difficult labour; the infant is blue, and perhaps thought by the midwife to be dead; it may be convulsed, but recovers. There is probably no marked paralysis at first, but after a few months it is noticed that an arm or a leg, or both legs, are weak; then contractions take place, the legs becoming adducted, and the toes pointing, the forearms supinated and the elbows more or less fixed. The intelligence is often affected, and the child is late in talking. Such cases are common in asylums, as recorded by Shuttleworth ('British Medical Journal,' vol. i. 86, p. 185), Schultze (Gerhardt's 'Handbook,' vol. ii.), Langdon Down ('British Medical Journal,' vol. i. 77, Feb. 24), and others. That no definite symptoms of meningeal hæmorrhage should be present at first agrees with what has already been remarked concerning the development of the cortical substance, and its connection with the ganglia at the base of the brain. Not only is the grey matter on the surface in an immature state, but so also is its connection with the lower

parts. It is only a few months after, when the voluntary power is being put forth, that it is noticed that there is a difference between one limb and another. Convulsions may be present, and if there is any marked paralysis, it is probably peripheral, being caused by effusion of blood at the base of the brain, on the pons or cervical cord. Is cerebral hæmorrhage caused by direct pressure on the brain during labour? We confess to doubting it; at any rate there can be hardly a doubt that the common cause is asphyxia, due to interference with the placental circulation, or compression of the funis.

**Cephalhæmatoma.**—During birth a hæmorrhage may take place from the vessels of the periosteum of the skull, and a collection of blood form between that membrane and the bone; more rarely a hæmorrhage occurs between the occipito-frontalis aponeurosis and the periosteum, or between the skull and the dura mater. The name 'cephalhæmatoma externum' is applied to the first two, thus :—

Cephalhæmatoma externum	{	1. Sub-aponeurotic.
		2. Sub-periosteal.
„ internum	.	3. Sub-cranial.
Meningeal hæmorrhage	....	4. Sub-arachnoid.

In the common form the tumour is sub-periosteal. The swelling is generally discovered for the first time a day or two after birth, when the



Fig. 4.—Double Cephalhæmatoma in an Infant twenty days old (from a photograph).  
Labour difficult, forceps applied, right facial paralysis.

swollen and distorted head of the infant should begin to assume a more natural shape, occupying a position immediately over a parietal bone, generally the right. According to the statistics of Hennig and Hofmohl, a cephalhæmatoma occurs about once in every two hundred births; in one hundred and twenty-seven cases noted by Hennig, it was situated fifty-seven times over the right parietal bone, thirty-seven times over the left, twenty-one times over both, seven times over the occipital, three times over the frontal, and twice over the temporal bone. It forms a more or less tense elastic tumour, neither hot nor tender, the scalp is not discoloured, and it does not extend beyond the limits of the bone over which it is situated inasmuch as the periosteum is firmly attached to the sutures. The tumour varies in size from

a walnut to a small orange, increases in size for a few days after birth, and then commences slowly to diminish. After it has existed for a week or two, a ridge of bone may generally be felt at its circumference, where new bone has been thrown out by the periosteum (see fig. 5 *c'*). When the tumour is examined for the first time in this stage, it is apt to give the impression that there is a circular defect in the parietal bone, through which a fluid tumour is protruding. At times, especially in chronic cases, thin plates of bone may form here and there in the periosteum forming the roof of the tumour and give rise to a feeling of crepitation when it is handled. In the course of a few weeks or a month the tumour shrinks and disappears, leaving for perhaps many months a more or less complete bony ridge, which marked the circumference of the tumour. The etiology of these blood-swellings is not very clear, but, like other hæmorrhages which take place during birth, they owe their production in part to asphyxia, in which there is increased tension in the cephalic veins, and a condition of blood which readily allows

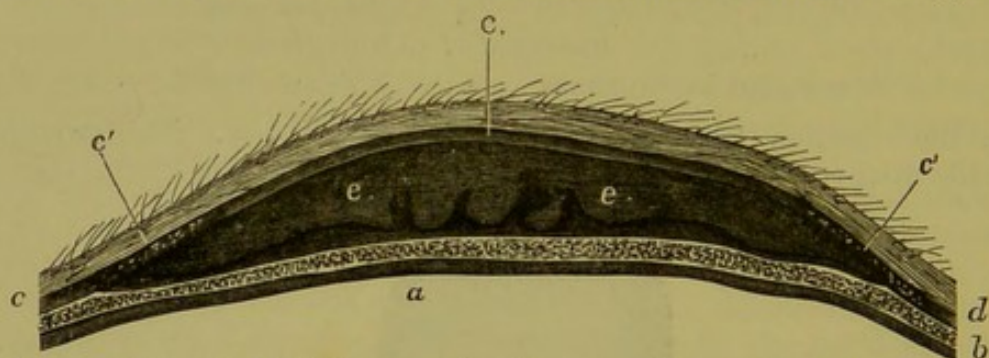


Fig. 5.—Section of a Cephalhæmatoma (semi-diagrammatic), Hennig. *a*, Dura mater; *b*, parietal bone; *c*, periosteum; *c'*, ossification of ditto; *d*, scalp; *e*, blood clot.

of extravasation. From the fact that the tumour mostly occurs at the site of the presenting part, being over the right parietal bone in nearly three-fourths of the cases, it would appear that pressure played an important part in its causation. But, on the other hand, cases are reported in which a blood-swelling appeared over a parietal bone in a case of breech presentation (Runge, McNutt). Small extravasations, the size of a pea or a shilling, may frequently be seen beneath the periosteum in making *post-mortems* on newly-born infants. If the caput succedaneum be incised, the tissues immediately beneath the scalp will be found infiltrated with a jelly-like effusion with numerous minute hæmorrhages scattered through it, and on examining the parietal bone numerous small hæmorrhages may be seen beneath the periosteum, some linear in shape, corresponding with the lines or foramina in the bone situated near the inter-parietal suture or posterior fontanelle. According to Féré the edges of the foramina play an important part in wounding the vessels during labour, and producing a hæmorrhage, as they are the means of transmitting small veins from the scalp to the cerebral sinuses. It is important to bear in mind that not infrequently an effusion of blood external to the skull communicates with an effusion of blood between the bone and dura mater through one of these openings, and further, a meningeal hæmorrhage may also take place.

Three *post-mortem* examinations made by Runge are worth recording, as illustrating some of these points: (1) breech presentation; delay in deliver-

ing head; infant born in condition of asphyxia; died on the eighth day in convulsions. The *post-mortem* showed a cephalhæmatoma over the left parietal bone surrounded by a bony ridge; a large hæmorrhage over the convexity of the brain beneath the dura mater, reaching to the base and upper part of the cervical cord. (2) A premature infant delivered by forceps in consequence of maternal eclampsia; born asphyxiated, died on the first day; there was a cephalhæmatoma over the right parietal bone, communicating through a fissure in the bone with a second effusion of blood beneath the bone between it and the dura mater. There was also meningeal hæmorrhage. (3) Infant born asphyxiated, reanimation, death on the sixteenth day from arteritis umbilicalis. There was a cephalhæmatoma, covering the whole of the right parietal bone; a hard bony wall roofed in the circumference of the swelling. A surface hæmorrhage had taken place at the base of the brain.

The diagnosis is not generally a matter of difficulty. A blood tumour beneath the periosteum is distinguished from a caput succedaneum, inasmuch as the latter does not fluctuate, disappears in a day or two, and extends beyond the limits of a parietal bone. It is distinguished from a meningocele in that the latter corresponds to a suture or fontanelle, pulsates, and increases in size when the infant cries. Very rarely a blood swelling takes place beneath the scalp, between the latter and the periosteum. In such cases the scalp is discoloured, no bony ring would be formed, and the swelling might extend beyond the sutures. The prognosis as far as a cephalhæmatoma is concerned is favourable, but inasmuch as it is possible that it is complicated by meningeal or extra-dural hæmorrhage the prognosis must be guarded, and any brain symptoms would necessarily be of evil omen.

*Treatment.*—The treatment of these blood swellings has been much discussed. On the one hand it has been urged that if the cephalhæmatoma is subperiosteal, it should be aspirated without delay while the blood is fluid and before coagulation has taken place, as in this way the long delay during which absorption and deposition of bone is taking place is avoided. On the other hand it has been pointed out that it is never possible to tell if the blood swelling does not communicate with a blood extravasation within the skull, thus rendering surgical interference risky, and moreover that, although absorption of the effused material may be tardy, it is both safe and sure, and a good result may be confidently looked forward to. The latter course is certainly to be recommended; surgical interference in a newly-born infant always has its risk, there is always the possibility of introducing septic organisms into the blood-swelling by aspiration, and at the most, all that is to be gained by such a proceeding is the gain of a few weeks of time. We believe that all cephalhæmatomata are most safely let alone, care being taken to protect them from injury; small ones may be shaved and painted with collodion, or during sleep some spirit lotion may be kept applied. In the rare event of their suppurating the treatment would be that of an ordinary abscess—viz. evacuation of the pus and drainage.

**Hæmatoma of the Sterno-mastoid.**—If an attempt be made by an unskilful midwife to disengage the after-coming head by pulling on the legs or body of the infant, there is a strong probability that injury will be done to the neck or other part, especially as the muscles of the semi-asphyxiated infant are flabby and toneless, and the blood readily oozes out of the vessels.

Such an injury does at times take place, giving rise to a blood tumour beneath the sheath of one of the sterno-mastoids in consequence of the tearing through of some of the fibres of the muscle or injury to some of its vessels. It is not often that an opportunity occurs of verifying this *post-mortem*, inasmuch as no serious consequences arise from this accident, and the pathology of these so-called 'sterno-mastoid tumours' has been disputed;<sup>1</sup> but three cases recently published by M. Tordeus have made it clear that these swellings are due to local hæmorrhage resulting from injuries at birth. At least three-fourths of these cases are breech presentations; in the remaining fourth, which occur in head presentations, the injury is no doubt caused by dragging on the head in order to disengage the shoulders and body. The swelling in the neck may be noticed by the mother a few days after birth, or it may escape observation for some weeks, or even more. On examination a tumour about the size of a pigeon's egg may be felt in the upper part of the right sterno-mastoid; it is generally irregular, or perhaps elongated, in shape, and if not seen for some time after birth, when cicatrisation has taken place, it is hard and cartilaginous to the touch. The left muscle is less often affected than the right; sometimes the whole length of the muscle is affected, though the usual place is generally the upper part. The tumour disappears in the course of a few months, but for a long time a cicatrix may be felt. There is no treatment required. These cases mostly occur among the poorer classes, who are attended in their confinements by neighbours or unskilled midwives (*see TORTICOLLIS*).

**Obstetrical Paralysis.**—In cases of delayed labour, where the forceps have to be applied, or where force is used to disengage an arm, or traction applied to it, some nerves or strands of nerves are apt to be injured either by stretching, direct pressure, or compression by extravasated blood. The most common and best known is an injury to one of the facial nerves through pressure exerted by one of the blades of the forceps during extraction. A facial paralysis is thus produced, which as a rule is temporary, and disappears in a few days or weeks. The other and less common form, which has been described by Duchenne as 'obstetrical paralysis,' is due to an injury to one or other of the cords of the brachial plexus, produced by the pressure of the finger hooked in the axilla in order to extract the arm and shoulders, or the arm has been forcibly wrenched when it has been used to lay hold of to drag the infant through the pelvis. Occasionally an injury may be done to the brachial plexus as well as to the facial by the grip of the forceps blades, as in a case recorded by Roger, where the face and arm were paralysed. After death an effusion of blood was found at the stylo-mastoid foramen, and also round the cords of the brachial plexus. The cord most often injured is apparently the fifth cervical nerve, which, as Ross has shown, is readily injured, at the point where it descends over the transverse processes of the fifth and sixth cervical vertebræ on its way to join the brachial plexus, by force applied to the arm or clavicle. The prognosis in paralysis of the arm from a lesion of the brachial plexus is more serious than it is in paralysis of the facial, but it will necessarily vary according to the amount of injury done and the degree of paralysis present. The symptoms presented by this form of paralysis may be illustrated by the following cases which came under our notice:—

<sup>1</sup> They have been described by some authors as gummata.

In the first case, the head, according to the mother, was born first ; there was then a delay ; finally the left arm was disengaged by the finger hooked in the axilla, and the child born after some delay and difficulty. The infant was first seen when seven weeks old. At this time its arm hung uselessly by its side, the elbow extended, the humerus rotated inwards and adducted, the forearm pronated, the hand closed, the paralysed muscles being the biceps and brachialis anticus, the infra-spinatus and teres minor, the deltoid and supinators. The muscles affected were soft and flabby. The arm was regularly galvanised, the Faradic current being used. Three years afterwards great improvement had taken place ; the elbow could be flexed and the hand could be used, but a paresis remained of the deltoid and supinators. In another case, seen first at ten weeks of age, the same muscles were paralysed, much improvement took place, but the infant died at six months of age of bronchitis. In a third case, which was a footling, the left arm engaged the pelvis with the head, and had to be brought down by the accoucheur. The arm was noticed to be bruised and useless after birth. Unfortunately this case was lost sight of. In two cases reported—one by Seeligmüller, the other by Thorburn—the paralysis was more extensive than in the above cases ; there was also retraction of the eyeball and contraction of the pupil of the same side. Probably there was here a more severe injury, involving the whole brachial plexus and also the sympathetic. In some cases a temporary anæsthesia has been noticed. In the treatment of these cases it must be borne in mind that one or more of the cords of the brachial plexus has been injured, accompanied by a local hæmorrhage ; and, therefore, the more at rest the arm can be kept for the first few weeks the better. It seems doubtful if any shampooing or galvanising the muscles can at first do much good. The treatment must be rather that of a fractured bone—rest at first, and afterwards more or less active movement to exercise the muscles and prevent stiffness. The arm should be carefully wrapped up in cotton-wool, flexed and supported by being fixed to the side, care being taken to prevent undue disturbance during the daily bath, or allowing it to hang down and drag on its connections with the trunk. It must be borne in mind that the circulation of blood will be sluggish, and easily obstructed by tight bandaging. At the end of three weeks, when there is reason to believe that absorption of the effused blood has taken place, movements of the arm may be begun, in order to give the muscles some exercise and to call forth the voluntary efforts of the child. Electrical treatment may now be commenced, that form of current being used (mostly the Faradic) which most readily produces a contraction of the paralytic muscles. The weakest current which will cause a contraction will be the best to use. Galvanism in some form or other, shampooing the muscles, applying stimulant applications to the skin, must be persevered with as long as any improvement takes place. The prognosis in the severe cases is gloomy as far as the paralysed muscles are concerned, the arm remaining in a condition of extension and pronation, being unable to be raised to the mouth. In other cases, as in the one mentioned, recovery takes place sufficiently to allow of flexion of the elbow, though a certain amount of weakness may be left about the shoulder and in the supinators of the wrist. In the majority of cases considerable improvement may be expected in the course of months or years.

**Icterus neonatorum.**—Infants often suffer from a more or less pro-

nounced jaundice which comes on a day or two after birth. It has been estimated by Continental writers that this occurs in from 60 to 80 per cent. of the total births, but these observations have been mostly made in lying-in hospitals, where it appears to occur much oftener than in private practice, though there is little doubt that on account of the slowness of the yellow coloration of the skin, and the frequent absence of discoloration of the sclerotic, it may easily be overlooked. Jaundice may arise from or be symptomatic of various pathological conditions, the principal during the first week of life being the following :—1. The common form in which no disease is apparent. *Icterus neonatorum*. 2. Jaundice accompanying a condition of septicæmia following disease of the navel ; in acute fatty degeneration of the newly born ; in Winckel's disease. 3. Jaundice due to congenital stricture, or obliteration of the common or hepatic duct, or to syphilitic perihepatitis. The common form to which the name of '*icterus neonatorum*' is generally applied differs from the other forms in not being accompanied by any serious symptoms, and in passing off in a few days or a week. In these cases the yellow coloration of the skin makes its appearance on the second day, less often the third, rarely either before the second or after the third, and lasts, according to its intensity, from two or three days to a week. The yellowness is first noted on the face, around the mouth and chest, then on the abdomen, later on the limbs ; it may be easily overlooked, unless pressure is made by the finger on the skin. In mild cases the sclerotics remain unaffected, and the urine does not stain the linen ; this is the more noteworthy, as in the jaundice of adults the sclerotics are affected before the skin is tinged, and pigment very early is present in the urine ; probably the vascularity and transparency of the infant's skin will account for the difference. When the jaundice in the infant is more intense, the sclerotics become tinged ; the urine stains the diapers, and bile pigment may be detected. The stools are unchanged and contain the usual quantity of bile. In cases which die when suffering from this form of jaundice, the internal organs are found stained yellow, especially the cartilages, the brain, and in a lesser degree the abdominal viscera. The majority of infants who are jaundiced appear in perfect health ; it has, however, been asserted by Hofmeier that infants with *icterus* do not flourish as well as other infants, that their loss of weight during the first week is greater than that of healthy infants, and that a higher percentage of urea and uric acid appears in the urine. The cause of this form of jaundice is uncertain ; it is much more frequent in lying-in hospitals than in private practice, and in premature weakly infants with partially expanded lungs than in full-time and healthy infants. There have been many hypotheses concerning its cause, but none of them are entirely satisfactory. One of the most recent and most plausible explanations has been suggested by Quincke ; he attributes the jaundice to the ductus venosus remaining patent, thus allowing some of the portal blood (which contains bile-pigments) to pass into the general circulation, instead of all of it being submitted to the action of the liver. Virchow and others believe it to be a hæmatogenous jaundice, the bile-pigment originating in a destruction of blood corpuscles which it is supposed takes place shortly after birth.

While this form of jaundice *per se* is a symptom of little importance, and in the vast majority of cases the infants do well, it is well to remember that

occasionally cases occur which are jaundiced shortly after birth, and which die about the ninth or tenth day without any definite disease being discoverable. These cases sometimes occur in the same family, as in the following remarkable instances: the father and mother were both healthy and in comfortable circumstances, there was no history of syphilis, the first and second children were never jaundiced, and are at present alive and well; the third, fourth, fifth, and sixth children became jaundiced on the second or third day, and died on the ninth or eleventh day. In all the skin and conjunctivæ were jaundiced, the urine contained bile-pigment, the stools were normal. The fifth child was seen with Mr. G. H. Pinder, their medical attendant, when five days old; it seemed a perfectly healthy infant, except that it was jaundiced. The infant became weaker and drowsy, and died comatose on the ninth day. A partial *post-mortem* only was obtained; the abdominal viscera were bile-stained; the ductus venosus was only partially closed; there was nothing abnormal about the bile-ducts. What is the nature of these and similar cases it is at present impossible to say. The diagnosis between icterus neonatorum and the jaundice which accompanies pyæmia does not present much difficulty, for in the latter case there would be some suppuration or phlebitis of the umbilical cord. In acute fatty degeneration and Winckel's disease there is usually cyanosis, purpuric spots and hæmorrhages. In jaundice from obstruction of the ducts, the jaundice is intense and bile is absent from the stools. Nothing much can be said about the treatment of infantile jaundice, which consists rather in attending carefully to the general health of the infant than in the administration of any special drug. Small doses of hyd. c. cret. may be given for its laxative effect, and to relieve any tendency to mechanical congestion of the liver.

**Acute Fatty Degeneration of the newly born.**—Buhl, in 1861, described the symptoms and morbid anatomy of a rare disease, occurring in newly-born infants, to which he gave the name of acute fatty degeneration. His observations have since been confirmed by Hecker, Furstenburg, Roloff, and Runge, though it cannot be said that this condition is sufficiently well known for it to take its place as a well-defined and definite disease. The infants suffering from it are generally born in a condition of asphyxia, without obvious cause, and some die asphyxiated. If they survive they usually suffer from more or less cyanosis, with hæmorrhage from the bowels, stomach, or from the navel on the separation of the cord. There is often jaundice, and blood extravasations take place beneath the skin, conjunctiva, or mucous membrane of the mouth; there may be general œdema; death usually takes place within two weeks. At the *post-mortem* minute hæmorrhages are found in the various internal organs, sometimes they are infiltrated with blood; the tissues are bile-stained. On microscopical examination of the tissues of the heart, liver, kidneys, &c., they are found to be in a condition of fatty degeneration. The nature of the disease is quite unknown. It is interesting to note that a similar condition has been noted in newly-born pigs and other domesticated animals.

**Winckel's Disease.**—A disease somewhat similar to the last has been described as occurring in an epidemic form by Winckel, and is characterised by cyanosis, jaundice, and hæmoglobinuria. This epidemic occurred in the Foundling Hospital, at Dresden, in 1879, where twenty-three infants were

affected in the course of a month. The symptoms noted were first of all a bluish tinge on the skin of the face, body, and limbs, with a more or less icteric tint; in some cases there was vomiting and diarrhœa. The urine was of a light brown colour, with a sediment consisting of epithelium and casts; the blood contained an excess of white corpuscles and many granular bodies. The symptoms mostly began on the fourth day after birth, death occurring in one case in nine hours, though the average duration of the disease was about two days. The sections showed a yellow staining of the skin and internal organs. The spleen was large and hard and dark red; the kidneys were usually dark brown in colour, the microscopic examination showing their tubules to be filled with granular pigment. There were punctiform hæmorrhages on the surface of the various internal organs, and fatty degeneration of the liver and heart.

**Gastro-intestinal Hæmorrhage.**—The vomiting of blood, or its passage per anum, is not an uncommon occurrence in the newly born. The most common cause, especially of hæmatemesis, is the swallowing of blood oozing from a cracked nipple, which the infant sucks, or from some wound in the infant's mouth or nose. Large quantities of blood may be swallowed in this way and vomited in a more or less altered condition, or passed as blackish masses with the fæces. The source of the bleeding may be a small ulcer or ulcers in the stomach or duodenum which may open a large vessel and cause fatal hæmorrhage, as in a case recorded by Goodhart and another by Sawtell. In the majority of cases the bleeding appears to be capillary, due to a congested state of the portal system, or to a purpuric condition, or a tendency to hæmophilia. In some cases there is a slight discharge of blood from the rectum and genital organs after birth, which may be due to congestion of the pelvic veins, through stoppage of the circulation through the iliac arteries when the cord is ligatured. The hæmorrhage in most instances comes on within the first twenty-four hours; if the amount of blood lost is large the infant quickly becomes pallid, the skin cold, the fontanelles depressed, and convulsions probably follow. Death usually takes place within twenty-four hours of the commencement of the symptoms; if the infant survives this period and no fresh attack comes on, there is reason to believe there is no lesion of the stomach or duodenum and there is good hope that the infant may survive. The treatment would naturally depend upon the diagnosis as to the cause. Small doses of ergotine (quarter grain to half grain) in syrup, by the mouth or subcutaneously, would be the most likely to be of service.

**Hæmorrhage from the Genital Organs.**—It sometimes happens that there is a small oozing of blood from the vagina during the first few days succeeding birth, sufficient to stain the napkins. The blood may often be seen oozing from the vagina, while no lesion of any kind can be detected. The discharge lasts for a few days only, generally from two to five, the health of the infant does not suffer, and recovery seems always to take place. Cullingworth has collected thirty-two such cases, two of which came under his own observation. He agrees with Cameron in believing that the bleeding is due to a congestion of the pelvic veins, the result of the cessation of the circulation in the iliac arteries when the cord is tied. As already stated, there is sometimes a coincident discharge of blood from the rectum, due

apparently to the same cause. It must not be forgotten that cases of precocious menstruation may occur, commencing shortly after birth, and continuing monthly afterwards.

**Diseases of the Navel. Separation of the Cord.**—Under ordinary circumstances the umbilical cord shrivels up and drops off at a period after birth varying from the first to the fifth day, thin small cords drying up and separating earlier than large soft ones (Bouchut); the cicatrix is not usually dry and firm until the tenth or twelfth day.

**Umbilical Polypus.**—Occasionally, after the cord has separated, a small red prominent projection is left with a moist surface, and sometimes (Holmes) a fine central canal; this 'polypus' is the result in most cases of incomplete withering of the cord, at other times the outgrowth is rather of the nature of a simple granulation polypus from irritation, the so-called 'fungus of the navel.' The projection, when small, is often hidden by the overhanging skin of the part, and may remain for weeks or months, giving rise to slight discharge from the scar and perhaps excoriation of the skin around. Like the simple granuloma in appearance is the so-called **adenoma** or enteroteratoma of Küstner and Kolaczek; this, however, consists of muscular fibre and tubular glands lined with cylindrical cells; it is supposed to be a prolapse of the remains of the vitelline duct. This form of outgrowth is much rarer than the other, slower in growth, and occurs in older children, being met with up to the fourth year. Huttenbrenner describes another variety as a remnant of the allantois, while Féré speaks of **sarcoma** of the umbilicus, which appears, according to Runge, to be the simple granuloma. Virchow, however, describes a case where an outgrowth four inches in length existed; it was red upon the surface and made up of spindle-celled tissue.

The *treatment* of these affections is very simple: for the larger ones a ligature should be applied tightly round the base, and the mass allowed to fall off; the smaller ones may be snipped off with scissors or rubbed down with nitrate of silver, or dusted over for a few days with powdered nitrate of lead, which we have found an effectual remedy. It must be remembered that there is considerable variation physiologically in the process of separation of the cord; in weakly children it falls off later and the raw surface is slower in healing. Where the cord stump is projecting it is liable to be irritated by friction and its healing is slow; this is the condition described as **excoriation**. When a sort of 'mucous surface' remains and goes on discharging, the so-called **Blennorrhagia** exists, while the presence of a thick consistent film on the surface of the sore has been described as **croupous** or **diphtheritic exudation**; in some instances it is probable that a true diphtheritic membrane may be formed.

Where there is any spreading ulceration after separation of the cord, infective influences should be looked for; the mischief may spread superficially or it may tend inwards and involve the peritoneum.

**Simple ulceration** is never fatal unless it extends deeply; it should be treated, according to Runge, by the application of salicylic acid and starch—1 in 5 for the milder cases, or 1 in 3 if there is any sloughing; ointments he disapproves of.

**Omphalitis** is a rare condition. When it exists the navel itself and the surrounding parts are inflamed and swollen, the wound remains unhealed,

and the skin around is red, shiny, tense, and painful. The disease may spread and involve nearly the whole of the abdomen either superficially or throughout the entire thickness of the abdominal wall; the infant becomes very ill, the legs are stiff and drawn up, breathing is thoracic, and small abscesses may form and burst from time to time. The disease begins in the second or third week of life and may last for some days or even weeks. The prognosis is good if the extent of mischief is small and suppuration occurs early, bad if the disease is widespread, and especially if it tends inwards towards the peritoneum; if the navel vessels are involved, general sepsis or gangrene is likely to result. The younger the child the greater is the danger.

The cause of this disease is doubtful. Probably it arises from bad management of the navel and infection. Fribe believes some cases are syphilitic; is it possible that some may be instances of sloughing phagedæna? According to Bouchut it is sometimes complicated by bleeding. Treatment consists in cleanliness and the application of salicylic acid beneath a warm wet dressing (Runge). All abscesses should be opened early, and any tendency to gangrene met with stimulants and antiseptics.

**Gangrene** of the navel begins either as an ulcer or from omphalitis; it occurs also in cases of cholera infantum; as a purely local condition it is rare, and Wiederhofer believes arises from intense omphalitis. Premature separation of the cord or irritation tends to produce gangrene.

The disease usually begins as a blister containing muddy fluid; on bursting this leaves an ulcer, or a sore may exist from the first; the mischief spreads rapidly either superficially or deeply; a bright red zone is seen surrounding a central slough, which after a time comes away; there is rapid prostration of strength, though but little pyrexia. Recovery from gangrene of the navel is rare, though sometimes the slough separates and the cavity granulates up; more often death results from peritonitis or exhaustion, or again from gangrene of the bowel and perforation, which is sometimes met with; occasionally a fæcal fistula is formed.<sup>1</sup> In many cases general sepsis occurs, and Ritter believes the gangrene is merely a result of the septic condition. In cholera infantum there is sometimes rapid gangrene without any sign of reaction, and this may occur as late as several months after birth; it is always fatal.

The *treatment* of gangrene consists in free stimulation and the use of antiseptics; nitrate of silver, perchloride of iron and salicylic acid are recommended by Runge, to whose work, 'Die Krankheiten der ersten Lebensstage,' we are indebted for nearly all our information on these diseases. Fæcal fistula, if the child survives, should be treated as in older children.

**Umbilical Arteritis.**—In fifty-five subjects of disease of the umbilical vessels Runge found fifty-four cases of arteritis, and in only one was there phlebitis alone. The mischief begins as inflammation of the cellular tissue round the vessels, and then spreads to them, producing thrombosis. Pelvic cellulitis, which sometimes occurs, is the result of septic lymphangitis spreading directly along the cellular tissue, and is not due to embolism.

Birch Hirschfeld believed in phlebitis as a common affection, but Runge points out that the greater frequency of arteritis is due to the fact that the

<sup>1</sup> In one remarkable case an intussusception occurred through a fæcal fistula.

area of cellular tissue surrounding the arteries is twice as great as that round the veins. Inflammation in cases of arteritis may spread far and wide from the navel, and even reach the bladder or its neighbourhood. Where arteritis exists the navel presents often a projecting discoloured ulcer covered with a scab; sometimes, however, the scar is healed and quite natural in appearance. The disease may arise either before or after separation of the cord, and suppuration or sloughing may occur.

Sometimes the lumen of the arteries is seen open, and the vessels are full of pus or breaking-down clot; suppuration usually spreads along the vessels as far as the cellulitis extends, beyond this adherent coagula are found. At times the arteries are pouched, and the sacs formed are found full of pus; the intima of the vessels is always dull and has lost its polish.

The most common complication of the disease is pneumonia; this was found in twenty-two of Runge's fifty-five cases; septic inflammatory foci may, however, also occur in the liver, spleen, kidneys, peritoneum, bones, and joints, &c. Erysipelas sometimes attacks the part and slight jaundice is common, though severe jaundice with hepatitis is rare. Of Runge's fifty-five cases, in nine there was arteritis alone, in sixteen there were complications such as syphilis, 'atrophy,' cerebral hæmorrhage, &c., and in the remaining thirty cases there were pyæmic lesions. Buhl, Wiederhofer, and Müller differ from Runge in thinking that usually the disease affects only the abdomen and its viscera. Peritonitis is to be suspected as soon as distension appears. Tetanus is an infrequent complication. Arteritis is a disease of dirt and neglect; it occurs in epidemics, and is often associated with puerperal fever; it may be inoculated by the lochia or decomposing umbilical cord, and has been found associated with ophthalmia neonatorum. It usually runs a rapid course, lasting from four to eighteen days, and is especially fatal to young and premature children; in older infants the prognosis, though bad, is not absolutely so; in fatal cases death is usually sudden.

**Umbilical Phlebitis.**—As already pointed out, umbilical phlebitis is a rare disease. Birch Hirschfeld, in examinations of sixty infants who died of septic diseases beginning in the navel, found eleven cases of phlebitis, four cases of simple thrombosis of the vein, and thirty-two cases of arteritis, while in three instances both the arteries and vein were involved. Runge has only twice seen phlebitis apart from arteritis.

The general appearances of phlebitis are very like those of arteritis: there is thickening of the perivascular tissue, the lumen of the vein is diminished; it is tortuous and contains pus or sanious material, the intima is cloudy and eroded. Usually the whole vein as far as the liver is affected, and there may be hepatitis; Wiederhofer found Glisson's capsule and the portal vein both involved. Peritonitis and intense jaundice are both common. The etiology of the disease is the same as that of arteritis. The symptoms of phlebitis are fever, icterus, altered respiration, inspiration being short, expiration prolonged, while the breathing is shallow, frequent, and entirely thoracic; the upper part of the abdomen is tumid, and there is local tenderness, the knees are drawn up and the child is restless. It is difficult to diagnose phlebitis from arteritis; the intense icterus in the former is the most characteristic feature. The disease lasts only a few days, and is always fatal from general sepsis. The treatment of both arteritis and phlebitis consists

in the application of salicylic acid or other antiseptic and the use of stimulants and free nourishment, together with careful cleanliness.

These diseases appear to be almost unknown in this country at the present day, judging from the absence of any literature, but they are likely to be met with in dirty quarters of large towns.

**Umbilical Hæmorrhage** is to be looked upon as a symptom rather than a disease in itself; it is met with in the shape of bleeding from the umbilical vessels themselves, and as a general oozing from the raw navel surface.

Bleeding from the vessels may occur from slipping or imperfect tying of the ligature round the cord; as, for instance, when a thin ligature cuts into the vessels. Bleeding, of course, by no means necessarily follows slipping of the ligature, or even failure to tie the cord at all; the aspirating action of breathing prevents any hæmorrhage in most instances, and this is supplemented by the contraction of the vessels after birth.

Asphyxia may, however, produce some escape of blood as the vascular pressure rises in slight degrees of suffocation; in other instances deficient muscular contraction appears to be the cause, hence bleeding is most common in premature children who have been asphyxiated or whose lungs have not expanded. If it arises from imperfect muscular contraction it may occur some hours after birth (Hofmann). As the vessels begin to contract at the cord, and the obliteration extends towards the hypogastrium, there is more risk of bleeding if the cord is cut very short. So, too, drying up of the cord tends to obliterate the vessels, while gangrene and swelling tend to prevent their closure. Bleeding may also occur later from rough handling of the navel and separation of the scab. All danger of this form of hæmorrhage may be prevented by tying the cord firmly with a broad ligature not too near the abdominal wall; should bleeding occur, pressure or the application of astringent powders, a fresh ligature or acupressure will arrest it.

Idiopathic or spontaneous bleeding so called is a very rare occurrence, and its etiology is obscure. Grandidier collected twenty-two cases from various sources. The bleeding usually occurs about the fifth day, just after or more rarely before the cord comes away,<sup>1</sup> the blood trickles from the surface of the umbilicus, and not from any distinct vessel; the oozing may be continuous or intermittent. The subjects of the affection are generally healthy full-time children; there is often, however, slight icterus, in other cases there is some intestinal disturbance, vomiting, colic, &c., with deep icterus, cyanosis, and drowsiness before the bleeding occurs; in any case these symptoms appear soon afterwards. Bleeding not seldom comes on from the stomach or intestines, or there may be general purpura, and sometimes there is œdema of the hands and feet together with the navel hæmorrhage.

The great difficulty or impossibility of stopping the flow is characteristic of the condition. Most of the cases die before the second week; the mortality is put down as 83 per cent.; the infant usually dies comatose, less often in convulsions.

Umbilical hæmorrhage is a symptom of several diseases, probably in some cases it is due to hæmophilia; syphilis, privation, drink, and other depressing causes acting upon the mother are assigned as reasons for it. Syphilis,

<sup>1</sup> 'It may, however, come on in the third week.'—MINOT.

septicæmia, and 'fatty degeneration of the new born' are causes that have been established by *post-mortem* evidences. The blood shows nothing abnormal microscopically; in all cases, however, micro-organisms have been found and emboli seen in various parts from which bleeding has occurred. The blood in these children does not clot readily. It is said to be a commoner disease in America than elsewhere.

Pressure by various means, such as pads, filling the navel with plaster of Paris, underpinning, &c., may be tried as means of treatment with some hope of success; caustics and astringents, such as perchloride of iron, do not appear to be of much use; the actual cautery has succeeded. Idiopathic bleeding is very rarely met with; Fürth has collected records of some cases in 'Arch. f. Kinderh.' B. v. H. 7 and 1; it is sometimes epidemic. Weiss had 31 cases out of 742 children in one year at Prague.

For further details, *vide* a paper by Dr. Francis Minot in the 'American Jour. of Med. Sci.' Oct. 1852.

For other morbid conditions of the umbilicus, see 'Deformities of the umbilicus.'

**Tetanus nascentium.**—This disease is almost unknown in this country at the present day, although in past times, when less attention was paid to general hygiene in lying-in hospitals, it was common, and sometimes was the largest factor in infant mortality; it was also frequent at one time among the negro population in America. The disease appears to be caused chiefly by unhealthy conditions of the navel arising from exposure to wet, cold, and bad air, also by accidental injuries, and possibly, as Marion Sims believed, by continuous pressure upon the brain from yielding of the soft occiput when the infant is kept constantly lying upon its back. Hartigan, in the 'American Jour. of Med. Sci.' for Jan. 1884, supports Marion Sims's view, and points out that parietal pressure may have the same effect. Tetanus ('nine-day fits') usually appears in the first two weeks of life, most commonly from the third to the tenth day, the limits, according to West, being from the fifteenth hour to the fifteenth day. The symptoms are usually acute, the earliest being inability to suck from spasm of the facial and jaw muscles (trismus); general contractions, however, soon occur, the spasms are continuous, but increase in violence at intervals; in most cases there is no complete relaxation. The child often utters a peculiar whining cry and there is well-marked risus sardonicus; the maximum rigidity is generally reached in twelve hours, and the child dies in a fit or becomes comatose.

The spasms are increased by any exposure to cold or by noise; emaciation is very rapid and there is often jaundice. Death usually occurs in one or two days; in rare cases the disease is chronic. Hartigan says the chronic form begins with dysentery and coldness and pallor of the skin, hence it has been called 'white lockjaw.' It is attended by wasting and twitchings, and was described by Marion Sims as 'Trismoid.' Unlike the acute form which always occurs within the first month of life, the chronic variety may appear at any time within six months, and may be a sequel of the acute, due to occipital pressure. Hartigan supports the pressure view by the statement that convulsions can be brought on at will by compressing the occiput.

<sup>1</sup> Syphilitic umbilical bleeding was first described by Behrend in 1877; its occurrence is, however, doubted by Petersen (*Jahrb. f. Kinderheilkunde*, Bd. xxi. H. 4).

The pathology of the disease is, however, still uncertain, the spinal and other hæmorrhages found after death being more probably a result than the cause of the tetanus. The disease is readily recognised by the spasms and general rigidity.

The *treatment* consists in avoidance of irritation and the removal of insanitary conditions. Opium, chloral, bromide of potassium, cannabis indica, belladonna, and other drugs have been occasionally successful ; warm baths sometimes relieve the spasms, and spinal icebags are worth a trial ; anæsthetics, such as ether and chloroform, are useful to relieve pain and allow the child to be fed, but none of these remedies have given any constant good result. Further details of the disease and references will be found in the works of Bouchut and Meigs and Pepper.

Hartigan, following Marion Sims, advocates not only the avoidance of occipital pressure by posture, but where this is insufficient would elevate the depressed bone by puncturing the skull and prising out the indentation.

## CHAPTER III.

## THE HYGIENE AND DIET OF INFANTS AND CHILDREN.

**Newly-born Infants.**—One of the first cares of the nurse after the navel has been properly attended to, should be to direct her attention to the infant's eyes, carefully wiping away, by means of a soft rag, any mucus or vaginal discharge which may adhere, and thoroughly cleansing the eyelids with warm water. This is a matter of much importance and should never be neglected, for if conjunctivitis or a purulent ophthalmia be set up, much trouble may ensue and some time elapse before a healthy state is again attained, and the risk of corneal opacities and consequent loss of sight is by no means small. The temperature of the room in which mother and infant are should be maintained, at least in winter, at 65°, and means be taken to thoroughly ventilate it without producing draughts.

In giving the infant its first bath—necessary on account of the slimy whitish secretion with which the infant is covered—care should be taken that it is done before a good fire, and that the water of the bath is not too warm; the temperature should not exceed 90°; the infant's skin is exceedingly tender and hot baths are liable to give rise to urticaria or even pemphigus. The infant is usually given a daily bath in order to secure cleanliness, especially about the genital organs and buttocks, which are fouled by contact with the diapers, and nothing is more likely to give rise to excoriations and intertrigo than the skin being smeared with decomposing urine. Some infants' skins are far more tender than others and liable to eczema, and require constant care to avoid irritation. For such, care should be taken in the selection of a soap which is free from excess of alkali, such as the best class of pure Castile soaps, or Unna's 'over fatty' soap, all excess being removed in the bath. The skin should be carefully dried with a soft towel, and some fine dusting powder applied to the folds of the groin and buttocks. This may consist of finely powdered maize or buckwheat flour mixed with 2 per cent. of salicylic acid, or 5 per cent. of boracic acid, to prevent any tendency to decomposition. Pure boracic acid, as in the 'Sanitary rose powder,' answers very well, and as it is soluble in water is easily removed by washing. The diapers should be of a soft and absorbent material; at least a dozen should be provided for use during the twenty-four hours.

In the first few days, before the cord has separated, a flannel binder loosely applied is necessary to protect it and keep the dressings in position, but afterwards all binders should be avoided; at least nothing tight should be applied round the abdomen which would cause discomfort to the child by compressing the abdominal viscera.

It is hardly needful to say that a cot should be provided for the infant with a firm mattress protected by a waterproof covering, and under no circumstances whatever should the infant be allowed to sleep in bed with its parents or nurse ; fatal accidents through suffocation of the infant beneath the bed-clothes are constantly occurring in consequence of the mother falling to sleep with her infant in bed with her.

**Clothing.**—All the clothing should be loose, and as far as possible consist of woven or knitted woollen material, but it will have to be protected from being fouled by the discharges by means of napkins, which may be made of 'swansdown' or similar material. The common tendency is to load the chest and body with too great an amount of clothes and to leave the legs and thighs too much exposed. For the latter, long loosely fitting woollen drawers coming to the waist should be used, carefully protected from being wetted by the diapers.

**Infant Feeding.**—The natural food of an infant is the milk from the breast of its mother, no kind of food being thought of for the first eight or nine months of its life. The importance of this is illustrated by the fact that of the deaths of infants which occur under one year, three-fourths are of infants brought up on artificial food. The mother's health may of course sooner or later interfere with the performance of this duty to her infant, but it is of great importance that it should be attempted, if for only a few weeks or months, for to undertake the artificial feeding of an infant from the first is to expose it to serious risk.

The infant should be put to the breast a few hours after birth, after the mother has somewhat recovered from the pains and fatigue of labour, and has had some sleep. The infant should have regular hours of nursing ; every two hours will be often enough for the first week—that is, some eight to ten times in the twenty-four hours ; as long an interval as possible being left during the night in order not to disturb the mother, the last meal for the night being taken at 11 P.M., the nurse then taking charge of the infant and placing it in its cot for the night. It is of much importance that both mother and infant should get as much rest at night as possible, and if the infant frequently wakes crying, every means should be taken to hush it off to sleep again, and for this a little sweetened water or barley water may be used. It is not unlikely that for the first few days, especially in primiparæ, the supply of milk will be scanty and the infant will hardly get its full supply ; but this is a matter of little importance, and it is in many respects well not to overload the stomach at first, but to give it an opportunity of gradually accustoming itself to its new function.

Observations differ somewhat with regard to the amount taken daily by the infant during the first few weeks of life ; in the first place it must be borne in mind that the newly-born infant's stomach is only capable of containing about  $1\frac{1}{2}$  oz. ; anything beyond this would over-distend it, though it is probable that absorption goes on quickly. It has been shown experimentally, by weighing infants after feeding, that the amount taken daily during the first month varies from 10 to 15 fluid ounces, though generally much less during the first few days. During the second month from 15 to 20 fluid ounces, and from the third to the sixth, probably from 20 to 40 ounces will be taken every day.

The milk of the first few days, or colostrum, differs from the milk of later periods in that it has a higher specific gravity, contains less sugar, more salts, and is coagulated by heat in consequence of the large amount of albumen it contains. The albumen, according to Pfeiffer, diminishes as lactation progresses; while the amount of sugar increases, the amount of fat remaining tolerably constant. The same author has shown by analysis that the last portions of the breast milk, like the 'strippings' from the cow, contain more fat and less albumen than the early portions. The amount of milk secreted remains tolerably constant up to the end of the seventh month, when it begins to decline. Menstruation usually recommences about the fifth month, and is generally no bar to the continuance of nursing, though at this period the sugar in the milk appears to be increased, and the infant may possibly suffer in consequence from an intestinal catarrh. The mother during lactation should take great care of her health, especially in the matter of diet, avoiding excess of stimulants and taking a fair quantity of milk.

The best substitute for the mother's milk is unquestionably the milk of a wet nurse. Many difficulties often occur in procuring a wet nurse, but when it is possible, it is certainly best to do so when the infant is a weakly one and the mother's milk fails from the first or after a few weeks. The wet nurse should be strong and healthy, untainted by any hereditary disease, between 20 and 30 years of age, and the time of her confinement should correspond as nearly as possible with that of the mother; for a newly-born infant a wet nurse who has been confined more than four months before is unsuitable.

**Artificial Feeding.**—The most convenient substitute for human milk is diluted cow's milk. The difference between the two, however, is considerable, as will be seen on comparing the analysis of the two :—

*Human Milk.*

	(PFEIFFER)		(MEIGS)	Average of 43 women
	8th day	65th day	371st day	
Water. . . .	89.62	89.72	87.72	87.163
Solids . . . .	10.38	10.28	12.28	12.837
Casein . . . .	1.665	.844	.718	1.046
Albumen . . . .	.700	.652	.834	—
Fat . . . . .	3.345	1.827	3.984	4.283
Sugar . . . . .	3.274	6.22	6.088	7.407
Salts . . . . .	0.446	0.18	0.126	.101

The various experimenters have published divers results in the analysis of human milk, but this is probably accounted for by their using different methods of analysis as well as taking the milk at different periods, the latter portions of the milking being richer in fat than the earlier portions, and also the milk from different periods of lactation varying.

As Meigs, however, has pointed out, the chief differences lie in the different estimates of the casein and sugar.

*Cow's Milk.*

	(BIEDERT)	(MEIGS)
Water . . . . .	85.7	87.012
Solids . . . . .	14.3	12.988
Casein . . . . .	4.82	3.222
Albumen . . . . .	.75	—
Butter . . . . .	4.3	4.209
Sugar . . . . .	4.03	5
Salts . . . . .	.54	.527

It cannot fail to be noted that there are marked differences in the results of different analysts as regards the various constituents in both cow's milk and human milk, and while it is probable that the composition of milk is liable to vary, yet it is more than probable that some at least of the published results are based upon erroneous methods of analysis. This, however, is of comparatively small importance, as the chief differences between the two milks can be deduced from the analysis with tolerable certainty. In the first place, it is clear that the solids of cow's milk are greater than of human milk, and this is due to the greater proportion present of casein, fat, and salts, the sugar being the only ingredient which is present in less quantities. The most important difference is in the quantity and quality of the casein; in rich cow's milk the amount is from 4 to 5 per cent., in human milk from 1 to 2 per cent. (*Pfeiffer, Meigs, Biedert*), and further, the curd of cow's milk differs both chemically and physically from that of human milk. In cow's milk, even when diluted or rendered alkaline, the casein is precipitated in hard lumps, which tend to run together; it is curdled not only by artificial gastric juice, but also by dilute acids both mineral and vegetable, while human milk, when curdled by gastric juice, precipitates fine, almost gelatinous flocculi, and is not precipitated by dilute acids. Cow's milk, when it reaches the stomach, is almost instantly curdled; the masses of hard curd long resist the action of the gastric juice, while human milk is more slowly curdled, a fine flocculent precipitate being formed which is readily redissolved by the gastric juice. The problem of how to render cow's milk suitable for infant feeding is in part solved if the milk is diluted so as to reduce the percentage of curd by at least one half, sugar and fat being added to bring them up to the proportion present in human milk, but beyond this there is the difficulty, that the cow-casein long resists the infant's digestive juices.

If the infant has to be brought up from birth on cow's milk, the difficulties and risks are evidently much greater than if the mother is able to nurse it for a few weeks or months, and thus start it on its career of gastric digestion. During the first few days it will be well to remember that the infant does not require much, and that its digestive organs are easily overworked, a condition of catarrh is thus set up and the digestive juices are secreted in smaller quantities, and their efficacy impaired. Any excess of food, more especially curd, will be vomited, or, if passed into the small intestines, will decompose, producing flatulent distention and great discomfort.

The amount of food to be given must depend to some extent upon the

weight and strength of the child, five ounces of good cow's milk daily being probably sufficient to supply the wants of an average infant for the first two or three weeks of its existence. The five ounces of milk should be diluted with water to make fifteen ounces, and sweetened with sugar of milk or cane sugar, and it would be well in most cases for two tablespoonfuls of cream to take the place of an ounce of the added water. The substitution of cane sugar for milk sugar is attended in most cases with no practical disadvantage, and the former has the advantage of being about one-sixth the price of the latter. The day's supply may be mixed in the morning when the milk arrives, the night's supply in the evening, and be kept covered up in a cool place; one and a half ounces of the mixture is to be placed in a boat-shaped feeding-bottle and given to the infant every two hours, except during the night, so that about ten feedings in twenty-four hours will take place.

It is needless to say much on the question of feeding-bottles, of which there are an immense variety, and upon which much ingenuity has been expended. In the first few weeks the old-fashioned boat-shaped bottle, fitted with an indiarubber cork (not an ordinary cork, as it soon gets foul), is better than those with long flexible tubes, which are more difficult to keep clean; and the former has the advantage of obliging the nurse to hold the bottle and regulate the amount taken by the infant. Great care should be taken to keep the bottle and teat clean, and for this purpose a solution of boracic acid answers as well as anything. The teat should be frequently replaced; of the necessity for this anyone can convince himself by slitting up one which has been in use for some weeks, and investigating the layer of deposit and growth of fungus which is invariably found to line it, unless it has been kept soaking in an antiseptic solution. It is a good plan to have several teats, and keep them, when not in use, in a solution of boracic acid. During this time the medical attendant should ask to have the stools of the infant, and all that it passes, kept for his inspection. The stools should be during the early months of an infant's life semi-fluid in consistency and of a golden-yellow colour. In most infants fed artificially, curd will be present to a larger or smaller extent. After the first fortnight or three weeks, if the infant continue well and no large excess of curd be present in its food, larger quantities of milk may be permitted—8–10 oz. of milk with an equal quantity of water in the twenty-four hours; at 2 months of age 15 oz. of milk with 5 oz. of water, or barley water and cream may be given; at from 4–6 months 20 oz. to 30 oz. diluted, and at 6 months it may be given pure. From 6 months to 12 months the infant is still fed from the bottle, but some starchy food, such as thick barley-jelly, or well prepared oatmeal or wheatmeal, may be added. In infants of weak digestive powers, the milk must be diluted more freely than recommended above.

While many infants will thrive upon diet of cow's milk and water, taking it well from the first, it is one of the commonest experiences of practice to find that 'cow's milk does not agree,' and if there is no vomiting the infant is apt to suffer from flatulence and colic and pass large masses of undigested curd in its stools. Very often the infant vomits its milk shortly after taking it, large curdy masses coming up upon which the gastric juices have spent themselves in vain. Sometimes the infant will go on fairly well for a while, apparently thriving while passing large curdy stools, then convulsions or pro-

gressive wasting or diarrhoea will warn the attendants that curdy masses are lying undigested in the intestines, giving rise to various forms of trouble. The mother, perhaps, will consult her friends respecting the cow's milk, and will probably resort to condensed milk or one of the many infants foods, in the hope of finding some food which will suit the infant. If, then, the child fails to digest the curd of cow's milk, as evidenced by curdy stools or vomiting, or if there is reason to believe that it will not digest, what other foods are there which can be safely substituted? Among these, peptonised, or pre-digested, milk foods undoubtedly take a high place.

**Peptonised Milk.**—This can be prepared in the usual way, by diluting, adding an alkali and pancreatic ferment, and boiling when the process is complete; the day's or night's supply being made morning and evening. It is, however, more readily prepared by adding the pancreatic extract to the food shortly before taking; this saves both time and trouble.

In the early months it is best to take equal quantities of milk and water, add 2 oz. of boiling water to 2 oz. of cold milk; the temperature of the mixture will be about 120° F.; add three grains of 'Benger's Peptonising Powder;' in ten minutes digestion will have proceeded far enough to soften the curd, then add three or four teaspoonfuls of cream, sweeten with sugar, and give at once to the infant without boiling. When the infant is old enough, larger quantities of milk may be used, and barley water or decoction of starch may be substituted for the boiling water. In the use of all pancreatised foods, there is the risk that digestion may proceed too far, and not only an unpalatable taste be developed, but compounds formed which may give rise to vomiting or intestinal disturbances; they are, moreover, expensive, and require some care and intelligence on the part of the friends or nurse in their preparation.

**Biedert's Cream Mixture.**—Biedert, impressed with the difficulties infants often experience in digesting the curd of cow's milk, sought to minimise the difficulty by using a mixture of cream, sugar and water to which variable amounts of milk are added. His No. 1 mixture, which is to be used for infants during the first few weeks, has no added milk, the curd which is present in the cream supplying the nitrogenous element; in round numbers it consists of 4 oz. of cream, 12 oz. of warm water, and  $\frac{1}{2}$  oz. of milk sugar; this mixture contains 1 per cent. of casein,  $2\frac{1}{2}$  per cent. of fat, and 3.8 per cent. of sugar. As the infant grows older, or its powers of digestion improve, 2 oz., 4 oz., or more of milk are added, his strongest mixture containing an equal amount of added milk. This food is often of much value, most infants digesting cream exceedingly well, and many infants who vomit cow's milk immediately begin to do well when placed upon this mixture.

**Meigs's Cream Mixture.**—Dr. A. V. Meigs has modified Biedert's mixture in the following way: packages of milk sugar containing 17 $\frac{3}{4}$  drachms are obtained from a druggist, one of these is dissolved in a pint of warm water, the sugar-water being placed in a cool place for use. When the infant is to be fed the nurse is to mix *two* tablespoonfuls of cream, *one* of milk, *two* of lime-water, and *three* of sugar and water; the food when warmed is ready for use.

It may be asked, is milk sugar superior to cane sugar or dextrine and starch sugar in the artificial feeding of infants, for it has the disadvantage

of expense and also of readiness of decomposition, passing into lactic acid. We must confess that, as far as our experience goes, we have never been able to prove its superiority, or to convince ourselves that infants did better on one form of sugar than another, and we believe that in any one of the above mixtures cane sugar can be safely substituted for the milk sugar.

**Condensed Milk.**—Condensed milk has long been a favourite substitute for mother's milk among the lower classes, and its use is by no means confined to the lower orders, though it has had but few defenders among medical men. The fact that it contains a large proportion of added cane sugar has been sufficient to condemn it in the eyes of most, and many serious allegations have been made against it. It has been accused of producing eczema, diarrhoea, constipation, rickets, and it has been alleged that while children who have been brought up on it are fat and plump, they readily succumb when attacked with acute disease. We must confess to doubting the value of much of this evidence, and the fact that children unquestionably strong and healthy have been brought up on it from birth may be set against the rickety children who are said to owe their rickets to their having been fed on condensed milk. That it is a favourite food among the lower classes there can be no doubt; it is convenient, it does not readily turn sour, and it may often be substituted for fresh cow's milk, when the latter causes vomiting, with good effect. The reason of its being useful in gastric catarrh, not being vomited when cow's milk and water have been, is probably due to the fact that the condensed milk, as generally mixed, contains less curd than the mixture of fresh cow's milk previously used; it seems certain also that the casein of condensed milk is more slowly thrown down than the casein of fresh milk.

This will become apparent if we compare the following tables from A. V. Meigs:—

	Human	Cow's milk	Condensed milk (Eagle Brand).	Condensed milk one teaspoonful to six tablespoon- fuls of water
Water . . .	87.163	87.012	27.942	92.673
Fat . . . .	4.283	4.209	10.335	1.095
Casein . . .	1.046	3.222	9.522	.868
Sugar . . .	7.407	5.000	50.861	5.206
Ash . . . .	.101	.527	1.340	.158
	100.000	100.000	100.000	100.000

From this it is clear that, if the condensed milk is mixed in the proportion of one teaspoonful to six tablespoonfuls of water, there is no excess of sugar as compared to human milk, but a great deficiency of fat and a slight deficiency of casein. This would indicate that the addition of cream to condensed milk would render it far more deserving of being called a food. Condensed milk thus forms, we believe, a valuable substitute for fresh cow's milk, especially at those times when cows are being fed on turnips or other watery food, or during the hot weather, when milk is apt to turn sour. Care

should always be taken to select some reliable brand and to be careful in diluting it, for if it is made too strong there will be a large excess of cane sugar, and if too weak a greatly disproportionate amount of fatty and nitrogenous stuffs. One heaped-up teaspoonful to six tablespoonfuls of water will be about the right proportion. Other forms of condensed or preserved milk are also to be obtained, the unsweetened condensed milk being one of these. This latter is milk which is concentrated to about one-third of its bulk without the addition of any cane sugar. To obtain milk resembling the fresh milk it must be diluted with two parts of water. One of the difficulties in using it consists in the fact that it does not keep as long as the sweetened variety.

Loeblund & Co.'s 'Kindermilch' consists of preserved milk in which dextrine and starch sugar take the place of cane sugar in sweetened condensed milk; it contains less water than ordinary condensed milk. It may be used in a similar proportion. It consists of—

Water . . . . .	20.58	Fat . . . . .	12.22
Maltose . . . . .	33.84	Albuminoids . . . . .	9.86
Dextrine . . . . .	8.63	Ash . . . . .	2.24
Milk sugar . . . . .	12.63		

In some cases this food will be found to suit better than condensed milk, especially in those where there is a tendency to diarrhoea, the dextrine and maltose being more suitable than the cane sugar.

Undoubtedly one great disadvantage of using thick foods is the difficulty in measuring amounts, inasmuch as 'a teaspoonful' is certain to differ materially, not only in the size of the spoon, but also in the amount taken up, while the measuring of liquid foods can be done with the greatest accuracy.

If the condensed sweetened milk be used in too large proportions, the large amount of cane sugar will be likely to set up intestinal catarrh and diarrhoea. Another form of condensed milk which has recently been introduced is the peptonised condensed milk of Savory and Moore. This preparation is very palatable, easily prepared by mixing warm water with it, and much of the curd has been converted into peptone. It keeps well for some days after the tin has been opened, being preserved by the addition of cane sugar; it appears to be concentrated to  $\frac{1}{6}$  to  $\frac{1}{7}$  of its bulk. In cases where cane sugar is not an objection it is often useful.

**Whey.**—A mixture of whey and cream or whey and milk has been recommended by Frankland, and is often well digested (*see Appendix*).

**Diet from 6-12 Months.**—While some mothers are strong enough, and are sufficiently good nurses to suckle their children to the end of the first year, there are many others who begin to flag about the 6th or 7th month, and in such cases it is desirable to supplement the breast by means of some milk food. Weaning in any case should be carried out by degrees, and it is well to discover what kind of food answers the best before the nursing at the breast is entirely given up. There is no lack of artificial or patent foods from which to choose. If the infant is entirely dependent upon artificial food, it should take from  $1\frac{1}{2}$  to 2 pints of good cow's milk every twenty-four hours, between 6 months and 1 year. Whether this should be given undiluted must

depend upon the digestive powers of the infant, which may be gauged by its power of digesting casein as determined by an inspection of its stools and by its growth and weight. Some form of starchy food may be added with advantage, for now the digestive powers of the infant are sufficiently advanced to form dextrine and maltose out of starch, thus forming a valuable and easily assimilated carbo-hydrate. Care must be taken that all starchy matters are thoroughly boiled so that the starch granules become gelatinised, as raw starch is less easily digested. It is a good plan, when starch is being given, to test the stools from time to time with iodine, to see if any undigested starch is passing through the intestines.

Barley-jelly, whole-meal flour, maize, oatmeal all answer very well if thoroughly cooked and made sufficiently thin to pass through the tube of ordinary feeding-bottles.

Instead of these starchy foods, which have the merit of being wholesome and cheap, some of the artificial foods containing pancreatine, such as Benger's, or Savory and Moore's, or Allen and Hanbury's, in which the starchy elements in the process of preparing are converted into dextrine and maltose, may be given. It must be borne in mind, however, that the starch is most perfectly acted on by ferments after it has been rendered soluble by boiling, while the act of boiling destroys the ferment. A more perfect result is obtained by adding malt extract to the food after it has been boiled, and allowed to become just cool enough to taste; it is then set aside for a few minutes before giving it. Five meals in the twenty-four hours will, as a rule, be sufficient, some 6 to 8 oz. being taken at each meal. The *first* meal may be taken between 7 and 8 A.M.; the *second*, between 10 and 11 A.M.; the *third*, 1 to 2 P.M.; the *fourth*, from 4 to 5 P.M.; and the *fifth*, the last thing at night. There is no harm in giving the infant a well-toasted crust to nibble, but thick foods should not be allowed, and beef-tea or eggs are certainly unnecessary, and best avoided.

There is no better guide during infancy, as to how the infant is progressing and how its food is suiting it, than periodical weighings. Twice a week will be quite sufficient during health, all that is necessary during infancy being an ordinary pair of kitchen scales. When heavier weights are required a more expensive weighing-machine is necessary, but the weighing of older children can, at least in towns, be arranged for. Nothing so certainly indicates malnutrition as a steady loss of weight, or, what is common, a gain which is much below normal. Reference has already been made to the loss of weight which mostly occurs during the first few days or weeks, but after the first week a regular gain of from 5 to 6 oz. per week should be maintained for the first two months, the infant weighing at the end of two months on an average over 10 lb. During the 3rd and 4th months the infant gains somewhat less, namely 5 to 4 oz. weekly; at the end of the 4th month 13 lb. is an average weight.

During the 5th and 6th months the child will gain 4 to 3½ oz. weekly, and by the end of the 6th month will be about 16 lb., or double its original weight. During the 7th, 8th, and 9th, 3½ oz. to 3 oz. will be an average weekly gain, and by the end of the 9th month 20 lb. weight may be reached. During the last three months 2 oz. to 1½ oz. per week; the weight is usually over 22 lb.

It must not, however, be forgotten that infants may put on fat which naturally adds to their weight without their being necessarily strong and healthy ; care must be taken to weigh them at the same time of day, so that there may be no mistake.

At twelve months of age, if the child be strong and healthy, the bottle may be gradually left off, and food of a more solid character may be substituted, but milk is still to be the staple food.

#### **Diet from 12 Months to 18 Months of Age.**

*First meal*, 7.30 A.M. Fine bread sops with milk, or oatmeal or hominy porridge made with milk.

*Second meal*, 11 A.M. A drink of milk.

*Third meal*, 1.30 A.M. Breadcrumbs and gravy or a lightly boiled egg and bread and butter. Sago or rice pudding.

*Fourth meal*, 5.30 P.M. Bread and milk.

*Fifth meal*. Milk to drink.

After eighteen months of age, when healthy children have cut their first set of double teeth, small quantities of fish, fowl, or meat may be allowed. Of fish, boiled whiting, sole, or cod, carefully freed from all the bones, is readily taken by most children. Boiled fowl is better than butcher's meat in early childhood. Of the latter, underdone mutton-chops, torn into shreds and mixed with breadcrumbs or well-mashed potatoes, form the best and most digestible kind of butcher's meat. Rice, sago, or tapioca puddings, stewed apples or preserves of various fruits, may be allowed.

Children unfortunately are often strangely fastidious in their tastes, and will frequently take a dislike to many forms of the most digestible foods. It is always well to introduce as much variety as possible into their diet. For older children hominy porridge with treacle for breakfast, to be followed by small quantities of bacon or egg, with cocoa or weak tea, are as a rule well digested and are beneficial, provided that the porridge or bread and milk forms the *pièce de résistance* of the repast. Soups made in various ways from meat and vegetables form an exceedingly wholesome and digestible meal. Pastry, as a rule, is bad ; boiled rice with raisins or stewed fruit of various kinds is much to be preferred.

When the child is old enough to sit up to table at dinner and take meat cut from a joint, the greatest care should be taken to see that the meat is carefully cut up into small pieces before being put into the mouth, and is carefully masticated before swallowing. So important is this, that if there is any doubt as to the cutting up by the nurse, it will be well to insist that all the meat should first be put through a mincing-machine ; the gravy can be afterwards added to it. Masses of half-masticated meat will not be digested if bolted in the usual way, and will be passed almost unchanged in the fæces, and if the food is thus bolted, it is less satisfying, and leads to more than is required by the system being consumed. A stand must always be made against the common practice of giving children biscuits or ginger-breads at almost all hours of the day. The stomach requires rest like every other organ in the body, and is certain to become deranged if sweet things are being taken at all times.

## CHAPTER IV.

## DISEASES OF THE DIGESTIVE SYSTEM.

**Dentition.**—The influence of dentition upon the health of the infant depends very much upon the child's strength. A strong and vigorous infant which has been brought up at the breast will cut its teeth one after another without trouble, and but for the appearance of the teeth through the gums the friends will not be aware that dentition is in progress. On the other hand, if the infant is rickety, weakly, or the victim of hereditary tendencies, the period of dentition will be a period of danger, and the irritation caused by the pressure of the tooth expanding its socket and cutting through the gum is very liable to give rise to various forms of disease, the process of dentition acting rather as the exciting than the predisposing cause. The first dentition begins during the middle of the first year and ends usually by the appearance of the posterior molars in the middle of the third year. In some, without any known cause, the first teeth make their appearance before this time; indeed, it is not infrequent for infants to be born with a tooth already cut; such teeth, however, are imperfectly developed, and consist merely of a thin shell of enamel. Some by no means strong children cut their teeth early. In rickets dentition is delayed; in those cases in which rickets makes its appearance prior to the sixth month, dentition may not commence during the first year, the infant being toothless at a year old. In other cases the infant only becomes rickety towards the end of the first year, when the incisors are perhaps through the gum, and then there follows a long delay.

The infant's mouth at birth is dry, and the gums, while more or less swollen over the sockets of the tooth germs, are much less so than a few months later. In two or three months the sublingual glands enlarge, the mucous membrane of the mouth becomes of a brighter colour, and the mouth is moist. A few months later, by the fifth or sixth, saliva is formed in much larger quantities, so that it is frequently dribbling from the mouth, and the infant is constantly putting its fingers into its mouth as if there were some sort of irritation going on there. Moreover, while up to this period it has taken its food well and slept the whole night without disturbing its mother, it now becomes restless, wakes crying, suffers from dyspepsia and flatulence, and is at times feverish. The gums may become tender, the whole mucous membrane congested, aphthæ appear on the tongue, inside the lips or on the hard palate, and the infant is feverish and cross to a degree. Perhaps now the edge of a tooth, usually one of the lower middle incisors, will be felt through the gum. Some days or even weeks will perhaps elapse before the edge of the tooth is actually cut. It is a singular but by no means unusual

circumstance for a tooth to advance so as almost to stretch the mucous membrane of the mouth, and then become stationary for some time. The teeth, as a rule, make their appearance in groups; the times of their being cut have already been referred to on p. 10. Some of the commoner dentition troubles may be mentioned here.

*Feverishness.*—When the gum is swollen and tender prior to the cutting of a tooth the infant is apt to be irritable, having fits of crying without any apparent cause, which nothing will pacify; at first gently rubbing the gum will give ease, but at a later stage this only aggravates the trouble from the acutely painful state of the gum. The fever is intermittent, the child being hot and feverish for the most part at night and unable to sleep, while towards morning it cools down and dozes for a few hours; the temperature may reach  $102^{\circ}$  or  $103^{\circ}$ , rarely more. Such attacks may often pass away without the tooth being cut, or may continue for some time after the edge of the tooth has appeared, and before the rest of the tooth has made its way through.

*Stomatitis.*—The mucous membrane of the mouth, more especially that of the tongue, hard palate, and inside of the cheeks, may be the seat of small superficial ulcers or small spots denuded of epithelium, their surface being of a grey or yellowish colour, and their edges surrounded by a zone of erythematous redness. These spots are evidently sore, and may be the cause of the infant refusing the breast and crying whenever liquids containing salines such as beef-tea are taken. Sometimes these aphthous patches are present on the gum at the spot where the tooth is appearing.

*Enlarged Glands.*—Occasionally it happens in children predisposed to glandular enlargement that the irritation caused by these aphthous patches gives rise to a swelling of the glands, either the submaxillary when the lower jaw is affected, or the parotid lymphatic glands, which receive the lymph from the upper jaw. These swellings may subside or end in either acute or chronic suppuration. In the latter case successive teeth being cut keep up the source of irritation.

*Diarrhœa.*—During the hot months of late summer or autumn, the irritation of teeth is the exciting cause of intestinal catarrh and diarrhœa. In infants a transference of a lesion from one part of the body, more especially from one mucous membrane to another, is exceedingly common; this diarrhœa is especially common in artificially fed infants. Even at other times than in hot weather a severe or even fatal diarrhœa may supervene when a tooth is being cut.

*Bronchitis.*—During dentition, especially when the incisors are being cut, infants seem very prone to catarrh of the bronchial tubes and sometimes catarrhal pneumonia.

*Eczema and Lichen.*—It constantly happens that infants who suffer, or are liable to suffer, from eczema are much worse while a tooth is pressing through the gum. The eczema very frequently gets well in the intervals, the face and body being free, until a tooth comes near the surface, and there is a return of the eczema, the face and forehead flush up and papules appear which begin to ooze and crust. Lichen in the form of strophulus or urticaria is also common.

*Convulsions.*—It may be taken for granted that no healthy infants suffer from convulsions; those who do are either rickety or the children of neurotic

parents, and inherit a tendency to nerve disturbance. Spasmodic affections of various groups of muscles occasionally take place.

*Treatment.*—Much controversy has arisen from time to time with regard to the use of the gum lancet, and the propriety of employing it in assisting dentition, many practitioners being in the frequent habit of using it, while others have not employed it for years. If the mucous membrane over the tooth is red, swollen, and tender, and the edge of the tooth can be felt, much pain and discomfort will be spared the infant by its use, presuming, of course, it is not a 'bleeder,' nor comes of a family in which there is a history of hæmophilia. The relief afforded is due in all probability to the local loss of blood, as well as to the relief of tension in the gum. That it has been done often unnecessarily, and that many troubles are attributed to dentition that have no connection with it, is no argument against the use of the lancet in proper cases. The evidence is too strong to be lightly explained away, that fits of crying, feverishness, or even convulsions may be quickly relieved by freely lancing a swollen and tender gum. It, perhaps, need not be said that it is useless to lance the gum unless there is evidence that the cutting edge of the tooth is near the surface, or disappointment will certainly follow. In one case coming under our notice, in which an upper incisor was lanced in a rickety child, the tooth was not cut till exactly a year after the operation. The feverishness and tenderness in the mouth and sleeplessness may be generally relieved by mercurial purges, bromides or simple salines.

( 1 )

Bromide of potassium . . . . .	gr. ij
Tincture of hyoscyamus . . . . .	℥v
Liquid extract of liquorice . . . . .	℥v
Water to . . . . .	℥j

*One teaspoonful every two or four hours.*

( 2 )

Calomel . . . . .	gr. ss-gr. j
White sugar . . . . .	gr. j

*The powder at night.*

The above may be given to an infant of six months of age. As much as five grains of bromide may be given if the infant is very restless, or two or three grains of chloral hydrate.

Painting a tender and swollen gum with a saturated solution of bromide of sodium in glycerine and water will often relieve pain. If the gums remain spongy, or there is aphthous stomatitis, the following lotion may be used :—

( 3 )

Borax . . . . .	℥ss
Tincture of myrrh . . . . .	℥ss
Glycerine . . . . .	℥j
Rose-water . . . . .	℥j

*To be used as directed.*

The size and hardness of the temporary teeth differ much in different children ; in weakly rickety children they are not only late in appearing, but when they do appear are dwarfed and consist of mere shells, quickly

becoming black and carious, or loose and falling out of their sockets. In other children the enamel appears deficient, and caries occurs early. Great care should always be exercised in the preservation of the first set of teeth. A soft tooth-brush should be used every night, and the mouth thoroughly cleansed with warm water, in order to dislodge the fragments of food which have collected between the teeth. If the teeth show signs of caries, it is a good plan to use the tooth-brush after every meal, mixing a few drops of an alkaline mixture with the water (sp. ammon. aromat. ʒj, sp. vini rect. ʒiij). Whenever it is possible, carious temporary molars should be properly filled.

The **second dentition** is not accompanied by the same troubles as the first, or at any rate to the same degree. The first molars and incisors usually make their appearance unobserved, and rarely occasion any inconvenience. The second molars may give more trouble. It sometimes happens that the gums get into an unhealthy state, being spongy, and bleeding readily, while the teeth become loose and give pain during mastication. It is during this period that ulcerative stomatitis may be present. Gumboils may be another source of trouble. If it is of importance to attend to the cleansing of the mouth during early childhood, it is of still greater importance to do so when the permanent teeth are appearing, and no effort should be spared to prevent their premature decay.

**Diseases of the Mouth. Catarrhal Stomatitis.**—Catarrhal inflammation of the mouth may be primary, but it is more often secondary, accompanying dentition, dyspepsia, pneumonia, and other diseases. Stomatitis is especially apt to make its appearance during the first year of life, though it is common during the whole of childhood. Infants who are thus suffering, having begun to take the breast, suddenly let it go and cry, and are apt to stuff their fingers in their mouths; the infant is feverish and irritable, the saliva is increased in quantity, and the mouth feels hot if the finger be inserted; the salivary glands, especially the sublingual, are swollen and tender. On examination of the oral cavity, patches of intense redness are to be seen on the mucous membrane inside the cheek, on the gums, or hard palate, the tongue is generally bright red and clean, or the surface is covered with a thick creamy fur, the edges and tip being clean and red. This form of stomatitis is often called **Stomatitis erythematosa**. Very frequently at the seat of these erythematous patches, an exudation of yellowish or greyish secretion takes place, or there is a breach of surface where the epithelium is denuded and small shallow ulcers are formed. These yellowish patches or ulcers are surrounded by a zone of redness. Such patches are usually termed **Aphthæ**, and when present the term 'aphthous stomatitis' is often applied. Older children are subject to these attacks, and it is often seen to affect a whole household at the same time, the adults by no means always escaping. It is doubtful if it is contagious, but it is certainly epidemic; it is sometimes associated with tonsillitis. The attack is often accompanied or preceded by feverishness, and some gastric derangement and often diarrhoea, crops of herpetic vesicles appear about the lips and nose, tongue, soft palate and cheek, followed by small or large patches of yellow exudation or actual ulceration, with an inflammatory zone around. The spots remain sore for several days. Similar attacks have been described as occurring both in infants and children from drinking the unboiled milk of cows suffering from 'foot

and mouth' disease; and in any case where these affections occur in a wide-spread epidemic it is well to make careful inquiry into this as a possible cause.

During attacks of tonsillitis, scarlet fever, measles, &c., aphthæ often make their appearance on the tongue and inside the lips, while the corners of the mouth become excoriated.

In infants aphthous patches, two in number, situated on the hard palate, one on each side of the median raphe, near the junction of the hard and soft palate, are often seen; these are round superficial ulcers  $\frac{1}{4}$ – $\frac{1}{3}$  in. in diameter, their base being of a yellowish colour and surrounded by erythema. They have been described as Bednar's aphthæ, or plaques ptérygoidiennes, by Parrot. They are produced by the pressure of the back of the tongue against the hard palate in sucking.

The treatment must depend upon the cause, whether the stomatitis depends upon dentition, gastro-intestinal catarrh, or other pathological condition. In most cases a mild purge will be useful to expel any indigestible food present in the alimentary canal, to be followed by one- or two-grain doses of chlorate of potash in a little glycerine and water.

( 4 )

Chlorate of potash . . . . .	gr. j
Syrup of orange-peel . . . . .	℥xv
Water . . . . .	ʒj

*A teaspoonful three times a day for an infant of six months.*

Locally the spots may be touched with a solution of permanganate of potash (5 grs. to the oz.) or boracic acid (15 grs. to the oz.). If the spots are slow in healing, they may be touched with lapis divinus. This latter consists of equal parts of sulphate of copper, alum, and saltpetre fused together. The diet should consist of milk and barley-water made more dilute than usual, or in older children milk and sops. Beef-tea or saline fluids are generally objected to on account of causing smarting in the mouth.

**Parasitic Stomatitis. Thrush.**—This form of stomatitis differs essentially from the forms already described, as it is due to the presence and growth in the epithelium of the mouth of a species of cryptogam. It is especially common in newly-born infants and in those of a few months old, who are suffering from some form of wasting disease, and when the mucous membrane of the mouth is in an unhealthy condition. It appears as small white distinctly raised points or scattered patches on the soft palate, mucous membrane of the cheek, lips, and tongue. If touched with a small paint-brush the patch is found to adhere firmly to the mucous membrane and cannot be detached as milk flocculi can, for which it may readily be mistaken; if forcibly detached there is left a red surface denuded of epithelium. The mucous membrane of the mouth is often red and unhealthy around the patches, in other cases it is quite normal. In mild cases these white patches are small and few in number, in other cases they become confluent and large, and the surface of the tongue and cheeks is covered with them. Infants so affected are mostly weak and ill and often suffer from diarrhœa, or gastric catarrh with wasting. It occurs in older children in the last days of tuberculosis, tubercular meningitis, typhoid, and pneumonia. If a piece of the white raised patch be detached and examined microscopically it will be found

to consist of flattened epithelium and the spores and threads of the parasitic growth. The latter consists of fine-jointed and branching stems, some of the buds forming capsules, conidia, or spores, by which the growth is propagated. The identity of this cryptogam has been a matter of doubt.

It has been identified as the *Oidium lactis*, or fermentation plant, which is present when milk turns sour; but Grawitz has cultivated it in solutions of sugar, and believes it to be identical with the *Mycoderma vini*, or *wine ferment*. Rees, who has further investigated it, has named it *Saccharomyces albicans*. Its chief seat is the mouth, but it has been found by Parrot in the larynx, œsophagus, and stomach. It grows in the epithelium, but its fibres and spores may penetrate into the subepithelial tissues.

**Treatment.**—It is of much importance that great care should be taken to cleanse the mouth after the infant has taken the bottle, especially in a weakly infant of low vitality. This can be done with a large paint-brush or soft wet rag, and on the first symptoms of thrush the borax lotion (p. 45) or similar solution should be used. As an application to the parasitic patches a solution of sulphate of copper (2 grs. to the oz.) or carbolic acid (2 grs. to the oz.) is very effectual when applied with a paint-brush.

**Ulcerative Stomatitis.**—This form mostly occurs during dentition, and is perhaps most common during the period of the second dentition, or from the age of five to ten years. The children who suffer from it in the severe form are mostly unhealthy, either recovering from some infectious disease, have been badly fed, or have been exposed to unhealthy surroundings; it is also common in tuberculous children. A very similar condition is produced by scurvy, rickets, chronic mercury or phosphorus poisoning. The first symptoms consist in increased salivation, the gums become pale, swollen, and spongy, and the breath foul; the salivary glands are swollen and painful, and there is often much swelling of one or other of the lips. The spongy gums bleed, and the blood together with the matters taken as food decompose, giving rise to a very foul condition of the breath. The first part of the gums to be affected is usually that near the incisors or eye-teeth of the lower jaw; the front part of the gums suffers more than the back. The gums sometimes swell so as to partly cover up the teeth, irregular ulcers form on the swollen gums, which, as they increase, expose the roots of the teeth, the latter become loose and perhaps fall out. The ulceration is at first confined to the gums, but may involve the sulcus between the gum and cheek, and also the mucous membrane lining the cheek or inside the lower lip. In mild cases the symptoms are much less severe than this.

Necrosis of the jaw is apt to follow in some of the more severe cases of ulcerative stomatitis; instead of the process ceasing, as it usually does, the mischief spreads and a chronic osteomyelitis of the jaw is set up, much intensely fœtid discharge comes away, the child's health suffers, the cheeks become puffy and flabby, the ulceration of the gums spreads, and after a while it is found that a large piece of jaw, carrying perhaps two or three teeth, is loose; this is taken away, and in some instances the process stops; often, however, any new bone that may have formed becomes infiltrated with the foul discharges, and the mischief spreads along the jaw, piece after piece is taken away, until at last the entire jaw may have to be removed. We have removed the whole bone from condyle to condyle for this condition. Many

surgeons believe that the disease begins as a periostitis and not as an ulceration of the gums, and that alveolar abscess is the starting-point; this is so sometimes, though we think certainly not always.<sup>1</sup>

The child's health materially suffers from the discharge and foul state of the mouth. In one instance, after removal of the jaw, the child was sent home convalescent, but died suddenly, apparently from falling back of the tongue. Restoration of the jaw is very imperfect in these cases, for the new bone necroses as fast as it forms. The process closely resembles phosphorus necrosis, but it is not due to that poison.

*Treatment.*—After every meal the mouth should be well rinsed with warm water or Condyl's fluid, and the gums and teeth cleaned with a bit of absorbent wool or soft rag, not sponge, so that the same bit may never be used again; the gums should then be mopped over with the glycerine of borax 2 parts to tincture of myrrh 1 part. Of internal remedies, by far the most efficient is chlorate of potash, given in five- or six-grain doses three times a day. The diet should consist of fluids and sops, beef-tea and other nourishing liquids being given freely, especially in those cases where the disease occurs in the poorly nourished and underfed. This treatment will usually suffice to arrest the disease, but once the bone becomes seriously involved, in some cases nothing seems to have any effect. Strong nitric acid, carbolic acid, &c., seem to have little power, and the purulent infiltration only ceases when the whole bone has been destroyed. These plans should, however, be carefully tried, chloroform being of course given, and subsequently there should be very frequent cleansing of the mouth with equal parts of rectified spirit and water. As soon as the disease has ceased to spread, any loss of bone or teeth should be supplied by a plate with artificial teeth, to prevent falling in of the lips and the prematurely senile appearance that otherwise results. Even where the alveolus alone is destroyed, since no new formation of bone occurs the permanent teeth are often loosened and fall out.

**Cancrum oris.**—*Cancrum oris* occurs almost invariably in squalid, half-starved children after one of the exanthemata; sometimes, however, it seems to have no such predisposing cause. The disease begins as an inflamed spot on the inner surface of the cheek or upon the gum, the mischief rapidly spreads, both in depth and area, and the whole thickness of the cheek and gum becomes involved. On the outer surface the cheek is swollen, shining, stiff, and pale, or sometimes dark red, its vessels are thrombosed, and soon a black spot appears in the centre of the pale waxy area; the cheek is perforated, the black spot becomes a definite slough which partially separates. Then the edges of the gap become black and the sloughing spreads, preceded by a zone in which the skin is pale and œdematous. In severe cases the whole side of the face is rapidly destroyed, the gums slough away, the jaw necroses, and the teeth drop out. There is intense fœtor of the discharge and breath, which poisons the child, frequently causing pneumonia and death before the process is complete. Dr. Wilks considers that when the sloughing attacks the gum first it may be only an aggravated form of the ulceration met with as a late condition in scarlet fever; this is seen

<sup>1</sup> Dr. Angel Money has reported a case coming on after typhoid and affecting the upper jaw. The lower jaw is the one most commonly attacked.

usually in the lower jaw, while in true cancrum oris the upper jaw is attacked.<sup>1</sup>

Sansom has described an organism which he found in the blood and diseased tissues; when taken from the blood and inoculated into guinea-pigs and mice, it was found again in their blood.<sup>2</sup> In a fair number of instances the process is arrested and the sloughing ceases, the parts clean up and heal rapidly, leaving, of course, a more or less severe deformity. In fatal cases, death is due to exhaustion or septic pneumonia. The amount of pain and distress suffered is variable, sometimes but little of either exists.



Fig. 6.—Deformity resulting after recovery from cancrum oris; subsequently remedied by a plastic operation.

*Treatment.*—The treatment of cancrum oris consists in the free local application of the actual cautery, or, better, of pure nitric acid. The child should be put under chloroform and the parts carefully dried with lint; sticks dipped in strong nitric acid should then be rubbed well into the edges of the sloughing parts and over the surface of the gums, after cutting away any loose sloughs and removing sequestra. Care must, of course, be taken not to allow the acid to run

over the sound skin. Several applications of the acid should be made, the parts being dried between each. Afterwards, a little iodoform should be powdered on and the surface smeared well with carbolic oil. No less important than the local treatment is the free administration of stimulants and abundant nourishment. As much wine or brandy as the child will take (about 3–4 ounces of brandy in twenty-four hours for a child of five years), carbonate of ammonia and bark, eggs beaten up with milk, strong soup and meat extracts should be given. In these cases, as in phlegmonous erysipelas, patients seem to be able to take almost an unlimited amount and to thrive upon it. Opium should be given, but with caution, as it is not always well borne. If the child recovers, the deformity is often remediable to a considerable extent by a plastic operation. Perhaps the most troublesome after condition is closure of the mouth by adhesions; an attempt to prevent this should be made during healing by the use of screw-gags or mouth-openers, and later, by division of the scar tissue; in some cases even section of the jaw and the establishment of a false joint may be required. It must be confessed, however, that the treatment of this cicatricial contraction is far from satisfactory, and often no permanent good result is obtained.

Some cases of cervical cellulitis (so-called angina Ludovici) closely resemble cancrum oris in their results (*vide* Diseases of Lymph Glands).

<sup>1</sup> An excellent description and figure is given in Mr. Cooper Forster's book on the *Surgical Diseases of Children*.

<sup>2</sup> *Med. Chir. Trans.* 1878.

**Acute Tonsillitis.**—It is hardly possible to exaggerate the importance of a thorough examination of the throat of a feverish child, especially when the cause of its illness is not obvious. A child, more particularly a young one does not, like an adult, volunteer the information that its throat is sore and painful during the act of swallowing, and will even deny that it is sore when it is actually suffering from severe tonsillitis. Without a careful examination it is quite possible to overlook not only tonsillitis but scarlet fever or diphtheria, especially if there is some chest complication present to throw the observer off his guard; or he may come to the conclusion that a case of submaxillary 'mumps,' or croupous pneumonia with physical signs delayed, is a case of scarlet fever. Anyone who has had any experience of a fever hospital will be able to call to mind many cases where errors have been made through neglecting to examine the tonsils or from want of knowledge of their appearance in health and disease.

Children are very liable to tonsillitis in its broadest sense, and this is in harmony with the fact that the lymphatic system during childhood is extremely active and especially prone to inflammation. The use which the tonsils fulfil is uncertain, but, whatever their exact function, it is certain that they belong to the lymphatic system, and they have been justly compared to Peyer's patches inasmuch as they resemble them in structure, consisting of a congeries of lymph follicles or so-called 'solitary glands.' They have a large blood supply and their lymph sinuses freely communicate with the lymphatics of the mouth and pharynx, and also with the deep cervical glands situated behind the angle of the jaws. Their surfaces are covered with deep clefts or pits which serve to increase the surface of the mucous membrane covering them, and these clefts or crypts, as they are called, are apt to become filled with thick yellowish secretion, and are then seen as yellow points scattered over their surface. One of the functions of the tonsils is probably the formation of leucocytes, or white blood-corpuscles, which are shed into the salivary secretion, and the cheesy secretion formed during inflammation consists principally of these bodies. Tonsillitis occurs under the influence of many different conditions during childhood, and possibly the proneness of the tonsils to inflame is in part, at any rate, the result of their position at the entrance of the fauces, where the various forms of aerial poisons, bacilli or other germs, would, when inhaled, be especially prone to lodge. Many of the zymotic diseases are accompanied by, or, what is a very significant fact, are preceded by tonsillitis. Thus the tonsils are the seat of inflammation in scarlet fever and diphtheria. Typhoid fever sometimes commences with a sore throat, measles and *rötheln* are mostly attended with some congestion or catarrhal inflammation about the fauces. The tonsils are apt to become inflamed as the result of cold, as from a wetting or exposure to a draught or keen east wind, or possibly also from some gastric disturbance. There can be little doubt also that tonsillitis is at times due to inhaling sewer gas or unwholesome smells. It also appears sometimes to precede or accompany an attack of acute rheumatism, or peri-endocarditis.

The record of tonsillar complication is not complete without reference to the epidemics of sore throats which are apt to occur in schools, hospitals, and other public institutions, or wherever many children are brought together. Some of these epidemics have appeared to be modified scarlet

fever or diphtheria, as proved by their belonging to a scarlatinal or diphtheritic epidemic which was coexistent in the neighbourhood or preceded or followed the epidemic of sore throats. But in other cases it has been clearly shown that there is an epidemic or infectious form of sore throat which closely resembles both scarlet fever and diphtheria, but which, while similar in many respects, is actually distinct, as shown by its not protecting from either of the above diseases.<sup>1</sup> Some cases of epidemic sore throat have apparently been traced to the consumption of the milk of cows suffering from 'foot and mouth' disease. Whenever sore throats occur in a household or school, the possibility that they are the result of the scarlatinal or diphtheritic poison should always be kept in view, while at the same time the milk supply and the sanitary condition of the establishment should be carefully investigated.

**Acute Catarrhal Tonsillitis.**—From whatever cause the tonsillitis is due, whether sporadic or epidemic, the symptoms are mostly the same. The

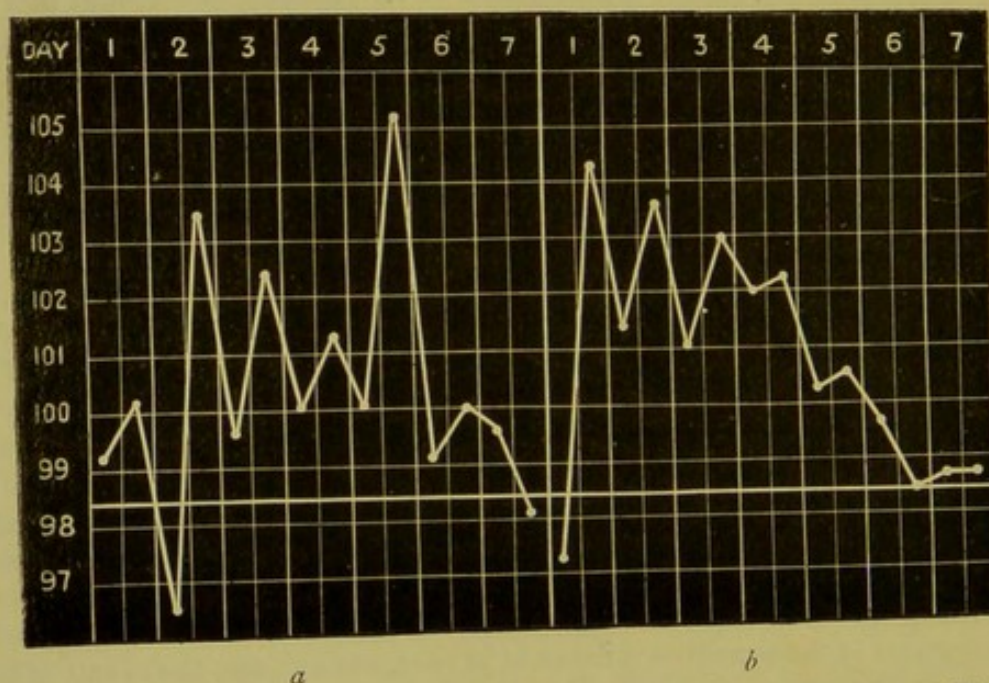


Fig. 7.—Epidemic Tonsillitis. *a*, child aged three years; *b*, child aged four years. These two cases belonged to an epidemic of sore throats; scarlet fever was not certainly excluded, but in no case was there a rash.

attack usually begins suddenly, though it is often preceded for a few hours by a feeling of soreness in swallowing. Unlike scarlet fever, it is usually unattended by vomiting; the evening temperature runs up to 103° or more, the tonsils are swollen and red, there is much secretion of mucus, and in a few hours yellow points make their appearance upon the tonsils, the result of secretion retained in the crypts. The tongue is furred, but does not become of a 'strawberry' appearance as in scarlet fever. In some cases, instead of the yellow points seen on the tonsils there is a yellowish exudation formed by the coalescence of the yellow spots on the inner surfaces of the tonsils; this does not adhere, as a rule, with any degree of firmness, and may be removed by a brush. But in other cases membrane undistinguishable from that of mild diphtheria forms on the tonsils, less often on the uvula or pillars of the

<sup>1</sup> Vide *Tonsillitis in Adolescents*, by C. Haig-Brown, M.D.

fauces ; it is usually not difficult to remove, and does not leave a bleeding surface. Such cases have been called *croupous angina*, *pseudo-diphtheria*, or *diphtheritic sore throat*. The inflammatory lesion remains for the most part tonsillar, and shows but little tendency to spread and involve the nasal mucous membrane or the middle ear, and while the glands at the angle of the jaw may become enlarged, they are not hard or surrounded by cellulitis. There is no true ulceration of the tonsils or sloughing of the palate. The temperature remains remittent for a few days, gradually returning to normal.

Such is the clinical history of an attack of acute catarrhal tonsillitis, but it must be remembered that many such attacks are exceedingly mild, and are accompanied by but little pyrexia, and may perhaps come and go without much complaint being made about them. Acute tonsillitis from any cause is apt to leave the tonsils enlarged and the mucous membrane covering them in a condition of chronic catarrh. Repeated attacks in children liable to glandular swellings, accompanied as they are by catarrh of the naso-pharynx in many cases, give rise to various troubles which will be described later on.

*Diagnosis.*—The most important question to consider, when called to see a case of tonsillitis, is whether scarlet fever and diphtheria may be excluded with certainty ; as, if they can, it is tolerably certain that the case is not one which will give rise to any anxiety either on account of the patient himself or his friends. Unfortunately, however, it is not often possible to express an opinion without misgivings ; that which appears to be a simple tonsillitis may be scarlatinal or diphtheritic in origin. It need hardly be said that the child suffering from tonsillitis should be stripped and a careful examination made of the surface of the body by a good light in order to detect a rash, and the faintest rash would necessarily arouse suspicion. In the absence of a rash a certain diagnosis is mostly impossible, but glandular enlargement, discharge from the nose, much yellow exudation on the tonsils, true ulceration of the tonsils or soft palate, otitis, if present, would make the diagnosis of scarlet fever a probable one. Should desquamation follow, if it is certain there has been no rash, it is of no diagnostic importance. If nephritis occur in the third week, it points to the scarlatinal nature of the attack as beyond doubt. A strawberry tongue is rarely present in the absence of a rash. The difficulty of diagnosis between mild diphtheria and tonsillitis accompanied by greyish exudation is hardly less than that between tonsillitis and scarlet fever in the absence of a rash. Albuminuria, nasal discharge, glandular enlargement and cellulitis, all point to diphtheria ; if paralysis follow, the diagnosis of diphtheria is certain.

*Treatment.*—Every attack of tonsillitis during childhood should be treated not only with respect but with suspicion, and the case should at once be isolated as far as it is possible to do so. It should constantly be before the mind of the practitioner that the case may be one of abortive scarlet fever or diphtheria, and that the next case to which he is called in the same household may be a genuine attack of one of the above zymotic diseases. It is always wise, when called to such cases, to give a guarded diagnosis and prognosis until the case has been under observation for a few days. The patient is to be confined to his room or to his bed, according to the severity of the attack, and his diet should consist of milk, beef-tea and sops.

If there is much pain in swallowing, hot fomentations medicated with belladonna or opium may be applied externally and renewed at frequent intervals. The tonsils should be painted with a solution of boro-glyceride in water (1-12), or iodine, ℥xx, glycerine ℥j, and water ℥j; black-currant jelly or lozenges are also useful. Salines, such as the citrates or chlorates of the alkalies, combined with aconite or salicylate of soda, if there is much fever, may be given during the febrile stage; acids and cinchona during convalescence.

**Chronic Tonsillitis.**—So-called chronic tonsillitis, or tonsillar hypertrophy, is a very important child's disease, though by no means limited to childhood. The affection consists in an actual overgrowth of the tonsillar adenoid tissue, so that the tonsils become greatly enlarged and project as rounded or irregular masses in various directions. Most commonly they grow inwards towards the middle line, and may reach such a size as to meet and be flattened by mutual pressure; they may then almost completely block the orifice of the pharynx. In other instances they enlarge vertically and become large oval masses, projecting far down into the pharynx and upwards and backwards towards the posterior nares. In other cases again they protrude outwards, separating the layers of the soft palate and forming a bulging mass on the roof of the mouth. Sometimes the surface is almost smooth, marked only by the orifices of the tonsillar crypts, and sometimes it is quite rugged and irregular.

The overgrowth is often accompanied by recurrent attacks of acute inflammation, in other cases there is no pain or acute distress at any time. The secretion of the mucous glands may be retained and thick pellets of inspissated matter be shut up in the crypts. Occasionally, on examining the region of the tonsil, instead of the usual appearance, a large yellow mass will be seen blocking up the whole of that side of the pharynx; it is soft and fluctuating, and on incision gives exit to a large quantity of thick *débris* of mucus, pus, cholesterine, &c. This condition we have sometimes thought to be a congenital mucoid cyst. It is rather alarming at first sight and looks like a large abscess on the point of bursting. The symptoms are those of tonsillar hypertrophy with more or less dysphagia.<sup>1</sup>

The ordinary enlarged tonsil is usually pale, and in old cases hard and sometimes almost cretaceous. The enlargement may be found at any age from birth (being sometimes congenital) to puberty, or more rarely later; it gives rise to a definite series of symptoms, all or most of which are usually present together. A vacuous, heavy look, from obstruction to breathing and consequent imperfect aeration of the blood, also imperfect development, and often stunting of growth; the mouth is kept open, the breathing is stertorous and in sleep snoring; there is usually chronic nasal and often aural catarrh, from the extension of irritation from the tonsils to the neighbouring mucous surfaces. The speech is nasal and indistinct or dead, the chest is often ill developed, pigeon-breasted, or, as pointed out by Lambron, has the diaphrag-

<sup>1</sup> The causes of tonsillar hypertrophy are obscure; it has been supposed to be the result of irritation of neighbouring parts causing enlargement, as in other parts of the lymphatic apparatus, in some cases possibly connected with one of the exanthems, in others perhaps the result of the obstruction of the tonsillar mucous glands; or, as some writers think, it may be a result of the so-called strumous diathesis.

matic constriction (M. Mackenzie). Recurrent acute tonsillitis is generally complained of, but there is seldom constant dysphagia ; there is an increase of the pharyngeal mucus due to catarrh, and the breath is often foul. The actual dwarfing and stunting from this condition is sometimes very marked. We have seen a difference of several months' growth in twins, one of whom had enlarged tonsils, the lost ground being rapidly regained after removal of the glands.

*Treatment.*—Chronic tonsillar hypertrophy, when once well established, is little affected by mere local applications or constitutional treatment ; it is only during an attack of acute inflammation that good can be done by such means. In the early stages of the affection astringents, such as glycerine of tannin, and tonics sometimes succeed. The only efficient mode of treatment is by removal ; caustics and the actual cautery are inferior methods of obtaining the same result.

For that form of enlargement where the tonsils project inwards, or inwards and downwards, nothing is so efficient, simple, or easy as removal with the guillotine.<sup>1</sup> Chloroform should be given if the child will not allow removal otherwise ; there is no objection to it except that it makes the operation somewhat more troublesome.

As much tonsil as can readily be removed should be taken away, but it is not necessary to remove the whole gland, the part left behind usually soon shrinks. Both tonsils, if enlarged, should, if possible, be removed at one sitting.

The guillotine cannot be satisfactorily used unless the tonsils project considerably towards the middle line ; in many cases, however, its use may be made easier by pressing the tonsil inwards with the finger applied to the neck just in front of and below the angle of the jaw.<sup>2</sup> Where the overgrowth is outwards and the guillotine cannot grasp the tonsil, the vulsellum and guarded blunt-pointed bistoury must be used, care being taken to keep the edge of the knife turned somewhat inwards. In some few cases even this is impracticable, and it is only in these rare instances that puncture with the Paquelin cautery should be employed ; the cautery may be thrust through the anterior pillar of the fauces, or directly into the gland between the pillars at one or two points ; shrinking will usually follow. Potassa fusa is sometimes used, but is dangerous and tedious ; scraping away the tonsils with a sharp spoon is the best plan if the gland is very friable and soft.

Removal of enlarged tonsils while acutely inflamed is usually condemned. We have, however, done it with great relief to the patient ; it is, of course, much more painful for a few minutes.

After removal some swelling often follows, and may last for a week or so, but soon subsides. After free removal the enlargement rarely recurs. We have, however, seen two or three instances where a re-growth, larger even than the original size, has appeared after a lapse of some months. We should be inclined to look with suspicion upon such cases as possibly indicating a tendency to lymphomatous growth elsewhere.

<sup>1</sup> Fahnestock's is the one that we prefer, though it is a somewhat delicate instrument and liable to get out of order ; the ones usually sold are too large and clumsy for convenient use.

<sup>2</sup> The tonsil cannot be felt externally, but a lymphatic gland lies just on its outer side, and when enlarged is often mistaken for the tonsil (Treves).

We have unintentionally enucleated a tonsil with the guillotine on two occasions, the whole gland coming away entire instead of being cut through; the result was, of course, satisfactory. It has recently been proposed to revive this old method of enucleation, but we think in the majority of cases it will not be found practicable. After the operation iced milk only should be allowed for the first day, and milk and soft food for the next day or two; after this the ordinary diet may be gradually resumed. Painting the tonsils with glycerine of tannin after the operation is perhaps useful.

We have never seen bleeding follow the operation to any serious extent; when it does occur it usually arises from injury to the pillars of the fauces, which are sometimes stretched over the tonsil so tightly as to be indistinct. A little ice to suck is all that is needed in most cases; should there be any severe bleeding, pressure or the application of the cautery, or perchloride of iron, might be required. Injury to the carotid is, of course, out of the question.

The argument against the excision of tonsils, that the overgrowth subsides as the child grows up, is altogether invalid in any severe case, for the mischief to the general development, and often to the hearing power, is done before the tonsils subside. There is probably no foundation for the idea that any wasting of the testes occurs from removal of the tonsils; it is much more likely that a lack of development would be due to the tonsillar enlargement than the reverse. The operation is an altogether harmless and beneficial one.

**Tonsillar Calculus** is a very rare condition, due to collection of secretion or inflammatory material and subsequent calcareous degeneration; the tonsil is enlarged, hard, and often painful, the calculus can be felt by a probe, and should be turned out of its cavity.

For the connection of tonsillitis with adenitis, the reader is referred to the chapter on Diseases of the Lymphatic Glands.

**Nasal Adenoids.**—It often happens that a child is brought with all the symptoms of tonsillar hypertrophy, and yet the tonsils are little if at all enlarged, or if they are their removal does not cure the affection. In such cases there is probably overgrowth of the post-nasal adenoid tissue, the '*pharyngeal tonsil*' so called. This condition, which was first described by Meyer, is very common in childhood and is often overlooked; it is, however, readily found out and treated if its symptoms are remembered.

A finger passed back into the pharynx and turned up behind the soft palate to the posterior nares will feel warty, sessile, or pedunculated masses about the upper surface of the soft palate and round the posterior nares, often almost completely blocking the apertures.

These excrescences bleed readily, but are not tender to the touch. In such cases free scraping with the finger-nail will sometimes suffice for the removal of the growths; in other instances, the use of an artificial steel finger-nail, or, better still, scraping the masses away with a Volkmann's spoon passed through the anterior nares and guided by a finger in the pharynx, is the best treatment. A Meyer's ring scraper may be employed if preferred; the last two methods of course require the use of chloroform. It is often necessary to repeat the operation before all the growths are removed.

The affection is an exceedingly common one, and may be met with at all

ages. We have seen it in quite the first few months of life, and it is even said to be sometimes congenital. No treatment except mechanical removal is to be recommended, though the application of caustics may in some cases be effectual.

**Post-pharyngeal Abscess.**—Abscess in the prævertebral fascia is usually either the result of caries of the cervical spine (see Spinal Disease) or of suppuration of the lymphatic glands in this region from irritation about the pharynx or posterior nares. The symptoms are dysphagia and dyspnœa, with pain and dribbling of saliva or mucus; a peculiar nasal or palatal resonance in the cry is described by Politzer.<sup>1</sup> On examination, a soft fluctuant swelling will be felt, and the posterior wall of the pharynx will be seen to project unduly, and possibly the yellowish colour of the pus may be seen through the mucous membrane. When the abscess is due to simple mucous irritation it should be opened through the mouth with a guarded knife, the child being turned on its face as soon as the incision is made, to allow the pus to flow out readily. We have seen post-pharyngeal inflammation give rise to so much dyspnœa without any visible pointing as to render tracheotomy necessary. Occasionally a large mucous cyst, such as that described as occurring in the tonsil, will be found on the posterior wall of the pharynx; free incision is all that is required for these conditions. In other instances suppuration tracks round the outer side of the pharynx from the tonsil or soft palate or from suppurating cervical glands or other neighbouring parts. Where there is external evidence of abscess it is better to make the opening in the neck, so that the wound may be rendered aseptic, as in abscess from spinal disease. Other causes of post-pharyngeal abscess are injuries and pharyngitis; it may also occur in the course of scarlet fever or be the result of a breaking-down gumma. Many cases are recorded by Bokai as idiopathic; it is not improbable that some of these were glandular. Wiel gives otitis as a cause. Convulsions, facial paralysis, great swelling of the neck, and spasm of the sterno-mastoid may sometimes occur (M. Mackenzie). The disease has been mistaken for many different affections, probably most often for croup. Examination of the throat by the eye and finger will always clear up a doubt in the later stages, though, as already pointed out, the diagnosis may be very obscure at first.

Retro-œsophageal abscess sometimes occurs, and may give rise to dyspnœa necessitating tracheotomy, rarely to dysphagia; it may be due to spinal caries or extension of suppuration from other parts.<sup>2</sup> It is not so common in children as the retro-pharyngeal abscess; when it occurs there is swelling on both sides of the neck, dryness of the throat, tenderness, and pain on movement, with fever and alteration of the voice. The abscess may burst into the œsophagus or burrow round the neck. According to Barthez and Rilliet, a form of dry coryza, with even coma or convulsions, may occur, and the onset may be sudden. After the abscess has burst, 'traction diverticula,' or stricture of the gullet, may result. The prognosis is bad. Fomentations and feeding by enemata or an œsophageal tube should be the early treatment, with incision at the posterior border of the sterno-mastoid as soon as there is distinct evidence of suppuration.

<sup>1</sup> *Jahrbuch f. Kinderheilk.* B. xxi. H. 1, 2.

<sup>2</sup> Ripley, *Archiv. of Pædiatrics*, Feb. 1884

**Stricture of Œsophagus.**—Apart from congenital malformations, œsophageal obstruction in children is due either to paralysis, or to cicatricial strictures, resulting usually from swallowing hot or corrosive liquids, such as potash, hydrochloric acid, &c. In such cases there is immediate danger of suffocation from implication of the larynx, as well as more or less dysphagia from pain and swelling. These troubles, however, may be slight and transient, and yet after a time cicatricial stricture may appear. The most common seat of such contractions is high up in the gullet, but they may be very extensive. The position of the stricture may be ascertained by auscultation during drinking, or by the passage of bougies,<sup>1</sup> after the history of the accident and the dysphagia have led to the discovery of the obstruction. A careful examination should be made of the œsophagus, to find out if possible the calibre, position, and number of the strictures, but bougies must be used with the utmost gentleness.

The best treatment of œsophageal stricture in such cases is usually that by gradual dilatation with bougies.<sup>2</sup> The drawback to it is that relapse is very apt to occur as soon as the daily passage of the instrument is omitted. Forcible dilatation by MacCormac's dilator and internal œsophagotomy have been employed; the former may be useful, the latter is too dangerous. Failing these, œsophagostomy may be performed if the stricture is limited to the upper part of the gullet, or if not, gastrostomy; the latter operation is the safer and the more generally applicable one. If an operation is to be done, it must not be put off too long. As soon as it is clear that dilatation is insufficient and the child is losing weight, no further time should be wasted. Done early, and done in two stages (Howse), good success may be expected from gastrostomy and the rest given to the gullet by the operation may result in restoration of the canal subsequently (Davies Colley). For details of the operations we must refer to the general text-books.

Œsophageal stricture from congenital syphilis, and obstruction from pressure of abscesses outside the gullet or from traction by cicatricial tissue around (periœsophageal abscess), are occasionally met with.

**Swallowing Foreign Bodies.**—It is very common for children to be brought with a history of having swallowed a farthing or button or something of the kind, and much alarm is caused to the child and its friends. In many cases the history is a mistaken one, in others the foreign body passes into the stomach, gives rise to no symptoms, and is voided in a day or two with the motions.

The only treatment required in such cases is to give the child plenty of bread, potatoes, suet pudding, &c., to provide a sufficient faecal sheathing for the harmless passage of the body.

In some few instances, however, an angular mass such as a bone, or some sharp-pointed object as a pin, may be swallowed, and may be arrested in the pharynx or œsophagus. In such cases there is usually some obvious sign of its presence, such as pain, dysphagia, retching or vomiting; possibly some blood-stained mucus is brought up.

<sup>1</sup> In new-born children the distance from the gums to the cardiac orifice is about seven inches (Sir Morell Mackenzie).

<sup>2</sup> Keller records thirty-five cases under two years of age with twenty-three cures, improvement in three cases, and five deaths, four remaining under treatment.

If there is no urgent dyspnœa, a careful examination of the fauces should first be made, to see if the object is not lodged between the pillars; failing this, the finger should be passed to the back of the throat and the root of the tongue and epiglottis be searched, care being taken not to mistake the cornua of the hyoid for a foreign body. If nothing is found, and the site of the body can be felt from the outside in the neck, and especially if the mass is hard, angular, and insoluble, an attempt should be made to remove it with the bristle probang or coin catcher, or, failing these, possibly with œsophageal forceps, though these are more dangerous. Failing these plans, the choice lies between an attempt to push the foreign body on into the stomach and the performance of œsophagotomy. The first plan should be followed in the majority of cases, and can be best managed by the gentle, steady use of a good-sized bougie. It is applicable to instances where the foreign body is soft, smooth, and rounded, and not likely to give rise to trouble in its passage through the intestines. It must be remembered that a feeling of soreness and irritation may remain about the fauces for some time after the passage and removal of a foreign body, and may give rise to the belief that there is still something there. In cases of swallowing fish-bones, and their becoming impacted, doses of hydrochloric acid or vinegar and water may be given, but the remedy is unpleasant and tedious. An anæsthetic may be used to lessen the discomfort of examination. Emetics, as a rule, are not good treatment.

**Œsophagitis.**—Infantile œsophagitis, first described by Billard, is a rare disease, supposed to be caused by irritation from bad milk, improper feeding, or sore nipples. The symptoms are unwillingness to suck, crying and immediate regurgitation after beginning to suck, and often some tenderness about the neck on pressure. The inflammation may be local or general, and may give rise to ulcers or sloughing, and possibly to subsequent stricture. The prognosis is bad; the disease may come on immediately after, or even exist at birth. It is not likely to be mistaken for anything except congenital malformation, in which the obstruction is absolute. Cleanliness, careful feeding, and the administration of glycerine of borax in small doses, constitute the treatment.<sup>1</sup>

Other rare conditions met with are congenital hypertrophy of the mucous glands and varix of the œsophagus.

<sup>1</sup> Sir Morell Mackenzie.

## CHAPTER V.

DISEASES OF THE DIGESTIVE SYSTEM (*continued*).

**The Dyspeptic Diseases of Infancy and Childhood.**—No infant, whether fed at the breast or with artificial foods, escapes having indigestion in one form or another; various dyspeptic ailments are certain sooner or later to supervene and form no insignificant part of the troubles of an infant's life. We have not far to go to seek an explanation of this. The alimentary canal of an infant is exceedingly intolerant of any form of irritation, while, with very slender resources to fall back upon, it has to perform a large amount of work in the digestion of food in order to make good the losses incident to life and supply suitable material for the rapid growth which is taking place. During the whole of infancy the digestive apparatus is worked to its uttermost capacity in digesting the food required for the infant's maintenance and growth, and any overtaking of its powers is exceedingly likely to be followed by disturbed function. The commonest causes of indigestion in infancy are practically the same as those in adults, the appetite perhaps is in excess of the digestive powers, and more food is taken than can be digested, or the food taken is of an improper quality; in both cases the result is the same, the presence of decomposing food in the alimentary canal giving rise to vomiting, flatulence and diarrhoea. In some cases the excessive and continued vomiting points to the stomach being most affected, in others the passage of loose stools containing undigested food, with much flatulence, indicate that the small intestines are involved, the large bowel when colic, tenesmus and an excoriated condition of anus are present. Before long a catarrhal condition of the mucous membrane is set up, or in the milder cases perhaps there is a deficient secretion of the digestive juices, or they are impaired in quality so that the food taken undergoes decomposition, irritates the bowels, and leads to its being quickly expelled instead of undergoing the normal process of digestion and absorption. In discussing these dyspeptic conditions arising during infancy and childhood, it is convenient to consider the prominent symptoms separately, always bearing in mind, however, that they are only symptoms of morbid conditions and not diseases.

**Flatulence and colic** may be present unaccompanied by either vomiting or diarrhoea, both breast-fed and bottle-fed babies alike suffering, though the latter more frequently. It is the result in many instances, perhaps most frequently, of the infant taking its food too quickly and in too large quantities; digestion is performed imperfectly, decomposition ensues, and gases are formed which distend the bowels. The abdomen is distended, the infant is restless and cannot sleep, it is constantly crying and tossing about, and brings up or passes large quantities of flatus with much relief. Ease

for the most urgent symptoms may be found in giving the infant a few teaspoonfuls of an equal quantity of lime-water and cinnamon-water, or small doses of carbonate of ammonia and soda in peppermint-water, or a small piece of these compressed salts, known as 'soda-mints,' dissolved in a little syrup. It will be necessary, temporarily at least, to lessen the amount of food which the infant is taking; this can be done in breast-fed children by giving them some sweetened barley-water or whey before taking the breast and not allowing it to be given for too long or too often. In artificially-fed infants the amount of food, especially the amount of curd, must be reduced either by dilution with barley-water, lime-water, or by predigesting the curd. Large enemata of warm water (10-15 oz.) and hot fomentations to the abdomen will generally relieve the severer cases of colic due to flatulence, and a grain of mercury and chalk powder combined with half a grain of Dover's powder may be given by the mouth.

**Vomiting.**—Vomiting is a very common complaint for which medical aid is sought. That this vomiting is readily brought about is hardly to be wondered at when it is remembered with what vigour an infant will suck, and yet the stomach of a newly-born infant cannot hold more than a wine-glassful of fluid without being over-distended, and that, moreover, during digestion active peristaltic movements take place. The most frequent way in which food is rejected from the stomach is what is termed by mothers 'possetting,' and which consist of eructations of small quantities of fluid from time to time without any effort, the food escaping from the corners of the infant's mouth, the result of a too vigorous peristaltic action of the stomach. Fluid will also frequently regurgitate during the eructation of gases from the stomach. In true vomiting there is more or less retching, and the contents of the stomach come up with considerable force. The most frequent cause of this is an irritable condition of stomach due to a catarrhal state of the mucous membrane, in which the curdling ferment is abnormally active, while the digestive ferment is present in smaller quantity than usual. Vomiting is especially common in infants who are taking cow's milk, and who are unable to digest the large quantities of hard curd contained in the milk. Sometimes the vomiting is the result of over-distention, or the occurrence of excessive quantities of wind, or of coughing. The vomiting of breast-fed infants is frequently due to their being given the breast at too frequent intervals, or from some other cause, as the ingestion of unsuitable food on the part of the mother; or she may be suffering some great anxiety which is in itself quite sufficient to cause an alteration in the quality of the breast milk. Vomiting may be the result of some congenital or acquired obstruction of the bowels. It must also be borne in mind that vomiting in infants and children is frequently reflex, and not due to any lesion of the stomach, but the result of cerebral disease, as meningitis or tumour, or to the irritation caused by cutting a tooth. Vomiting is sometimes the first, and for a time the only symptom in tubercular meningitis, and may precede for a week, or even longer, any marked cerebral symptoms. Reflex vomiting may at first be entirely undistinguishable from dyspeptic vomiting, the condition of the tongue is no certain guide, and it is only as the cerebral symptoms become more marked, the abdominal walls either retracted or in a toneless, flabby condition, that a diagnosis can be made. In older children the vomiting of

an acute gastric catarrh may last for a few days, but any long-continued or habitual vomiting is very suspicious of cerebral disease. Hysterical vomiting is occasionally seen in girls about puberty.

The treatment of vomiting must necessarily depend upon its cause. Vomiting in the breast-fed infant, provided the mother's manner of life or diet is not at fault, is probably the result of too large quantities of milk being taken, and it will generally be sufficient to insist upon regular hours of feeding at not too frequent intervals, and to give the infant a few teaspoonfuls of sweetened lime-water before it has the breast, with a dose or two of hyd. c. cret. to act on the bowels. Vomiting in the bottle-fed infant is more difficult to deal with, especially when a gastric catarrh exists. The infant is under these circumstances very intolerant of cow's milk, even when largely diluted, the milk being quickly curdled by the acid mucus in the stomach, and the hard lumps of curd are vomited in masses. In the milder cases of vomiting in infants, it may probably be sufficient to resort to diluting the milk with barley-water in the proportion of one-third to two-thirds of the latter, or of using Mellin's food. Condensed milk, if properly diluted, is nearly always retained more readily than fresh cow's milk by vomiting infants. Whatever food is resorted to, great care must be taken that too large quantities are not given at a time or taken too quickly. In severer cases, where no form of fresh milk is tolerated, milk peptonised by the addition of Benger's peptonising powders or condensed peptonised milk sent out in tins by Savory and Moore, are frequently useful, and are retained when no other form of milk is tolerated. If the vomiting is severe and continued, the bottle must be done away with and the infant fed by the spoon. An alkali, such as carbonate of soda with two or three grains of pepsine in powder, may be given before meals, and is often of use; or bismuth and nux vomica may be given, as in the following mixture:—

( 5 )

Liquor of bismuth and citrate of ammonia . . . . .	℥v
Tincture of nux vomica . . . . .	℥ss
Glycerine . . . . .	℥x
Caraway-water . . . . .	to ʒj

*One teaspoonful three times a day before meals.*

**Diarrhœa.**—Looseness of bowels is symptomatic of many different disorders and morbid conditions. An attack of diarrhœa frequently ushers in scarlet fever, or may be present in all stages of the malignant form; it may accompany typhoid fever; it is often present in septicæmia, empyema, uræmia, peritonitis. The commonest form in children is the result of an accumulation of undigested food in the intestines, or of some irritating matters taken in the food. Infants at the breast are liable to suffer from looseness of bowels soon after birth on account of the colostrum not agreeing; they are also liable to suffer from the taking of improper food on the part of the mother during menstruation; the consequence of over-feeding or a fit of anger, or other strong emotions on the part of the mother, has been known to be followed by diarrhœa in the infant. Artificially-fed infants are much more liable to suffer than infants at the breast. The difficulty with which the curd of cow's milk is digested overtakes the

digestive powers, the undigested curd irritates the bowels, and increased peristalsis of the bowels is set up. An intestinal catarrh is soon established, the infant is restless, peevish, and cannot be got off to sleep, the abdomen is distended with gas, the legs are drawn up, and the infant passes perhaps five or six stools or more per diem.

An examination of the napkin shows, instead of the bright yellow homogeneous stools of the healthy infant, curdy flakes or other undigested food, and a greenish slimy liquid which stains the diaper. The infant is thirsty, takes the breast or the bottle vigorously at first, but is soon satisfied and pushes it away when offered. The tongue is coated and the mouth is often the seat of aphthous stomatitis. Vomiting may be present, but is mostly absent. In a day or two the infant begins to waste, the muscles of the limbs grow flabby, and the skin hangs about the thighs in loose folds, and the parts about the anus and genitals become red and frequently raw. In most cases improvement takes place after a few days; the stools become more normal and the infant quickly recovers. Some infants are liable to such attacks especially during hot weather, and the final result may be a more or less chronic condition of catarrh, to end finally in general malnutrition from gastro-intestinal atrophy. Rickets is a very frequent sequence of intestinal catarrh.

Not infrequently the symptoms point to a catarrh of the large bowel, and are more of a dysenteric character. Dysenteric diarrhœa may be primary or follow an attack of simple diarrhœa, the general affection passing away and leaving a local inflammatory condition in the colon, sigmoid flexure and rectum. The same form of diarrhœa frequently succeeds whooping-cough and measles. There is distention of the abdomen, with often more or less tenderness in the left iliac region on pressure, frequent passage of small liquid stools, consisting largely of mucus, biliary matters, and perhaps blood, preceded by much straining and forcing down and frequently followed by prolapse of the rectum. Older children often suffer from this form of catarrh of the large bowel, passing lumpy mucoid stools, and getting up perhaps several times in the night to sit on the vessel, only passing each time a little mucus streaked with blood. Dysenteric diarrhœa is apt to become chronic, alternately better and worse, until the patient is reduced to a condition of wasting.

Sometimes dysenteric diarrhœa occurs in epidemics in winter as well as in summer. We have known several such epidemics.

Older children sometimes habitually suffer from what has been termed 'lienteric' diarrhœa, in which a loose stool is apt to follow the ingestion of food. Such children are generally subject to loose bowels, a diarrhœal stool following any form of excitement, especially a fright, the immediate cause being an exaggerated peristaltic action of the ileum and colon. There is often in such cases a catarrh of the large bowel, as evidenced by the excess of mucus which they pass; phthisical children also may suffer in this way. A form of diarrhœa which has been termed 'fat diarrhœa,' from the presence of an excessive quantity of fat in the stools, has been described, which is presumably due to catarrh of the duodenum and pancreatic duct.

*Treatment.*—In the slighter forms of diarrhœa in infants, where there is not much restlessness, distention of abdomen, and not more than four or five loose stools during the day, it will be mostly sufficient to underfeed them

for a day or two, and give them some mild laxative, as castor oil or hyd. c. cret. and a simple alkaline mixture. Infants at the breast may be given a few teaspoonfuls of sweetened barley-water in lieu of the breast, or after the infant has been partially satisfied at the breast. Bottle-fed children should have their milk more diluted than usual, or a mixture of cream and barley-water should be substituted, such as

Cream	.	.	.	.	.	.	.	½ ounce
Barley-water	.	.	.	.	.	.	.	3 ounces
White sugar	.	.	.	.	.	.	.	1 teaspoonful

If the purging be at all severe and curdy masses are vomited, or appear in the stools, it will be best at once to withhold all milk for a day or two, and to substitute some more digestible and less fermentable food. Peptonised milk will sometimes answer very well in the less severe forms of diarrhœa, but it must be borne in mind that in any given case much of the curd remains unconverted into peptones, and the unchanged curd may often be seen in large quantities in the stools, even where great care has been taken in the peptonising of the food; peptonised milk is of more service in gastric catarrh and vomiting than in acute diarrhœa. In the severer cases, where the stools are frequent, the blandest and most unirritating foods must be given; such, for instance, as

Arrowroot-water	.	.	.	.	.	.	.	2 ounces
Whey	.	.	.	.	.	.	.	2 "
White sugar	.	.	.	.	.	.	.	1 teaspoonful

or,

Barley-water	.	.	.	.	.	.	.	10 ounces
White of egg	.	.	.	.	.	.	.	1 ounce
White sugar	.	.	.	.	.	.	.	1 or 2 teaspoonfuls

Either of these may be given out of a bottle every few hours, and in amounts according to age.

The medicinal treatment in the early stage consists in giving a laxative for the first twelve or twenty-four hours. In these cases the diarrhœa is probably the result of a congestion of the mucous membrane of the intestine, and the presence of irritating, perhaps putrescent materials, and it is wiser to assist elimination rather than attempt to prevent it by means of opium or astringents. To this end emulsion of castor oil or small doses of calomel may be given, the latter being preferable if there is vomiting, on account of its being more readily retained by the stomach.

( 6 )

Castor oil	.	.	.	.	.	.	.	℥xv
Powdered acacia	.	.	.	.	.	.	.	gr. v
Syrup of ginger	.	.	.	.	.	.	.	℥v
Peppermint-water	.	.	.	.	.	.	.	ʒj

*One teaspoonful every four hours.*

Or, calomel  $\frac{1}{6}$  to  $\frac{1}{2}$  of grain may be given with a grain or two of white sugar every four hours.

By the end of twenty-four or forty-eight hours the laxative will have done

all that can be expected of it, and the stools will be yellow, homogeneous, and less frequent. A sedative may now be useful, such as bismuth or zinc.

( 7 )

Carbonate of soda . . . . .	gr. ij
„ bismuth . . . . .	gr. jss
Powdered tragacanth . . . . .	gr. j
Spirits of Chloroform . . . . .	℥ijss
Cinnamon-water . . . . .	to ʒj

*Every four hours.*

( 8 )

Oxide of zinc . . . . .	gr. jss
Powdered tragacanth . . . . .	gr. j
Spirit of nutmeg . . . . .	℥iij
Glycerine . . . . .	℥xv
Cinnamon-water . . . . .	to ʒj

*Every four hours.*

In the majority of cases of simple diarrhœa the attack is arrested by these means—namely, a liquid diet in which milk is excluded or given sparingly, and a laxative for a day or two followed by bismuth or zinc. It not unfrequently happens, however, that a simple diarrhœa without urgent symptoms passes suddenly into the acute or inflammatory form, or, on the other hand, into a more or less chronic condition of looseness of bowels with marked loss of flesh.

As improvement takes place, milk diluted with whey or Mellin's food may be allowed in small quantities, or, what is useful and readily prepared, milk diluted with twice its bulk or an equal quantity of arrowroot-water (a teaspoonful to 10 oz.) and sweetened with white sugar. Malt extract may be added a few minutes before taking. During convalescence, diluted acids with pepsine or astringents are the best class of remedies.

( 9 )

Dilute nitric acid . . . . .	℥j
Syrup of orange-peel . . . . .	℥x
Decoction of pomegranate root . . . . .	to ʒj

*After each meal.*

( 10 )

Dilute nitro-hydrochloric acid . . . . .	℥j
Liq. Pepticus (Benger) . . . . .	℥xx
Syrup . . . . .	℥x
Orange-flower water . . . . .	to ʒj

*After meals.*

**Constipation.**—Small weakly infants very commonly suffer from inactive livers and sluggish bowels: as also do infants fed on starchy foods, who are fat, yet weakly, and who are developing the symptoms of rickets. All such children are apt to have pale stools deficient in bile, the bowels acting

only once every two or three days, or even only once a week. The immediate cause is mostly a want of tone in the bowels—the peristaltic action being sluggish and not easily evoked—and a deficiency of the intestinal secretions and probably also of bile. Intestinal digestion is imperfect, and absorption slow and inefficiently performed. In breast-fed children it may be due to poorness of the milk; the constituents of the milk are digested, the material to be rejected per anum is small and imperfectly stimulates the colon. The remedy may be found in giving one, two, or three meals daily of Mellin's food made without milk, to which a little cream is added; or by giving Biedert's mixture. In infants fed on cow's milk or starchy foods, a change in the food should be made in the direction of the diminution of the curd in the milk and the addition of dextrin and maltose or starch sugar. This can usually be effected by diluting the cow's milk and adding barley-water, arrowroot with some good extract of malt, or by using some of the malted foods. Massage applied to the abdomen by the warm oiled hand is always useful; purgatives are to be avoided; small doses of *nux vomica*, 'cascara cordial,' or belladonna and podophyllin may be given. Malt extract is also very useful. In older children, prunes, tamarinds, stewed figs, or stewed apples may be given.

**Acute Gastro-intestinal Catarrh; Inflammatory or Zymotic Diarrhœa; Cholera infantum.**—With the commencement of the warm weather in June or July, there is an increase in the number of cases of infantile diarrhœa; and by the time the end of July or the beginning of August is reached—especially if the weather is sultry and the thermometer standing above 80° F. in the shade—there is tolerably certain to be, in large cities, an epidemic prevalence of diarrhœa. That there is a close connection between hot weather and diarrhœa does not admit of a doubt, and indeed the mortality from summer diarrhœa in any given year could be predicted if the temperature of the atmosphere were known, yet it is quite uncertain how the high temperature acts. It has been surmised that the diarrhœa is due to the presence in food or in the air of some form of organism which requires a certain degree of heat for its cultivation, and which, entering the system, gives rise to the disease. If this were so, a certain interval would take place between the commencement of the hot weather and the advent of the epidemic, and this is what does usually take place, the hot weather being present for some days or more before any number of cases of diarrhœa occur, and frequently also in September the prevalence of diarrhœa continues for a while in spite of the cooler weather which then generally prevails. This fact is suggestive of the hot weather being only indirectly the cause, but favouring the development of some form of organism which, entering the system, gives rise to the disease. The prevalence and mortality of this disease differ very greatly in different seasons, a hot sultry summer being productive of a severe epidemic, a cold and damp one of a much smaller amount. All classes of society are apt to be attacked, both children and adults, but it is the former which suffer most, and it is in them a formidable and frequently fatal disease, not only in its acute stage, but also from the effects of chronic atrophy of the intestine, which is apt to supervene. It is most frequent and fatal between the ages of three months and two years. It is much more prevalent and fatal in large cities, among the poorer classes who

inhabit close crowded courts in low-lying districts, especially if situated near the mouth of a river; while it is comparatively rare among the better-housed classes of society, especially amongst those who live on high, bracing sites. It occurs more often among artificially-fed infants than among breast-fed, especially if the former have already suffered from a similar form of bowel complaint, or are sickly from any other cause. One of the most striking peculiarities of the epidemics is the tendency to recur year after year in the same city or locality; thus, in Leicester, Preston, and Nottingham the diarrhœa mortality year after year is constantly high, while in Oldham, Rochdale, and Halifax, towns which in many respects resemble the former, the mortality from this cause year after year is small. These differences are at present unexplained either by the sites of the towns or by the employment or manner of life of their inhabitants. The epidemic prevalence of diarrhœa has been attributed with more or less plausibility to the use of sour milk, unripe fruit, inhalation of sewer gas, emanations from the soil, &c., but that no one of these can be a constant cause is shown by the fact that infants taking the breast occasionally suffer, that it occurs in towns where there are no sewers, and it is not especially prevalent in some towns where sewer gas is frequently present in the houses (Ballard). While it is doubtful if sour or contaminated milk can be the constant cause, yet it seems probable that the milk supply has in some epidemics been at fault. It must be within the experience of many to have seen attacks of diarrhœa in a household or school set up by decomposing or contaminated milk or tainted animal foods. One of the reasons, no doubt, that babies at the breast comparatively rarely suffer is that they receive their milk-supply direct from the breast, while in babies artificially fed there are various risks of contamination and decomposition before the milk reaches the infant. On the other hand, it is certain that sour milk does not by any means invariably produce diarrhœa, as healthy infants may again and again be seen sucking sour milk out of dirty bottles, and it seems to be necessary that during these changes some poisonous alkaloids should be formed, which, when taken, give rise to irritative diarrhœa. It seems most probable, in reviewing the whole subject, that the presence and development of some forms of micro-organisms in various animal foods or in the intestines are instrumental in the production of poisonous decomposition, alkaloids, the presence and absorption of which give rise to the symptoms.

At the present time, however, in spite of many searches, it cannot be said that any specific organism has been certainly isolated and cultivated.

In some few instances it has been clearly proved that contamination of the water-supply of a town has been the cause of an extensive epidemic of diarrhœa.

*Symptoms.*—The symptoms may supervene suddenly in an infant in apparent health, though more frequently an infant is attacked who has already suffered for a day or two from intestinal disturbance or has had an attack of diarrhœa a week or two before. The first symptom is generally vomiting; this is followed by a loose motion and accompanied by more or less fever, at the same time the infant is restless and irritable, the abdomen is distended with gas and the legs are drawn up. The vomiting in the severest cases is very distressing, everything taken being rejected immediately, the vomited matters consisting of undigested food, and subsequently, of simple

mucus tinged with bile ; the stools are watery and consist of undigested food, they are usually at first yellow and frothy, or green, containing lumps or flocculi of curd. Later, in severe cases, they consist of little else than slightly coloured water, or resemble the rice stools of cholera, and as the attack becomes more chronic, they are of a dirty brown colour and very offensive. The tongue becomes coated with a thick white fur, the thirst is mostly extreme, the child eagerly taking the bottle or spoon, but vomiting immediately afterwards ; there is great restlessness, the child may doze for a short time, but rarely manages to get off into a sound sleep.

The fever is seldom high and mostly intermittent, varying from 99° F. to 102° F., in exceptional cases 105° F. or still higher. The stools become more and more frequent as the disease advances, sometimes being passed every few minutes, perhaps escaping unconsciously or being preceded by a short cry or an expression of pain on the infant's face. Very often more or less erythema or excoriation occurs about the anus and genitals. After a longer or shorter period, according to the acuteness of the case, symptoms of collapse make their appearance. There is a change in the infant's face which strikes the most casual observer ; the eyes are sunk in the head and kept partly closed, the fontanelle is depressed, the face is pallid or of an earthy tinge, the muscles of the neck and limbs lose their tonus and the head rolls about when the infant is moved. There is no longer any great restlessness, the infant is generally listless and drowsy, and takes little or no notice of its friends. In this stage the vomiting usually ceases, the stools become less frequent and are smaller, and the abdomen becomes sunken and its walls flabby.

The further progress of the attack depends upon whether improvement sets in ; if so, the diarrhoea ceases, more or less colour returns to the infant's face, it takes notice of its friends, and, though still weak, begins to use its limbs and take its food. In other cases it becomes more exhausted, it wastes rapidly, parasitic stomatitis makes its appearance and frequently convulsions occur, which quickly bring the end. The fatal event is often preceded by the occurrence of cerebral symptoms, such as coma and Cheyne-Stokes respiration, a condition which has been termed 'false hydrocephalus' from its resemblance to meningitis, and indeed it is often believed by the friends and others that death has occurred through 'water on the brain.' In this state the coma is profound, the pupils dilated, and at times unequal, the respirations irregular, the child is pulseless, and there may be twitchings of the face or limbs. The state of the fontanelle will generally assist the diagnosis in deciding whether the cerebral symptoms are due to arterial anæmia of the brain, as in false hydrocephalus, or to meningitis ; in the former case the fontanelle is depressed below the level of the cranial bones, inasmuch as the brain occupies less space than normally, in consequence of the arterial system being nearly empty, the result of a failing heart.

The length of time the disease lasts differs considerably, so rapidly fatal are some attacks that the term *cholera infantum* has been applied to them, and indeed in a few instances this resemblance to Asiatic cholera is very close indeed. Such cases occur much more commonly in the large cities of the continents of Europe and America than in our own cooler climate.

The following case may be taken as an instance. A boy of five years of age was taken suddenly ill with vomiting and purging at 1 A.M. and died at

2.45 P.M. on the same day. When admitted to hospital at 11 A.M., he was completely collapsed; the pupils contracted, the conjunctivæ nearly insensible, the lips were pallid, the pulse could hardly be counted, the temperature was  $104^{\circ}$  F. In spite of brandy, ammonia, and nitrite of amyl, he failed to rally. The post-mortem examination showed the body to be well nourished and rigor mortis strongly marked. The intestines were distended with gas, and contained a small quantity of pale gelatinous fluid, the mucous membrane of the whole length of the alimentary canal was pink with minute extravasations of blood, and the solitary glands were enlarged. The tissues generally were pale and dry. The case occurred in August 1880, a summer which was unusually hot, and during which zymotic diarrhœa was very prevalent.

In a few cases, convulsions may supervene during the first few days, and bring about a fatal termination. In the majority of fatal cases the duration is somewhat longer, perhaps a week to ten days, the infant passes through the acute attack, the symptoms then assume more or less of a dysenteric character, and it succumbs through exhaustion and inanition from a failure of the alimentary canal to recover its normal functions. Many infants who escape the acute attack in August, die in September or October from gastrointestinal atrophy, which has followed as the result of the acute attack.

In many cases, as already remarked, the character of the diarrhœa after the first few days points to the principal lesion being in the large bowel, but cases of acute diarrhœa having a dysenteric character from the first, and resembling in many respects the dysentery of the tropics, occasionally occur during hot weather in this country, and may prove rapidly fatal. Cases of this type have been recorded by Hensch, Goodhart, and Eustace Smith. Such cases commence with the sudden onset of vomiting, colicky diarrhœa, and feverishness; there is much straining at stool, abdominal tenderness, and often a purpuric rash or petechiæ appear on the skin. The stools consist largely of blood and mucus. In one case a girl aged  $12\frac{1}{4}$ , who was admitted to the hospital under the care of Dr. Hutton, was taken ill during the hot weather at the end of July with vomiting and diarrhœa, delirium, petechiæ on the body, and epistaxis. She was admitted to hospital on the sixth day of her illness in a collapsed condition with a pulse of 190 and temperature of  $102^{\circ}$  F.; she passed loose stools containing some hard lumps with blood and mucus; the epistaxis again supervened, the temperature rose to  $104^{\circ}$  F., and she died exhausted on the ninth day of her illness. The post-mortem showed the folds of the mucous membrane of the colon to be of an ashy grey colour with well-defined ulcers varying in size from a pin's head to  $\frac{1}{2}$  in. in diameter; the changes were all more marked below the sigmoid flexure. It is important to remember such cases.

*Complications.*—By far the most common complication of acute intestinal catarrh is broncho-pneumonia, or bronchitis and collapse of lung. The symptoms are apt to be latent, but any dyspnœa or high temperature would necessarily call for a careful examination of the lungs. Thrombosis of the cerebral sinuses occasionally takes place in the later stages, but it is comparatively rare; the symptoms consist in distention of the veins emptying into the cavernous sinus with œdema of the forehead and eyelids; there will also be tonic spasm of the limbs and neck, and convulsions. Albuminuria frequently occurs during acute diarrhœa; nephritis and uræmic

convulsions have been described by some authors. Peritonitis occasionally, but rarely occurs, hyperpyrexia may also occur.

*Sequelæ.*—Should the infant recover from the acute attack, it is by no means certain that complete recovery will take place; for it is extremely probable that gastro-intestinal atrophy may supervene, or a chronic diarrhœa remain, the result of chronic catarrh with follicular ulceration of the colon, sigmoid flexure and rectum. In the latter case the symptoms are those of dysenteric diarrhœa; defæcation is frequently accompanied by much pain and straining, the stools consist of mucus, often tinged with blood, or are dark brown and liquid. The rectum becomes prolapsed, and is sometimes returned with difficulty, and the child rapidly wastes. General œdema may be left.

*Prognosis.*—Acute intestinal catarrh must always rank as a serious disease, not only from its tendency to prove fatal during the attack itself, but because it so frequently passes on into a subacute or chronic form of catarrh to be succeeded by atrophy. The younger the infant, the more serious the prognosis becomes, especially if it has been artificially fed; in older children, though the attack may be severe and the depression produced very great, the disease usually terminates favourably. The onset of cerebral symptoms is of very unfavourable augury, and the chances are against the infant, though the case is not hopeless. Convulsions are generally followed by death. In those cases in which infants lapse into the chronic stage the prognosis is serious, as they are already exhausted by the acute attack.

*Morbid Anatomy.*—If death has taken place early in the disease, the body is well-nourished and perhaps even plump, but the face retains the same expression it had during life, the eyes and cheeks being sunken. On opening the body, minute hæmorrhages are usually present on the surface of the lungs and heart, and there is hypostatic congestion at the bases of the lungs. The mucous membrane of the stomach and bowels is swollen and pink from capillary congestion, the congestion often being present in patches, and minute hæmorrhages may have taken place. The mucous membrane of the large intestine is congested, especially along the summit of the folds of the membrane. An excess of mucus is generally present, and the contents are liquid. The Peyer's patches and solitary glands are most frequently swollen; the kidneys are pale, the cortex frequently enlarged. In the later stages, the body is more or less emaciated, the lungs are semi-solid at their bases from the presence of catarrhal pneumonia, the mucous membrane of the small intestine is swollen and congested, but the principal changes will be noted in the large intestines. Here the mucous membrane is generally much congested, especially about the cæcum and descending colon, there may be superficial ulceration or excoriation at the summits of the folds of mucous membrane, or the bowel may be pitted with deep but small ulcers from the results of breaking down and discharge of the solitary glands. Microscopical examination of the intestines shows a distention of the network of capillaries of the villi and mucous membrane, and an exudation of leucocytes is mostly present in the sub-mucosa and between the tubules or crypts of Lieberkuhn. Numerous micro-organisms are present. The solitary glands especially in the large bowel are very often in a state of softening in their centres, or their contents have discharged, giving rise to sharply-cut ulcers.

On examining the brain, no constant or indeed definite lesion is found ; in most cases the sinuses are distended with blood or occupied by a firm pale clot, but this condition of engorgement appears to be the result of death taking place through cessation of respiration, or during a convulsion, and is due to mechanical causes from interference with the return of blood to the lungs. The symptoms referable to the brain during the last few hours of life, coma, Cheyne-Stokes respiration, &c., have been attributed to exhaustion, and an anæmic (arterial) condition of brain due to diminished arterial tension. The suggestion that they are due to uræmia is improbable, though it is not unlikely they are due to the absorption of poisonous bodies from the alimentary canal. Meningitis is extremely rare ; in one case, however, which came under our notice, lymph was found about the optic commissures.

Though many attempts have been made by experimenters to demonstrate the existence of a specific organism in the alvine discharges of zymotic diarrhœa, by cultivating the various bacteria present in the stools, it cannot be said that these have been successful. Bacteria are present in the normal stools of infants as well as in diarrhœa stools, and nothing certainly specific has been demonstrated. That these symptoms manifested are due to some form of poison being generated in the intestines, such as muscarine or ptomaines, there is no room for doubt ; but under what conditions or in what way they are formed we are at present in total ignorance.

*Treatment.*—The most important part of prophylactic treatment is connected with the food which the infant takes and the purity of the air which it breathes. No weakly infant who is being reared on artificial food and who has previously suffered from intestinal catarrh, ought, if it is possible to avoid it, to remain in the crowded part of a large town during the hot weather, but should be sent away to a bracing seaside place, or country quarters should be found for it among breezy hills. The greatest care should be exercised in the selection of pure milk and in its storage before it is taken by the patient, as there is little doubt that milk readily absorbs noxious gases, is easily contaminated by micro-organisms present in the atmosphere, and changes are set up which render it unfit for food. Care must also be taken that the infant is not given food in excess of its digestive powers, as undigested curd or other foods are exceedingly likely to decompose in the alimentary canal and give rise to irritation and diarrhœa. The stools, both of infants at the breast and bottle-fed children, should be carefully watched, and any traces of undigested food or of unusual foulness or looseness of bowels should be the signal for lessening the amount of food taken. No infant at the breast should be weaned during the continuance of the hot weather, and if diarrhœa makes its appearance it should, if possible, be returned to the breast.

The indications for treatment when the diarrhœa has commenced are in the first place to give a laxative to clear away all irritating or decomposing foods and relieve the congested bowel, and secondly to give food only in small quantities and of the blandest character. The first indication can be fulfilled by giving castor oil, as long ago advocated by Dr. Geo. Johnson, or by a dose or two of calomel. The former may be given in emulsion in combination with an unirritating antiseptic, as boracic acid or salicylate of soda ;

the latter helps to prevent decomposition in the emulsion, and perhaps also plays a similar part in the stomach in checking putrefactive changes. The following prescription may be used.

( 11 )	
Salicylate of soda . . . . .	gr. j
Castor oil . . . . .	℥xv
Powdered acacia . . . . .	gr. vij
Syrup of ginger . . . . .	℥vij
Peppermint-water . . . . .	to ʒj

*Every two hours. For an infant of six months to a child of five years.*

The oil may be given by itself in half-teaspoonful or teaspoonful doses, but it is apt to cause sickness. Instead of the castor oil, especially if there is much sickness, small doses of calomel may be given, and on account of its small bulk and tasteless character it is in many respects to be preferred. It is better, if the attack is a sharp one, to give it in small and repeated doses, especially in weakly infants;  $\frac{1}{4}$  to  $\frac{1}{2}$  grain may be given to infants and young children every two hours, until one or two grains have been given. In the course of twelve hours or more, according to the intensity of the diarrhoea, all appearances of undigested food will have disappeared from the stools, the latter perhaps continuing frequent and watery.

Unless the infant be at the breast, all milk or milk foods should be stopped and barley water with white of egg substituted (p. 64). The most troublesome symptom at first is frequently the vomiting; this may be constant, following every attempt at feeding, and it will be necessary to desist from all attempts at feeding for some hours, only moistening the mouth with a small brush dipped in iced water. Counter-irritation and hot applications to the abdomen at this stage are undoubtedly serviceable. For this purpose a liniment composed of five drops of oil of mustard to an ounce of camphorated oil may be gently rubbed over the abdomen, and spongio-piline or several folds of flannel wrung out of hot water applied. Or the spongio-piline may be wrung out of water at  $110^{\circ}$  in which mustard has been diffused in the proportion of two tablespoonfuls to a gallon.

The medicinal treatment of acute diarrhoea is often very unsatisfactory. The vomiting may continue, the stools in spite of the most careful dieting may be loose and frequent, and the child may rapidly lose ground. The drug which one is tempted to fly to is opium in one form or another, in the hopes of allaying irritation and diminishing the frequent flux from the bowels, which appear to the friends at least to be the cause of the child's increasing weakness and distress. It must, however, be borne in mind that the disease is something more than a congested, irritable state of bowels in which the contents are rapidly passed downwards into the colon and rectum, since the diarrhoea is rather the result of a form of irritant poisoning. There cannot be the least doubt that in many cases with the cessation of the diarrhoea the child becomes no better, but rapidly passes into a condition of collapse with cerebral symptoms, due in all probability to toxæmia; or the temperature rises and pneumonia supervenes. It must however be admitted that the treatment of the worse cases of summer diarrhoea in infants is extremely un-

satisfactory, and this is borne out by the number of drugs which have been employed.

The drug which has appeared to us the most successful in the vomiting in the early stages is carbolic acid, the glycerine of carbolic acid being given in drop doses every two hours or even oftener. Carbolic acid has a sedative action on the stomach, and helps also to check the decomposition changes which go on. Other drugs of a similar class, namely creosote, resorcin, naphthalin have been given as antiseptic remedies in the hopes of checking the putrefactive changes in the bowel and preventing the formation of toxic products. Salicylate of soda has also been used<sup>1</sup> and is highly spoken of by Dr. Emmett Holt of New York, who has used it extensively; he gives it in doses of one to three grains every two hours according to age. Resorcin may be given in  $\frac{1}{2}$  to 2 grains dissolved in water every two hours and naphthalin may be given in 1 to 5 grain doses rubbed up with sugar. In the few cases in which we have tried the last two, we have not been particularly satisfied with the result. Both bismuth in the form of carbonate and oxide and zinc oxide (see p. 65) are usually of undoubted service. Opium, in the early stages, is useless and harmful, more especially when there is undigested food in the stools and where the vomiting is persistent. In the latter stages, if the stools continue small and numerous, especially if they approach the dysenteric type—the large bowel being chiefly involved—opium is of much value in soothing the patient and diminishing irritability. It is best given by enema or subcutaneously. The advantage of the former method is that it is more slowly absorbed and its topical effects are useful; one or two enemata of laudanum during the twenty-four hours will mostly relieve the irritative diarrhœa, when accompanied by straining and colicky pains, without the necessity of omitting or altering the medicine given by the mouth. Two to five drops of laudanum may be given in warm decoction of starch to an infant of six months to twelve months, the effects carefully watched and repeated in the course of six to twelve hours if necessary;  $\frac{1}{30}$  of a grain of morphia may be given subcutaneously to an infant of a year. If there be much fever, tepid sponging, or in cases of greater severity sponging with ice-cold water, may be practised.

Stimulants may be required from the first, but it is wise to reserve them for a later stage, especially as they are apt to give rise to sickness. Brandy, a sound port, or champagne, are the form of alcoholic stimulants most useful, and they are usually required to be given freely in the later stages if collapse is threatened. Ammonia, camphor, and musk are valuable remedies if symptoms of collapse have made their appearance. Camphor may be given in the form of spirits of camphor, three or four drops every second hour; musk in the following prescription:—

( 12 )									
Musk . . . . .	.	.	.	.	.	.	.	.	gr. ss
Powdered acacia . . . . .	.	.	.	.	.	.	.	.	gr. v
White sugar . . . . .	.	.	.	.	.	.	.	.	gr. ij
Rose-water . . . . .	.	.	.	.	.	.	.	.	to ʒj

*Every second hour.*

<sup>1</sup> By A. Jacobi.

Camphor and musk are not agreeable medicines to take, and are apt to cause nausea.

Even when convalescence is established great care must be exercised for many weeks in the management of the patient ; the child is certain to be left with impaired digestive powers, anæmic, and liable to gastric or intestinal disturbance. A severe attack will often affect the child's health and development for many months, so that it is late in talking, or standing alone, and at 18 months or 2 years of age resembles a child of 12 months old or less. Moreover the diarrhœa may become chronic or return in a subacute form, and a child may thus be lost who has managed to struggle through the primary attack. The diet during convalescence requires the most extreme care, and a return to a milk diet should not be allowed until there is evidence of much-improved digestive powers. Broths and beef-tea made with barley or some light starchy food, meat juice, scraped underdone chops, whey, Mellin's food, may be given in moderation.

The mineral acids, pepsine wine, decoction of pomegranate bark, the vegetable bitters and astringents, will be useful as the child improves.

*Summary.*—Place the child in the coolest room of the house and sponge frequently if there is much fever.

Stop all forms of milk food, giving barley or arrowroot-water with white of egg ; if there is much vomiting stop all food for some hours.

Apply hot fomentations or counter-irritation to the abdomen.

Give castor oil or calomel till all undigested food has disappeared from the stools, followed by zinc, bismuth, carbolic acid or resorcin. Later, if there is much restlessness or colic give opium by the rectum. In severe cases brandy or other stimulant will be required, but it is apt to cause vomiting.

In infants at the breast lessen the quantity of milk taken and give some barley-water.

## CHAPTER VI.

DISEASES OF THE DIGESTIVE SYSTEM—(*continued*).

**Chronic Gastro-intestinal Catarrh—Gastro-intestinal Atrophy.**—In some cases a gastric catarrh exists with but little evidence of the intestines being in any way affected, and in other cases the intestines may be the only part of the alimentary canal which appears to suffer; but in perhaps the majority of cases, especially in infants and small children, there is no sharply defined limitation between the two, the whole of the alimentary canal appearing to be involved.

The terms **chronic vomiting, chronic diarrhoea, simple atrophy, malnutrition, athrepsia**, are sometimes applied, according to the most prominent symptom which is present; thus, chronic vomiting is the most marked and striking symptom which may be present in catarrh of the stomach; diarrhoea is mostly present, or at least more or less looseness of the bowels, in the early stages of an intestinal catarrh, though the latter may exist without any marked diarrhoea, or in the later stages there may be constipation. If the only marked symptoms are dyspepsia and wasting, then the term simple atrophy has been applied. In all these conditions, while the symptoms may differ, the anatomical groundwork is the same—namely, a chronic gastro-intestinal catarrh, which in later stages passes into a gastro-intestinal atrophy.

Thus, an infant soon after birth, or perhaps when a few months old, suffers from repeated and frequent vomiting, or it suffers from diarrhoea, or if these are absent, there are other chronic dyspeptic troubles, such as flatulence and colic; it fails to thrive and gradually wastes, and after a more or less protracted course, during which the wasting becomes extreme, it dies exhausted or is carried off by some intercurrent disease. In some cases the course is very short, perhaps only a few weeks, but in the majority the course is chronic and the infant lives for months, suffering constantly from dyspepsia, unable to digest its food, finally dwindling away and dying at last. The less severe cases, especially if they come under treatment, gradually improve, and after months of the most careful feeding and nursing completely recover, though such cases usually become rickety or are otherwise weakly. Recovery is only possible during the earlier stages; if the catarrhal stage has passed on into one in which there is advanced atrophy of the mucous membrane of the stomach and intestines with the secreting glands, recovery is of course impossible.

This gastro-intestinal atrophy rarely occurs in children over 18 months of age, and indeed is most common in infants under 6 months. Older children

suffer from chronic intestinal catarrh, which rarely goes on to atrophy, though it is frequently the precursor of tuberculosis of the mesenteric glands.

In the majority of cases, chronic gastro-intestinal catarrh is the result of improper feeding. Infants who come of a healthy stock and are nursed at the breast of healthy mothers, rarely, if ever, suffer from it, at least as a primary disease. It is the infants who are fed from the first on cow's milk or the various forms of starchy foods that chiefly suffer. The infant may go on fairly well for the first few weeks or more, suffering more or less from dyspepsia; then comes an attack of diarrhoea or vomiting, and forthwith it begins to go down-hill; no food seems to suit, though often changed, and it never recovers its digestive powers, which appear to have been hopelessly damaged. Some infants appear to go on fairly well till they suffer from an attack of broncho-pneumonia, or measles, or whooping-cough, which they survive only to begin gradually to waste. In some few instances, more especially in dispensary practice, atrophic infants may be seen of a few months old, who have been, according to their mother's account, entirely breast-fed. In these cases the infants have been congenitally weak or premature, and very probably the mother's milk has been deficient in quality and quantity, or the child may have been fed whenever it cried, and in every way been badly cared for.

*Symptoms.*—**Infants.** The history which is generally obtained from such cases is that they were suckled for a few weeks or months after birth, then the mother had to go to work or her milk failed and the infant was made over to a friend or hireling to be artificially fed, and from this time it began to waste. On cross-questioning the mother or caretaker, it is found that it has been fed on sopped bread or biscuits, because cow's milk did not appear to satisfy it, or it vomited the milk curdled, and it has constantly suffered from colic, vomiting, or more commonly diarrhoea. On the other hand, there is sometimes constipation, but this usually has been preceded by diarrhoea; the diarrhoeal symptoms being most marked in those suffering during the summer months. If the symptoms be analysed, three stages in the course of the disease may be recognised as first clearly pointed out and emphasised by Parrot, whose description of these cases under the name of athrepsia leaves nothing to be desired. The early symptoms or first stage are those of a simple gastric or intestinal catarrh, in the second the progressive wasting becomes the prominent phenomenon, and in the last stage the infant passes into an exhausted condition in which cerebral symptoms make their appearance.

*First stage.* The infant suffers from a simple diarrhoea or looseness of the bowels; the stools, instead of being bright yellow and homogeneous, are liquid, curdy, and often green in colour, or contain an excess of mucus; the abdomen is distended with gas and remains constantly in this condition, the tongue is coated, and patches of aphthous stomatitis appear in the mouth. The infant is restless, constantly whining, and will not sleep at night. Frequent vomiting may be a prominent symptom, the milk being returned curdled. The tissues become flabby, and then wasting commences. In the *second stage* all the symptoms are intensified and the characteristic wasting becomes manifest. The stools for the most part are loose and frequent, and consist of undigested food, being often pale and putty-like, with a peculiar odour; at other times they are of a dark-brown colour from the presence of altered bile. The

infant is mostly voracious, liquid food does not appear to satisfy it, and by the mistaken kindness of its friends it is fed with sopped bread or some thick food, a diet which has the great merit in their eyes of keeping it quiet for a longer time than liquid food, or diluted milk ; at times it cries incessantly, hardly ever appearing to sleep or only dozing for a short time unless under the influence of a 'soothing syrup' supplied by its nurse. The mouth becomes the seat of parasitic stomatitis, the skin is harsh and dry, small boils or a lichenous rash make their appearance, the buttocks and genitals are raw and excoriated. Its temperature is below normal, the feet and hands are congested, the face has a pallid earthy tint, and a sickly lactic acid smell is given out from the body, especially the abdomen. The wasting is extreme, the face being shrivelled, the skin wrinkled and hanging in folds about the thighs and arms. In the *third stage* the infant passes into a moribund state ; it is too feeble to cry loudly, it becomes heavy and drowsy, taking little notice of anything. It becomes more and more somnolent, and death ensues, probably preceded by muscular twitchings, strabismus or general convulsions.

If we analyse the principal symptoms of the disease we shall find that sometimes one symptom, as diarrhœa, sometimes another, as vomiting, is the most prominent. In the majority of the cases there is more or less *diarrhœa* throughout the whole course, so that such cases would come under the category of **chronic diarrhœa**, or this chronic condition may alternate with the acuter forms. The stools at first are yellow, liquid and frothy, with flocculi of semi-digested curd ; later they become green, the acid contents of the intestines acting on the bile-pigments ; when the diarrhœa has become chronic the stools are either liquid and of a dirty brown colour, or more often, especially if milk is being taken, they are white and semi-liquid, the bile-pigment having disappeared, and they consist of decomposing foul-smelling curd and mucus. Sometimes the stools consist almost entirely of mucus, the mucous membrane both of the small and large intestine secreting large quantities ; the child is constantly passing stools of mucus and undigested food.

In some cases **chronic vomiting** is the most troublesome symptom, there being no diarrhœa but sometimes constipation. Cases of chronic vomiting with the consequent malnutrition are at times most difficult to deal with. So great is the irritability of the stomach that everything is rejected, either immediately after being taken, or after the lapse of perhaps half an hour. Diluted milk, peptonised preparations, meat-juice, cream, and a variety of patent foods are tried one after another, separately or mixed, only to end in disappointment, the infant meanwhile becoming more and more wasted. Under such circumstances among the poorer classes the infant is given some thick food as sopped bread or corn-flour. Vomiting in many cases appears to be the result of the rapidity with which cow's milk is coagulated in the infant's stomach and of the hard lumps of curd which are thrown down, this occurring even where the milk is reduced to one part of milk to five of water. In other instances it appears to be due to the rapid changes occurring in the sugar of milk, lactic acid being formed, and the contents of the stomach are rejected, having a strong smell of sour and decomposing milk. In the catarrhal condition of the mucous membrane of the stomach much mucus is formed, while the gastric juice is weak, but its curdling power undiminished. Many such cases go from bad to worse, no food appearing

to agree, all forms coming up alike. It must not be forgotten, in a case of constant vomiting, that it may be due to cerebral disease or some congenital defect. The prognosis in chronic vomiting is unfavourable if it commences in an artificially reared infant and becomes thoroughly established, and is associated with progressive wasting.

As the child wastes the skin becomes rough and harsh and hangs in folds upon the limbs and trunk, and very frequently as the anæmia increases, the face, hands and feet become œdematous. This œdema is due to anæmia rather than to any kidney complication. An erythematous rash is apt to make its appearance about the anus in those cases where there is much diarrhœa, and spread over the perineum and thighs. Small boils and abscesses are also common. Pemphigus may also appear.

The temperature is constantly below normal, often measuring 96° or 97° F. all through the twenty-four hours.

*Complications.*—Broncho-pneumonia is very common. Tuberculosis of the mesenteric or mediastinal glands may occur, or there may be a more general distribution throughout the body. It must be borne in mind that it is only in the more severe and neglected cases that intestinal catarrh passes on into atrophy, in the majority of cases the course of the disease is intermittent, sometimes better at other times worse, and as the child grows older the symptoms of rickets become grafted on to those of a chronic catarrh of the bowels.

**Older Children.**—A chronic intestinal catarrh is not so serious a disease in children over two years of age as in infants, as it is rarely followed by an atrophic condition of the glandular apparatus of the stomach and intestines, but takes rather the form of habitual indigestion than anything else. It is however apt to be exceedingly chronic in its course and to be followed by various evil consequences, the most serious of which is tuberculosis of the lymphatic glands, or there is a constant state of health below par, which in itself is a source of danger. Chronic catarrhal affections of mucous membranes, either of the nose, mouth, respiratory tract, or intestines, are exceedingly apt to be followed by swelling and caseous degeneration of the lymphatic glands with which the mucous membrane is connected. The intestinal lesion finds its origin for the most part in unsuitable food; the mucous membrane of the stomach and bowels is kept in a constant state of irritation by food which is too great in quantity or of too indigestible character. Weakly children are especially apt to suffer, particularly those who are brought up in our large cities and whose time is spent either in-doors or playing in the street. Children who suffer habitually from ozæna, chronic tonsillitis, or chronic disease of the strumous type, are the chief sufferers from chronic gastro-intestinal catarrh. It is very common in rickety children. Both the children of the well-to-do and the poor classes suffer.

*Symptoms.*—There is habitual indigestion with perverted appetite, the child refusing its bread and milk and craving for 'tasty' bits from its parents' table, or altogether refusing its meals unless its food is highly seasoned, at other times the appetite is excessive. The abdomen is invariably rounded from the constant distention of the stomach and intestines with gas given off from the decomposing half-digested food. This distention is very frequently

accompanied by more or less pain. The face is generally pale with dark areolæ around the eyes, fat is absorbed as the disease progresses, the muscles become flabby, and the emaciation of the child contrasts markedly with its large tumid abdomen. Such children have usually coated tongues, at other times the tongue is red and glazed, showing the enlarged fungiform papillæ more distinctly than usual and resembling the 'strawberry-tongue' of scarlet fever. Sometimes the surface has a worm-eaten appearance, being coated with a thick fur except in irregular sinuous patches where the surface is red and glazed. The bowels are generally confined, the stools being frequently pasty with much mucus; there are apt to be intercurrent attacks of vomiting and diarrhœa. There is very frequently more or less feverishness at night, especially in the subacute cases. Headaches are common, there is often restlessness at night, grinding of teeth and night terrors. Sometimes when the disease is subacute, and there is some feverishness towards evening, the symptoms resemble mild typhoid fever and constitute what at one time was called 'infantile intermittent fever.' It is important to bear in mind that subacute intestinal catarrh may be present with an evening exacerbation of temperature as the principal symptom and with no vomiting or diarrhœa. An intermittent fever during early childhood with no pulmonary symptoms is probably, if typhoid can be excluded, due to an intestinal catarrh. It will not fail to be noticed that diarrhœa is a prominent symptom in the majority of cases of infants suffering from chronic intestinal catarrh, while in older children not only is the diarrhœa not present, but there is usually constipation. The explanation of this is perhaps not very clear, but it must be borne in mind that those cases where diarrhœa is present and excessive are more acute in character and run a more rapid course than those where the bowels are less irritable; there is also more likely to be diarrhœa in the early stages where the mucous membrane is congested, than in the later stages where the bowels have become more tolerant of irritation and the muscular walls wasted through long illness.

*Diagnosis.*—The disease most likely to be confounded with chronic intestinal catarrh is tuberculosis of the mesenteric glands, or the early stages of tubercular meningitis. During the first three or four years of life, it happens very frequently that infants or young children are thought to have 'consumption of the bowels,' because they have capricious appetites, 'pot-bellies,' and have lost much flesh, when in reality they are suffering from a chronic intestinal catarrh. That the diagnosis is often difficult, is only what is to be expected when it is remembered that an intestinal catarrh of more or less severity is the exciting cause of mesenteric tuberculosis; and in an advanced case, it may be quite impossible to say if a tuberculosis of the glands has supervened. Mesenteric disease is, however, much less common than simple intestinal catarrh, and is infinitely less so during the first six months of life than gastro-intestinal atrophy. Any evidence of tubercle in the lungs, or enlarged veins on the surface of the abdomen, or the detection of rounded masses by palpation in the abdomen, would favour mesenteric disease. In older children the fact that those suffering from intestinal catarrh grind the teeth, are restless at night, are subject to night terrors and headaches, is sufficient for most parents to become alarmed, fearing that the child is commencing with tubercular meningitis.

*Morbid Anatomy.—Chronic gastro-intestinal Catarrh.*—In the early stages there is swelling, and injection of the mucous membrane of the stomach, and small and large intestine. The surface is grey, streaked with red, and there is an excess of mucus; the changes are usually most marked in the ileum and colon, especially about the sigmoid flexure; in these places the solitary glands are enlarged, the mucous membrane is raised in folds, and often much injected, and follicular ulceration may be present. The microscopical appearances somewhat resemble those already described in acute catarrh. The surface of the mucous membrane of the stomach is covered with masses of leucocytes and micrococci embedded in mucus. The capillaries are everywhere distended, the gastric glands are separated from one another by columns of leucocytes effused between them, the whole mucous membrane is swollen, and the muscular layer thickened.

Similar changes are seen in the intestines, leucocytes are present in large numbers in the submucosa and between Lieberkuhn's glands, the latter are compressed and finally disappear, so that in places only masses of round cells are seen taking the place of the glands. A stage of atrophy succeeds that of chronic catarrh, and the appearances presented are those of a wasting of the mucous membrane, and a destruction of the secreting glands. The chronic swelling of the mucosa, and infiltration with leucocytes, has led to a wasting and cicatrization of the tubular glands.

In *infantile atrophy*, the stomach and intestines are distended with gas, the former is frequently dilated, the mucous membrane is everywhere pale, the intestines are thin and translucent. This is especially marked in the more advanced cases, the intestinal walls are exceedingly thin, the solitary glands and Peyer's patches are wasted and have almost disappeared, with perhaps brownish spots or streaks where minute hæmorrhages have taken place. These appearances will be varied with those of chronic catarrh according to the amount of atrophy that has taken place. The microscopical appearances show the mucous membrane of the stomach to have undergone wasting, being reduced to perhaps one quarter its normal thickness. The gastric glands in places have completely disappeared, in other places they are compressed and partly destroyed by round cells and young connective tissue fibres. In the small intestines the appearances will be those of chronic catarrh, or these with the addition of destruction of the glandular apparatus. The tubular glands in places have disappeared, or are compressed or dilated by a connective tissue growth, villi have completely disappeared, or only their remains are present, the solitary glands are atrophied or have disappeared. Similar changes may be found in the colon. Parrot has described various other lesions in the alimentary canal of infants dying within a few weeks of their birth; such as a spread of the parasitic growth from the mouth to the stomach and intestine, preferably the cæcum. The same author has found minute circular ulcers in the stomach, from which hæmorrhage has taken place, less often larger and irregularly shaped ones; he has also seen the mucous membrane of the stomach to be the seat of a diphtheroid exudation. In the later stages, when the blood is profoundly altered, thrombosis of the renal veins, pulmonary veins, or sinuses of the brain may take place. Fatty degeneration (*steatose* of Parrot), softening or meningeal hæmorrhage, may take place in the brain. The kidney may be the seat of uric acid infarcts.

*Treatment.*—The treatment of chronic gastro-intestinal catarrh in **infants** consists principally in careful feeding; the blandest and least irritating forms of food must be selected, while frequent weighings of the infant should be resorted to in order to ascertain if any progress is being made. Where there is much diarrhœa, milk must be used sparingly or altogether omitted for awhile, as the hard curds formed in the stomach are beyond the digestive powers of the weakened stomach and intestines. Small quantities of whey and barley water, white of egg and barley water, or the juice of an underdone chop, may be given at short intervals during both day and night. Improvement having taken place as regards the diarrhœa, milk in some form or other must be given. Peptonised milk is often of much value under these circumstances, when made by mixing 3 oz. of boiling decoction of arrowroot with 3 oz. of cold milk, adding two teaspoonfuls of cream, half a peptonising powder (Benger), sweetening and giving to the infant after it has stood for fifteen minutes. The cream mixtures are often of much service, such as 1 oz. of cream, 3 oz. of barley water, one teaspoonful of sugar, or 1 oz. of milk, 3 oz. of water, 1 oz. of cream, and a large teaspoonful of sugar. Every care must be taken that the feeding-bottle is clean, and the food prepared with the most scrupulous care. Whenever the weather permits, the infant must be taken into the open air as much as possible. The medicines given must be selected according to the most prominent symptoms. If the stools are loose, contain much mucus and curd, and are foul or stinking, small doses of castor oil emulsion or calomel should be given, to be followed by bismuth and small doses of opium. If the stools are dark brown or yellow and very liquid, astringents in the form of extract of logwood, catechu, or pomegranate will be of most service, especially if small doses of opium are given by the bowel. If the diarrhœa approach the dysenteric type, much mucus and blood being passed with straining and forcing down, enemata of nitrate of silver and opium, alum or vegetable astringents will be useful. One of the following may be prescribed :—

( 12 )

Tincture of catechu	.	.	.	.	.	.	℥v
„ kino	.	.	.	.	.	.	℥v
Syrup	.	.	.	.	.	.	℥x
Cinnamon-water	.	.	.	.	.	.	to ʒj

*Every four hours.*

( 13 )

Nitrate of silver	.	.	.	.	.	.	gr. v
Water	.	.	.	.	.	.	to ʒss

*For an enema.*

( 14 )

Extract of logwood	.	.	.	.	.	.	gr. ijss
Tincture of krameria	.	.	.	.	.	.	℥v
Glycerine	.	.	.	.	.	.	℥x
Cinnamon-water	.	.	.	.	.	.	to ʒj

*Every four hours.*

The treatment of chronic gastric catarrh in infants when it has become confirmed is very often extremely discouraging.

In the milder forms of vomiting the importance of diluting the milk so as to reduce the quantity of curd or of peptonising the milk to gain the same end must be insisted upon. It is also of much importance not to give food too frequently, but to give the stomach a complete rest for several hours. In severer cases in which milk or whey, in whatever form it is given, returns sour and curdled in a few minutes, other food must be substituted at least for a time. In such cases Mellin's food, either made with water or weak veal broth (half a pound to the pint), may be given; the bottle being discontinued and the infant fed with a spoon. Instead of veal broth, raw meat-juice or 'liquid meat' may be used. After a few days, milk may be again tried, or small quantities of cream may be added to the Mellin's food in lieu of the meat-juice. In this acid condition of stomach small doses of sodæ bicarb. and pepsine are often very useful.

( 15 )

Bicarbonate of soda	.	.	.	.	.	.	.	gr. ij
Pepsine	.	.	.	.	.	.	.	gr. j
White sugar	.	.	.	.	.	.	.	gr. j

*To be given before food three times a day.*

In **older children** careful dieting is of the utmost importance, and the first difficulty encountered will probably be that the child has been over-indulged and so spoilt by its parents, that it is difficult to get it to take a carefully selected and restricted diet. In arranging a diet it must be borne in mind that the child should take only such quantities as the impaired state of the digestive juices can deal with, any excess being liable to undergo decomposition in the intestines, and give rise to flatulence and other troubles. It is also most important to give the stomach a complete rest during the intervals between meals; sweet biscuits taken during the morning or a run on the kitchen at frequent intervals during the day are fruitful sources of chronic indigestion, and the plainest and most peremptory directions should be given to the parents by the medical attendant that nothing whatever should be taken except at regular meals. If the child refuses, or only half gets through its breakfast, this should by no means be supplemented by a second edition at the parents' table, or a tasty lunch to make up for the morning's deficiencies. It is wiser by far if the breakfast is but half taken to let the child wait till the next meal; a little starvation can do no harm, at any rate much less than over-indulgence and the formation of bad habits. The importance of fresh air and change of scene in cases of habitual indigestion can hardly be over-estimated. The worst form of exercise is a 'constitutional' taken with the nurse or governess; out-door games of various kinds, gymnastics, riding or driving, or some form of recreation which will occupy the mind and give an interest to the exercise, are far preferable to any dull routine. A change to the seaside, or some bracing elevated inland site where there is a keen cool air, will often work wonders in these cases. It must, however, be remembered that such cases are often worse, or there is no improvement at first; children when first removed to the seaside are apt to do too much and eat too much; they are over-tired and fretful at night, and attacks of dyspepsia or perhaps eczematous or other eruptions occur. A caution is often necessary to prevent this.

It is wiser in most cases to lay down a complete diet chart for the guid-

ance of the parents, though a certain latitude must necessarily be permitted on account of varying tastes. The following diet tables may be taken as samples, which can be modified according to circumstances.

**Diet for a child of 5 to 7 years, indigestion not severe :**

*Breakfast*, 8 A.M. A breakfast cupful (8 oz.) of bread and milk, made from wholemeal bread ; a teaspoonful of malt extract may be added ; this may be followed two or three times a week by the yolk of a lightly-boiled egg and strips of toast, or a piece of toast and dripping or bacon fat.

*Dinner*, 12 to 1 P.M. A broiled mutton chop *finely minced* or fresh white fish, with mashed potato, spinach, or French beans ; to be followed by ground rice pudding or a baked apple. Milk to drink.

*Tea*, 4 to 5 P.M. A cup of cocoa and milk, with toast or stale bread.

*Supper*, 7 P.M. A cup of beef tea or mutton broth.

In the more severe and protracted cases it is well to avoid farinaceous food as much as possible, as recommended by Dr. Eustace Smith.

*Breakfast*, 8 A.M.—Half to three-quarters of a pint of fresh milk, alkalised by twenty drops of the saccharated solution of lime ; a slice of toast with yolk of egg, or fresh fish.

*Dinner*, 12–1. A small mutton chop or boiled sole, a thin slice of stale bread, with half to a wineglassful of sherry or claret, well diluted.

*Tea*, 4–5 P.M.—Same as breakfast.

*Supper*, 7 P.M.—A cup of beef tea.

In all cases of habitual indigestion it is of much importance to sponge every morning with cold or tepid water (60°–70°), keeping the child's feet in warm water during the process, if it is subject to cold feet or has a sluggish circulation. A shower bath is often of much service. After the morning's bath friction with as rough a towel as the child's skin can stand should be used. The child's dress should consist of woollen garments next to the skin, and every chance of getting cold should be avoided.

The medicines which are most likely to be of service in chronic intestinal catarrh are laxatives such as rhubarb, senna and aloes ; or saline purgatives such as sulphate of soda ; alkalies as carbonate of soda ; arsenic, and nuxvomica.

Arsenic is often of much value, but requires to be given in increasing doses to bring out its full value. For a child of seven years, three-drop doses may be given, and gradually increased to six drops, or it may be given in small granules, which are readily taken by children, preferably an hour after food. At the same time it is well to order a saline purgative, which shall keep the bowels relaxed rather than loose.

Rubinat or Friederichshall water half a wineglass to a wineglassful in warm water, or a teaspoonful of effervescing Carlsbad salts, may be taken before breakfast two or three times a week, and decreased or increased according to the state of the bowels.

Alkalies with senna or rhubarb are often prescribed with much advantage ; such as :—

( 16 )	
Bicarbonate of soda . . . . .	gr. v
Syrup of rhubarb . . . . .	ʒss
Compound infusion of gentian . . . . .	ʒiij
<i>Three times a day.</i>	

or,

( 17 )

Iodide of potassium	. . . . .	gr. ij
Bicarbonate of soda	. . . . .	gr. v
Syrup of senna	. . . . .	℥ss
Infusion of calumba	. . . . .	to ℥iij

*Three times a day.*

Later, when convalescence is established, acids and bitters should be given.

( 18 )

Dilute nitric acid	. . . . .	℥v
Compound tincture of cinchona	. . . . .	℥xv
Syrup	. . . . .	to ℥j

*In a wineglass of water, three times a day.*

If the bowels keep confined, a small granule containing half a grain of aqueous extract of aloes may be taken at dinner time daily ; in many cases a grain will be required to keep the bowels well open. This may be supplemented, especially if the stools are pale, by an ounce or two of Hunjadi water, to which an equal quantity of warm water has been added, to be taken two or three times a week before breakfast.

**Intestinal Worms.**—The worms which most commonly infest children are the thread-worms, round-worms and tape-worms, of which the former are the more common.

**Thread-Worms (Oxyuris).**—These troublesome pests inhabit the lower bowel, namely cæcum, colon, sigmoid flexure and rectum, and also the vagina, an unhealthy state of the mucous membrane with sluggish bowels appearing to favour their development. To the naked eye they appear like short



Fig. 8.—Oxyuris vermicularis, female. Highly magnified. (Quain's 'Dictionary of Medicine.')

pieces of white thread ; under a low power the females, which are the most numerous, are seen to taper at each end, and their uterine ducts will be seen to contain numerous oval-shaped ova, some of the latter containing embryos.



Fig. 9.—Eggs of oxyuris vermicularis inclosing embryos  $\times 450$  diam. (Quain's 'Dictionary of Medicine.')

These parasites gain entrance into the system by the ova being taken in the food, or perhaps more frequently by means of the ova adhering to the fingers of those already affected, they are thus conveyed directly or indirectly to others. The extreme fertility of these worms makes it certain that anyone who is affected with thread-worms and is not of scrupulously cleanly habits, will have ova adhering to the neighbourhood of the anus which may be transferred by the fingers to the individual's own mouth or to others. The symptoms are very uncertain, the diagnosis being usually made by the patient's friends detecting the parasites in the chamber vessel used by the child.

The most common symptom to call attention to the presence of thread-worms is the irritation and itching which they are apt to give rise to at the anus or entrance to the vagina. Girls will suffer from excessive discharge of mucus from the vagina, sometimes containing blood, from the presence of

oxyurides in the vagina or the result of scratching. In many cases the presence of thread-worms seems to give rise to no symptoms whatever. Weakly anæmic children with sluggish bowels are most often affected. The treatment consists in expelling the worms, preventing their re-entrance, and in improving the health of the child so that it is less likely to provide a favourable cultivation ground for these unwelcome guests. The first indication is best fulfilled by a sharp purge to expel or else to drive them into the lower bowel, to be followed by enemata to destroy those present in the colon and rectum and wash away any excess of mucus present; a grain to two grains of calomel, in combination with two or three grains of resin of scammony, may be given to children of three to eight years of age overnight, and the following evening, if the bowels have been well acted upon, an enema of infusion of quassia as large as can be given should be used. It will be well to repeat the enemata every other evening for a week or two. Great care should be exercised to see that the child is washed about the genitals with soap and water after each stool to prevent re-infection. Injections should be used repeatedly to free the vagina of any of these worms, if there is any vaginitis or irritation. Weak carbolic acid lotions will answer very well, and some dilute red oxide of mercury ointment (1-3) may be smeared at the entrance to the vagina. The general health of the child must also be thought of and a careful diet prescribed, excess of sweets and starches being avoided. If constipation exist, Rubinat or Hunjadi water should be given every other morning before breakfast, in sufficient quantity to produce a soft stool without purging; sulphate of iron, gr.  $\frac{1}{2}$ -j, with spirits of chloroform and orange-flower water, twice a day, is often very useful. Codliver oil in selected cases is of great service.

**Round-worms (*Ascaris lumbricoides*).**—The common round-worm measures from four to twelve inches in length, the females being somewhat longer than the males; they are reddish white and have more or less resemblance to common earth-worms. They mostly inhabit the small intestines, but are apt to wander into the stomach, large intestines, or even into the gall bladder. Several may exist in the intestine at the same time, in exceptional instances many hundreds may be present. They gain entrance into the system by means of their ova which are swallowed with the food, the shells surrounding the ova are dissolved by the gastric juice, letting free the embryos. The symptoms produced by the presence of round-worms cannot be certainly distinguished from those of dyspepsia or intestinal catarrh with which the lumbricoides are so commonly associated. The passage of a round-worm per rectum is often the first thing to call attention to the subject; on the other hand, mothers often dogmatically assert that their child has worms because he 'picks his nose' and his 'food appears to do him no good.' The latter symptoms, it is needless to say, are not diagnostic of the presence of worms, but of an unhealthy state of the alimentary canal. The presence of one or two round-worms rarely produces any symptom *per se*, unless they pass into the stomach or bile-duct. In larger numbers they may give rise to colicky pains, especially at night; diarrhœa, vomiting, and symptoms of obstruction of the bowels have occasionally resulted. In rare instances worms have found their way into the peritoneal cavity and been discharged with the contents of an abscess through the abdominal wall. The treatment is not as

difficult as the diagnosis. Santonin combined with calomel or castor oil should be given and is almost certainly successful after a dose or two have been given. Santonin, gr. j-iiij, calomel, gr.  $\frac{1}{2}$ -j may be given overnight, and some fluid magnesia or other saline next morning before breakfast. Or the santonin dissolved in two or three teaspoonfuls of castor oil may be given before breakfast. The santonin may be repeated once or twice, but not oftener, until the physiological effects (if any have been produced) have passed off. If the santonin cause vomiting, smaller doses should be tried or compound scammony powder substituted.

**Tape-worms** are as common in children as in adults, both the *tænia solium* and *mediocanellata* being found. Infants and young children less often act as hosts for tape-worms, but they have been found in infants under a year old. Attention is first called to the fact by the passage of the joints or proglottides in the stools. Older children will often complain of pain in the epigastrium and peculiar movements are felt inside, they are apt also to lose flesh and to suffer from various dyspeptic symptoms. The difficulty of dislodging the greater part of the creature is not great, but the head is not so easily expelled, especially that of the *tænia solium*. The success of the treatment by means of the administration of male fern depends upon the intestine containing as little food as possible. A dose of castor oil should be given overnight sufficiently large to act freely before morning; twenty to thirty drops of ethereal extract of male fern (freshly prepared) should be given in half-an-ounce of mucilage and water before breakfast; breakfast should consist of some light refreshment such as beef-tea; at noon another dose of castor oil should be given, which will act in the course of the day, bringing away the intruder. Careful search should be made for the head, bearing in mind that the joints are likely to break about an inch from the head, that the latter is about the size of a large pin's head, and the thickness of the worm itself near the head is only that of stout thread.

If, after careful search by a competent observer, the head is not discovered in the stools, after a few days the treatment may be repeated, but it is not wise to continue to repeat the male fern, as toxic symptoms are apt to arise. Decoction of pomegranate root may be substituted if it is necessary to continue the treatment.

**Ascites.**—Fluid is sometimes present in the peritoneal cavity of the child without dropsy elsewhere, and it may be difficult to decide as to its cause. The diagnosis of ascites when it forms part of a general dropsy, as in cardiac disease or renal disease, is easy and does not call for special comment.

An ascites which is primary in a child is usually the result of some lesion of the peritoneum, as chronic peritonitis, or the result of portal obstruction such as cirrhosis or perihepatitis. The detection of a large or moderate quantity of fluid in the peritoneal cavity is not difficult, the percussion note being dull in the flanks, while the region round the umbilicus is tympanitic in consequence of the distended intestines floating upwards when the patient is lying on his back; change of position on to the side will float the intestines to the highest point, and the flank which is uppermost will now be resonant. While change of the patient's position will thus cause the fluid to gravitate to the lowest point if the fluid is free in the peritoneal cavity, it must be borne in mind that in chronic peritonitis there may be a matting

together of the intestines which prevents them from floating upwards, and consequently there may be no alteration in the percussion note after change of position. The amount of dulness to percussion may vary from day to day according to the varying distention of the intestines. In ascites the superficial veins of the abdomen are usually enlarged, the skin becomes shiny and stretched if the fluid is excessive, and often the umbilicus is protruded and pouched out, containing fluid which can be pressed back into the abdominal cavity. The detection of a small quantity of fluid in the abdomen is difficult, especially when the intestines are much distended with gas and the large bowel is loaded with fæces, the latter giving a more or less dull percussion note in the flanks. Fluctuation may be detected by passing the finger into the rectum; fluid may thus be detected in the pelvis. A careful observer is hardly likely to mistake simple distention of the intestines with wind for ascites; the thrill imparted to the contained fluid by gently tapping the flank is absent in the flatulent distention, and on percussion the abdomen is universally tympanitic. The diagnosis of the cause of the ascites is often difficult, as a large accumulation of fluid may be due to chronic peritonitis and closely resembles an ascites due to portal obstruction. Chronic peritonitis may be quite unaccompanied by pain or tenderness from first to last, and the fluid may be excessive. Any matting or induration of the omentum or intestines to be felt through the abdominal walls, or slight evening rise in the temperature or signs of tuberculosis elsewhere (as in the testis), or chronic diarrhœa, would be in favour of chronic peritoneal effusion. A normal temperature, the ascitic fluid freely movable, the general health good, slight jaundice or bile-pigment in the urine would be in favour of portal obstruction, as cirrhosis or mediastinitis. The possibility of hydatids of the peritoneum must be borne in mind.

## CHAPTER VII.

DISEASES OF THE DIGESTIVE SYSTEM—(*continued*).

**Acute Peritonitis.**—Acute general peritonitis is not an uncommon disease during infancy and childhood, not indeed frequently occurring as a primary disease, but usually spreading from some other part or originating in consequence of the leakage of the intestinal contents into the peritoneal cavity, or it may follow a blow or kick on the abdomen. The foetus also suffers from peritonitis perhaps more subacute than acute, and the adhesions which are left surrounding and matting the intestines are apt to interfere with the growth and development of the gut, and lead to stenosis or obstruction by narrowing the bowel or tying it up in coils. Acute peritonitis occurs in the newly born, secondary to arteritis or septicæmia; but such cases are rare in private practice. Apart from these cases, peritonitis is not common in infants and young children. Dr. West mentions a case of idiopathic peritonitis occurring in an infant of seven months, which proved fatal in six days; the attack was sudden, accompanied by vomiting and abdominal distention; after death, lymph and serous fluid were found in the abdominal cavity. It has been known in infants to spread from a suppurating mesenteric gland. Acute peritonitis occurs in older children by no means infrequently, often supervening in the midst of apparent health, and without cause, unless the effects of cold or of a more or less severe blow be accepted as such. At the post-mortem there is nothing to indicate where the inflammation commenced. Not infrequently the peritonitis is the result of some lesion in the cæcum, vermiform appendix, or mesenteric glands. It sometimes occurs in tubercular subjects: thus a phthisical boy of nine years old was suddenly seized with pain in the abdomen and vomiting, and died in ten days; at the post-mortem an acute general peritonitis was present, and also adhesions from old peritonitis and some calcified mesenteric glands. Acute peritonitis may be caused by the spread of inflammation from other parts, as from the pleura, an empyema bursting through the diaphragm, from the pericardium, ulcers in the stomach, ileum, or cæcum, or from an intussusception. It may occur in the course of typhoid fever from perforation of the intestine and extravasation of fæces. It is rare in the course of scarlet fever, but it is not uncommon in the last stages of the succeeding nephritis, when uræmic phenomena have set in; it is then mostly of a purulent character. We have seen peritonitis post-mortem, which appeared to have succeeded to or been associated with an acute intestinal catarrh, with symptoms of an inflammatory diarrhœa.

*Symptoms and course.*—The symptoms of acute peritonitis in the infant

and child are by no means always as characteristic as they are in the adult, and cases will sometimes occur where extensive peritonitis is found at the post-mortem which was not suspected during life, especially when supervening in the course of some other disease. The attack usually begins with vomiting, sometimes diarrhoea, great pain and tenderness in the abdomen referred to the region of the umbilicus; the amount of tenderness on pressure varies even in cases where no opium has been given, and where the patient is under the influence of this drug pain may be entirely absent. Constipation after the onset is a marked feature when the attack is established, no fæces and often no wind passing by the bowel; the vomiting is constant, the distention of the bowels very great, so that the coils of distended small intestines may be seen through the abdominal walls, and the case may readily be assumed to be obstruction of the bowels from some mechanical cause. Though no complete obstruction exists, yet the coils of intestine are seen post-mortem to make sharp turns on one another, 'kinks' being formed, which, with the layers of lymph on their surface, must seriously impede the passage of their contents. The paralysis of the muscular coat of the bowel, by diminishing or arresting the normal peristaltic movements, prevents the onward movement of the intestinal contents. The vomiting is mostly constant as long as food is given; undigested food, bile, and sour-smelling intestinal contents may be brought up, but the vomited matters are never fæcal as they are in hernia or intussusception. There is usually moderate fever, the temperature being  $101^{\circ}$  to  $102^{\circ}$  F. In the later stages the abdominal distention is extreme, the coils of distended intestine are prominently discernible through the walls of the abdomen, the face becomes pinched, the pulse quick and thready, and the patient dies collapsed, often suddenly at the last. While this is the all but universal ending of a case of general peritonitis, when the symptoms have fully declared themselves, cases undoubtedly occur in which the diagnosis of peritonitis is made, on account of the distention and pain in the abdomen, which gradually improve under treatment, and finally recover. There is reason to suppose that cases of acute peritonitis will occasionally get well, even when the attack has been a general one. In other cases the symptoms of a local suppuration, hectic, local tenderness, and swelling, succeed to those of a general peritonitis. In such cases, however, there may have been a local peritonitis from the first.

*Diagnosis.*—A pleurisy of the base of one or other of the lungs is often mistaken for peritonitis, as the sharp stabbing pain is apt to be referred to the abdomen where the intercostal nerves terminate. In such cases, especially if the pleurisy involve the diaphragm, the similarity to peritonitis may be great, and it is common to find that hot fomentations or mustard poultices have been placed upon the abdomen by the friends under the idea there is peritonitis. Where pleurisy exists there is no real tenderness of the abdomen on pressure, and the physical signs of pleurisy or pleuro-pneumonia will be detected in the chest. An attack of colic is not often likely to be mistaken for peritonitis, in the former there is pain and distention of the abdomen but no tenderness or elevated temperature. An intussusception may be mistaken for peritonitis; but the attack of pain is more sudden in the former, and there is not often much tenderness; the detection of an elongated tumour would decide the diagnosis. Acute peritonitis is apt to be mistaken for acute

obstruction of the bowels, such as results from the constriction of a knuckle of bowel by a band. The distention of the intestines with flatus, the vomiting of sour-smelling intestinal contents, as well as complete obstruction to the passage of wind, may be present in both ; there may be little tenderness, and but slight or no fever. The diagnosis may be very difficult or impossible, though the history of the case, the absence of fæcal vomiting and the less complete obstruction to the passage of both flatus and fæces in the case of peritonitis, will usually help the decision. It is hardly necessary to add that it is only in some cases of acute peritonitis that the difficulty exists, as usually the pain, tenderness, and distention of the intestines are diagnostic of peritonitis.

*Morbid Anatomy.*—The tendency to pus formation, which all inflammations in children exhibit, is noticeable in peritonitis, as in acute cases the fluid found in the peritoneum is thick and turbid, or it may rank as pure pus. The amount of lymph and fluid varies in different cases ; pus or turbid serum will often be found in meshes of lymph between the coils of intestines, a larger collection being present in the pelvis. In all cases of apparent idiopathic peritonitis, a careful search should be made for a local starting point ; the cæcum, mesenteric and retro-peritoneal glands being carefully examined.

*Prognosis.*—This is always grave ; the more acute the symptoms, the more rapidly the fatal result occurs. The prognosis in any case mostly depends on the diagnosis, for if acute general peritonitis is present, a fatal result is almost certain.

**Perityphlitis.**—Instead of a general peritonitis taking place, a local inflammatory action may be set up, which results in simple inflammatory induration going on in many cases to the formation of an abscess, or a general peritonitis may supervene. The commonest local peritonitis is a typhloperitonitis or perityphlitis, as it is generally called. The cæcum is especially apt to be the seat of irritation, a peculiarity which it doubtless owes to its being a cul-de-sac, in which foreign bodies or impacted fæces are apt to lodge, and give rise to various forms of trouble. Pins, fish bones, cherry stones, are apt to lodge in the cæcum, and gravitate into the cæcal appendix, and as the latter is not traversed by the intestinal contents as they pass downwards, concretions are likely to form from the deposition of phosphates of lime and other salts. As a result, ulceration of the cæcum or appendix is very apt to take place, and a perforation to be followed by a local or general peritonitis. The symptoms presented by perityphlitis in the child resemble those present in the adult. The attack may begin with diarrhœa and perhaps vomiting, with more or less obscure pain and tenderness in the abdomen, and feverishness. It is often extremely difficult to localise the pain and tenderness in a small child, and it may be quite impossible at first to refer the tenderness to any one spot, especially as the abdominal muscles are apt to be rigidly contracted, and the child cry directly it is touched. The state of the bowels varies, sometimes being relaxed, at other times obstinately constipated. In the course of a few days, during which time the pyrexia continues, if a satisfactory examination can be made, more or less resistance may be detected by palpation in the iliac or lumbar region, and a dulness on gentle percussion, though this may be masked by the distention of the small intestines. The patient may now, especially if he has been judiciously treated, gradually improve, and all pain and tenderness disappear in the course of a

week or two. On the other hand the tenderness may increase, a distinct hardness and induration may be felt in the right iliac region, the right leg is drawn up, and the child cries with pain if it is moved. The subsequent course of the attack differs, there may be a gradual subsidence of all the symptoms, or if the abscess is not opened, the hectic fever may continue, the child gradually emaciate, while the pus which has been formed is making its way to the surface, and the abscess may point in the iliac region, may discharge into the bowel, or, in rare cases, into the bladder or vagina. Fæces may be found in the pus discharging from the iliac abscess, and a fæcal fistula result, or all the signs of general peritonitis, abdominal distention, extreme tenderness and collapse, may come on.

The diagnosis of perityphlitis is often by no means easy, and yet of much importance, inasmuch as a mistake in diagnosis may readily cost a life. In the early stages, the diseases most likely to be confounded with it, especially in small children, are coprostasis or accumulation of hardened fæces in the cæcum, and invagination of the intestines; in a later stage, when the patient is seen for the first time after an abscess has formed, there may be uncertainty as to the source of the pus. Children who have just begun to run alone, and are able to make frequent excursions into the kitchen, or who are fed on all sorts of indigestible food, are especially liable to suffer from an accumulation of hardened fæces in the cæcum, which may set up more or less irritation, and give rise to symptoms exceedingly like those of a perityphlitis. There are distention of the abdomen, colicky pains, vomiting, slight feverishness, constipation, or, on the other hand, diarrhœa; and it must be borne in mind that looseness of the bowels is quite compatible with a loaded cæcum or large intestine. It may be possible to detect a fæcal tumour in the right lumbar region. The diagnosis in a fretful, spoilt child may be exceedingly difficult, but the symptoms of impacted fæces in the cæcum will be rather those of colic, the pain coming on spasmodically, with no pain or tenderness in the intervals; while in perityphlitis the pain will be constant, and the tenderness on deep pressure unmistakable. In any given case it is far better to err on the safe side, and to mistake colic for typhlo-peritonitis, than to fall into the far more serious error of dosing a child suffering from a local peritonitis with purgatives and enemas. An ileo-cæcal invagination with its symptoms of sudden obstruction of the bowel is probably not very likely to be mistaken for perityphlitis; the sudden attack in an infant in perfect health, the colicky pains, the straining, and passage of blood and mucus, and the presence of a painless tumour, would in most cases prevent a mistaken diagnosis. To make a diagnosis, an examination under chloroform may be necessary with the finger in the rectum.

**Peritoneal Abscesses—Intestinal Fistula.**—Apart from the suppuration which is liable to take place as the result of a typhlo-peritonitis, other abscesses are liable to occur in the abdomen, due in the majority of cases to glandular inflammation and originating in the mesenteric, retro-peritoneal or rectal glands. Local abscesses may also occur as the result of a blow or following a perforation of the intestine in typhoid fever or tubercular ulceration. As an instance of a glandular abscess in the abdomen the following case may be taken as an example. A girl of seven years of age was admitted to hospital, having suffered for thirteen days with pain in the abdomen, fever and vomit-

ing ; on admission there was some dulness below the umbilicus and great tenderness, the temperature varied from  $100^{\circ}$ – $102^{\circ}$ . The day after the umbilicus became prominent and the skin red, it gave way and pure pus was discharged ; the wound continued to discharge for some time—on one occasion a cheesy mass was removed from the sinus followed by a fresh discharge of pus ; the sinus finally closed on the forty-eighth day. At the end of ten weeks the girl was fat and strong ; there was some induration, but no pain or tenderness below the umbilicus. On one occasion there was some pus in a stool. In several cases which have come under our notice, with somewhat similar but more chronic symptoms, there has been evidence that an abscess had formed, probably in a mesenteric gland, and had opened into the bowel, pus being discharged with diarrhoeal stools. Other cases occur which are by no means so satisfactory in their terminations as the above, being in many instances associated with a chronic tubercular peritonitis or mesenteric disease. There are symptoms of abdominal trouble, attacks of vomiting and diarrhoea, hectic fever and wasting, an induration and at length an inflammatory blush around the umbilicus ; the latter becomes perforated and pus discharges. Frequently, sooner or later, the discharge becomes faecal from the presence of intestinal contents, a fistulous opening having become established. In the majority of such cases the abscess apparently originates in a mesenteric gland, an abscess cavity is formed which is surrounded by coils of small intestine matted together, the abscess opens both at the umbilicus and into the bowel in some part of its course ; but as such cases are mostly chronic, opportunities for post-mortem examinations are not frequent, and when an opportunity presents itself there is so much matting of parts that it is difficult to make out the origin of the abscess.

The following case illustrates this difficulty. A girl of four years of age was in hospital, June 1879, with obscure abdominal symptoms, hectic and wasting ; in the following December she was admitted with a sinus at the umbilicus discharging pus and intestinal contents, an abscess having broken ten weeks before. The fistulous opening continued to discharge pus and liquid yellow gaseous faeces till her death, in October 1880. At the post-mortem the liver and spleen were lardaceous. The umbilical sinus was connected with an abscess cavity containing one or two ounces of pus and faeces and surrounded on all sides by intestines matted together ; this cavity communicated with the ileum a foot and a half above the caecum by two openings large enough to admit a little finger. On the peritoneal surface of the small intestines were cretaceous nodules, apparently the remains of a past tubercular peritonitis. In the ileum were many cicatrices and calcareous remains of old ulcers and cheesy solitary glands. In this case the perforation of tubercular ulcers or the suppuration of mesenteric glands had been the cause of the abscess and fistulous openings. In several cases coming under our notice the fistulous openings have closed up permanently, one after discharging for seven months, and in some others the fistulous opening has closed but the patient died of general tuberculosis.

*Treatment.*—As soon as the diagnosis of acute peritonitis is established no time must be lost in administering opium in some form or other, the dose being repeated so that not only is the pain relieved but the child is rendered drowsy. The narcotic may be given by the mouth or by subcutaneous injection.

tion. For a child of from one to two years, two or three minims of the tincture may be given and repeated every three hours ; for a child of from five to ten years, five to eight drops, its effects being carefully watched. Hot fomentations should be applied to the abdomen ; some, however, prefer the application of ice—the former is much more comforting to the patient. If the vomiting is severe, all food by the mouth must be stopped and only small quantities of ice allowed ; in many cases the vomiting and consequent distress of the patient is maintained by giving large quantities of fluids, such as milk and beef-tea. Small enemata of beef-tea and brandy may be given by the bowel, but it must be borne in mind that large enemata of any sort are liable to do harm by setting up peristalsis of the bowel. Free stimulation with brandy, champagne, ether, must be resorted to in the last stages. In typhlitis and other local forms of peritonitis, the same treatment must be carried out—all forms of laxatives and enemata must be condemned as likely to aggravate the inflammation : rest in bed, opium fomentation, small doses of opium and belladonna by the mouth, the most restricted diet, the food being given in the most digestible form and in small quantities. As long as the slightest pain or tenderness is present, the most complete rest must be maintained and all purgatives and enemata avoided. The formation of an abscess must be carefully watched for, and surgical proceedings taken without delay if there is any indication of suppuration.

Since acute purulent peritonitis is practically certainly fatal if it becomes generalised, it is of the utmost importance to provide an outlet for a localised abscess rather than allow it to go on and rupture into the general peritoneal cavity. Hence, as soon as it is clear that a local form of inflammation is not subsiding under medical treatment, the safest course is to carefully cut down upon and let out the matter. In perityphlitic abscess ('appendicular peritonitis'), when with fever, local pain, tenderness and induration and retraction of the leg no improvement takes place, an incision should be made just internal to the anterior superior spine of the ilium and the successive muscular layers divided until the neighbourhood of the abscess is made clear either by the sense of fluctuation or by the œdematous condition of the tissues ; a director is then thrust in the direction of the suspected cavity, and if pus appears the opening is enlarged with dressing forceps and the cavity drained and treated on ordinary principles (antiseptics being used unless the pus is foul). There is little danger in such an operation ; even if no abscess is met with and the peritoneal cavity is opened no ill result is likely to follow, while the danger of rupture of an abscess into the general peritoneal cavity is very great. Local peritoneal abscess elsewhere is much more uncommon, though it may be met with on the left side (perisigmoid abscess), and this can be made out at times by rectal exploration, the treatment is that of the perityphlitic condition. It is of little importance in such cases to make out whether the abscess is really a local peritonitis or a collection of matter in the cellular tissue outside the peritoneum, since, if peritoneal, it is usually completely shut off by adhesions from the general cavity and there is no fear of pus flowing from the wound into the peritoneum. Local abscesses elsewhere must be treated on similar principles. Should a general purulent peritonitis already exist the question of treatment is more uncertain and the prospect far less hopeful ; there is, however, little doubt

that the right course is to open the abdomen, wash it out with some unirritating antiseptic such as boracic lotion, and drain the peritoneum. Should there be faecal extravasation from perforation of the caecal appendix or from a typhoid ulcer, the case must be looked upon as well-nigh desperate; the attempt however may be made to expose the perforation, suture the intestine, and in the case of the appendix remove it and close the end. We have three times performed abdominal section in children for peritonitis, once for local abscess among coils of intestine in the left ilio-pelvic region, once for localised abscess in general tubercular peritonitis, and once for general peritonitis with symptoms so closely resembling obstruction that it was thought probable that such condition did exist. None of these cases recovered, but there is no doubt that in two a chance of recovery was given by providing an outlet for the pus. In not a few cases of iliac abscess we have also operated and always successfully, and though it may be said that these are a different class altogether from the local peritonitis group, it is difficult to distinguish between the two, and there is certainly a risk of perforation into the peritoneum.

In cases of recurrent 'appendicular peritonitis' the question of removal of the appendix is to be seriously considered, since life is in constant danger as long as the source of the mischief remains.

**Chronic Peritonitis.**—Chronic peritonitis is a comparatively common affection during childhood and in the vast majority of cases is tubercular. A few cases of chronic non-tubercular peritonitis in which the diagnosis has been confirmed by a post-mortem have been recorded, notably one by Hensch which ran a course of six weeks; at the post-mortem cloudy fluid and organising lymph was found in the peritoneal cavity. This case seems to have originated in a blow. Cases also not infrequently occur in practice of chronic peritonitis with ascites, in which there is no evidence of tubercle in any organ and which completely recover; this however is no bar to the acceptance of the belief that such are tubercular, as there is ample post-mortem evidence to show that tubercles and lymph on the surface of the peritoneum may become cretaceous or be converted into fibrous tissue. Two forms of chronic tubercular peritonitis are met with in practice, in which for the most part a well-marked clinical difference exists, one distinguished by the large amount of ascitic fluid and in which probably ascites is the only symptom present, and the chronic cicatrising form in which there is induration and thickening of the great omentum and a matting together of all the abdominal organs with little or perhaps no fluid. The same tubercular process is going on in both cases, but produces in one a large amount of effusion, in the other less or perhaps no fluid, but the effusion of lymph and its gradual organisation and cicatrisation.

*Ascitic Form.*—Chronic peritonitis is by far the most common cause of ascites, or rather dropsy commencing in the peritoneal cavity during childhood, while, as well known, some form of portal obstruction is the commonest cause in adults. Ascites due to chronic peritonitis is not common during the first year of life, not that it does not occur, but the infant dies before the chronic stage is reached. It is not uncommon during the second year of life and occurs with some frequency up to and beyond puberty. There is generally a history of pain in the abdomen of more or less obscure kind

which has been regarded as due to indigestion, probably also both feverishness and diarrhoea, and then the belly begins to swell. In some cases the enlargement of the abdomen is the first symptom which leads the friends to think anything is wrong with the child. On examination a rounded and distended abdomen is found, there is dulness and fluctuation to be felt in the flanks if the patient be lying on his back; while there is a more or less extended region of resonance around the umbilicus where the distended small intestines are buoyed up to the surface. The abdomen is often intensely distended, the skin tense and shining, the abdominal veins enlarged and tortuous, and in young children the skin at the umbilicus is protruded and contains fluid which can be pressed back into the abdomen. There is mostly complete absence of pain and tenderness, the disease is frequently feverless during the greater part of its course, and the patient looks rather as if he were suffering from ascites due to some obstruction in the portal system. The course of the disease is essentially chronic, and recovery by no means hopeless, as there are not a few recorded instances of complete and permanent improvement taking place.

Thus in one case a girl, aged thirteen years, who was in hospital for some five months, and from whom eight to nine pints of ascitic fluid were removed through one of Southey's canulas, completely recovered, and was four years after a strong girl, supporting her mother and family by her work. In several similar cases we have seen recovery take place, one suffered from a tubercular testis which discharged through the scrotum and healed. On the other hand such children are apt to be carried off by a tubercular meningitis, or the mesenteric glands become cheesy, or a tuberculosis of the lungs takes place. In any case it will of course be necessary to carefully examine the lungs, and a long continued hectic and wasting would suggest a more extended area of tuberculosis. In cases which end in recovery there is probably a matting together of the intestines, and frequently more or less induration may be felt about the great omentum or cæcum. In cases which are of long standing it occasionally happens that a perihepatitis with more or less cirrhosis of the liver takes place. This was the case in a boy of 3½ years who was admitted to hospital under the care of Dr. Hutton, with ascites, œdema of feet and ankles, jaundice and enlarged liver; at the post-mortem the liver weighed 15 oz., the capsule was thickened and the surface was irregular and granular; on section there was a great excess of fibrous tissue, and old and recent peritonitis and tuberculosis of the lungs.

*Cicatrising Form.*—In many cases of tubercular peritonitis there is little or no ascites from first to last, but lymph is effused on the surface of the peritoneal covering of various organs, and if the patient live long enough, fibrous adhesions are formed. On the post-mortem table, local or general peritonitis is frequently found in children dying of tuberculosis; thus, out of 105 post-mortems of tubercular children made during the four years 1882–85, there was peritonitis in 38, though in a comparatively few of these was the peritonitis an early and important lesion. While this form of peritonitis is mostly chronic, yet some cases run a more active or subacute course. The early symptoms are pain in the abdomen, mostly referred to the umbilicus, often attacks of sickness and diarrhoea, hectic, and the presence of indurated or irregular-shaped masses felt through the abdominal walls. The amount

of tenderness on pressure differs greatly, being most marked in the acuter cases, and being absent in the chronic ones. But in cases wasted and exhausted by acute disease, even a purulent peritonitis may be present without any pain or tenderness. The state of the abdomen varies, it being sometimes distended with wind, at other times more or less retracted; often no distinct tumour can be felt, but on very gentle percussion a distinct loss of resonance, or a muffled resonance, may be detected over the umbilical region in consequence of the thickening and induration of the great omentum, or a resistance may be felt on palpation, or hard irregular tumours can be detected, the result of matting together of the omentum or intestines. Hectic fever is mostly present, the temperature rising to  $102^{\circ}$  or  $103^{\circ}$  at night, and falling to normal in the morning, and more or less general wasting of the body ensues; but the amount of fever and wasting present will depend upon the extent to which the mesenteric glands and thoracic viscera are affected. Diarrhœa is not usually a marked symptom unless tubercular ulceration have taken place. The subsequent course of these cases differs much; in the minority, after several months of hectic, improvement slowly sets in and the patient improves, for a time at least appearing fairly well. In the majority the fever continues, the wasting becomes more apparent, diarrhœa, and perhaps cough, comes on, and the child sinks. In others, the lungs remain free to the end, but mesenteric disease ensues, ulceration of the bowels takes place, perhaps local abdominal abscesses form, and the liver, spleen, and kidneys become lardaceous. In only 4 of the 38 cases of fatal tubercular peritonitis mentioned were the lungs and mediastinal glands found entirely free from tubercle.

*Prognosis.*—The course of chronic tubercular peritonitis is usually long, unless some intercurrent disease, as tubercular meningitis, supervenes. Children may be under observation for many months, with either ascites or induration of the omentum, with more or less hectic, and with no evidence of any active disease in the lungs, and finally to all appearance completely recover. On the other hand, the onset of diarrhœa, hectic, progressive emaciation, and cough, with evidence of lung mischief, points to the existence of more or less generalised tuberculosis, which necessarily shortens the duration of the illness. Albuminuria, as pointing to lardaceous disease, would be of bad omen.

*Diagnosis.*—When a child is presented with an ascites which has made its appearance gradually without pain or fever, it is perhaps not unnatural to attribute the collection of fluid in the abdomen to obstructed portal circulation. In an adult the commonest cause of ascites is cirrhosis of the liver, in a child by far the most frequent cause is chronic tubercular peritonitis. In a given case it may be quite impossible to make a certain diagnosis, inasmuch as for awhile the ascites may be the only symptom present; there may be a complete absence of pain or tenderness, the most careful palpation may fail to detect any induration of the omentum. The bowels may float up and cause a resonant note on percussion at the umbilicus when the patient is on his back, the resonance shifting to the flank which is uppermost when he lies on his side. It may be impossible to feel the edge of the liver, or map it out by percussion. In other cases, however, there will be less difficulty, for there may be hectic fever, or diarrhœa, or abdominal pain and tenderness, or after paracentesis lumps or masses of indurations may be felt. A

family history of tuberculosis would naturally favour the view of tubercular peritonitis; and occasionally the presence of a cheesy deposit in a testis will decide the diagnosis.

*Morbid Anatomy.*—Fluid varying in quantity will be found in a few cases; it may be clear or cloudy serum or pus, in which latter case it is usually localised; it is not uncommon, on separating the intestines, to find small local collections of pus. Tubercles and lymph are usually present on the great omentum and mesentery, matting the intestines together, also between the liver and diaphragm and around the spleen; where there is no large collection of fluid, the adhesions are frequently very extensive; the intestines and stomach may be adherent to the abdominal wall, so that on opening the abdomen, the intestines are frequently cut into. The intestines, mesentery, great omentum, liver and spleen may be so matted together, partly by lymph, partly by fibroid adhesions, that it may be impossible to separate them. The intestines may be so adherent and bound down, as to form bends and kinks, that it is impossible to unravel. Cheesy mesenteric glands and tubercular ulcers will very likely be present.

*Treatment.*—Any pain and tenderness in the abdomen in a child with tubercular tendencies should excite apprehension and never be neglected. Rest in bed should be enjoined, and a diet consisting of beef-tea and milk should be given. The pain may be relieved by applications of belladonna and glycerine covered with cotton wool, or by fomentations. The bowels should be relieved by enemata and laxatives rather than purgatives. In the chronic stages, when the abdomen contains fluid or there is evidence of thickened and indurated omentum or cheesy masses, mercurial applications may be used. Linimentum hydrarg. may be painted over a surface the size of one's hand and repeated daily for a week, selecting a fresh place every day, a flannel binder being applied. Or an ointment of yellow oxide of mercury (20 grains to the oz.), with an equal quantity of ung. belladonnæ, may be used, with cotton wool to cover it. If the fluid is excessive, tapping with one of Southey's cannulas should be resorted to.

Tonics and cod-liver oil emulsion should be given. Chronic purulent peritonitis, whether tubercular or not, should be treated by incision and drainage, if the child's health is failing; and there is good evidence to show that not only may temporary relief be thus given, but long lasting, if not permanent, recovery may take place as the result of incision.

**Iliac Abscess.**—The occurrence of iliac abscess, right or left, is frequent in children, and the various causes of such mischief should be borne in mind; the principal ones, some of which have been already mentioned, are caries of the spine, tubercular disease of the mesenteric glands—in this case the abscess is more often umbilical—disease of the hip, innominate bones or sacro-iliac joint, perinephritic abscess, rare in children, and the still rarer cases of hydatid cysts. Empyemata, superficial abscesses and abscesses the result of injury, 'simple psoriasis,' &c., are to be thought of in addition to those already described as resulting from irritation of the cæcum or appendix. But besides all these, it is common to find iliac abscesses the cause of which remains obscure, and we are satisfied that in many of these cases the suppuration is simply due to inflammation of lumbar, iliac or pelvic lymphatic glands, just as cervical abscesses occur from irritation of the glands of the

neck. The source of irritation is often doubtful, but is sometimes due to the presence of worms or other irritating matters in the bowels; sometimes to extension from the more superficial lymph glands. The diagnosis can often be made by careful exclusion and by the history; rectal examination is often of much value, by enabling the extent and position of the abscess to be made out, as well as sometimes by revealing a source of irritation. These abscesses should be opened antiseptically and drained in the usual way; it will often be found that they extend for long distances upwards or downwards into the pelvis. The limb on the affected side should be steadied by a splint or by extension. The prognosis is good provided no permanent source of suppuration be present. Every case that we have seen has recovered, and we believe this is largely due to early opening of the abscesses.<sup>1</sup>

**Acute Obstruction to the Bowels.**—Children occasionally suffer from acute obstruction caused by twists in the bowel, constricting bands, impaction of foreign bodies, and internal hernia; by far the most frequent cause is, however, an intussusception.

**Intussusception.**—The commonest cause of obstruction of the bowels in infants is the presence of an invagination of the bowel. Many reasons have been given for this somewhat frequent accident. There is no doubt that one cause is to be found in the great reflex irritability of the muscular coat of the infant's bowel; vigorous peristalsis is easily set up, and moreover, the intestinal walls being thinner during infancy than in later life, an invagination of one portion of the gut into a lower portion more readily takes place. This is seen in the post-mortem invaginations so often found: the act of dying seems to stimulate the peristalsis of the bowels, and it is no uncommon thing to find on the post-mortem table many invaginations in the ileum an inch or two in length. In some cases an accident, such as falling out of bed, or some rapid movement up and down in the parent's or nurse's arms, has preceded symptoms of an intussusception, and it is possible that a sudden movement might cause a toneless piece of gut to become invaginated. It must also not be forgotten that the infant's intestines, especially the cæcum and colon, are more movable than those of an adult, having a wider mesentery, and consequently one piece of bowel is more easily dragged into another portion.

With regard to the frequency of intussusceptions at different ages, it has been stated by Pilz that, out of 293 cases, 153 were in their first year, and of these 98 were from 4 to 6 months of age. According to Leichenstern, out of 122 cases, 73 were under a year old, and 49 from one to five years of age. It is certainly the common experience that the majority of cases occur in infants under a year, and that from 4 to 6 months of age is a very common time.

In at least three-fourths of the cases in infants the invagination is ileo-cæcal, in the minority of cases it is ileum into ileum or colon into colon. In the ileo-cæcal variety the ileum enters the cæcum, not through the ileo-cæcal valve, but the cæcal valves are pushed before it, so that the valves themselves occupy the lowest part, and as it travels downwards, more and more of the ileum enters, dragging its mesentery along with it and forming the inner tube, while the middle layer is formed by the inverted cæcum and

<sup>1</sup> For details of some of these cases we may refer to a paper in the *Arch. of Pædiatrics*, vol. i. 1884, and to the *Children's Hospital Abstracts*.

colon, the colon also forming the outer layer. The layers of an intussusception therefore consist of (1) an outer layer of intestine into which the invagination takes place, the peritoneal coat being external and the mucous membrane internal; (2) a middle layer continuous with the outer layer at its upper end, but turned inside out so that the mucous membrane is external and the peritoneum internal; (3) an internal layer formed by the intestine entering the outer layer with its mesentery and vessels and which becoming nipped as it travels downwards forms the stoppage. In consequence of the mesentery becoming dragged in, the included intestine does not lie in the centre of the containing gut, but is more or less tilted to one side. As a result of the invagination, the inner and middle layers become congested and oedematous and of a dark-red colour; blood is extravasated from the congested mucous membrane and is passed per rectum. In some cases, lymph is thrown out by the serous surfaces and a local or general peritonitis takes place. In a few cases, more particularly in the ileum into ileum variety, sloughing may take place and the invaginated bowel be separated and passed per rectum, while faeces may be extravasated or recovery take place by a process of cicatrisation. The extent to which life is threatened depends very largely upon the tightness with which the bowel is nipped and the circulation of blood obstructed, and this appears to vary to a considerable extent, so that death may ensue in a few hours with the symptoms of collapse, or, especially in older children, where the bowel is only partially obstructed and the circulation of blood through it but slightly interfered with, the course may be chronic, going on for weeks or even months.

*Symptoms.*—An infant of a few months, who may very probably have suffered for a few days from symptoms of bowel irritation, suddenly begins to kick and scream as if in violent pain which nothing appears to relieve. It soon begins to vomit continuously, and strain as if it wanted to pass a stool, but nothing escapes but a little blood and mucus. In the intervals between the attacks of vomiting and colic, the infant may be tolerably quiet, but it is usually restless and moaning as if in pain. An examination of the abdomen shows it to be moderately distended and resistant, and on careful palpation in the course of the transverse colon, an inch or so above the umbilicus and towards the left hypochondriac region, an elongated tumour may be felt, which is movable, and, as a rule, not acutely tender. There may be also a feeling of want of resistance in the right lumbar region from the absence of the cæcum and ascending colon. In very fat infants it may be impossible to detect such a tumour. The rectum should be next carefully explored with the finger, and the presence of a tumour there, which is pressed down when the child strains, while the withdrawn finger is covered with blood, would establish the diagnosis. The position of the tumour necessarily varies according



Fig. 10.—Ileo-cæcal intussusception. A piece of the outer layer (colon) has been removed to show the middle layer.

to the length of the included gut ; but inasmuch as the colon is nearest the abdominal wall where it crosses the upper part of the umbilical region, if this part is involved, as it usually is, the tumour will be most readily felt here. The temperature is mostly normal or subnormal, unless there is peritonitis, when it may be raised a degree or two. The tumour is usually not acutely tender, but if the case be an acute one, or in other words, if the included gut be tightly jammed and its vessels strangulated, the child may scream on its being pressed. If the case continues unrelieved, the vomiting, straining, and distress continue, the child wears an anxious, pinched expression, with sunken eyes, and dies with the symptoms of collapse. The period at which death takes place varies ; in infants it may be within twenty-four hours, more often from the third to the fifth day.

While the above description applies to the majority of cases, it must be borne in mind that the symptoms are at times far less well marked, so that the presence of an intussusception may be overlooked ; there may be perhaps vomiting, colicky pains and mucoid stools, the infant dying in convulsions. On the other hand, it is possible that an invagination may occur, and fortunately right itself before it becomes tightly impacted.

In older children, when the ileum into ileum variety occurs, the obstruction is mostly complete and the symptoms are those of strangulated hernia, or constriction of a knuckle of bowel by a fibrous band. The onset is sudden, the contents of the stomach being first vomited, then the intestinal contents, and finally, the vomit has a distinctly fæcal odour ; neither wind nor fæces are passed per rectum, but in some instances small quantities of mucus and blood. The abdominal pain is usually of an intermittent and colicky character ; the abdomen is rounded but not tender, at least in the early stages. In this case a tumour is not likely to be felt through the abdominal wall, inasmuch as the lower end of the ileum, which is usually involved, lies deeply and is probably covered by distended intestine ; though in one case reported by Hertzka, where the tumour was supposed to be due to an ileum invagination, a swelling was felt in the region of the navel which was three inches long, movable and tender ; the child recovered. In these cases no rectal tumour is present.

When an ileo-cæcal intussusception occurs in other than an infant, the course is usually more chronic, and the symptoms less acute. There are attacks of colic and vomiting with obstruction of the bowels, though the latter is not always complete, as there may be slimy stools passed with or without blood. An elongated tumour is mostly felt in the usual position, lying across the abdomen immediately above the umbilicus. If strangulation does not occur, the case may go on for weeks or months. The cause of the obstruction in such cases is apt to be overlooked as the obstruction to the passage of fæces is not complete, and the symptoms not acute, and the tumour felt closely resembles distention of the large bowel with hard fæces.

*Morbid Anatomy.*—On making a post-mortem examination, care must be taken to distinguish between an intussusception which has taken place during life and given rise to the symptoms noted, and an intussusception which is post-mortem and caused by the irregular yet vigorous peristalsis of the bowels which may take place during the act of dying or after death. In the latter case the invagination involves the ileum, or, at any rate, the

small gut, and there are often several of them. They are rarely more than an inch or two in length, are readily pulled out by gentle traction, and while a ring of congestion may be seen near the seat of constriction, or where the gut has been doubled on itself, there is no œdema or marked congestion or effused lymph. A post-mortem invagination does not completely occlude the passage of the gut. In the examination in a case of the ileo-cæcal variety which has become strangulated, an elongated mass, dark red in colour, is seen lying in the course of the transverse colon, continuous with it at its lower end, while the ileum with its mesentery is seen to enter at its upper end; the ascending colon and cæcum will have disappeared. In most cases the contained gut cannot be withdrawn without tearing, as it has become rotten from gangrene. Its passage will, in an acute case, be completely occluded, partly on account of the œdematous and congested two inner layers, partly by reason of the tilting on one side of the inner gut through the dragging in of its mesentery. Lymph may be found effused between the two peritoneal surfaces, gluing them together, and there may be evidence of a more general peritonitis.

In chronic cases less congestion is seen, the bowel probably is not entirely obstructed, and the bowel above is generally hypertrophied and its mucous membrane in a condition of ulceration.

*Diagnosis.*—The diagnosis in an acute case is not likely to give rise to difficulty, inasmuch as the sudden attack of vomiting, with pain and tenesmus, and the discovery of an elongated tumour, through the abdominal wall or per rectum, makes the case tolerably clear. But the question of the presence of an intussusception sometimes arises in infants who are suffering from symptoms of obstruction to the bowels of an uncertain origin, possibly with a certain amount of thickening or resistance in the right iliac fossa, which may be due to the impaction of fæces in the cæcum or to an invagination. In all such cases as long as any doubt exists purgatives should be avoided and small doses of opium given to allay the pain and straining. If there is pain on deep pressure, it is better to avoid enemata, trusting rather to narcotics.

*Treatment.*—The treatment which is to be adopted must necessarily vary according to the acuteness of the case and the time the symptoms have lasted, for if the bowel has passed into a gangrenous condition it is obvious that only harm can be done by mechanical treatment which might have been of the greatest service in an earlier stage. The question to ask oneself before commencing treatment is, what is the state of the invagination? is the gut tightly jammed? is it gangrenous? Unfortunately these questions are very difficult to answer, inasmuch as in some cases the inner layer of bowel becomes tightly impacted from the first, and no amount of force applied by distending the bowel per rectum will replace it, while in other cases success has attended inflation of the lower bowel with air several days or even a week after the onset of symptoms. Thus in a child<sup>1</sup> aged seven months, under the care of Dr. J. S. Bury, injections of oil and afterwards of air were employed fourteen hours from the commencement, but failed to reduce the invagination, the infant dying twelve hours later, within twenty-six hours of the onset; at the post mortem 'reduction was quite impossible without tearing the gut;' there was some lymph effused locally. In this case, by the

<sup>1</sup> *Medical Times*, Feb. 19, 1881.

end of twenty-four hours, the bowel was tightly strangulated and neither injections nor abdominal section could have been of any use. Such a case is no doubt exceptional, and it would probably have ended fatally under any circumstances unless mechanical replacement could have been undertaken, or laparotomy performed within a very short time of the seizure. By the time the invaginated portion of bowel has travelled along the colon as far as the rectum, the collapse produced, especially in a small infant, is very great, and the difficulties in the way of replacement are necessarily much greater than if only a few inches of bowel are involved. But cases appear to differ very much in the amount of œdema and congestion taking place in the nipped bowel, and consequently in the difficulty of replacement. While some cases, such as the one just referred to, are acute and irreducible almost from the first, others are reported in which the intussusception was reducible some days after the onset of symptoms; in one case, reported by Dr. W. B. Cheadle,<sup>1</sup> in a boy aged five-and-a-half years, the invagination was successfully reduced by massage and the injection of air on the seventh day from the onset. In another case, reported by F. H. Elliott,<sup>2</sup> in an infant of eight months, attempts at intervals to reduce the invagination were only partially successful, but finally succeeded.

As soon, then, as the existence of acute intussusception has been ascertained it becomes necessary to decide without delay whether the patient shall be left to nature, or whether mechanical means shall be employed to overcome a mechanical obstruction.

Recoveries after spontaneous reduction and after sloughing have been recorded, but they are so rare that waiting for a natural cure means practically abandoning the child to almost certain death.<sup>3</sup> It is then clear that some attempt at reduction should be made, and we have the following plans at our disposal for this purpose. (1.) Inversion of the child, combined with external taxis or succussion. The child is held up by the legs with the head downwards, and an attempt made to draw the contents of the abdomen to the upper part of the abdominal cavity by kneading and stroking with the hands through the abdominal wall, or by sudden shaking movements of the child an attempt is made to dislodge the intussusception. It is clear that this plan can only be expected to succeed when the intussusception is small in extent and recent in formation; it is in such cases worth a trial since it is unattended with danger. Chloroform should be given during the manipulations.

(2.) Distention of the bowel with fluid or air in the hope of pushing back the invagination. If fluid injections are employed an enema tube fitted with an anal shield should be passed into the rectum and warm water or oil allowed to flow into the bowel from a vessel raised above the level of the patient's body. The amount thus injected must vary with the age of the child, and the position of the intussusception; from one to two pints is about the usual quantity, and a fall of from 3 to 6 feet is required.

Inflation by air is best managed by passing the nozzle of an ordinary pair of bellows, fitted with a shield which may be readily extemporised,<sup>4</sup> into the

<sup>1</sup> *Lancet*, Oct. 23, 1886.

<sup>2</sup> *Lancet*, Jan. 8, 1887.

<sup>3</sup> Even if recovery by sloughing takes place the risk of subsequent stricture has to be considered.

<sup>4</sup> The nozzle of a Higginson's syringe is all that is required.

rectum, and blowing air in till the tumour is felt to give way, or it is not safe to distend any further. In both these methods the abdomen should be carefully watched and a hand kept on the intussusception tumour to feel for any change in its size or position.

These plans are open to the objections, first, that there is distinct danger of over-distention and rupture of the bowel, as shown by the experiments of Bryant and others ; secondly, that they can only succeed where no adhesions have formed between the adjacent peritoneal surfaces ; and thirdly, that even if reduction does apparently take place it may be incomplete or invagination may recur. A case of our own well illustrates this last fact. Harold T., aged 7 months, was admitted into the Children's Hospital, May 30, 1887, with symptoms of acute intussusception of three days' duration. The invagination could be felt externally in the left iliac region, and internally per rectum. Under chloroform inflation was employed without success, ten ounces of water were then injected through an indiarubber tube three feet long with the result of causing disappearance of the tumour and increase of resistance previously deficient in the right iliac area. He slept quietly for some hours and then began to scream again and the intussusception reappeared. Injection was again apparently successful and the child spent a quiet night. The next afternoon the symptoms reappeared, but were once more relieved by injection. The next day the general condition was worse, and as it was clear that no complete reduction had taken place abdominal section was performed, the intussusception found and reduced ; the bowel was inflamed but not gangrenous, there were no adhesions and the invagination was ileo-cæcal. The child sank and died an hour later.

(3.) Abdominal section may be performed and the obstruction relieved by more direct means. The section is best made in the median line below the umbilicus, the bladder having been previously emptied. As soon as the abdomen is opened the intussusception should be drawn to the surface and carefully examined. If the bowel is in good condition a careful attempt should be made by gentle traction to withdraw the 'intussusceptum ;'<sup>1</sup> if this can be done and the bowel is not too much injured for recovery, it should be left to itself and the wound closed. If the bowel, however, is too much injured to have a reasonable chance of recovery, or if the intussusception is irreducible, one of three courses must be followed—either the bowel must be opened above the tumour and an artificial anus made, the invagination being left to itself, or the intussusception must be resected and the two ends of the gut stitched together, or finally, after resection the two ends may be brought out of the wound and fixed to its edges, an artificial anus being made. The plan of leaving the intussusception alone has no advantages, inasmuch as the injured bowel will almost certainly act as an irritant and set up peritonitis. The plan of resection and suturing together the ends of the bowel, if successful, gives of course the most perfect result, but it is open to the objection that it is long and tedious and the child is likely to die of exhaustion, and further, there is great danger of leakage even after the most careful suturing. The best course then is to resect the tumour and fix both ends of

<sup>1</sup> Reduction is sometimes best managed by squeezing the tumour and drawing the 'intussusciens' off the 'intussusceptum,' rather than by directly pulling out the invaginated gut.

the gut to the abdominal wound. Subsequently, *i.e.* after several weeks, should the child recover, an attempt may be made to restore the natural channel and close the artificial anus by the usual method. The general peritoneal cavity will be shut off from the ends of the bowel, and these may either be dissected away from the edges of the wound and united to one another by sutures, or the spur ('éperon') between them may be removed by the enterotome and so the aperture closed. This, though a less showy plan and one requiring more prolonged treatment, is far safer than the other method. The utmost care in all cases must be taken to prevent escape of the intestinal contents into the peritoneal cavity; this is managed by emptying the segment of gut dealt with before opening it and keeping it empty by pressure of an assistant's fingers or a clamp, such as a pair of forceps shielded with soft rubber and fixed very lightly on the bowel so as not to bruise it. All blood, &c., must be carefully cleaned out of the peritoneum, and most surgeons will prefer to use antiseptic measures.

Given, then, a case of acute intussusception, inversion and injection should first be gently tried,<sup>1</sup> and failing these, immediate laparotomy, with reduction of the invagination if possible, and if not the tumour should be resected and an artificial anus made which may be subsequently closed. For further details we must refer to the general text books or to Mr. Treves' work on Intestinal Obstruction.

Chronic intussusception is exceedingly rare in children, except, perhaps, as one form of so-called prolapse of the rectum, which is really intussusception of the upper into the lower part of the bowel. A chronic invagination may however occur elsewhere; its duration may be weeks or months; Treves records a case of a year's standing and a doubtful one of many years' duration. We have had a child under the joint care of our colleague Dr. Hutton and ourselves in which a chronic intussusception of the ileo-cæcal variety existed for a year, and which ultimately died of fæcal extravasation from gangrene found at the time of abdominal section. The whole tumour was soft and pulpy, there was intermittent constipation, no vomiting, tenesmus or bleeding, much distention with visible peristalsis at times, at others a flaccid abdomen, no definite tumour was to be felt in the rectum or abdomen, and in fact the symptoms in this case as in most of those on record were very uncertain and not at all characteristic of intussusception. Enterotomy or resection was the only thing that could have relieved this case, and if the symptoms were at all urgent we should recommend it in another case, reduction of the invagination being quite impossible. The bowel in these cases sometimes sloughs away as in the acute form. In the simple rectal form the prolapse is usually reducible and can be cured by rest, avoidance of straining, and if necessary, the use of the cautery as in other cases. It is of the utmost importance that the motions should be passed in the recumbent position and should be kept soft by doses of cod-liver oil or by olive oil enemata.<sup>2</sup>

<sup>1</sup> If injection proves successful, the child should be kept under the influence of opium, and the pelvis raised above the level of the head.

<sup>2</sup> For further information Mr. Hutchinson's paper in the *Med. Chir. Trans.* 1874, may be referred to, also Herz, *Arch. f. Kinderheilk.* B. v. H. 9 and 10; the latter records 6 recoveries out of 20 cases of laparotomy at ages ranging from 14 days to 14 years.

**Chronic Obstruction of the Bowels.**—Reference has already been made to the constipation of infants and older children, due to an atonic condition of the colon or a chronic intestinal catarrh; but other causes of inactive bowels exist which are attended with serious inconvenience, and even fatal results. There is reason to believe that occasionally fibrous bands, due to old, perhaps a foetal, peritonitis, mat together the coils of intestine, more especially the lower part of the ileum, and consequently check or interfere with the peristaltic action of the bowels. It appears also that occasionally the sigmoid meso-colon and meso-rectum are shorter than usual, fixing the lower bowel, and perhaps more or less forming a kink at its natural curves, where hardened faeces may lodge and a temporary obstruction take place. A fatal case, which seems to have been due to this cause, is recorded by Dr. Eustace Smith, the patient being a boy of eight years who died shortly after coming into hospital. Whatever may be the cause, cases not infrequently come under observation where the child has suffered from constipation all its life, large accumulations of faeces taking place in the colon which have to be removed by enemata, and where the bowels, if left to themselves, only act once or twice a week. In some of such cases an enormously dilated colon has been found after death with superficial ulceration of its mucous membrane, the cause of such dilatation being by no means clear. It must not be forgotten also that a chronic intussusception may exist for many months, and give rise to the symptoms of chronic obstruction. A careful examination of the abdomen should be practised in order to ascertain the presence of a tumour, and to determine if possible its nature, whether due to collections of hardened faeces, matting of the omentum and intestines, as in chronic peritonitis, or to the presence of an invaginated bowel. An examination of the rectum should always be made.

## CHAPTER VIII.

## DISEASES OF THE DIGESTIVE SYSTEM—(continued).

**Tubercular Ulceration of Bowel and Mesenteric Disease.**—In the majority of cases of children dying of tubercular disease, tubercular ulcers are present in the intestines, and the mesenteric glands are enlarged and 'cheesy' on section. This association of ulceration of the intestines with cheesy mesenteric glands is so much the rule that it is impossible to separate the two clinically, and it must also be remembered that anatomically the solitary glands and Peyer's patches are lymphatic structures. The frequency with which these lesions complicate phthisis or general tuberculosis is shown by the fact that in 103 consecutive post-mortems made at the General Hospital for Sick Children, Manchester, on children of all ages dying of tuberculosis, in 62 there was tubercular ulceration of the intestines, in 71 cheesy mesenteric glands, in 55 both ulcers and cheesy glands existed together, in 7 tubercular ulcers without cheesy glands, in 16 cheesy glands without ulcers. These numbers, as far as the frequency of tubercular ulceration is concerned, do not overstate the fact, as it is far more likely that the presence of ulcers in the intestines, especially if they are small, should be overlooked, than their frequency overrated. These statistics also show the frequent association of ulceration of the intestines and disease of the mesenteric glands, though this association is not constant, and one may be found occasionally without the other. Ulceration may exist without the mesenteric glands joining in the process; but there is a strong probability amounting almost to certainty, that if extensive ulceration be present the glands will be found to be affected. On the other hand, it is certain that ulceration is not the necessary precursor of mesenteric disease; for just as a chronic catarrh of the nasal mucous membrane may in an unhealthy subject set up glandular enlargement and abscess, so a catarrh of the intestine, if long continued, is exceedingly apt to give rise to mesenteric disease. Although mesenteric disease is so commonly found in children dying with a widespread distribution of tubercle, it is by no means so common to find tubercular disease beginning with symptoms of tabes mesenterica, as is commonly believed, for in practice it is constantly found that infants and children who have habitually distended abdomens, with more or less wasting, are put down as suffering from 'consumption of bowels.' In the greater number of these cases there is no mesenteric disease, but a chronic and obstinate catarrh of the intestines which is perfectly remediable. Besides the very frequent association of ulceration and mesenteric disease, chronic tubercular peritonitis is a frequent complication.

Infants and children of all ages suffer from tuberculosis of the intestines and glands, but it is perhaps less common before the age of one year than afterwards. The common cause of marasmus in infants is a gastro-intestinal atrophy rather than tubercular disease, such infants succumbing before the tubercular process is set up, though in some cases cheesy glands may be found. It has just been noted that in at least 70 per cent. of cases dying of tuberculosis, disease of the mesenteric glands was present, and in rather more than 55 per cent. tubercular ulceration was associated with it; it is of some interest and importance to inquire in how many of these cases was the tuberculosis of the intestine and glands primary, and the tubercular lesions elsewhere secondary; and in how many instances the tubercular disease began with abdominal symptoms. A primary tuberculosis of the intestine is suggestive of infection by means of tubercular bacilli taken in food, as, for instance, in the mother's milk or that of a foster-nurse, or the milk from a tuberculous cow. Direct experiments in feeding young animals with tuberculous material, or milk from consumptive cows, have demonstrated the possibility of a direct infection taking place, though there have been many experiments with negative results.

Of the 103 fatal cases of tuberculosis referred to above, in 13 or about 12 per cent. the early symptoms were referable to the abdomen; in a few of the cases, symptoms of lung mischief were absent during life, and the lungs were found free from tubercle, or only slightly affected; in the majority of cases the physical signs and symptoms pointed during life to lung complications, which supervened sooner or later, and at the post-mortem more or less extensive pulmonary lesions were found, though in some instances these only supervened during the last few weeks or months of life. Tubercular ulcers are most frequently found in the ileum, and in the large bowel, especially in the cæcum. In chronic cases they may be very extensive, with much matting together of different coils of intestine, and of the omentum by peritonitis. The walls of the cæcum are often much thickened. The ulcers, if recent, are sharply punched out; if chronic, their edges are thickened and irregular, mostly running across the gut. The mesenteric glands when affected are enlarged and cheesy, sometimes a few, at other times nearly all the glands seem to have undergone cheesy changes; occasionally suppuration takes place. The ulcers may cicatrise, and by puckering the gut give rise to some obstruction to the passage of the intestinal contents, especially in the large bowel or at the cæcum.

*Symptoms.*—If a child of over two years of age suffers from a chronic looseness of the bowels, with wasting and hectic, there is a strong probability that it suffers from abdominal tuberculosis. This probability passes more or less into a certainty if it comes of a tubercular stock and presents the usual tubercular aspect, such as marked pallor, long curved eyelashes and excessive growth of fine downy hair upon the skin. The abdomen is usually more or less distended with gas, the superficial veins are enlarged, there may be tenderness on deep pressure, and perhaps some thickening may be felt over the cæcum, or some matting of the omentum. The symptoms are often varied according as ulceration of the bowels, mesenteric disease, or chronic peritonitis is extensively present. In most cases of tubercular ulceration there is troublesome diarrhœa, though it must be borne in mind that this

diarrhœa in many cases completely stops for a while, or, indeed may be absent from first to last. There is no special feature about the diarrhœa of tubercular disease; there is a general tendency to looseness, and colic may come on after errors in diet, or directly after food is taken, or may appear to be the result of cold. The stools are mostly liquid brown or yellow with an excessive quantity of mucus and perhaps streaks of blood, but too much stress must not be laid upon the character of the stools. The tongue is usually clean and red, with enlarged and congested fungiform papillæ. It is of course necessary to carefully examine the lungs in all such cases, as any confirmatory evidence of tuberculosis there would be of great importance from a diagnostic point of view. The course of such cases is often chronic, and they often greatly improve for a while, probably on account of the intestinal catarrh which is present undergoing improvement, or the ulcers may slowly cicatrise and heal. On the other hand, there is a constant risk of a tubercular meningitis supervening, or some acute lung trouble carrying them off. Sooner or later, however, the diarrhœa, wasting and hectic reappear, the child becomes more and more pallid, the abdomen more distended, the feet swollen, and the face puffy. The diarrhœa at the last is often constant, and the desire to go to stool, only a little mucus or liquid fæces passing, is very distressing and not easily relieved. The emaciation at the last is often extreme. When symptoms of abdominal tuberculosis follow on those of chronic tuberculosis of the lungs, the diagnosis is not difficult, and a more rapid course may be predicted. When the tuberculosis of the intestines is primary and uncomplicated with other trouble, the course may be very chronic, extending over several years, improvement taking place from time to time.

In those cases where the mesenteric glands are chiefly affected the symptoms are still less definite, though this, as has been pointed out, is not often the case, as varying degrees of tubercular ulceration of the intestines and chronic cicatrising peritonitis are apt to be present. The symptoms are usually those of chronic intestinal catarrh, perhaps without marked diarrhœa, with wasting and hectic. It must be remembered that a distended abdomen which is chronically in this condition, with some wasting and an evening exacerbation of temperature, does not necessarily mean mesenteric disease, any more than the signs of a chronic pneumonia are necessarily to be interpreted as the signs of tubercle; we only infer in both cases that tuberculosis exists if we get confirmatory evidence elsewhere. A history of tubercle in the family, the steady progress of the disease, wasting, great pallor and hectic, would help the diagnosis. The supposed large glands should be carefully felt for, taking care not to mistake fæces in the large bowel or indurations of the mesentery or cæcum for enlarged glands. The fingers should be laid on the abdomen below the umbilicus and pushed well in, and gently moved about; the mesenteric glands lie deeply, can rarely be distinctly felt, they are movable and of size varying from hazel nuts to walnuts. If the abdomen is distended with gas even large groups of glands may exist and yet not be felt. An early diagnosis is rarely possible by discovery of enlarged glands; it is only towards the close that they can usually be felt, when the tonus of the abdominal muscles is diminished and the intestines more or less collapsed.

*Diagnosis.*—A child with a temperature raised a few degrees at night, with distended abdomen, chronic diarrhoea, and which resists treatment, and which has produced wasting and marked pallor, is probably the subject of tubercular ulceration of the intestines. If, at the same time, local indurations can be felt in the region of the cæcum or in other places, or if there are signs of tubercular disease in the lungs, the diagnosis becomes still more probable. Moreover, the diarrhoea probably persists in spite of liquid diet, rest in bed and astringents, and is only temporarily kept in check by opium. Mesenteric disease is much more frequently diagnosed than discovered post-mortem. A progressive wasting due to chronic intestinal catarrh or gastrointestinal atrophy is frequently attributed to caseous degeneration of the mesenteric glands and a fatal termination is looked upon as inevitable. It is well, however, to bear in mind that mesenteric disease is uncommon before eighteen months or two years of age, and, moreover, great wasting may be due to intestinal catarrh without mesenteric disease. It is but seldom that enlarged glands can be felt; the diagnosis mainly depends upon the signs of tubercle elsewhere in the body and upon the family history. If there has been much diarrhoea, hectic and symptoms of chronic peritonitis, followed by extreme wasting, there is good reason to suspect mesenteric disease.

*Treatment.*—The treatment of tubercular ulceration and mesenteric disease is the treatment of tuberculosis in general. Fresh air and careful dieting are all important. The special treatment consists in keeping the diarrhoea in check, while nourishing food easy of assimilation is being supplied to the patient. The class of foods must be selected from those which contain much nutriment in little bulk, such as eggs, fish, meat, fats, milk, rather than foods containing large quantities of starch and sugar. If there is but little diarrhoea milk may be allowed in moderate quantities, but the amount taken must not be excessive if much looseness of the bowels exist, as too much fluid taken is apt to aggravate the diarrhoea. In all stages of the disease minced underdone meat, whether chicken, beef, or mutton chop, is of great value. The child's portion may be taken from red juicy meat found close to the bone in a large joint of roast beef. It should be finely minced, being cut as fine as it is possible to cut it, and gravy being poured over it before being taken. Of this large quantities will be taken readily by the children; some crumbs of stale bread being with it, but even small quantities of starch are apt to disagree and give rise to flatulence. An egg or part of an egg beaten up in milk may be given once or twice a day. The diarrhoea is best kept in check by careful dieting, avoidance of more food than the child can digest, and if excessive, the food for awhile must consist almost entirely of pounded underdone meat or meat juice. Small doses of opium combined with mercury and chalk may be given in the following formula:—

( 19 )

Mercury and chalk . . . . .	gr. j
Dover's powder . . . . .	gr. j

*Every night (for a child 3 to 5 years).*

or

( 20 )

Compound Kino powder . . . . .	gr. ij to iv
White sugar . . . . .	gr. ij

In the later stages small enemata of laudanum and starch may be required, but too often the diarrhœa is quite uncontrollable. Opium fomentations are useful. If the diarrhœa is due to the presence of undigestible food, laxatives such as a powder containing rhubarb and soda should be given. Cod-liver oil, either as an emulsion or in combination with other tonics, is useful in all stages except when the diarrhœa is excessive; the following formula of Dr. L. Starr is a good one:—

( 21 )	
Cod-liver oil . . . . .	℥ij
Dry extract of malt . . . . .	℥iv
Hypophosphite of lime . . . . .	gr. xvj
"          soda . . . . .	gr. xvj
"          potash . . . . .	gr. viij
Glycerine . . . . .	℥ij
Powdered acacia . . . . .	℥ij
Water . . . . .	to ℥iv

*One teaspoonful three times a day.*

**Congenital Obstruction of the Bowels.**—It is not an uncommon circumstance for a newly-born infant to suffer from complete obstruction of the bowels; passing no meconium per rectum (which may be normal) and shortly after being put to the breast, commencing to vomit, first milk, then bile and finally meconium. In the meantime the abdomen becomes distended, the face pinched, and the infant dies in a few hours or perhaps lingers for a few days. At the post-mortem various obstructive lesions may be found. There may be a stenosis of the duodenum or more frequently the ileum, the gut perhaps being narrowed or even reduced to a mere band of fibroid tissue which runs along the free edge of the mesentery for perhaps several inches, and opens out again into normal bowel lower down; this cicatrization of a portion of bowel has been produced by a foetal peritonitis which may have been local or general. In a few cases a twist in the lower end of the ileum has been found. In rare instances, a new growth, or hernia or a knuckle of bowel, has been found tied up by some band or persistent omphalo-mesenteric duct.

Obstruction of the bowels in infants a few weeks or months old may be due to a congenital lesion which has caused a partial obstruction and which is rendered complete by the impaction of hard curdy fœculent matters.

In all cases of vomiting with signs of obstruction of the bowels, a careful examination of the anus and rectum should be made.

**Imperforate Anus.**—The lower segment of the large intestine, including the sigmoid flexure and rectum, is very liable to important malformations.

In the first place there may be mere malposition, the sigmoid flexure descending on the right side or in the middle line instead of on the left; this would not necessarily give rise to any inconvenience during health, and would be mainly of importance should there be any disease of the bowel in later life.

The more immediately important conditions are the various forms of obstruction of the lower bowel from want of development of some part of it, or the presence of abnormal openings from imperfect differentiation of the digestive and genito-urinary segments of the cloaca.

Several varieties of malformation are found. There may be a well-formed anus, but communication between this and the rectum may be cut off by the presence merely of a membrane which has persisted from the time when the epiblastic involution dipped in to meet the intestine. (*Imperforate rectum.*) Sometimes the rectum itself is deficient altogether or for a varying distance, the anus also being undeveloped. In other instances the rectum is well formed but the anus is absent. (*Imperforate anus.*) In these varieties there is no external opening at all and the meconium is retained. Sometimes the anus is undeveloped, and the rectum, instead of ending blindly, opens into the anterior or genito-urinary segment, *i.e.* into the urethra or bladder, or much more commonly in the female, into the vestibule; <sup>1</sup> this last is the most common variety of abnormal orifice in those children that survive infancy.

Occasionally a 'tablike fold of skin' passing from the scrotum to the coccyx obstructs but does not close the anus (Cripps). Rarely there is an unnatural anus in the groin or in communication with the bladder, or, as in a case of Erichsen's, a fistula below the umbilicus; scrotal, penile and perineal fistulae have also been met with as well as congenital stricture of the rectum which was not actually imperforate. (*Vide Prolapsus recti.*) As a less important condition mere tightness of the anus may also occur.

When the anus is present, but there is no communication with the bowel, the malformation is often overlooked at first, and it is thought that the infant is simply constipated; in such cases purgatives are often given and the child's distress much increased. Constant crying, distention of the abdomen with visible intestinal coils and subsequently vomiting and collapse come on, and unless an examination with the finger is made and the obstruction discovered the child dies exhausted. On examination it will be found that the finger can only be passed a very short distance; if the rectum is developed and there is only a membranous septum, the bulging of the gut as the child strains will be plainly felt, but should the bowel end higher up this sensation may not be distinguishable.

Where the anus is absent and the rectum ends just above it, as according to Cripps it usually does, the bulging will often be readily made out,<sup>2</sup> but if the rectum ends higher up there may be no impulse; in such cases the perineum is narrow and the pelvic outlet smaller than it should be.<sup>3</sup>

When the rectum ends in the urethra there is passage of fluid faeces and flatus by the urethra, together with absence of the natural orifice. Subsequently, if the child survives, there is much trouble from obstruction of the urethra by

<sup>1</sup> Not into the vagina, as is commonly stated; the vaginal orifice in these cases is nearly always in our experience seen in front of the rectal outlet. We have only once met with a case of the rectum opening into the vagina itself; this was in a child kindly sent us by Dr. Cullingworth, who thinks it not an uncommon condition. Bodenhamer, out of 287 cases, found 85 opening into the vulva or urinary tract, while in 53 there was no anus and the rectum ended blindly; these are the two most common types.

<sup>2</sup> When there is no anus the rectum is generally nearer the surface than where an anus is developed but the rectum ends blindly.

<sup>3</sup> Where the rectum ends high up in the pelvis a fibrous cord may be prolonged downwards in the position of the natural bowel; this cord was thought by Mr. Curling to represent the rectum obliterated by intra-uterine ulceration; its presence, however, is not constant.—*Vide Parker, Path. Soc. Trans.*, 1884.

faecal matter and from irritation set up by the decomposed urine. Kelsey<sup>1</sup> points out that if the opening is into the bladder the meconium is mixed with the urine, while if it is urethral the bowel contents may escape independently of the urine. When the rectal outlet is within the vestibule the bowels may be sufficiently relieved for the deformity to escape notice and there may be no impairment of health; indeed the presence of such malformation may remain unknown until adult life. In many cases, however, though the opening is sufficient for the escape of the fluid or soft faeces of childhood, it is not large enough to allow the passage of solid motions and obstruction arises later on. There is no incontinence of faeces in these patients, the internal sphincter preventing involuntary escape.

As in so many other congenital malformations, a large number of children the subject of these deformities do not survive birth. Where, however, a living child is found to have no outlet at all for its intestinal contents immediate treatment is of course necessary, although it is said that patients have grown up and relieved the bowels by periodical vomiting of faeces. As soon then as the deformity is recognised a decision must be come to as to what is the best mode of relief.

*Treatment.*—Where a thin septum alone closes the gut a single crucial incision, using a speculum if necessary, and subsequent dilatation with a bougie or the finger, is all that is required. The child, if it survives, may in no way suffer afterwards, though we have seen a case of a girl of 10 or 12 years old who had been operated on in infancy and had not got perfect control over the bowels.<sup>2</sup>

Where the separation between the rectum and the surface is greater, bulging of the distended gut should be carefully felt for and an incision made just in front of the coccyx and carried down to the bowel, which should then be freely opened and brought down and stitched to the skin.<sup>3</sup>

If no bulging can be felt an attempt to reach the bowel should still be made by a similar incision and the dissection should be carefully carried upwards, keeping well back in the hollow of the sacrum and feeling from time to time for the bowel. As it is most important that the child should strain, chloroform should only be given during the first steps of the operation, and fortunately this is the most painful part of it.<sup>4</sup> If the gut is found, it should be treated as in the other cases, or if it cannot be readily brought down, it must be left but kept patent in a similar way, or a tube may be kept in through which faeces can pass. Amussat and Verneuil resected the coccyx and lower part of the sacrum in order to bring the gut to the surface.

Should it be impossible to reach the bowel from below by dissection,<sup>5</sup> in no case must any blind puncturing with a trocar in hopes of finding the gut

<sup>1</sup> *Archives of Pediatrics.*

<sup>2</sup> Holmes thinks the sphincter power is not lost, and Cripps records eleven cases of practically perfect results.

<sup>3</sup> Cripps and Thom of Toledo (America) disapprove of stitching the rectum to the skin; it is certainly useless if there is much tension, if not we prefer to do so.

<sup>4</sup> With a similar object it has been advised to delay operation until the bowels are distended. This we cannot endorse.

<sup>5</sup> Curling considers  $1\frac{1}{2}$  inch should be the limit to the depth of dissection—the rectum is usually within this distance.

be employed; by such means there is much more likelihood of puncturing the peritoneum, especially as it usually descends lower than in normal anatomy. Either Littre's operation of opening the bowel in the groin or Amussat's (Callisen's) lumbar operation must be performed. As there is some uncertainty in all these cases as to the course of the bowel, and as in a certain proportion the colon lies in the middle line or to the right side, it is wiser on the whole to do Littre's operation;<sup>1</sup> the anus is much more conveniently placed for self-management in after life, and there is little choice in the matter of danger between the two; Littre's operation then should be selected. The operation consists in making a vertical<sup>2</sup> or oblique incision about 2 in. in length in the left groin above and a little external to the middle of Poupart's ligament; the abdominal wall having been cut through and the peritoneum opened, the distended bowel will present at the opening and should be picked up with forceps, transfixed and treated as in the ordinary colotomy operation.<sup>3</sup> If the child can bear the delay in opening the bowel the operation should be done in two stages as in gastrostomy; to avoid leakage Cripps suggests the use of a coarse thread in stitching the gut to the edge of the wound; the use of a round sewing needle answers better.

Edmund Owen has six times performed Littre's operation, twice successfully; three of his cases died from the operation being too late, peritonitis existing at the time. In the only instance in which we have done inguinal colotomy the result was perfectly satisfactory, the child got quite well, but died some months after of bronchitis. It has been suggested that after opening the sigmoid flexure in the groin, a probe should be passed downwards and an anus made in the natural position with the guidance of the probe. Owen's two successful cases of Littre's operation died after the performance of this second operation, but Byrd and Kronlein have been successful.<sup>4</sup>

Curling's statistics and opinion are much in favour of the inguinal operation, Cripps' figures are inconclusive.<sup>5</sup> Huguier's operation of opening the gut in the right groin on the ground of the more frequent position of the colon on the right side than the left is not supported by Giraldès' statistics, quoted by Holmes, where in 431 autopsies the colon was in its normal position in 396 instances; in eighty of these Littre's operation had been performed, and in every case the sigmoid flexure was on the left side. Atkin of Sheffield records a case in which the small intestine was opened by the inguinal operation, the whole colon being rudimentary ('Lancet,' January 31, 1884); and our colleague, Mr. Whitehead, tells us he operated in the left loin on one occasion and found at the post-mortem that the cæcum had been opened.<sup>6</sup>

Cripps' table gives the following results:—

Of 16 cases of inguinal colotomy 11 died  
 " 3 " lumbar " 2 "

<sup>1</sup> The danger of opening the peritoneum is not so unequal in the two plans as might be thought, since there is often a mesentery in these cases.

<sup>2</sup> A vertical incision is probably the best, since, if the sigmoid flexure does cross to the right, a slight upward prolongation of the incision will enable the surgeon to reach it.

<sup>3</sup> For a description of the operation we must refer to the general text books.

<sup>4</sup> Vide Kelsey, *Arch. of Pediatrics*, February, 1885; also Goëde vide Cripps.

<sup>5</sup> Vide also Erckelen, *Arch. f. Klin. Chir.*, Langenbeck, 1879.

<sup>6</sup> Pillore advised opening the cæcum.

Of 17 cases of puncture . . . . .	14 die
" 8 " resection of the coccyx . . . . .	5 "
" 39 " perineal incision . . . . .	14 "
" 14 " operation for vaginal (i.e. vulvar) anus . . . . .	1 "
" 3 miscellaneous cases . . . . .	3 "

Bodenhamer records eight recoveries out of twenty-five Littre's operations. The deaths are mainly due to peritonitis, or failure of relief.

Where there is a fistulous opening between the rectum and the bladder or urethra, Littre's operation should be performed, unless the gut can be reached from the perineum, when possibly the communication with the urinary tract may close spontaneously. When the unnatural anus opens in the vulva, in the cases we have seen it has usually been by an orifice in the side of the distended rectum and not by a terminal opening, that is, the rectum has been pouched and projecting below the vulvar aperture. In such conditions a bent probe should be passed through the orifice into the gut and made to press against the perineum just in front of the coccyx. An incision is then made upon the probe, the rectum freely opened and treated in the usual way. Great care must be taken to keep the new aperture patent, otherwise it is prone to contract and the fæces continue to pass both ways. In some cases it is said that the vulvar orifice will contract and close of itself (Holmes). In our own cases we have not found this to occur, and in one of them we pared the edges of the vestibular opening and sutured them; no union however resulted, and we afterwards laid open the perineum, dissected away the gut from the vestibular wall, stitched it carefully to the skin and then sewed up the perineum, with a successful result; the patient was about six years old. In another instance we performed the same operation in a child of nine months, but it died some weeks later of inanition. Dieffenbach appears to have been the first to adopt this plan, which, however, is often called Rizzoli's operation. It is, we think, well to wait until the child is two or three years old before doing the second operation.

One of the difficulties we have met with in these cases is that of keeping the bowels regular even when there is quite a free opening; this we believe to be due to imperfect muscular development of the rectum. Enemata, castor oil emulsion, and occasional more active purges are required under these circumstances. Sometimes when the case is one of vulvar anus a collection of hard fæces is found in the intestine above at the time of operation; this requires removal as the child is often unable to void it even when a good-sized aperture has been made.

**Deformities of the Umbilicus.**—In some cases of extroversion of the bladder there is no trace of an umbilicus to be seen in after life, the scar being lost in the malformed abdominal wall. In other cases the umbilicus is abnormally large—that is, a considerable part of the abdominal wall is formed by the structures of the cord, and sloughs away when the cord shrivels up so that an actual deficiency of the abdominal wall results. In two cases of this condition we have seen that were operated upon, one by Mr. Howse and one by ourselves, a portion of the liver protruded through the opening and was covered only by the sloughing tissue. In our own case we dissected away the dead part and closed the abdominal opening by sutures,

but without success ; in a third case, under our care, the part was simply protected from irritation and left, but this child also soon died.<sup>1</sup> The frequent presence of the liver in the hernia has given rise to the name of Hepatomphalos, but the stomach and other viscera are often included in the protrusion.

At the third month of intra-uterine life there is still a coil of intestine lying in the umbilical cord outside the abdominal cavity ; should this condition persist a true congenital umbilical hernia is found. The importance of this fact is that in ligaturing the cord the gut might be included in the ligature and strangulated, a mishap that has actually occurred. In slighter cases there is only a small protrusion standing out from the abdominal wall much like the end of a glove finger, the bowel is reducible and the treatment is that of an ordinary umbilical hernia. In other instances, owing to persistence of the vitello-intestinal duct, Meckel's diverticulum remains open, and passing up to the umbilicus may open there, giving rise to fæcal fistula, as in a case of our own where a ligature round the protrusion, followed by the application of strapping to draw together the sides of the orifice, procured closure of the fistula. Edmund Owen advises emptying the bowel by free purging and subsequent administration of opium, thus giving time for the fistula to close ; he applies a dry pad over the fistula and leaves it undisturbed. Success has followed this treatment, but it appears to be applicable to older children rather than to infants. *For patent urachus, &c.*, vide *Surgery of the urinary organs*.

Congenital hiatus of the abdominal wall may occur in other parts besides the umbilicus from simple failure of closure of the ventral laminae. Of this extroversion of the bladder is an instance. In some cases the recti fail to meet one another in the middle line and ventral hernia may result with great weakness of the abdominal wall.

Well-arranged pads applied by means of a belt must be employed to prevent protrusion, or possibly in some cases it might be justifiable to cut down upon and stitch together the margins of the aperture, an operation probably not of a very serious nature and not of course necessitating any injury to the peritoneum.

**Umbilical Hernia.**—Umbilical hernia then in children may be congenital or acquired ; in the congenital form it is due to persistence of the fœtal condition where a coil of bowel lies outside the abdomen ; in other cases as already pointed out, it is the result of failure of closure of the ventral laminae.

The acquired form usually appears within the first few months of life ; in this case the rupture protrudes not through the centre of the scar which is occupied by the fibrous remains of the vessels, but usually above it or even through an independent opening in the linea alba. Astley, however, believes that the protrusion is generally through the ring. Both forms of hernia are readily reducible and usually consist of small intestine ; the amount of protrusion varies from a mere convexity of the navel to a prominent glove-finger-like outgrowth.

<sup>1</sup> Underwood records a case of recovery in which the treatment consisted in poulticing, and Tanner and others have had successful cases. In a case of Brodie's, *Path. Soc. Trans.*, vol. xv., besides the hepatomphalos, there was diaphragmatic hernia with deficiency of the pericardium, and a coil of bowel lay in contact with the heart.

The treatment consists in applying a flat pad of wood or poroplastic felt about the size of a penny and two or three times as thick ; this pad should be covered with flannel and fixed over the umbilicus by a broad band of strapping encircling the body or by a soft webbing belt ; we prefer the former as more efficient and less likely to slip, though it is not so comfortable as the belt. If the pad is worn constantly for from one to three months according to the age of the child, the hernia is usually 'radically cured.' In cases which obstinately resist treatment the orifice might be cut down upon and sutured,<sup>1</sup> but it is clear that most cases of umbilical hernia in children are cured, since the condition is hardly ever seen in young adults.

**Inguinal Hernia.**—Inguinal hernia is met with in childhood in the following varieties.

1. The funicular process of peritoneum remains widely open and in free communication with the cavity both of the peritoneum and tunica vaginalis ; a hernia descending into this cavity is a true *congenital* hernia, or hernia of the tunica vaginalis (Teale).

2. The tunica vaginalis may be shut off from the funicular process at the upper part of the testicle ; a hernia coming down into the patent process is called a *funicular* hernia, or hernia into the funicular process.

3. When the same condition as in (2) exists but the hernia instead of descending along the canal of the funicular process pushes down a separate pouch of peritoneum behind the process, the hernia is called *infantile* or *encysted*. The same name is given to cases where the funicular process is obliterated at the internal ring or just above the testicle, and the septum is pushed down and invaginated into the lower part of the process. In the former case in cutting down upon the bowel from the front three layers of peritoneum, viz. two funicular and one sac proper, will be found in front of the gut ; in the second case two layers will overlie the bowel.

4. An ordinary acquired hernia may be met with. Hernia may of course be complete or incomplete—that is, it may descend into the scrotum or only distend the canal or bulge at the internal ring.

The first and second forms are much the commonest, and it is usually impossible to be certain which is present unless the parts are exposed by operation. Where the testicle is completely wrapped round by the hernia it is probably *congenital*, where the testicle remains a distinct boss upon the surface of the hernia it may be *funicular*, though it is not by any means always so. We believe the funicular variety is the more frequent. Infantile or encysted hernia can only be recognised by operation, but it may be suspected if after reduction of a hernia an unusual amount of thickening along the cord remains, or if there is a hydrocele of the cord in conjunction with a reducible hernia. Fortunately an exact diagnosis of these conditions from one another is not of much importance.

Hernia may develop at any age ; it is sometimes noticed immediately after birth, in other instances it comes down later when from failure of health or bronchitis or whooping cough the muscular walls of the abdomen become relaxed and are in addition overstrained by coughing, violent crying, straining

<sup>1</sup> A case of irreducible umbilical hernia containing omentum was successfully operated on by Roocroft in a girl of fourteen years.—*Lancet*, August 2, 1884.

in defæcation, micturition, &c. So common is it for straining in micturition to bring down a hernia, that it is quite certain that phimosis is a most fertile cause of rupture. The presence of a calculus or worms acts in the same way. Hernia very commonly accompanies ectopia vesicæ.

As is well known inguinal hernia is sometimes met with in female children, though not nearly so commonly as in boys.<sup>1</sup>

Most commonly an inguinal rupture in a child contains small intestine with or without omentum, perhaps most commonly without. Other parts of the intestinal canal are, however, not rarely found. We have several times during operation found the cæcum and vermiform appendix in a hernia, and not very rarely the appendix can be very distinctly felt through the coverings without an operation. The ovaries in girls and the bladder in either sex are sometimes protruded.

Generally a rupture is easily reducible, but often it is necessary to make the child lie down before it readily goes back, it then often does so spontaneously. Violent crying will sometimes make it quite impossible to safely reduce a hernia and the child must be quieted or anæsthetised before reduction.

It must be remembered that, though as a rule herniæ are opaque, a tightly distended rupture consisting only of bowel, and that full of flatus, in a thin-skinned child will be distinctly translucent; this fact was, we believe, first pointed out by Mr. Howse, and we have several times seen it.

Various abnormal conditions may complicate hernia; thus the testis may be entirely retained or imperfectly descended on the same side. A vaginal hydrocele or hydrocele of the cord may coexist with a hernia, or fluid as in a congenital hydrocele may distend the sac of a congenital hernia. The rupture of course may be single or double, and sometimes of a different species on the two sides. We have seen a 'funicular' and a 'congenital' hernia on opposite sides in the same child. Children the subject of hernia are undoubtedly often affected with intestinal disturbance which appears to be sometimes at least due to the hernia.

Ruptures in children are occasionally irreducible; when this is due simply to straining, as already pointed out, the difficulty is easily got over, in other cases the hernia may be obstructed by its contents as in adults; again, adhesions to the sac or to the testicle or matting together of bowel to bowel or bowel to omentum may prevent reduction. In one of our cases a large hernia was made irreducible by the presence of tuberculous mesenteric glands which had evidently enlarged after their descent, and it was only after removal of some of these and enlargement of the rings that the rupture could be reduced; the child recovered, but evidence of tuberculosis of course remained.

It is somewhat rare for a hernia to become strangulated in childhood. We have however met with several such cases; they differ in no respect from the similar condition in the adult, but considering the extreme tenderness of the tissues in children immediate operation is the wisest course in preference to

<sup>1</sup> Of 112 unselected cases of hernia seen in our out-patient department, there were

In males	.	57	right inguinal,	12	left inguinal,	16	double,	and	9	umbilical.
In females	.	4	"	"	5	"	"	no	"	9 (? 10) "

treatment by ice, &c. Elevation of the pelvis and abdomen, as well as direct taxis, should of course be first tried but very gently ; we have known a child die of the injury done to a coil of intestine which was reduced before the child was seen by us and could only have been strangulated for a few hours. The youngest cases with which we are acquainted were one of three weeks by Halsewood ('Lancet,' Dec. 1884) and one of four weeks by Maunder. The sac always requires opening, since the neck itself forms the constricting part.<sup>1</sup>

The *treatment* of hernia in children resolves itself into three questions—first, the removal of all causes tending to produce rupture, such as cough phimosi, &c. ; secondly, treatment by apparatus ; and lastly operations.

Ruptures in children sometimes get well of themselves without treatment or simply by keeping the child lying down and avoiding disturbance of its temper and bowels. In other instances circumcision will prevent further descent of a hernia by removing the source of straining.

Failing these means, the wisest plan is at once to provide a well-fitting truss, which should be seen to by the surgeon himself and not trusted to an instrument maker. The truss must be worn night and day without any intermission, never being removed on any account for washing or any other purpose except to put another on ; this is necessary, because the truss is in children used to cure rupture and not merely to palliate it as in adults. When it is absolutely necessary to change a truss, the new one must be got ready, the finger slipped beneath the old one to keep pressure upon the canal and then the truss changed, the child being kept on its back and soothed to prevent crying. During the treatment the skin must be carefully watched and kept dry and unirritated by the free use of boracic acid powder ; this can be dusted beneath the truss without removing it ; a little judicious packing with absorbent wool will serve to take pressure off any tender part. Almost any hernia during the first year of life that can be kept up without once coming down for three months will be permanently cured ; after the first year a longer time is required.

The ordinary trusses do very well if the parents can afford to frequently renew them, but they get stiff and hard and the springs soon rust and rot with the frequent soakage of urine, so that they have to be frequently changed, and a duplicate should always be at hand in case of sudden giving way. One descent of a hernia undoes all the preceding treatment ; this is the cardinal rule to impress upon the mother or nurse. The inflatable rubber trusses we have found useful and satisfactory when carefully managed, and they are not affected by urine nearly so rapidly as the common truss, but they require careful inspection from the first, as they are often imperfectly made and flaws or tears are soon fatal to them. The hard rubber truss is sometimes spoken well of, we have not tried it. If from bad management a sore is produced by truss pressure, careful padding will often avoid the necessity of leaving off the truss, but with proper attention and care that the truss spring is not too strong it seldom occurs.

Hydrocele and orchitis we have more than once seen as the result of wearing a truss ; in such cases we may be sure that the spring is too strong and a different truss must be applied. The use of spica bandages, &c., is an

<sup>1</sup> Sometimes in an hour-glass sac the constriction may be in the scrotum.

inefficient substitute for a good truss. The pad of the truss should be flat and not convex, and peaked trusses are never required ; the object is to prevent the hernia from entering the canal, not to merely cover up the rupture.

When a fair trial has been given to trusses, different ones being, if necessary, employed, and all sources of irritation have been removed and still the rupture cannot be kept up, an operation for its permanent cure should be performed.

Of all the various plans the one we think simplest and best, and the only one we shall describe, consists in making a free incision over the canal and upper part of the scrotum, cutting down to the sac, reducing the hernia, closing the neck of the sac, and passing silver wire or catgut sutures through the walls of the canal and twisting them up. To do this the sac must be opened and the finger passed into the abdomen to make sure that the canal is clear and to guide the needle. The needle, which must be in a handle, is passed through one side of the canal, and guided by the finger is brought out at the ring ; it is threaded with wire and withdrawn, then unthreaded and passed through the other side, then threaded with the other end of the same wire and again withdrawn ; two or three sutures are passed in this way till it is felt that there are enough to close the canal, the wires are then twisted up, cut short, and their ends well turned down into the tissues. One edge of the sac close up to the wires is then picked up and threaded upon the needle, and successive portions of the surface of the sac are pinched up and transfixed (like threading them upon a skewer) until the other edge is reached ; the needle is then threaded with catgut and withdrawn, leaving the ligature, which when tied puckers up the sac into closely applied folds which soon adhere and the sac is thoroughly obliterated ; by this means all trouble and disturbance in separating the sac from the cord is avoided and the closure is quite firm and complete. Sometimes we ligature the sac before closing the canal ; this is not quite so easy, and it is not a matter of importance. The silver wires are left in permanently unless they set up irritation, when they are removed as soon as they are loose, but this seldom happens. The wound should be well drained, preferably by an opening at the back of the scrotum. There is usually a great deal of swelling after the operation, but this gradually subsides and should be looked upon as a good sign of firm consolidation. For the methods of managing complications<sup>1</sup> of the operation we must refer to the ordinary text-books, for undescended testis to the chapter on that subject. A light truss should be worn for some months after the operation till the parts have fully consolidated.

The operation is not free from risk and not always successful ; we have had one death from peritonitis coming on some time after the operation and have had to operate twice in two or three cases. In the fatal case the canal was perfectly closed and the peritoneal surface almost undimpled.

Femoral hernia in children is very rare, we have never seen a case ; one recorded by Sabourin in a premature female infant was readily cured by a truss. E. Owen saw one in a boy of ten years out of 748 cases of femoral hernia ('Lancet,' June 6, 1884).

<sup>1</sup> An omental sac may be met with. We have seen a very perfect instance. The management of such cases and of adhesions differs in no way in the child from that of similar conditions in the adult.

**Prolapsus Recti.**—Slight degrees of prolapse of the rectum are not rare in children and are often only transitory, occurring perhaps once or twice and not again; the more severe forms are much rarer.

Prolapse of the rectum consists in protrusion of more or less of the rectal wall through the anus. The slight and most common form is simply a pushing out of a ring of mucous membrane which is readily reducible and often only comes down when the child strains. In other cases the whole of the rectal coats from mucous membrane to peritoneum may be protruded.

The first variety of prolapse is usually about half an inch long and appears as a red mucous ring with radiating folds diverging from the central orifice; the mucous and cutaneous surfaces shade off into one another at the margin of the protrusion. The second form is larger, reaching from one to two inches in length and is often conical in shape, its base being at the anus; the folds are not radial but annular, running round the prolapsed part; the orifice is central, and on passing the finger into it, it is evident that the whole thickness of the bowel, and not merely mucous membrane, is involved in the prolapse. Sometimes this form of protrusion reaches much larger dimensions, even six inches in length, and in such cases necessarily a large pouch of peritoneum is carried down, and this is more extensive on the anterior than the posterior aspect of the bowel. In one case that we examined post-mortem there was a definite diverticular pouch with a sharp lunated edge projecting from the recto-vesical hollow down the anterior wall of the rectum; it seemed to us probable that the presence of a coil of bowel in this pouch would have much to do with keeping down the prolapse.<sup>1</sup> Not only small intestine but the ovaries even may be found in this peritoneal pouch, which then becomes the sac of a rectal hernia; the characteristic gurgling or the presence of a solid body felt on manipulating the wall of the protrusion may give a clue to the extent of the disease.<sup>2</sup> In this form of prolapse also the mucous and cutaneous surfaces shade off into one another, though the transverse folds of mucous membrane on the surface of the prolapse may somewhat obscure the line of junction.

A so-called third form of prolapsus recti, where the upper part of the rectum or the sigmoid flexure is invaginated into the bowel below and protrudes from the anus, is recognised by its size and by the presence of a sulcus between the prolapse and the anal margin. This condition, however, is more naturally considered as an intussusception than as a prolapse.

The mucous surface of the protruded gut may be nearly natural but more often is excoriated and coated over with a thick slimy mucus, it sometimes becomes congested and may even slough from irritation or constriction by the sphincter, though in most cases the anus is so lax and patulous that the existence of a sphincter at all is hardly felt by a finger passed within the opening. Bleeding to small amounts often occurs, and there is much mucous discharge.

<sup>1</sup> The specimen from this case is in the Owens College Museum; this definite pouching is, so far as we know, undescribed hitherto.

<sup>2</sup> This variety of prolapse is sometimes curved as a result of traction by the mesocolic fold of peritoneum or the attachment of the rectum to the vagina.—*Van Buren*.

Rectal hernia sometimes comes down behind the bowel or may even protrude through a gap in the muscular coats.—*Kelsey*.

The motions come away freely, but the irritation and discharge weaken the child and he loses flesh and health. In most cases the prolapse is reducible with more or less difficulty, but often it returns immediately pressure is taken off; in others it remains up until the child strains from any cause and then redescends; in others again the protrusion after a time becomes irreducible from matting together of the parts and from congestion.

Where a rectal hernia exists it is subject to all the conditions of an ordinary inguinal hernia, i.e. it may be reducible or strangulated, &c.<sup>1</sup> Occasionally the prolapse sloughs and fæcal fistula results, or the wall may burst in attempts at reduction.

The causes of prolapsus recti are many, though it is obvious that there must be some weakness of the sphincter and levator ani or relaxation of the rectal walls in these cases or prolapse would be much more frequent than it is. Any condition that produces violent and constant straining in a child predisposed to it may bring on prolapse. The child is generally miserable and weakly when seen, but this is no doubt partly the result of the irritation. Phimosis, contracted meatus urinarius, stone in the bladder, cystitis, constipation, diarrhœa, worms, polypus recti, violent coughing, all may cause prolapse. Boeckel believes stricture of the rectum to be a cause, and in one case we found a tight annular stricture of the rectum about one inch from the anus, this only admitted the tip of the index finger in a child of about three years old; the stricture apparently formed the apex of the prolapse and may possibly have been a result rather than a cause of the protrusion.

The *diagnosis* of prolapsus recti is easy where the protrusion is large, the only doubtful point is what extent of rectal wall is included in it. If small it can only be mistaken for piles or polypus; the former are exceedingly rare in children and never form a complete ring, the latter is of course a single isolated, usually pedunculated swelling; a mistake can only occur from lack of examination. Kelsey lays it down that any prolapse over  $2\frac{1}{2}$  inches in length contains peritoneum, while the presence of a sulcus serves to distinguish between the second form and the rectal intussusception. The direction of the folds and the size distinguish between the first and second varieties.

The *treatment* of prolapse consists first in removing the cause of straining, next the child should be kept rigidly lying down in bed; the protrusion must be reduced each time it comes down, and if it constantly recurs an attempt should be made to keep it up by a pad and T-bandage, or by strapping the buttocks together with a broad piece of plaster. The bowels should be kept easily open so as to avoid straining, and it is sometimes useful to support the sides of the anus during defæcation by pressure or by drawing the skin tightly to one side; as advised by Van Buren, the motions should be passed into a napkin without the child being allowed to sit up.

- Enemata of cold water or astringents, tannin, quassia (2-4 oz. of the infusion), oak bark, sulphate of iron, &c., will do good in many cases, and it is only the more severe forms that are not cured by bed and the means above described; indeed, simple confinement to bed cures the majority of these children. Should the prolapse be irreducible an anæsthetic should

<sup>1</sup> Vide Kelsey, in an elaborate paper in *Archives of Pædiatrics*, 1885.

be given ; if this fails and there are no urgent symptoms a warm fomentation and putting the child, if old enough, upon his hands and knees with the pelvis raised, will sometimes succeed.

If sloughing occurs the prolapse must be protected from irritation, and dusted over with boracic or salicylic acid and kept clean. The sloughing will very likely cure the prolapse, but it may be at the expense of causing a stricture, and this if it is at the apex of a long prolapse will be high up in the rectum when the protrusion is reduced.

Failing milder measures, the actual cautery should be employed, four or five narrow lines being drawn in the long axis of the gut from skin margin to near the apex.

Paquelin's cautery is the most useful instrument and is better than nitric acid or nitrate of silver.<sup>1</sup> After the application the bowel should be reduced and a pad applied. Another useful plan is to excise wedge-shaped strips from the margins of the anus including a little of the mucous membrane, the base of the wedge being at the anus ; the edges of the wounds are then brought together and the resulting contraction supports the bowel. We have found this successful in a very severe case. In severe and irreducible cases the prolapse has been clamped and removed, but this should only be done as a last resort and with the full knowledge that in a large prolapse the peritoneum will probably be opened and the utmost care must be taken to reduce any rectal hernia that may exist. If the peritoneum is wounded it must be carefully closed with catgut sutures. This operation can hardly ever be justifiable and is not to be confounded with the method of treating prolapse by removal of strips of mucous membrane in the long axis of the gut by means of the clamp, a method sometimes employed.<sup>2</sup>

The bowels should be open two days after operation, as delay makes the first action very painful.

**Fistula in Ano** is an uncommon condition in children, though we have several times met with it. As in adults it is apt to be associated with tuberculosis. As pointed out by Mr. Holmes most of the fistulae are blind external ones, this is also our experience.<sup>3</sup> There is nothing peculiar in either the pathology or treatment, which is the same in children as in adults.

**Piles** in children are usually described as unknown, or almost so, and their occurrence is no doubt very rare ; we have, however, seen two cases of external piles ;<sup>4</sup> in another instance a child was brought to us for bleeding from the bowel, and on examination a condition indistinguishable from that of well-developed intero-external piles was found ; this had been giving trouble since the child was about one-and-half years old, but the affection

<sup>1</sup> Only the mucous membrane of the prolapse should be burnt through, while at the skin margin the cautery should lay bare the sphincter ; sufficient irritation must be produced to procure adhesions between the mucous and muscular coats. Bryant advises the application of nitrate of silver over the whole surface.

<sup>2</sup> Dr. Cullingworth related at the Pathological Society of Manchester, December, 1887, a successful case of complete excision of a large prolapse in a young lady in which the peritoneum was opened.

<sup>3</sup> We have only once met with a complete fistula.

<sup>4</sup> Ogston, jun., has recorded a case in a child three days old.

was probably congenital ; light was thrown upon the case by the presence of a large partially degenerated nævus on the buttock quite distinct and at a distance from the anus, and probably the case was really one of nævus of the anus. The disease was readily cured by applying ligatures just as for piles. There was no nævoid tissue higher up, though this is occasionally met with.<sup>1</sup> Ligature or the actual cautery is the best treatment.

Condylomata frequently occur in children about the anus or its neighbourhood as flat, sessile, pink or pinkish-white elevations, or sometimes as large irregular masses. They are usually a manifestation of congenital syphilis, but sometimes we believe simply the result of dirt and irritation. When syphilitic the local treatment is, of course, subordinate to the general measures, but dusting over with calomel or the application of black wash usually speedily cures them. Sometimes, especially if non-syphilitic, they are more obstinate and may require to be scraped away or treated with the actual cautery, nitrate of silver or chromic acid.

**Polypus of the Rectum** is one of the diseases which though not absolutely peculiar to children is by far most commonly found in them. Most cases of rectal bleeding in children, apart from that due to mere tenesmus and diarrhœa, are due to polypus, hence careful search should be made for a tumour in all cases where unaltered blood escapes from the bowel.

Rectal polypi are usually pedunculated rounded bodies about the size of a hazel nut; they are composed of myxo-fibromatous or soft fibro-cellular tissue, or in some cases are adenomata ; in the former form the surface is smooth, though sometimes superficially ulcerated or excoriated, and the pedicle is often long and thin, though the growth in its early stages may be sessile. Adenomata are granular or warty in appearance. The anterior wall of the rectum about an inch from the anus is the usual seat of these growths, sometimes however they are attached higher up in the bowel and may be even beyond reach of the finger.

Polypi besides the loss of blood give rise to irritation and tenesmus together with a mucous discharge from the gut and frequently to prolapse. The growth itself is often protruded from the anus during straining and is sometimes mistaken for prolapse or piles ; examination, however, readily enables a diagnosis to be made, as the polypus is quite separate from the general mucous surface. The pedunculated form is best treated by simple twisting off, or a ligature may be applied to the pedicle, which is then snipped through with scissors ; to do this conveniently the child should be anæsthetised and the rectum well dilated and a speculum used ; often during an examination the pedicle is torn through and the polypus comes away without further trouble and occasionally the mass is detached during defæcation and passed with the motion. The sessile form may be ligatured or snipped off and its base cauterised. Recurrence of the growth is improbable.

We have met with rectal polypus in two members of one family, and Cripps relates similar cases.

Occasionally the whole mucous surface of the lower bowel is the seat of warty adenomatous growths, as in a remarkable case recorded by our colleague Mr. Whitehead. Dermoid cysts have also been found.

<sup>1</sup> Howard Marsh and Barker have recorded instances : in one the patient, an adult, ultimately died of hæmorrhage.

Small superficial ulcers and fissures about the anus are common in dirty and in syphilitic children, but they are more common at a little distance from the orifice than actually at the anus. They give rise to pruritus, but seldom to the severe symptoms seen in adults, sometimes there is reflex irritation of the urinary organs, frequent micturition, &c. In the non-syphilitic cases cleanliness, the destruction of worms or other irritants and the application of nitrate of silver, is usually sufficient. Menthol has been recommended for the pruritus. Tuberculous ulcers may be met with.

Rectal ulcers are due to either follicular inflammation in which the rectum is involved in common with the rest of the lower gut or to rectal catarrh or the presence of a polypus. The symptoms are seldom marked and the condition is consequently not often seen; *vide* also Prolapse, and Dysentery.

Removal of irritation and improvement of the general condition of the intestinal mucous membrane is the only treatment required.

## CHAPTER IX.

DISEASES OF THE DIGESTIVE SYSTEM—(*continued*).

**Malformations and Deformities of the Digestive System. Hare-lip.**—The upper lip is developed from the fronto-nasal process and the maxillary processes which in the normal course of development fuse in

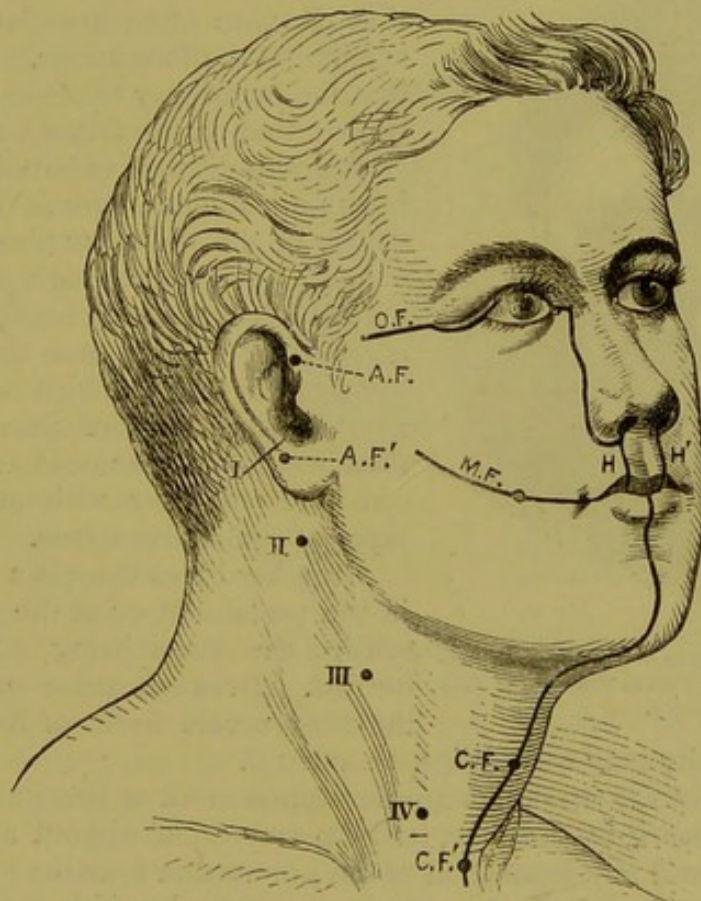


Fig. 11.—Shows the lines of union of the face, and indicates the origin of the chief malformations. AF, AF', situations of congenital auricular fistulæ. I., II., III., IV., indicate the external orifices of *branchial* fistulæ. I. is the external auditory meatus; OF, the orbital fissure; MF, the mandibular fissure; HH', the lines of lateral hare-lip; CF, CF', mark the situations of congenital *cervical* fistulæ. (From Bland Sutton, *Lancet*, Feb. 1, 1888.)

front of the mandibular fissure. Should this fusion fail to take place on either or both sides a single or double hare-lip respectively results. If the inward growth of the palatine processes which should take place to separate the nasal and buccal cavities fails, cleft palate occurs.

The præmaxillæ are formed from the globular processes forming the angles of the fronto-nasal process, hence, should the lateral process not fuse with the globular, a cleft between the præmaxilla and the maxilla will result on that side, while, if there is suppression of the two globular processes and septum median hare-lip follows ; this, though exceedingly rare in man, is met with more or less constantly in some mammals in which the globular processes fail to unite with one another.<sup>1</sup>

As to the actual causes of such arrest of development much controversy exists. It is commonly asserted that frights and shocks of various kinds, as well as strong *maternal impressions* of other sorts occurring about the time of the development of these parts, may determine the arrest of growth which results in such malformations. Although many instances have been brought forward to show a causal relation between the two facts, it is not clearly established that anything more than a coincidence really exists.

It is however certain that in many cases there is an *hereditary tendency* to such defects, and it is also certain that they are often associated with other congenital malformations. It is asserted that the hereditary tendency is commonly transmitted on the father's side.<sup>2</sup>

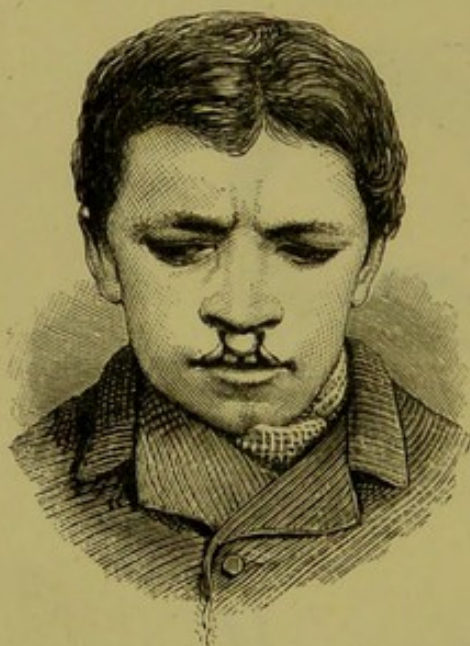


Fig. 12.—A simple case of Double incomplete Hare-lip. This is much rarer than the complete variety.

Various degrees of hare-lip are found ; in some instances there is merely a deficiency of the muscular fibres of the orbicularis, so that although the lip is not actually fissured there is a furrow from the absence of muscle and the consequent thinning of the lip which at the affected part consists only of skin and mucous membrane, often somewhat imperfect in structure, together with an intervening layer of connective tissue.

In other cases there is a shallow notch in the prolabium or at the anterior nasal orifice, the parts being otherwise well-formed. Between these conditions and the most severe forms of hare-lip all degrees of deformity may exist (Figs. 12 and 13).

As the superficial structures are developed more or less independently of the bony framework of the face, hare-lip may occur without any cleft of the palate, and without any separation of the præmaxilla from the maxilla. Most commonly, however, if the hare-lip is complete, i.e. if it extends into the nostril on one or both sides, there is also deformity of the bones, either non-union of the præmaxilla or single or double cleft palate. Thus there may be a mere notch in the line of the gum, a cleft through the alveolar margin on one side, a cleft running backwards on one side of the nasal septum through the hard and soft palates, or a double cleft isolating the præmaxilla

<sup>1</sup> Vide Bland Sutton, *Lancet*, February 18, 1888.

<sup>2</sup> Mr. Lucas believes that congenital absence of an upper lateral incisor is sometimes the forerunner of hare-lip and cleft palate.

from the maxillæ and leaving it protruding from the end of the nasal septum while the two halves of the hard and soft palate are completely separated and the nasal septum is seen in the middle line as a prominent ridge not attached to either side of the palate—complete or double cleft palate—the septum is often seen to taper off and end as a ridge upon the upper wall of the pharynx. It is usually said that cleft palate is always single, but the term may well be limited to those cases where the septum is attached to one palate process only. In other instances the failure of union may occur only in the soft palate, or more often in the soft with just the posterior edge of the hard palate, or in slighter degrees of the deformity still the uvula alone may be bifid. In some recorded cases the uvula has been absent (Mason).

Two other conditions associated with hare-lip and cleft palate respectively are of extreme importance as regards successful operation; the one is the flat, wide, distorted ala of the nose found in complete hare-lip; the other is the pitch of the palate arch, which may be either wide and flat or very high and narrow; the latter condition is said to be often associated with mental deficiency.

Sometimes the præmaxilla carries the four incisor teeth, and these are therefore implanted in the projecting mass in cases of complete double hare-lip. In some instances, however, one incisor tooth is attached to the maxilla, most commonly the outer tooth is suppressed altogether, its sac having apparently been lost in the cleft.



Fig. 13.—Severe Double Hare-lip. Showing the projecting præmaxilla.

*Rotation of Præmaxilla.*—Very frequently there is some rotation of the præmaxilla upon a vertical axis, especially in unilateral cleft; in such cases the teeth are also rotated and may be so directed that the outer border, or in some instances the cutting edge, looks directly forwards. This position of the teeth requires to be remedied after their complete eruption. As, however, hare-lip is now usually operated upon before the teeth are cut their exact position is in such cases of little importance at the time.

*Feeble Vitality.*—The deformity of simple hare-lip unaccompanied by malformation of the palate is important almost solely on account of the disfigurement, though it must be borne in mind that many of these children have other deformities or are weakly and, though without any actual malformation, do not seem to have sufficient vitality to make it possible to rear them.

When, however, the failure of union affects the palate as well as the lip other ill results follow; the child is unable to suck from inability to produce a vacuum in the mouth: its nasal passages and pharynx are exposed to the air and become affected with chronic catarrh, its tongue is dry and the air

entering its lungs is imperfectly warmed. Even when fed with a spoon the food often regurgitates through the nose. Hence to the already weakly condition of the child are added the dangers of insufficient nutrition and catarrh of the respiratory tract. It is not therefore to be wondered at that only a small proportion of children so affected survive; should they do so they are subject to the further drawback of imperfect and indistinct speech. It is alleged that many of these children die from starvation which might be prevented by operation; we do not think this is true, we believe they would die in any case from simple lack of vitality.

In those cases where the child is unable to suck it should be fed in an upright posture, when the milk is less likely to regurgitate through the nose, or one of the special obturator teats devised by Mr. Mason and others employed; probably the best of these is Oakley Coles' rubber teat.

The *treatment* of hare-lip is necessarily purely operative; several important questions have however to be considered in each individual case. First, it is clearly of no use to operate on an infant that is incapable of living from the presence of some other deformity incompatible with life, nor in cases where the general health of the child is feeble and it is losing weight, since union of the wound would not take place. No operation then should be done unless the child is in perfect health and the time of actually cutting a tooth should be avoided.

*Age for operation.*—Next comes the question of the best age for operation. On the one hand it must be borne in mind that there is a certain amount of risk attending the necessary loss of blood and the shock in a very young infant, and on the other hand that if the deformity is severe the effect of closing the cleft in the lip as regards moulding the subjacent parts into their natural shape will be greater the younger the child and the softer the tissues. As has been well shown by Dr. Rawdon of Liverpool and others, a most remarkable modelling process in the outline of the upper jaw takes place after closure of a hare-lip, and more than this, the width of the cleft in a divided palate is much reduced after a time by uniting the lip.

Increased facility in feeding and the removal of a hideous deformity are other reasons for early interference, while experience shows that early operation is not attended with a specially high rate of mortality.<sup>1</sup>

The common practice now is to operate at any time after the first three weeks of life in the less severe cases and a month or two later in the more serious deformities, double hare-lip being dealt with later still; operations are however often successfully done within the first few days of life. Our own preference is not to operate before a month in single hare-lip nor before six months in severe deformity.

*Operation.*—It is in our opinion much better in all cases to give chloroform for the operation. The coronary arteries should then be controlled by bulldog forceps or finger pressure, and the lip very freely detached from the maxilla, the dissection being carried far outwards along the jaw, upwards nearly to the lower margin of the orbit and inwards and upwards so as to freely detach the ala nasi from the subjacent bone.

<sup>1</sup> Many infants die shortly after the operation for hare-lip, but in most of these death is due to malnutrition, not to the operation.

The extent of the separation will of course depend upon the severity of the case, but as a rule failure is more often due to insufficient separation than to any other single cause.

The bleeding during this part of the operation is often free, but is easily controlled by pressure and stops immediately after the stitches are put in ; for this reason, we sometimes pare the edges of the cleft before freeing the lip, though if the paring is done last it is easier to adjust the edges exactly. It is very important to slice away the sides of the cleft freely, and not merely to scrape them or take away a thin shaving ; too little is much more often taken away than too much.

In adjusting the edges of the wound the chief points to attend to are that the prolabial margin on one side exactly corresponds with that on the other : secondly, that the highest suture is well within the nostril, so as to prevent a gap at the upper margin and to remedy the tendency to flattening of the nostril ; thirdly, to insert a suture on the inner and under (mucous) surface of the lip ; this more than anything else prevents the appearance of an unsightly notch at the lower end of the line of union. The main sutures should be made to include the whole thickness of the lip except the mucous membrane, the intermediate ones may be only superficial.

Silver wire sutures, usually about three in number, with intervening horse-hair stitches, will be found very successful, and are, we think, on the whole the best.

Hare-lip pins should be used where there is any degree of tension, but not otherwise. We sometimes put them in temporarily to keep the parts in apposition while the rest of the stitches are being inserted, and then remove them at the end of the operation. If the pins are left in it should be for not longer than forty-eight hours, the rest of the stitches may be taken out a day or so later according to the amount of irritation set up, and the condition of the child. Where the power of repair is feeble the sutures should be left in longer. Some surgeons prefer silk or gut sutures. The first stitch, if pins are not used, should be put in opposite the prolabial margin ; this answers the double purpose of controlling the coronary arteries and of fixing the level of adjustment of the two sides. If forceps have been used for controlling the bleeding they should be removed just before putting in the stitches.

Some surgeons apply a strip of strapping over the lip after the operation, or use a Hainsby's truss ; neither is necessary in most cases, and the former is objectionable in that it tends to collect blood and mucous discharge from the nostril and so to irritate the wound. It is, however, sometimes wise to put plaster on for forty-eight hours after removing the sutures until the union is quite firm, and it is a good plan to lay a narrow strip of lint over the line of union beneath the plaster.

If the child has not been weaned before the operation it should be allowed to suck as soon as it recovers from the chloroform ; in such case care must be taken to prevent injury to the mother's breast from the hare-lip pins or wire sutures. In most cases, however, the child has been bottle or spoon fed.

In any case the hands must be carefully secured by bandaging them to

the chest with a flannel bandage or by some similar means, and watch kept that no injury is done to the lip.

The principal *methods of operating* for single hare-lip are as follows; each case must be managed according to its special needs, no one method answering in all cases :—

1. The edges of the fissure are simply pared by a straight incision and brought together. This though answering well in some cases is apt to leave a notch at the prolabial margin unless there is abundance of material to work with. By making the line of incision slightly curved, with the concavity towards the cleft, the notching may often be avoided.

2. The single flap method shown in the fig. 14 is often useful.

3. Malgaigne's operation of turning down two opposed flaps may be employed, it is chiefly useful for cases where a notch remains after previous operation.

4. Perhaps the most generally applicable methods are those shown in fig. 14 (*c, d—e, f*)

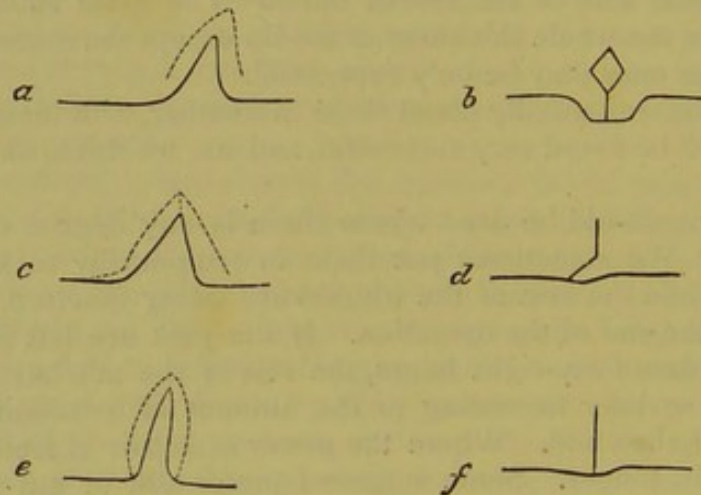


Fig. 14.—Diagrams slightly altered from Lane ('Operative Surgery') to show the modes of refreshing and uniting the edges in single hare-lip. In *a, b*, the angular incision allows two flaps to be turned downwards. In *c, d*, a single flap from the left side is fixed to the opposite side. In *e, f*, the edges are pared, making the lines of incision strongly *concave* inwards.

5. The more complicated operations of Giraldes and Collis are seldom employed, but it is occasionally very useful to carry the incision round the ala of the nose in severe cases; by this means the depth of the lip can be greatly increased; this plan was, we believe, first employed by Dr. Rawdon of Liverpool. Many other methods are described.

In double hare-lip two special difficulties have to be met, the management of the praelabium and of the præmaxilla. The praelabium may be

1. pared at its sides and free extremity so as to make a semicircular or tongue-shaped flap which is fitted between the upper parts of the two lateral flaps, these having been previously pared.

2. If long enough, the praelabium may be brought down to make the central part of the lip, being pared only at its sides, and the lateral flaps are then fitted to it instead of to each other.

3. The central flap may be removed altogether and the two sides brought together throughout their whole length.

4. The prælabium, having been dissected away from the præmaxilla, may be doubled upon its base and turned up to form a columna for the nose. The first and second of these plans are the most generally useful.

The præmaxilla in some cases may be pushed gradually backwards by constant pressure with a pad before the hare-lip is operated on, or it may be forcibly pushed back at once; this is open to the objection pointed out by F. Mason, that the wedging back of the præmaxilla may tend to keep open the cleft in the palate. Removal of a wedge-shaped piece from the septum nasi or of lateral pieces from the præmaxilla are plans sometimes adopted. The method we prefer where the præmaxilla cannot be covered is to shell out the bone, leaving the muco-periosteum to preserve the outline of the lip, and then bring the lip together; this, we think, is certainly better than entire removal of the præmaxilla,<sup>1</sup> which produces flattening of the lip. Where the præmaxilla is turned upon a vertical axis so that one edge looks forwards it may be forcibly rotated into position, but if the lip can be united over the projection the prominence will, as already pointed out, soon diminish.

Any notch left at the free margin of the lip or at the nostril can usually be closed by a subsequent operation. Should primary union fail throughout an attempt should be made at once to procure secondary adhesion by either putting in fresh sutures or, if the tissues are too soft and inflamed to hold them, by applying strapping to bring the sides together. If the child's health is good this will probably succeed; failure is, however, often due to malnutrition; in such cases union cannot be expected to occur and a second attempt should be put off until the health is improved. It is wiser not to operate too soon a second time; many cases that look unsatisfactory after operation improve much in time.

The particular mode of operating must be selected for each individual case, looking especially to the size of the central portion of the lip in double hare-lip and to the inequality of the two sides in the single deformity.

**Cleft Palate.**—The varieties of cleft palate have already been mentioned. The severer forms are commonly associated with double hare-lip—indeed it is said to be very rare for double hare-lip to occur without cleft palate, and no doubt this is true in the complete forms of hare-lip.

Here a brief account of the modes of treating the deformity can alone be given.

For choice the operation should be performed between the fifth and eighth years, but in the less severe cases it may be done as early as the third year; before this it is not wise to attempt it,<sup>2</sup> unless in exceptional circumstances. As in all plastic operations, care must be taken that the child is in good health. The other general rules to be observed are: the edges of the cleft must be freely pared, all tension must be carefully avoided, the muco-periosteum must be thoroughly loosened at the junction of the hard and soft palates in cases of cleft of the velum alone, no hard food must be given till union is complete, and if the operation is only partially successful or fails altogether, another attempt should be made at the end of three months.

<sup>1</sup> This method was introduced by Sir W. Fergusson.

<sup>2</sup> Mr. Clutton has operated successfully in two favourable cases of cleft of the soft palate at twelve months old.—*Lancet*, June 6, 1887.

*Staphyloraphy*, or the operation for closure of a cleft of the soft palate, consists in freely paring the edges of the cleft throughout, then a sufficient number of sutures are passed, and next the attachment of the soft palate to the hard is carefully loosened, and finally, the palate muscles having been divided to relieve tension, the sutures are tightened up. The exact mode of operating that we prefer is as follows. The child is anæsthetised, a pillow is placed beneath the shoulders, and the head allowed to fall right back so that the roof of the pharynx is almost horizontal; in this position light enters the mouth well, and the blood and saliva collect in a pool in the pharynx instead of irritating the larynx. A gag is then inserted, the whole of the cleft carefully pared, and then from four to seven wire sutures are put in in the following way:—a slightly curved needle in a handle is passed through the edge on one side into the cleft, it is then threaded with wire and withdrawn, the wire is disengaged, the needle passed similarly through the other side and threaded with the end already passed, this is then drawn through the second side by removing the needle, bringing the wire across the gap with the two ends projecting on the oral surface.<sup>1</sup> When all the sutures are passed an incision is made through the muco-periosteum of the hard palate down to the bone on each side of the front of the cleft and well away from it, the muco-periosteum is then carefully detached from the bone all round the anterior extremity of the cleft so that the soft parts are quite free and loose. Next holding all the sutures together in the left hand the palate knife is carried backwards and outwards from the incision already made until the levator and tensor palate are freely divided and the velum is quite lax.<sup>2</sup> A minute or two is then given up to firm pressure with a sponge upon the palate so that all bleeding may be stopped. Finally, the wires are twisted up in order from before backwards, the ends cut short, the cleft inspected to see that the lips are accurately adjusted and that there is no tension, and the gag is then removed.

Various modifications of the operation are of course well known and will be found described in the general text-books.

During the operation it is important to avoid the use of sponges as long as possible, since mopping out the pharynx much increases the amount of secretion poured out.

*The after treatment.*—The hands must be carefully secured to avoid injury to the palate, and no solid food should be given for a week. Many surgeons give nothing by mouth at all for forty-eight hours and feed the patient by enemata. Others allow milk from the first, and sops after two or three days; others again allow soft solids from the first; probably it is better to restrict the diet to milk for two or three days and then allow soup and sops till the end of the week; after this the ordinary diet may be gradually resumed, avoiding of course any hard or irritating material. The stitches we usually leave to take care of themselves, and nothing more is seen of them, the child probably spits them out. If, however, they are setting up irritation, or if after a few weeks they have not come away, they should be re-

<sup>1</sup> For knowledge of this most simple plan we are indebted to our colleague, Mr. Hardie.

<sup>2</sup> Sometimes it is well to divide the palato-glossus and pharyngeus by snipping through the pillars of the fauces.

moved. Any little granulating point or small perforation left at the anterior extremity of the cleft will usually heal up of itself; if it does not do so the application of nitrate of silver will sometimes succeed, or in other cases a second little operation may be required.

Only one mode of performing the operation of *Uranoplasty*, or closure of a cleft of the hard palate, will be described here; in our experience it is much more successful than the other plans, and if it fails there is less difficulty in a second operation than after the so-called osteoplastic method.

Operation by *muco-periosteal flaps* consists in paring the edges of the cleft throughout, then an incision is made midway between the alveolar margin of the palate and the cleft for its whole length down to the bone. The bridge of muco-periosteum between the incision and the cleft is then stripped off the bone with a blunt raspatory completely into the cleft throughout its whole length; this must be done most thoroughly so that there is no tension upon the flaps, which, however must not be bruised more than can possibly be helped. The sutures are then passed as in the operation upon the soft palate and twisted up.

In case of operation upon the soft palate alone we prefer the plan of paring the edges first, then passing the sutures, and then dividing the muscles before twisting the sutures; while in *uranoplasty* the edges are first pared, then the flaps raised, and lastly the sutures passed.

In quite young children it is an advantage, if there is a complete cleft of both hard and soft palates, to close the soft palate alone first and some months after to close the hard; the union of the velum tends to draw together the sides of the hard palate during growth and makes subsequent closure of the cleft more easy. Operation on a complete cleft of both hard and soft palates should be reserved for older children who can better bear the increased severity of the more extensive operation.

The *shape of the palate arch*, already alluded to, is of importance; the higher and narrower the arch the easier in most cases is the closure of the cleft, since there is proportionately more tissue to turn across the gap.

In some children the cleft is so wide, that is, the failure of growth of the palate processes is so marked, that it is impossible to close the opening by a plastic operation, in such cases an *obturator* should be fitted to the gap.

In some instances the deficiency may be lessened by operation, even though complete closure is impossible; a smaller obturator is then sufficient.

Obtulators are liable to increase the size of the opening by pressure unless carefully managed.<sup>1</sup>

The *results of the operation* are, in successful cases, that the power of swallowing is improved, the food no longer tending to pass into the nasal fossæ, and the tendency to pharyngeal catarrh is lessened. The voice is not improved by the operation itself, but closure of the cleft renders it possible by subsequent training to greatly improve speech; and if sufficient care is taken it may be rendered practically perfect; this no training can do while the cleft remains.

<sup>1</sup> Coles' modification of Suersen's is probably the best obturator.—Vide *Brit. Med. Jour.*, November 4, 1882.

Mr. Mason's plan of completely dividing the soft palate backwards is devised to remedy the rigidity of the velum, sometimes resulting after operation, which interferes with speech and deglutition.

A high-pitched roof to the mouth sometimes produces exactly the same effect upon speech as a cleft palate; this has been treated by Mr. Warrington Haward by loosening the muco-periosteum and excising a strip; the edges of the wound are then brought together so as to lower the pitch of the arch; much improvement followed in his case.<sup>1</sup>

**Other Malformations.**—The rarer forms of congenital malformation of the lips require little more than mention here.

**A median fissure** of the upper lip is of extreme rarity but does occur, it results from complete suppression of the lower part of the præfrontal process<sup>2</sup> (*vide* p. 125).

**Cleft of the lower lip** has occasionally been met with, as well as a peculiar mammillary projection on each side of the middle line.<sup>3</sup>

**Macrostoma**, or congenital enlargement of the mouth, is usually unilateral, occurs most commonly in females and is not hereditary; it may be associated with branchial fistulæ and supernumerary auricles together with hare-lip, as in a case of our own. In Guersant's case, figured by Mason in 'Surgery of the



Fig. 15.—Macrostoma on the left side with a faint scar-like mark leading up towards a depression at the base of a well-marked supernumerary auricle. (Mr. Southam's case.)

Face,' the deformity was bilateral and clearly due to failure of union of the superior maxillary with the fronto-nasal and external nasal processes, *i.e.* persistence of the lachrymal fissure.<sup>4</sup> In the more usual form it is a persistence merely of the great buccal aperture from incomplete fusion of the superior and inferior maxillary plates, *i.e.* of the maxillary process of the pterygo-palatine arch and the lower part of the mandibular arch from which Meckel's

<sup>1</sup> *Lancet*, January 15, 1887.

<sup>2</sup> For a discussion on this subject and information on median hare-lip in animals, see Mr. Bland Sutton's admirable lectures, *Lancet*, February 18, 1888.

<sup>3</sup> In one instance the cleft ran downwards from the angle of the mouth. Murray is quoted by Mason as having seen a case where congenital sacculi existed in the lower lip in four members of one family. A similar case is recorded by Sympton in the *Brit. Med. Jour.*, December 9, 1882.

<sup>4</sup> *Vide* also figs. in Förster's *Missbildung. des Mensch.*

cartilage and the lower jaw arise. The condition is easily remedied by paring and uniting the edges of the fissure to the required extent.

**Macrocheilia**, or enlargement of the lips, is occasionally met with as a congenital condition due to lymphatic overgrowth or enlarged mucous glands (cf. also *nævus*). When the deformity is sufficiently serious to require treatment a part of the lip may be removed either by taking out a wedge-shaped piece of the whole thickness of the lip or by splitting the lip and removing a part of its thickness and afterwards stitching together the skin and mucous membrane.

**Microstoma**, or congenitally small mouth, is occasionally seen and even complete closure—*atresia*. This is treated by enlarging the opening to the necessary extent, stitching together the mucous and cutaneous borders, and at the corners bringing a flap of mucous membrane across the angle to the skin.<sup>1</sup> Similar operations may be performed in cases of cicatricial contraction after ulceration, burns, &c.

In very rare cases the tongue is congenitally absent.

A common deformity, though not nearly so common as it is popularly supposed to be, is **tongue-tie** or congenital shortness of the *frænum*. Where this really exists the tip of the tongue is so tied down to the floor of the mouth and inner surface of the jaw that it cannot be protruded, and sucking is materially interfered with; slighter degrees of the deformity often exist, while in rare cases the tongue is so bound down to the floor of the mouth as to be practically immobile (*anchyloglossus*). Tongue-tie is easily recognised by pushing up the tip with the finger in the child's mouth; its treatment consists in snipping through the edge of the *frænum* with a pair of blunt-pointed scissors and then tearing the rest with the finger-nail while the tongue is pushed upwards. The division should be made near the jaw, and should not be too free or possibly the ranine vessels might be injured or even, it is said, 'tongue-swallowing' occur, from loosening of the tongue muscles in the child's subsequent efforts at sucking. A more probable danger is the occurrence of cellulitis.

Sometimes the tongue is malformed, cleft in the middle line or even trilobed,<sup>2</sup> or the muscles of one side may be deficient,<sup>3</sup> *e.g.* as sometimes in facial hemiatrophy.

**Sublingual cysts** may develop in the median line between the *genio-hyo-glossi* as a result of persistence of the lingual duct which runs from the *foramen cæcum* towards the isthmus of the thyroid; the cavity of these cysts is lined with epithelium and contains fatty material.<sup>4</sup>

**Macroglossia** is the term applied to a congenital affection of the tongue in which the normal lymph spaces are greatly enlarged and there is also an overgrowth of the connective tissue of the part; there is, in fact, congenital lymphangiectasis. The result of this is great enlargement of the tongue, which may be kept protruded from the mouth to varying degrees, and by its bulk and unwieldiness interferes with sucking and breathing. We have also met with slighter degrees of the same condition affecting only the sublingual

<sup>1</sup> Simple dilatation by plugs is advised by Holmes.

<sup>2</sup> Barling, *Brit. Med. Jour.*, December 5, 1885.

<sup>3</sup> Cholet in *Billard's Maladies de l'Enfance*.

<sup>4</sup> Bland Sutton, *Brit. Med. Jour.*, February 27, 1886.

tissue and resembling ranula. Associated commonly with macroglossia is hygroma or one form of 'hydrocele of the neck.' This is simply a similar condition of the lymphatics of the floor of the mouth and upper part of the neck. It appears as a soft, doughy swelling in the submaxillary region and may reach a large size, occupying the greater part of the sides and front of the neck (*vide* chapter on Tumour Growth).

In severe cases these conditions rarely admit of successful treatment, the children are generally marasmic and often otherwise malformed. Removal of part of the tongue with the *écraseur* or excision of a wedge from it with subsequent closure of the gap may be attempted. Galvano-puncture, electrolysis, setons and injections, are all worth thinking of, and pressure and astringents are said to have done good in some instances. It must be remembered that hygroma sometimes spontaneously disappears.

Slighter degrees of the deformity are occasionally met with in older patients; in them the condition has a less obvious connection with the lymphatics and appears to be sometimes mere overgrowth of the mucous and connective tissues.

**Ranula** is the result of occlusion of a mucous duct and the formation of a retention cyst, rarely it is due to obstruction of a sublingual salivary duct. It appears as a bluish-grey translucent swelling beneath the tongue, it is soft, fluctuant and painless, but produces deformity from pressure of the tongue upwards and the floor of the mouth downwards, and, if large, interferes with speech and deglutition. The swelling contains a clear glairy fluid like white of egg. Ranula may be treated by excision of a part of the cyst wall or by passage of a seton through it; both methods are frequently successful, but sometimes fail; if they do the greater part of the cyst wall should be clipped away with scissors and the surface remaining be well scraped or rubbed over with solid nitrate of silver. Relapse is believed to be sometimes due to the cyst being multilocular. Rarer forms of ranula are those due to enlargement of a bursa beneath the mucous membrane (bursa of Fleischmann), or of the one between the genio-hyo-glossi muscles—these may contain melon-seed bodies. Ranulæ connected with the submaxillary duct have often been described, but their existence is more than doubtful; the duct can always be made out lying on the surface of the cyst. Congenital dermoid cysts in connection with the branchial clefts are sometimes met with in the floor of the mouth, they may attain a large size or remain stationary for years, they contain the usual sebaceous matter, hair, &c.

A form of cyst arising in connection with the lingual duct which runs from the foramen cæcum towards the hyoid bone has already been mentioned.<sup>1</sup> The dermoid and bursal cysts are to be treated by free incision with scraping and subsequent drainage; in some cases the cyst requires dissecting out through an incision below the jaw.

**Other Affections of the Tongue.**—**Papilloma and condyloma of the tongue** are not rarely seen as well as nævi and mucous retention cysts. Papillomata may be snipped off, condylomata require of course specific treatment, mucous cysts should be treated like ranula.

Nævus of the tongue is not rare (*vide* chapter on Nævi); puncture with the actual cautery is usually the best treatment.

<sup>1</sup> It is due to persistence of the pharyngeal diverticulum from which the thyroid gland is developed.

Mason has described congenital pendulous fibro-cellular tumours of the tongue.

**Hypertrophy and Atrophy of the Face.**—In some cases one side of the face is congenitally hypertrophied and continues to grow more rapidly than the other side. Nothing can be done for this deformity, unless, perhaps, ligation of the external carotid was tried.

*Congenital atrophy*, or rather *arrest of development* of the face, is also occasionally seen, most often it is the result of either some cerebral deficiency or of some unilateral lesion, such, for instance, as torticollis; it may occur as an acquired deformity resulting from injury.

Congenital **atresia** of the mouth has been already mentioned, but in some cases the obstruction is not at the lips, but at the level of the pillars of the fauces and is clearly due to non-absorption of the septum marking off the buccal involution from the pharynx. If this rare condition is met with probably free incision and dilatation would relieve the obstruction.

Actual absence of the mouth with deficient development of the facial bones and instances of apertures below the natural position or on the cheek have been met with. (*Vide* Billard, *op. cit.*)

Ballard has recorded a case of deformity of the jaws produced by thumb-sucking, the upper jaw being drawn forwards and the lower depressed so that the face is 'overhung.'<sup>1</sup>

**Branchial Fistulæ.**—Small orifices large enough to permit the passage of a fine probe for distances varying from a quarter of an inch to two or three inches are sometimes met with in the neck on one side of the middle line. They may occur in the immediate neighbourhood of the external ear or lower down in the neck; the most common position is said to be just above the sterno-clavicular joint. The fine channel continuous with these openings usually runs upwards and towards the middle line. A little watery mucous discharge is often secreted from glands lining the interior of the passage, and it is said that occasionally there is a distinct communication with the pharynx. These fistulæ, which are often hereditary, may be single, or there may be two or three of them, and they may be symmetrical. Fragments of cartilage<sup>2</sup> may be found in their neighbourhood, and it is possible that pharyngeal diverticula may result from patency of the internal orifice (*vide* fig. 11).

The presence of these fistulæ is due to imperfect obliteration of the branchial clefts of embryonic life.

While the cervical branchial fistulæ are rare, it is quite common to see children in whom there is a small pendulous body, like a molluscous growth, upon the cheek just in front of the external ear. Sometimes there is more than one of these, and very often at the base of the little body is a minute orifice leading a short distance inwards. We have most often seen these '**supernumerary auricles**,' as they are called, unassociated with any other deformity; but in one instance the child, which had several of these auricles, had also macrostoma, double hare-lip, and cleft palate, and a small pendulous body exactly like one of the auricles upon the tip of the nose. Our friend

<sup>1</sup> *Path. Soc. Trans.*, vol. xv.

<sup>2</sup> Treves records a case in which a rod of cartilage existed but no fistula.—*Path. Soc.*, November 1, 1887.

Mr. Southam has recorded a somewhat similar case (fig. 15), and Mr. J. H. Morgan another.

The cervical branchial fistulæ represent the clefts between the hyoid and thyrohyoid arches, or between the thyrohyoid and subhyoid, or again, between the subhyoid arch and the upper boundary of the chest, while the presence of aural fistula occurring, as it sometimes does, in the helix or elsewhere, is due to persistence of one or more of the fissures between the 'tubercles' of which the pinna is built up,<sup>1</sup> the supernumerary auricles themselves representing displaced or ununited 'tubercles.'

The common 'supernumerary auricles, which may or may not have a little pit at their base,' are thought by Sir J. Paget to be 'probably growths of the same opercular skinfold as the auricle from which they look like bits detached, or they are auricles displaced but still in the line or region of the mandibular arch.'—Sir J. Paget, 'Med. Chir. Trans.' 1878.<sup>2</sup>

The auricles sometimes at least contain cartilage, and the association of enchondroma of the parotid occurring in later life with disturbance of the development of these parts has been pointed out by Mr. Jacobson.<sup>3</sup>

In very rare instances an orifice is met with in the median line of the neck. Of this we have seen two cases: in one there was a seam in the skin closely resembling the scar of a tracheotomy wound, and in the centre of this just above the sternum was a small opening; in the second case there was a discharging fistula over the lower part of the thyroid cartilage. These median apertures may be explained by failure of the branchial arches to close in the middle line; some have been thought to be due to abscesses or suppurating thyrohyoid bursæ; the first, however, is probably the true solution, as a lining of ciliated epithelium has been found in the canal.<sup>4</sup>

As these branchial fistulæ give rise to very little inconvenience it is usually best to leave them alone, especially as they are intractable to treatment from the difficulty of thoroughly destroying their secreting surface. The passage of a hot wire down them, or passing a probe in and then dissecting round it, or the use of the galvanic cautery, are the plans usually advised. In the second of our median fistulæ, in which there was a 'pinching' pain in the part, we with some trouble succeeded in obliterating it for a time by several applications of nitrate of silver fused upon a wire and passed well up the track; subsequently however, fresh secretion occurred, and even excision failed to entirely cure the condition.

Supernumerary auricles should be simply snipped off.

Instead of fistulæ congenital dermoid cysts may be found marking the sites of the various fissures, &c., of the embryo (*vide* chap. on Tumour-growth). Clutton has described a case of congenital papilloma in the line of the branchial fissures.

In some of these patients the lower jaw is imperfectly developed.

Any part of the digestive tract may be the seat of congenital malforma-

<sup>1</sup> *Vide* Mr. Bland Sutton's Lectures, *Brit. Med. Jour.*, February 19, 1887, and *Lancet*, February 1888.

<sup>2</sup> From whose writings much of our information on the subject is taken.

<sup>3</sup> *Vide* Guy's Reports.

<sup>4</sup> *Vide* Sir J. Paget, loc. cit.: also Tillaux and others, *Le Progrès Médic.*, February 21, 1885.

tion in addition to those already described. Congenital strictures<sup>1</sup> and pouchings<sup>2</sup> of the œsophagus, tracheal fistula,<sup>3</sup> displacements of the stomach, obliteration of the pylorus, absence of portions of the intestinal canal, and displacements of its various segments, are all met with and in certain cases may have some surgical importance, they cannot however be discussed here. Enterotomy might possibly be of service in some cases of congenital intestinal deformity where the obstruction was low down (*vide* p. 110).

<sup>1</sup> Charlewood Turner mentions seven cases in Ziemmsen.—*Vide Path. Soc. Trans.*, 1885.

<sup>2</sup> Sir Morell Mackenzie states that congenital pouching is extremely rare.

<sup>3</sup> May be combined with œsophageal deficiency usually at the middle third of the gullet. The fistula is a persistence of the embryonic condition.—*Sir M. Mackenzie*.

## CHAPTER X.

## DISEASES OF THE LIVER.

IN examining the liver of an infant or young child, it must be borne in mind that this organ is proportionately larger in the child than in the adult; it consequently occupies a greater space in the abdominal cavity, and thus to the inexperienced it may appear to be enlarged, when in reality it is only of normal size. The upper limit as determined by percussion (superficial dulness) reaches to the fifth space at the right edge of the sternum, to the upper border of the sixth rib in the nipple line, the seventh in the axillary and the ninth posteriorly, though the deep dulness reaches somewhat higher. While the edge of the right lobe does not in an adult extend below the costal arch in the recumbent position, in a child it always does. The size of the liver can be as readily estimated in a child as in an adult by percussion if the stomach is not over-distended, the lower edge can, however, be much more readily felt in a child than in an adult by placing the warm hand on the abdomen and gently pressing backwards and upwards. In most cases it can be easily determined if the edge is round or sharp or irregular.

The liver is not often smaller than natural during childhood; it is so only in the rare instances of the occurrence of acute atrophy or cirrhosis, and even here it is by no means always diminished in size. On the contrary, it is very frequently enlarged; this is due partly to its vascular nature, its veins being very readily distended, and partly also to the ready way in which it appears to store away fat.

The best instance of its enlargement from mechanical causes is afforded by the congestion which so frequently attends heart disease, where, in consequence of regurgitation through the mitral valves, there is an obstruction to the onward flow of the blood. There appears also often to be a temporary enlargement and a sluggish circulation in many cases of chronic intestinal catarrh, where there is said to be a functional derangement of the liver, accompanied by loss of appetite and pasty constipated stools deficient in bile, and an excess of pigment and perhaps uric acid in the urine. The liver is frequently enlarged from the presence of excess of fat; more rarely it is amyloid, or the seat of new growths, or abscess.

The common form of jaundice occurring in newly-born infants has already been discussed, the rarer form in which jaundice is due to lesion of the bile ducts may be referred to.

**Congenital Stricture or obliteration of the Bile-ducts.**—In these curious cases an obliteration of the common hepatic ducts appears to take place, which leads to a secondary or biliary cirrhosis of the liver if the infant

survive for a few months. The child may die from hæmorrhage from the navel or gastro-intestinal canal during the first few days of life. Such cases, though not common, are by no means rare. Among the more recently recorded cases are those of Wickham Legg and Glaister ; we have seen two cases in which autopsies were made.

*Symptoms.*—The infant is jaundiced from birth, the yellow colour being intense, affecting the skin, conjunctivæ, mucous membrane, and urine ; the stools are pale and completely devoid of bile. The infant frequently suffers from hæmorrhages, the stools then being black and the skin covered with ecchymoses. In one of our cases the motions were stated by the mother to be black immediately after birth. The liver may be enlarged. Such children may live for a few months ; both of our cases lived to be  $4\frac{1}{2}$  months old.

*Diagnosis.*—The obstructive jaundice of the newly-born can be readily distinguished from functional jaundice, the only form likely to be confounded with it, by the stools in the former being colourless while the latter contain bile.

*Morbid Anatomy.*—There is much emaciation, the internal organs are intensely bile-stained, with minute hæmorrhages on their surfaces. The liver is mostly enlarged and of a dirty green colour ; the surface is granular, the granulations varying in size from a millet seed to a hemp seed ; it has a tough feel and on section an excess of fibrous strands are seen accompanying the portal vessels, this is most marked at the great fissure ; the larger biliary channels contain green inspissated bile. On examining the vessels in the transverse fissure, the vein and artery are intact, but the gall-bladder is usually small and contains no bile, and the common and hepatic ducts are either shrivelled up and nearly obliterated or greatly diminished in size. Microscopical examination of such livers shows biliary cirrhosis. The etiology of these cases is obscure ; in some cases apparently the ducts are never formed. In one of our cases the mother had suffered from syphilis, but neither of the infants showed any symptoms. It is possible that a catarrh of the bile-ducts occurring during foetal life or a blockage from inspissated bile might lead to a permanent obstruction and obliteration. The cirrhosis follows as a result.

*Prognosis.*—Such cases are necessarily fatal in a few months and hardly admit of any treatment.

**Catarrhal Jaundice.**—Children of all ages are apt to suffer from a temporary jaundice, associated with gastro-intestinal catarrh, and which is in all probability due to catarrh of the bile-ducts.

*Symptoms.*—After a few days in which there are symptoms of dyspepsia, the conjunctivæ and skin become yellow, the urine contains much pigment and the stools are pale. A few days later the liver may be felt to be enlarged. As a rule, in the course of a few days or a week, all the symptoms disappear.

The diagnosis of catarrhal jaundice does not usually give rise to difficulty when it occurs in children. The possibility of the jaundice being due to acute yellow atrophy must be borne in mind, and any ecchymoses or brain symptoms would be very suggestive of the latter. Jaundice due to cirrhosis, or new growth, or syphilitic disease, could hardly be mistaken, as jaundice under these circumstances would not be an early symptom. It is possible that jaundice may be due to round worms finding their way into the duodenum, and entering the common duct.

*Treatment.*—The treatment of catarrh of the bile-ducts should be similar to that of gastric catarrh; the diet consisting of beef-tea, bread-sops, light puddings and milk. Sulphate or phosphate of soda may be given with infusion of rhubarb two or three times a day. Carlsbad salts or Friederichshall water will be useful in keeping the bowels open.

**Acute yellow Atrophy of the Liver.**—This curious and interesting disease appears to occur at all periods of life, infancy and childhood not excepted. Several continental writers have described cases occurring in infants a few days old, but whether these were in reality true cases of yellow atrophy may be open to doubt. Undoubtedly infants who are jaundiced shortly after birth, die in the course of a few days or weeks with symptoms of acute disease, but as far as can be judged from the reports, the naked eye appearances of the liver after death were not those usually found in acute yellow atrophy. In such obscure diseases as those named after Buhl and Winckel, jaundice occurs. While this disease cannot be said to be common at any time of life, it is perhaps rarer in childhood than in early adult or middle life, though it is very probable that cases are not infrequently overlooked, inasmuch as some of the recorded cases were not diagnosed during life. That they are not rare is certain, as Dr. Hyla Greves has collected 17 cases besides one observed by himself. We have only seen one case, which occurred in a boy of four years, and we have had the opportunity of examining the liver in a case of Dr. Railton's.

*Symptoms.*—The disease begins insidiously; the first symptoms are chiefly those of catarrhal jaundice, loss of appetite, constipation and jaundice, the stools are mostly pale, but sometimes quite normal, and the urine is bile-stained. The patient usually remains in this condition for a week or two, during which time neither his friends nor medical attendant suspect the serious nature of the disease. The liver at this period is enlarged and in some cases distinctly tender. Then come distinct cerebral symptoms which may not improbably be mistaken for the onset of tubercular meningitis. The child is irritable, vomits repeatedly, rambles at night, is perhaps very delirious or convulsed; the pupils are generally dilated. There are often ecchymoses about the body at the seat of slight injuries, and oozing of blood from the gums and œdema of the feet and face. After a few days the child passes into a condition of coma, there are also probably muscular twitchings, spasms of several groups of muscles, as the masseters, and perhaps local paralyses. The urine may contain leucin and tyrosin. In the later stages the liver diminishes in size, but this is not invariably the case.

*Diagnosis.*—Malignant jaundice in an early stage cannot be distinguished from catarrhal jaundice; it is only when cerebral symptoms appear, and there are dilated pupils, ecchymoses or constant vomiting, that the suspicion is raised that there is something more than simple jaundice. At this time the case is liable to be mistaken for meningitis, though the presence of jaundice and cerebral symptoms should indicate the true nature of the disease. It may possibly be confounded with pyæmia, phosphorus poisoning, or pneumonia with jaundice, but in all these the jaundice would as a rule follow and not precede the other symptoms.

*Morbid Anatomy.*—Organs bile-stained; hæmorrhages in various organs. Liver small, limp in texture, mostly bile-stained, some portions being greenish-

yellow, others orange red, often bulging in some parts, from shrinking in others. On section there are usually areas of red or yellow colour, in which the lobules are indistinct or entirely indistinguishable.

*Treatment.*—Unfortunately but little can be said under this head, as such cases have been invariably fatal.

**Cirrhosis of the Liver.**—A typical interstitial hepatitis or hobnail liver, resembling the cirrhotic livers common in adults, is occasionally seen in later childhood, and appears to be produced in the same way as it is in later years by the too liberal indulgence in alcoholic liquors. But such cases are decidedly rare. Interstitial hepatitis is also caused during early life in other ways; reference has already been made to the biliary cirrhosis, secondary to obliteration of the common bile-duct; it appears occasionally to owe its origin to mediastinitis or chronic heart disease; a perihepatitis with interstitial hepatitis is occasionally associated with chronic tubercular peritonitis; syphilis also appears to give rise to it.

*Symptoms.*—These consist of ascites with more or less icterus; the edges of the liver may sometimes be felt to be hard and irregular; there is enlargement of the spleen, and in the later stages there may be hæmorrhages and cerebral symptoms.

*Diagnosis.*—It is most likely to be confounded with ascites due to chronic peritonitis. In cirrhosis the liver is usually enlarged, the edge may possibly be felt after tapping, the spleen is enlarged and there is a disposition to hæmatemesis and other hæmorrhages; there may be jaundice. In chronic peritonitis indurations in the abdomen may be often felt after tapping, the spleen is not enlarged, and there is possibly evidence of tubercle in the lung; there is no jaundice.

The symptoms of portal obstruction due to a cirrhosis secondary to mediastino-pericarditis closely resemble those of primary cirrhosis, but there will often be evidence of obstruction to the venous blood entering the chest, such as distended jugular veins, especially marked during inspiration.

*Morbid Anatomy.*—The appearance of the cirrhotic liver due to alcoholism in the child does not differ from that in the adult. In peri-interstitial hepatitis secondary to chronic peritonitis, the capsule is thickened, sometimes enormously so, and mostly adherent to the diaphragm, on section bands of fibrous tissue are seen to enter and surround small islands of liver tissue which are usually fatty; microscopically much excess of embryonic and fibrous tissue are seen. Syphilitic hepatitis appears to exist in several forms. In some cases gummata are present on the surface or in the substance of the liver as caseous masses the size of marbles or walnuts, which cause scarring, and irregularly constrict the liver tissue by fibroid bands. Gubler has described a form of hepatitis due to miliary gummata resembling miliary tubercles scattered through the organ, with embryonic cells and excess of fibroid tissue. Syphilis also seems to give rise to a strangulation of the portal vessels in the transverse fissure by means of an inflammatory condition of the connective tissue passing on into a condition of cicatrisation, the so-called peripylephlebitis-syphilitica. These cases resemble, if they are not identical with, those described under *obliteration of bile-ducts* (p 140). In chronic heart disease, the liver frequently becomes tough and leathery and granular on the surface from the formation of an excessive amount of fibroid

tissue. In cases of mediastinitis where there has been some obstruction to the flow from the hepatic veins, the liver becomes often enormously enlarged and sponge-like from the dilatation of the capillaries and small vessels, and there is an excess of fibroid tissue formed.

**Treatment.**—The treatment of portal obstruction, the result of a cirrhotic liver, is only palliative, for there is but little reason to hope that even in syphilitic disease there is much chance of modifying in any way the fibrous tissue which is strangulating the portal channels in the liver. Relief must be sought by unloading the portal system by purgatives and diuretics and by removing the ascitic fluid by tapping, the latter is best performed by means of Southey's trochars. In syphilitic cases the local inunction of mercurial ointment and other specific treatment should be tried.

**Fatty Liver.**—The liver becomes enlarged from being infiltrated with fat in several different diseases during infancy and early childhood. It is common to find children who are fat, pale and rickety, with large livers, the edge of the right lobe reaching nearly into the iliac fossa and the left to the umbilicus. If an opportunity occurs for a post-mortem examination, such livers are found to be pale and greasy, the lobules being indistinct, and the cells are seen microscopically to be loaded with fat. Such children are usually anæmic, have large distended abdomens, coated tongues, pasty stools, and suffer from chronic indigestion. Under a careful dietary, small doses of mercurials and salines, such as Carlsbad or Rubinat water, improvement gradually takes place and the liver diminishes in size.

**Tuberculosis of the Liver.**—Although it is exceedingly common to find tubercles in the liver in children dying of general tuberculosis, it is exceedingly rare for these tubercles to have given any indication of their presence during life. Tubercular disease of the liver generally takes the form either of grey miliary tubercles scattered through the organ and on the surface, or of cheesy nodules rarely larger than peas or at the most small marbles which appear to have a special preference for the neighbourhood of the bile-ducts. These caseous masses may be found bile-stained on section, and small cysts formed of dilated bile-ducts filled with inspissated bile may be found which have been caused by compression of the ducts. Jaundice is rarely produced unless there are enlarged caseous glands in the transverse fissure compressing the common duct. In very rare instances caseous masses appear to form in the liver, resembling the caseous masses seen in the brain; these may cause enlargement of the liver and gradually soften down into a chronic abscess. We have seen only one case of this kind. This occurred in a boy of fourteen years who was admitted to hospital with an enlarged and tender liver; the latter was incised antiseptically and some thick pus evacuated, but he sank in a few days from thrombosis of the femoral vein and embolism. At the post-mortem a cavity containing cheesy material and thick pus was found and another caseous mass the size of a small orange was found in the right lobe. The intestines were matted together from old peritonitis, many mesenteric glands were cretaceous, there were scars of old ulcers in the small intestines and a cicatrix at the apex of the left lung.

**Hepatic Abscess.**—Children occasionally suffer from multiple abscesses, the result of the absorption of some septic material from the region of the portal vein, or from some abscess in the immediate neighbourhood. Thus

in one case under our care multiple abscesses in the liver were evidently secondary to an ulcer in the cæcal appendix caused by a pin which had been swallowed. In a second case there was a large hepatic abscess communicating through the diaphragm with an empyema in the right pleural cavity; and in a case of Dr. Hutton's hepatic abscesses were due to the contiguity of the liver with suppurating retro-peritoneal glands. Some cases have been recorded in which abscesses in the liver were secondary to typhoid ulcers and in others to the irritation of worms which had penetrated into the bile-ducts. The symptoms consist in enlargement of the liver, extreme tenderness, and intermittent fever. The prognosis is bad. If pus is found, it should be evacuated antiseptically.

**Hydatids.**—Hydatid cysts in the liver are not uncommon during later childhood, but are decidedly rare before five or six years of age. If the cyst is of any size and situated in either lobe so as to come in contact with the abdominal wall, it will form a smooth rounded swelling, continuous with the liver, neither painful nor tender, elastic to the touch, or actually fluctuating. Diagnosis under such circumstances is easy, especially if the tumour is tapped or aspirated, the fluid withdrawn being of low specific gravity, non-albuminous, and containing some of the scolices or pieces of cyst wall. If the cyst occupy the posterior part of the right lobe it may push the diaphragm upwards and discharge into the lung or pleural cavity; occasionally the cyst suppurates—in this case there is hectic fever, pain, and the symptoms of an abscess.

**Treatment.**—This consists in aspiration of the contents of the cyst, the latter collapses and the hydatid is destroyed. Aspiration may have to be repeated as the cyst may fill up with serum. If suppuration occurs incision is required.

**Tumours of the Liver.**—New growths originating in the liver during childhood are among the greatest rarities, though cases of carcinoma, sarcoma, adenoma, and cavernous tumours have been described. An interesting case of lymphadenoma of the liver, the only one which we have met with, was admitted to the Children's Hospital, under Dr. Humphreys (now of St. Leonards) in 1878.

A boy aged fourteen years suffered, for a month before coming under notice, with pain in the right hypochondriac region and wasting; he noticed a swelling in the same region about two weeks before admission. When first admitted he was pale and sallow, but not jaundiced, the liver was enlarged, the edge reaching nearly to the umbilicus, there was a large bossy swelling situated between the right costal arch and the umbilicus, the superficial abdominal veins were enlarged and tortuous. Aspiration of the tumour yielded nothing but blood. He wasted, there was a hectic temperature ( $98^{\circ}$  to  $102^{\circ}$ ), and the peritoneum and right pleura became distended with fluid. He died seven weeks after admission, having had symptoms for three months. At the post-mortem, the abdominal cavity contained much fluid, the right lobe of the liver was much enlarged and contained a hemispherical mass, which on section had the appearance and consistence of brain tissue, there were some hæmorrhages into its substance and fibrous bands passed through it. It was surrounded by a broad zone of compressed liver tissue. There was a mass of enlarged glands at the fissure. The right pleura was full of fluid.

Microscopically the new growth resembled the structure of lymphatic glands. In this case it was not easy to decide *where* the growth commenced, but, as in the analogous case of lymph-adenomata of the kidney, there is a strong probability that it began in the lymph glands of the fissure and grew into and compressed the liver substance.

**Enlarged Spleen.**—The spleen is a very vascular organ, is functionally more active in childhood than in after life, and is more apt to become temporarily engorged and enlarged. The best method of determining the enlargement during early life is by palpation rather than by percussion, as the lesser rigidity of the abdominal walls during early childhood usually readily permits of this. Palpation of the spleen is effected by standing on the patient's right side and gently pressing two or three fingers of the right hand into the left hypochondrium beneath the costal arch, when the lower and inner edge of the spleen if enlarged can be readily felt as a movable tumour which can be pressed upwards. It can hardly be said that the spleen is abnormally enlarged unless its lower edge extends below the costal arch. Enlargement is very common during childhood and accompanies various conditions. An enlarged spleen is most frequently associated with an anæmic condition, though exactly what the relation between the two is is uncertain. It is enlarged in many cases of rickets and syphilis, though certainly not in all cases; it is chiefly so in those cases in which pallor and anæmia are marked symptoms. It is enlarged and hard in ague, and also when lardaceous and in association with leucocythæmia and Hodgkin's disease. It is also enlarged in various acute diseases, such as typhoid fever, acute tuberculosis and pyæmia, and in some other febrile states.

**Diseases of the Retro-peritoneal Glands.**—There are a considerable number of lymphatic glands situated behind the peritoneum, at the back of the abdomen and in the pelvis. They are most numerous lying along the vena cava inferior and aorta and their branches. These glands may become enlarged and caseous in tubercular disease, or may be the starting point of a lymph-adenoma or abscess. When caseous, they are so in association with mesenteric disease; in one case under our care, the caseous glands surrounding the vena cava completely compressed the latter, giving rise to œdema of the lower limbs and enlarged veins on the surface of the abdomen. In another case a lymph-adenomatous tumour exactly simulating an enlarged spleen, which had commenced in some retro-peritoneal glands, was first noted in the left hypochondriac region. It grew to an immense size, occupying nearly half the abdomen.<sup>1</sup> Some of the more obscure forms of abdominal and pelvic abscesses appear to originate in these glands.

<sup>1</sup> See *Abstracts of Cases treated at the Children's Hospital*, 1881, p. 13.

## CHAPTER XI.

## DISEASES OF THE RESPIRATORY APPARATUS.

IT is necessary when examining the chest of an infant or child for the first time to have it completely bare, so that a thorough examination can be made, the infant lying in its cot or on its mother's lap ; care must of course be taken to have the room sufficiently warm, as infants readily take cold when a large surface of the skin is exposed, and they are very sensitive to draughts.

On *inspection* it will be noticed *firstly*, that an infant's chest is deeper than an adult's, or in other words the antero-posterior diameter more nearly approaches the transverse, the ratio being 1-2 in an infant,  $1-2\frac{1}{2}$  during childhood, and 1-3 or  $3\frac{1}{2}$  in adults ; the horizontal section is thus more circular in form during infancy than in later life. *Secondly*, the angle which the costal cartilages make with the sternum is larger in children than in adults, that is, the lower part of the thoracic cage is widened out more, a result due to the abdominal viscera occupying a relatively larger space and pressing the diaphragm upwards. This is seen in an exaggerated form in children who have enlarged livers and constant gaseous distention of the stomach and intestines. Any acquired deformity should be carefully noted ; various rickety deformities may be present, one side of the chest may be contracted from an old pleurisy or empyema, or the left chest may be bulged outwards by an hypertrophied heart or distended pericardium.

The position of the cardiac impulse should be determined. Note must also be made of the frequency and character of the respiratory movements, whether deep or shallow, whether one side moves more freely than the other, or there is any sinking in of the epigastrium or intercostal spaces and ribs. It should be borne in mind that mere frequency of respirations does not necessarily mean any respiratory disease, but may be due to rapidity of the heart's action accompanying high fever or cardiac feebleness.

After inspection it is usual to percuss the chest, placing one finger of the left hand against the chest wall and striking it with more or less force with the middle finger or forefinger of the right hand, taking care that the child lies or sits up straight, for if the body be twisted, so that one side bulges out more than the other, a fallacious hyper- or impaired resonance may be produced. All the regions of the chest must be carefully examined in turn. Too much stress should not be laid on a slightly impaired resonance, especially if the child is crying, unless the result of auscultation corresponds, and a subsequent examination confirms the result. A typical 'cracked-pot' sound is readily elicited in an infant on account of the yielding nature of the chest walls quite apart from the presence of cavities or any lung lesion.

It must not be forgotten in examining the chest that the diaphragm usually takes a higher position in children than in adults, especially when the stomach and intestines are distended with wind.

In *auscultation* the ear may be placed directly against the chest wall, or (which is much more convenient) a binaural stethoscope with a small chest piece may be used. All parts of the chest should be carefully examined, noting the character of the breathing, whether the air is entering every part of the lungs equally, or whether the air is not entering one part freely while other parts are being overworked. Weak breathing may be due to an early stage of pneumonia, effusion of fluid, collapse of lung or compression of a bronchus.

'Puerile' or 'harsh' breathing is due to a portion of lung being overworked, it is never safe to accept it as a sign of a lesion in the lung, as at first a student is inclined to do, and moreover the breath sounds may appear loud and harsh to an ear accustomed to adults. It is not uncommon in young children to note on one occasion that the breathing is weak or almost absent at one base and loud elsewhere, whereas after a fit of crying, or the next day, the weak breathing has completely disappeared; in these cases a bronchus with its branches has been temporarily plugged with mucus, which has become displaced by coughing. Bronchial breathing is present in consolidation of the lung from pneumonia or tubercular infiltration, but it is also present in the majority of cases in effusion of fluid, though in this case it is usually weak and distant instead of being intense and blowing. Cavernous or amphoric breathing is not often heard, as cavities of any size are rare in young children. Among the adventitious sounds, fine crepitation is rarely heard in the early stages of pneumonia, the rales being mostly of medium size; they may be 'consonant' or 'ringing' in character when conveyed to the ear through solid lung, or subcrepitant and ill-defined when the secretion is thick, and they have to pass through normal lung to reach the ear. Vocal resonance or fremitus often gives no definite result in girls or young children, though when the child is crying violently the increased resonance of the voice heard over a base or apex may be of diagnostic importance. It is needless to add that the physical examination of young children is often beset with difficulties on account of their restlessness or fright, and the examiner may have his patience often sorely tried and perhaps may fail to obtain a satisfactory examination from this cause.

**Laryngismus Stridulus, 'Child Crowing,' Spasm of the Glottis.—**

The term laryngismus is applied to a peculiar form of spasm of the muscles closing the glottis and of other respiratory muscles, producing a stridulous sound; it is independent of any lesion of the larynx, being produced reflexly, the source of irritation being at some distant part. In some forms of laryngitis there is a temporary stenosis produced either by spasm of the glottis or a turgescence of the mucous membrane to which the term 'false croup' or spasmodic laryngitis is applied, but it is quite distinct from the reflex spasm which has been described as 'child crowing.'

Laryngismus is an affection almost entirely confined to infancy and early childhood; it is met with in infants a few weeks old, but it is far more common during the period of the first dentition, that is, between the ages of six months and two years. It is rare after this latter age. As first pointed out

by Elsässer and afterwards by Jenner, it is frequently associated with rickets, most of those who suffer from it being rickety in a high degree, or afterwards becoming so; in some cases it appears to be associated with spina bifida. While there is little doubt that the spasms are reflex, it is very uncertain what the condition is which produces them. It is believed by some to be due to enlargement of the thymus gland, to enlarged bronchial glands, pressure on the vagus in the jugular fossa, or pressure on the posterior lobes of the brain through thinness of the occipital bones, but it is doubtful if any of these play an important part in its causation. It is certain that the nervous centres are in an irritable condition in rickets and easily disturbed by reflex influences; the eccentric irritation in these cases is probably derived from the digestive organs, as by far the greater number of infants who 'crow' suffer from dyspepsia, flatulence and constipation. Excitement often determines an attack, so that probably many afferent nerves may convey the irritation to the medulla, the unstable condition of the nerve centres allowing of a nervous discharge.

*Symptoms.*—In the milder cases, which are most common, the child's inspiratory movements are accompanied by a slight 'crowing' sound, which does not appear to distress it and which passes off during sleep. Sometimes this crowing will last for many hours or even days and then pass off again completely. When the attacks are more serious, the spasm is severe enough to gravely interfere with the entrance of air into the chest; for a moment perhaps the closure of the glottis seems to be complete and the respiratory muscles are in a state of spasm, the child becomes pallid or blue, then the obstruction is overcome and the air enters the chest with a long-drawn *crowing sound*. The paroxysms may come on without any provocation when the child is asleep or on waking up, at other times they come on when being fed, or when crying or laughing; sometimes a strong light or the appearance of a stranger will have the same effect. The attacks may be attended by spasm of the diaphragm, or tetanic contraction of the limbs, or the convulsions may be general. The spasm may be kept up to some extent between the attacks, so that even during sleep there is some stridor. In the large majority of these cases the signs of rickets are present; there is the square head with widely open fontanelles and perhaps cranio-tabes, the pigeon chest with beaded ribs and recession of the chest walls, and enlarged epiphyses, bowed spine and pallid face. There is usually also constipation, which appears to favour the tendency to convulsive attacks, and flatulent and distended abdomen. The attacks differ much from one another in severity: in some cases there is little more than a slight stridor during inspiration, whilst in others the distress is very great and death may quickly ensue. The possibility of sudden death in one of these attacks is by no means remote, and it is always well to warn the friends of this. The first attack may be fatal; in some cases coming under our notice young children apparently healthy have died suddenly, death being preceded by a crowing sound in the throat.

Spasm of the glottis is sometimes the cause of death in cases where the obstruction is not complete, as in the following case. A boy of one year old had difficulty in breathing from birth, was seized with a bad attack and was admitted to hospital; there was undoubted obstruction to inspiration and

much recession of the chest walls, necessitating tracheotomy, which was followed by much relief. Death followed five hours later without apparent cause. At the post-mortem there were no signs of rickets, there was slight congestion of the larynx and the thymus gland, all the other organs were healthy. Sudden death from spasm of the glottis occasionally occurs in cases of tuberculosis with enlarged and caseous mediastinal glands.

*Diagnosis.*—The following table gives the chief points :

<i>Laryngismus: Spasm of the Glottis.</i>	<i>Spasmodic Laryngitis (False Croup).</i>	<i>Membranous Croup.</i>
Occurs in rickety children under 18 months of age.	Rarely occurs under 2 years of age, commonest 2-7 years.	Occurs at all ages during childhood.
No fever, and no coryza or laryngeal catarrh.	Slight fever, mostly coryza and laryngeal catarrh.	Variable amount of fever, and perhaps some diphtheria of the fauces.
Occurs at any period of the 24 hours, and often many times.	The attack occurs at night.	Mostly worse at night.
No cough, inspirations are stridulous.	Metallic cough, stridulous respiration, variable dyspnoea.	Metallic cough, stridulous respiration, progressive dyspnoea.
Contractions of the limbs, or general convulsions, not uncommon.	Convulsions rare.	Convulsions rare.
The attack lasts a few seconds, and frequently recurs.	Attack passes off in the course of an hour or two.	Becomes steadily worse, though variations occur in its progress.
Occasionally fatal.	Rarely fatal.	Very often fatal.

*Prognosis.*—The great majority of infants who suffer from ‘child-crowing’ recover; the prognosis, however, must always be a guarded one, and as long as there is any tendency to spasm of the glottis the child cannot be regarded as out of danger. A ‘crowing’ child may at any time have general convulsions and die in a few moments. Improvement in the child’s general condition, and especially of its digestive powers, quickly leads to an improvement in the ‘crowing’; this we have noticed in several cases which rapidly improved under the careful feeding and attention in the hospital, but which quickly relapsed again when they were discharged. An attack of bronchitis or bronchopneumonia is very likely to prove fatal in a child subject to laryngismus.

*Treatment.*—The treatment of laryngismus mostly resolves itself into the treatment of rickets and of the dyspepsia and constipation which frequently accompany it. It will probably be found that the child is passing constipated curdy stools, deficient in bile, and is suffering more or less from dyspepsia. A suitable food is the first consideration. A wet nurse may be necessary, or peptonised milk in some form or other, or Mellin’s food with milk may be tried. Fresh air is of the greatest importance, whenever the weather is suitable the infant should go out; residence by the seaside is often of much service. Bromides are of use if there is a tendency to general convulsions, and may be given in small doses in laryngismus; it is not, however, wise to continue their administration for long together on account of the tendency to constipation which these drugs exert. Medicines which improve the digestive powers and regulate the bowels are of most service; extract of malt, rhubarb and soda, cascara in the form of an elixir, belladonna, and cod-liver oil, are the most useful of these.

**Spasmodic Croup, Laryngitis Stridulosa, False Croup.**—This affection differs from the last described in that it consists of a sudden stenosis of the glottis associated with a laryngeal or pharyngeal catarrh. A child, usually over two or three years of age, goes to bed apparently well with the exception, perhaps, of a slight hoarseness or cold in the head; after a few hours' sleep he is suddenly awakened with alarming symptoms of laryngeal obstruction. There is a loud metallic cough, stridulous respiration more especially with inspiration, the dyspnoea and distress are very great, there is recession of the chest walls, and all the accessory muscles are called into requisition. The orthopnoea and distress are so great that death seems imminent. In the course of a few minutes, probably before the arrival of medical assistance which is hastily summoned, the laryngeal obstruction has ceased and the child, tired out by its unwonted exertions, falls into a quiet sleep. The symptoms of a catarrh or tracheitis persist for some days perhaps with some clanging cough and more or less pronounced attacks of dyspnoea at night. Children who thus suffer are extremely liable to a recurrence whenever they take cold, and it is not uncommon for mothers to say that their child is very subject to 'croup.' Though these attacks are alarming they are rarely fatal, thus contrasting with laryngismus, but it must be remembered that the latter is frequently associated with general convulsions and, moreover, occurs at an age when spasm of the glottis would necessarily be exceedingly fatal if severe on account of the weakness of the respiratory muscles and want of rigidity in the chest walls.

These attacks of spasmodic croup differ very much in severity, in some cases they are exceedingly mild, but on account of their occurring at night, and the dread with which all forms of croup are held, they are exceedingly apt to alarm the friends.

*Treatment.*—Great care should be exercised to protect children subject to such attacks from cold. A damp house or a damp situation should be avoided and exposure to the cold east winds of spring should be carefully guarded against. Great benefit is usually derived from residence at the seaside. Cold sponging with tepid salt and water every morning on getting up will greatly assist in keeping the child free from attacks. Warm woollen clothing should be worn next to the skin, and care taken that the legs and neck are well protected. During the attack most relief is given by applying hot sponges to the throat and by administering an emetic of ipecacuanha powder or a teaspoonful or two of ipecacuanha wine. As the child gets older he becomes less and less liable to these attacks, which cease altogether before puberty is reached.

**Catarrhal Laryngitis.**—Children of all ages are liable to suffer from a catarrh of the larynx and trachea, though it is perhaps most common and is certainly most dangerous during the first two or three years of life. These attacks differ somewhat from those of spasmodic croup just described, inasmuch as there may be no violent exacerbation at night, yet in many cases all the symptoms are apt to be worse towards evening. They are mostly the result of cold, exposure to cold winds or a chill, and they may be associated with measles, either belonging to the premonitory symptoms or following the disappearance of the rash. The attacks are preceded for the most part by coryza, feverishness and cough, the first suspicious symptom being the changed character of the cough, which is at first hard or hoarse,

and then assumes the characteristic 'croupy' or 'brassy' character, which announces that there is some stenosis of the larynx. An examination of the fauces will probably show enlarged and congested tonsils with excessive secretion, and if the epiglottis can be seen the mucous membrane will be found to be of a pinker colour than usual; but it is rarely possible to get a view of the larynx by means of the laryngoscope. As the symptoms become more marked, the air is heard to enter the larynx with a hissing sound, there is dyspnoea, the alæ nasi work, the chest walls fall in during inspiration, and there is often much distress. In some cases the child has to be propped up in bed, and pays no heed to its toys, its whole attention being taken up in its efforts to breathe. The fever is variable, rarely high, usually  $100^{\circ}$  to  $101^{\circ}$ ; the pulse is quick and hard. In most cases the symptoms are milder than those just described, there being only a croupy cough and some acceleration of breathing. On the other hand, the case may become so urgent that tracheotomy is required to stave off impending death, though usually the effects of treatment render this unnecessary. Cases of simple catarrhal laryngitis in children rarely present the picture of stenosis of the larynx which is seen in the membranous variety; there is probably the 'croupy' cough and frequent breathing, but between whiles, especially after a fit of coughing, the child is comparatively comfortable and falls into an easy sleep. The prognosis depends upon the diagnosis: if the case be one of catarrhal laryngitis and the child is over two or three years of age, there is strong probability that it will recover. The younger the child, the greater is the danger.

**Membranous Croup.**—The questions which at once come to the front when discussing the ætiology of fibrinous exudations in the larynx are, Are such cases diphtheria? are they universally so? That membranous exudations are frequently diphtheritic in nature, being part of a general diphtheritic infection, is now so universally admitted by both English and Continental authorities that it is hardly worth while occupying any space in discussing the question. The fact which repeatedly comes under observation, that one member of a household suffers from pharyngeal diphtheria and another from membranous laryngitis or both combined, is sufficient evidence in itself that they both owe their existence to the same poison. Further, it has repeatedly happened that house surgeons and nurses have contracted faucial diphtheria from cases of membranous croup by direct inoculation by the matters expelled from the tracheotomy wound. Is membranous croup ever a non-specific and local disease? Mr. R. W. Parker answers this question by saying that 'membranous croup,' 'membranous laryngitis,' and 'laryngeal diphtheria' are synonymous terms. The difficulty really consists in diagnosing diphtheria in the absence of constitutional symptoms. Fibrinous exudations occur in various mucous membranes without there being any constitutional symptoms, and there is no known means of deciding by the microscope or otherwise if such are simply inflammatory in their nature or are the result of the working of the diphtheritic poison. That membranous exudations in the larynx may be simply inflammatory is rendered probable by the following facts.

Sporadic cases occur in country districts where no diphtheria is prevailing at the time, and no second case occurs. One or two children in the same family may suffer from catarrhal laryngitis and bronchitis, while another may

suffer from membranous croup, the attacks following exposure to cold. The attempt to inoculate some of the lower animals with membrane taken from some cases of croup has failed when similar attempts have succeeded in cases of true diphtheria. Fibrinous exudations in the trachea and larynx have been produced in the lower animals by the application of irritants. Membranous laryngitis occurs in connexion with measles, as we have frequently had the opportunity of observing, at a time when no diphtheria was prevailing in the neighbourhood.

Both scarlet fever and typhoid are occasionally complicated by membranous exudations, without there being any evidence to show that diphtheria complicates these diseases at such times. Membranous exudations are frequently present on the conjunctiva or tongue without any general symptoms.

From a consideration of these facts it would appear that membranous exudation on the epiglottis and interior of the larynx is most frequently the result of a diphtheritic affection, that laryngeal diphtheria differs in no respect from pharyngeal diphtheria except in the seat of the exudation. On the other hand, there is strong reason to believe that not *all* fibrinous and membranous exudations are diphtheritic, that fibrinous exudations may be thrown out on mucous surfaces when the inflammation is intense, as on a scalded glottis, without the poison of diphtheria being present. There is no means, in the absence of constitutional symptoms, of deciding in a given case where a membranous exudation is present whether it is to be considered diphtheritic or not.

1. **Membranous Croup.**—Simple membranous croup is a local inflammatory affection, resulting in the exudation of fibrin on the surface of the mucous membrane of the larynx or trachea. The membrane may be tough and adherent, or the secretion fibrinous and non-adherent. It is primary, being the result of cold, or occurs in the course of other diseases, especially measles. It is sporadic and non-contagious.

2. **Diphtheritic Croup.**—Diphtheritic croup may occur primarily, the laryngeal membrane being the first and only part attacked, or the pharynx, nose, or bronchi may be the first parts affected and the mischief may descend or ascend to the larynx. It is contagious and epidemic.

*Symptoms.*—The initial symptoms of the two forms of croup are practically identical, inasmuch as they are those of stenosis of the larynx. When the larynx is the primary seat of the attack the symptoms are those of catarrh, with restlessness, feverishness, and brassy cough. In the course of a day or two, sometimes sooner, there is more or less loss of voice and the cough has a peculiar ringing or metallic character, which is very characteristic.

It now becomes evident that there is some obstruction in the larynx, as the air enters the trachea with a hissing or stridulous sound, and the child is constantly endeavouring to cough something up and clutches at its neck as if to remove some obstruction. The tonsils are usually swollen, the fauces reddened, and perhaps the seat of false membrane. There is marked restlessness; the child wants to be nursed, then put back again into its cot, perhaps gets a few minutes' sleep, waking up with a hoarse cough and difficulty of breathing. The voice now is nearly lost, the child speaking in a whisper and making itself understood with difficulty. There is marked dyspnoea, which tends to increase as the disease progresses; the *alæ nasi* dilate, the extra

inspiratory muscles are called into action, and the epigastrium and inferior lateral region of the chest, the intercostal spaces, and supra-sternal fossa are drawn in during inspiration. The expiratory efforts are laboured, so that the abdominal muscles act with some force, and the air escapes through the larynx with a noisy sound. So laboured and noisy is the breathing that it can be heard some distance off. While the child goes from bad to worse, there are usually more or less marked exacerbations; the child is easier after a fit of coughing, during which mucus or perhaps some membrane is actually dislodged. All the symptoms are apt to be worse at night.

If no relief is obtained the symptoms of toxæmia begin to present themselves. There is a marked pallor or lividity about the lips and face; perspirations break out on the forehead; the child is alternately drowsy or restless and delirious, perhaps attempting to get out of bed; presently complete insensibility comes on, the pupils dilate, the attempts at respiration become more and more feeble, and death quickly ensues. The temperature is usually raised a degree or two in the earlier stages, but may be subnormal as the blood becomes more venous. An examination of the chest does not always yield positive results as to the state of the lungs. The whistling or stridulous sound produced in the larynx is heard all over the chest, masking the vesicular breath sounds, and making it difficult to diagnose the condition of the lung. The supraclavicular regions in front are usually unduly resonant from the presence of emphysema, while at the bases posteriorly the resonance is mostly impaired on account of the lung being collapsed, or air entering it very imperfectly. The diagnosis of pneumonia is difficult in the absence of impaired resonance, as the typical signs may be wanting on account of the small supply of air entering the chest; moreover, the pneumonic consolidation may be masked by emphysema. It is exceedingly difficult to diagnose the presence of membrane in the trachea and bronchi.

When the larynx is affected secondarily the symptoms are frequently much less marked, more especially if the membrane only spreads to the larynx after it has existed for some days in the pharynx or nasal mucous membrane. In this case the weakness and depression which exist before the laryngeal complication supervenes mask the symptoms of laryngeal stenosis. There is usually much less dyspnœa and distress than when a healthy child is suddenly attacked.

Albuminuria exists in a considerable number of the cases. When present in large quantities it points to the diphtheritic nature of the attack; but the mere presence of albumen does not necessarily mean the coincidence of diphtheria, as albumen is frequently present in cases of pneumonia and other chest affections where much lung is involved.

*Diagnosis.*—The diagnosis of stenosis of the larynx is not difficult, nor is it likely to be confounded with bronchitis or broncho-pneumonia where the obstruction resides in the bronchial tubes, or where there is extensive consolidation of the lung. In laryngeal stenosis the air rushes through the larynx, giving rise to a crowing or stridulous sound, especially during inspiration, but there is obstruction to the expiration also; the respiratory movements are laboured, as if to overcome the obstruction, and with this there is marked recession or sucking in of the chest walls during inspiration. There is loss or great impairment of voice. In pneumonia or bronchial obstruc-

tion, the dyspnœa may be great and the respirations frequent, with much indrawing of the chest-wall, but there is no stridor or loss of voice. The diagnosis of obstruction of the bronchial tubes, in addition to stenosis of the larynx, as in those cases where the membrane has spread downwards or where there is an accumulation of mucus below the larynx, is difficult and uncertain ; but in all such cases the dyspnœa will be great, and tracheotomy urgently required, and the presence of obstructed bronchi would not contraindicate operation, as an opening in the trachea would favour the coughing up of the obstructing material.

The differential diagnosis of catarrhal, membranous, and diphtheritic croup is generally a matter of great difficulty, and until the case has remained under observation for some hours or days often impossible. Even after tracheotomy has been performed, the nature of the case may still be doubtful, inasmuch as thick fibrinous mucus may be coughed up with no distinct membrane and recovery may take place without the diagnosis having been determined. The question of diphtheria or not diphtheria is one of the greatest importance, but unfortunately there is not much that can be said with certainty. It is easy to say that in diphtheritic croup there is asthenia, while in membranous laryngitis the attack is sthenic in nature. But, as a matter of fact, it occurs in practice that if the primary seat of the diphtheria is the larynx, the first and only symptoms are those of stenosis of the larynx, and the pallor and depression and asthenia which result are due to the toxæmia produced by want of oxygen, rather than by the working of the diphtheritic poison. It is for this reason that the symptoms of membranous formations are practically the same whether produced by diphtheria or not. If, however, the larynx is affected after the existence for some days of diphtheria of the fauces, the symptoms are necessarily modified. The diagnosis of diphtheria when primarily situated in the larynx has often to be made less from the symptoms of the patient than from his surroundings.

If diphtheria is epidemic at the time, or if the fauces are covered with membrane, or there is a large quantity of albumen present in the urine, the case is probably diphtheritic.

Stenosis of the larynx may be caused in other ways than by the exudation of membrane ; the larynx may be compressed by an abscess situated posteriorly between the larynx and œsophagus, or even laterally ; in this case there will be difficulty of swallowing as well as dyspnœa. The trachea may be compressed below the larynx by an enlarged thyroid or new growth, but the history of the case as well as the local enlargement would distinguish between the two. In infants and young children spasm of the glottis will in rare cases simulate membranous laryngitis, as in the case given (p. 149). The diagnosis may be difficult, but the absence of fever would point to spasm ; it is rare, however, for any spasmodic affection to come on gradually and progress from bad to worse, as is the case with diphtheritic laryngitis.

*Pathological Anatomy.*—The post-mortem appearances found in those who have died of membranous or diphtheritic croup differ according to the immediate cause of death. In the majority of cases this is due to the formation of membrane below the tracheotomy wound and to the lungs becoming choked or collapsed. In such cases membrane may be found beginning at the epiglottis and extending downwards to the smallest bronchi. As a

rule the membrane is tough and firmly adherent to the epiglottis and larynx, being separated with difficulty, while lower down the membrane is far less tough and is much more easily detached ; the bronchi usually contain semi-purulent fluid, and the bases of the lungs are usually pneumonic or collapsed while the apices are emphysematous. In some cases death results from asthenia or from septic poisoning the result of the diphtheritic infection ; in such cases the trachea and bronchi may be free from secretion.

*Treatment.*—The treatment of both catarrhal and membranous croup have so much in common that they may be conveniently considered together, and indeed this may also apply to diphtheria of the larynx when it is primary. The first appearance of 'croupy' symptoms should never be neglected ; the hard metallic cough, when once heard, should be the signal for placing the child in a warm room, where the temperature is maintained at 60° or 65° both day and night, giving at the same time fluid food or sops, demulcent drinks, and medicines which promote diaphoresis. If the symptoms become more pronounced, the child must be confined to its cot, and a tent rigged over it by means of sheets stretched over cords or a clothes-horse, so as to protect the patient from draughts and secure a moist atmosphere by the aid of the steam kettle. The temperature inside the tent should be maintained at about 70°, and steam from a kettle allowed to play freely into it, so as to render the air thoroughly warm and moist. The usual tendency of the friends of the patient is to overdo the steam and maintain too high a temperature, so that it is not uncommon to find the patient almost parboiled. During the early stages of laryngitis, when there is much swelling of the mucous membrane of the larynx, with little secretion, the steam gives more or less, at least temporary, relief. This is most marked in the cases of hospital patients who have been much exposed before being admitted ; in these cases the amount of relief given by the steam tent is often an important element in the diagnosis of catarrhal *versus* membranous croup. A steam kettle heated by means of a spirit lamp is preferable to either gas or to placing the kettle on the fire, as in the latter case the patient's cot has to be placed close to the fire. The products of the combustion of gas are objectionable, especially in a small room. Local applications applied over the larynx in the form of hot sponges or spongio-piline wrung out of hot water are often of much service. The sponges should be taken out of the hot water and squeezed by wringing in a piece of flannel and used continuously ; but if this exhausts the child too much, a piece of spongio-piline may be secured *in situ* by tapes and renewed every half hour. An emetic in this stage is often of much value in relieving the breathing and producing free expectoration, ipecacuanha powder answering very well. Five grains may be given in syrup of orange-peel every ten minutes till vomiting is produced. Sulphate of copper in gr.  $\frac{1}{4}$  to gr.  $\frac{1}{2}$  doses, repeated in a few minutes, will generally produce vomiting. It is useless to repeat emetics if they fail to give relief. It need hardly be said that it is wrong to give emetics in the later stages, when the breathing has become laboured and the lips blue or pallid ; to give emetics under these circumstances is to risk failure and to waste invaluable time. Of medicines, antimony unquestionably holds the first place, and in sthenic cases should be given with a free hand, though as an emetic it is too slow and nauseating.

Either the wine or tartar emetic may be given, in combination with citrate of potash or acetate of ammonia.

( 22 )

Wine of antimony . . . . .	℥x-xx
Liq. ammon. acet. . . . .	℥xv-xxx
Syrup . . . . .	℥xv
Water . . . . .	ʒj-ʒij

*2nd is hor. for a child one to five years.*

The only food admissible is milk diluted with barley-water or soda-water, preferably given warm to assist in producing perspiration. In most cases of catarrhal laryngitis relief of the most urgent symptoms follows this line of treatment, though probably for several days many of the symptoms will remain, with exacerbations at night; in such cases the antimony may be pushed, nauseating doses being given.

The question as to whether tracheotomy should be performed is always a difficult one, inasmuch as in many cases the most urgent symptoms will disappear under the influence of treatment without tracheotomy, and the operation, even in the most skilful hands, adds another element of danger to the case. If, however, the mucous membrane of the larynx is covered with tough adherent membrane, there is small probability indeed of avoiding operation, and there is nothing to gain by delay; for not only is there stenosis of the larynx, but probably also more or less membrane in the trachea, and much thick secretion, which cannot be coughed up through the larynx. It is impossible to lay down any rule for the performance of the operation, or to accept any one symptom which is to be taken as the signal. Dyspnoea and recession of the chest-wall do not necessarily indicate any immediate danger, and most will have seen cases in which there has been indrawing of the epigastrium and ribs recover without tracheotomy. If, however, the case passes into a later stage in which the voice almost disappears, the respiration becomes laboured, all the respiratory muscles joining in the attempt to draw in air and expel it from the chest, while the distress and restlessness is on the increase; it is then quite certain that the time has come for affording relief. Any marked pallor of the face, coma, or delirium, or other symptom of toxæmia, indicates that there is not a moment to lose.

In the cases of those who suffer primarily from pharyngeal diphtheria, the larynx becoming affected after the disease has existed for some time, no time should be lost in the performance of tracheotomy directly there is evidence of the spread of membrane to the larynx.

**Tracheotomy.**—The operation of opening the trachea in cases of membranous laryngitis must be looked upon as a means of relieving the mechanical obstruction to respiration; it can in no way influence the constitutional effects of the disease, though it may prevent the addition of gradual asphyxia to the other depressing influences of the poison. Further, we may, by the operation, prevent the spread of the membrane down the trachea, and thus, perhaps, lessen the risk of absorption of the virus as well as get rid of the obstruction.<sup>1</sup> What certainly may be looked for from the operation is that death from mechanical obstruction to the upper segment of the windpipe may

<sup>1</sup> Vide R. W. Parker.

be avoided, and that the distress caused by dyspnœa may to a great degree be relieved. It must not be forgotten that tracheotomy has its own dangers : first come the risks of the operation itself—hæmorrhage, injury to important neighbouring structures, and entrance of blood into the trachea ; later, there are the dangers of septic absorption, the exposure of a raw surface to the diphtheritic poison, tracheitis, pneumonia, and so on, from exposure of the tracheal mucous membrane to cold ; that this is a real danger a paper of Dr. Wilks shows.<sup>1</sup>

While we have thus indicated the objections to and the limited uses of the operation, we would yet urge its performance in all cases where there is severe dyspnœa ; we have no means of knowing that the child will die of asthenia, we do know that he will die of suffocation if unrelieved, and the other dangers mentioned are all usually avoidable by careful operating and after-management.

Extreme prostration without distinct evidence of asphyxia, and the presence of pneumonia or capillary bronchitis, may be looked upon as indications that tracheotomy will be of no avail.<sup>2</sup>

The younger the child the earlier should tracheotomy be done ; indeed, Parker quotes Dickinson to the effect that once there is membrane in the larynx there is little hope but in tracheotomy. Inasmuch as the operation is nearly always one of urgency, we must be prepared to do it under unfavourable circumstances as regards nursing, light, help and appliances. It is, however, usually possible to improvise fairly serviceable arrangements for the operation itself. A dressing-table or the top of a chest of drawers in private houses is the usual operating table. Candles give generally the best obtainable light when, as is so often the case, the operation has to be done at night, and care must be taken that the lights are entrusted only to those members of the household who can be depended upon to bear seeing the operation. These makeshift arrangements, together with the small size and anatomical relations of the parts, the urgency of the case, and the movements of the trachea in difficult respiration, make this operation, though often lightly spoken of, one of the most anxious in surgery.

If possible, at least one skilled assistant should be obtained besides the anæsthetist. As regards anæsthetics, it is in our opinion a question to be settled for each case ; if the child is so asphyxiated as to be unconscious of pain, and not likely to struggle, it is far better to do without an anæsthetic. We have seen chloroform prove fatal before the operation was begun ; on the other hand, if the case is operated upon earlier, and the child is conscious and restless, it is on all grounds better to give chloroform.

The child then should be placed upon a table of convenient height, and the lights if necessary arranged carefully ; everything required in the operation having been laid out upon a table or chair ready to hand before the child is taken out of bed, since at any moment the moving or the giving of the anæsthetic may increase asphyxia and demand instant action.

<sup>1</sup> *Guy's Reports*, ser. iii. vol. vi.

<sup>2</sup> If tracheotomy is otherwise indicated, the presence of bronchitis may not in all cases prevent the operation being successful. We have seen a case in which it succeeded perfectly under these circumstances as far as relieving the dyspnœa went, though the child died, when apparently convalescent, from ulceration into the innominate artery.

As soon as the child is unconscious, and not before, since it increases the dyspnœa, one pillow should be taken from beneath the head and placed under the shoulders, so that the head falls back and fully exposes the front of the neck.<sup>1</sup> The head must then be held by an assistant exactly straight, so as to avoid any chance of the operator missing the mid line of the neck. The thyroid cartilage is then to be felt for, and an incision,  $1\frac{1}{2}$  to 2 inches in length, according to the size of the child, made in the middle line from the lower border of the thyroid cartilage downwards nearly to the top of the sternum. The first incision should be carried through the skin and subcutaneous fat; the second assistant should then draw the edges of the wound apart with retractors, and the operator should by successive cuts divide the

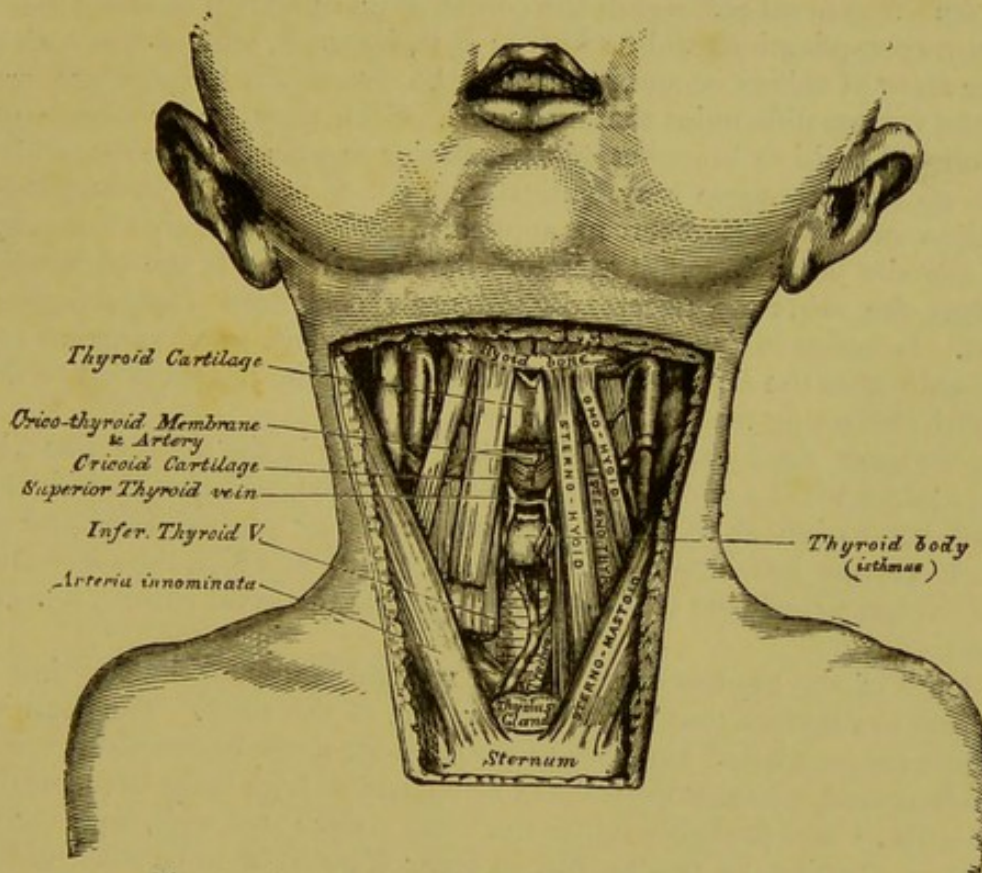


Fig. 16.—Anatomy of Child's Trachea. (From Gray's Anatomy.)

tissues until he reaches the intermuscular septum between the sterno-hyoids or lower down between the sterno-thyroids; on reaching this he should with a director tear through the line of junction, and the assistant should take them up with retractors. The tracheal fascia will now be exposed, and should be torn through in like manner, and the trachea bared. The tracheal hook is next fixed in the trachea, and drawn slightly forwards so as to steady the windpipe and make it prominent; a short, somewhat round-shouldered knife<sup>2</sup> is then made to pierce the trachea, and as soon as it has entered the handle is slightly depressed, and the windpipe is divided from below upwards for at least  $\frac{3}{4}$  inch. The knife is now laid aside, the dilator passed into the trachea

<sup>1</sup> Parker recommends a wine bottle wrapped in a towel as a neck support.

<sup>2</sup> I.e. rounded at the back and nearly straight in front.

and opened, and the hook removed ; a free blast of air and the driving out often of mucus or of membrane follows. If the trachea is free from membrane, the tracheotomy tube fitted with tapes is then passed in between or above the dilator blades, and the dilator is removed ; as soon as a blast of air through the tube shows that it is in place, the tapes should be tied round the neck and the operation is over. The child should be kept upon the table well wrapped up, with a warm sponge over the tube, for a short time to recover itself, and that it may be seen that there is no bleeding or other complication ; after a quarter of an hour the inner tube may be put in after clearing away all coughed-up matter, and the child put into its cot and the steam kettle arranged.

Such are the general outlines of the course of an operation in which there have been no complications and no hurry ; it is, however, seldom that such a favourable state of things occurs, and it will be convenient to consider more in detail the various difficulties that may arise. First, then, one or more large veins, inferior thyroid or branches of the anterior jugular, may be met with ; if there is no urgency these may be ligatured, either before or immediately after division, or forcipressure forceps applied. Should, by any rare chance, an artery of any size be wounded, it must of course be treated in the same way. In all cases the veins are necessarily intensely congested when dyspnoea is marked. In order to avoid danger of wounding veins, some surgeons lay aside the knife after the first incision and tear through the tissues down to the trachea with dissecting forceps or director.

Next, the most rigid care must be taken to keep in the middle line ; in young fat children it is not difficult to miss the trachea, which in them is not only small, but so soft as to be readily compressed or pushed aside and so missed. Everyone has heard of, if not seen, cases in which the dissection has been carried to one side of the trachea and thus the great vessels, &c. endangered.<sup>1</sup>

The depth of the trachea must also be remembered, and the fact that it recedes from the surface towards the lower part of the neck. The deep incisions must not be carried too close to the sternum, or the innominate vessels will be endangered, nor must the trachea be opened so high up as to divide the thyroid cartilage and probably injure the vocal cords ; it is well, however, to get as low an opening as practicable, in order if possible to be clear of the obstruction.

No regard need be paid to the thyroid gland, nor should any attempt be made in children to make a 'superior' or 'inferior' tracheotomy. In almost every case in which the operation has been done examination will show that two or three rings of the trachea and the cricoid cartilage together with, of course, the isthmus of the thyroid gland have been divided—that, in fact, a laryngo-tracheotomy has been done, and this is as good as any other operation.

It is not necessary by any means to use a tracheal hook ; if it is not employed, the left forefinger should be used as a guide and the trachea steadied by it or between it and the left thumb while the knife is carried upwards by the side of the finger or between it and the thumb ; in many cases, however, the hook does undoubtedly simplify the operation.

<sup>1</sup> In tracheotomy low down, the anterior jugular vein is the vessel most likely to be injured. This is, of course, of minor importance.

It is of great importance to have the skin wound very free, both to give room for the deeper steps of the operation and to prevent the possibility of discharge or air being pent up in the cellular tissue of the wound; no stitches should ever be put in. The tracheal opening should be large, median, and vertical; nothing is gained by a small opening and much trouble may arise in inserting the tube. The knife should enter the trachea somewhat sharply, but not with a stab or plunge which would endanger the posterior wall; cases have been recorded where the knife failed to pierce the mucous membrane, and hence the tube was passed into the submucous tissue; in other instances a tough diphtheritic membrane has been pushed before the knife and tube—under either condition of course no relief was obtained by the operation.

If there is any large collection of membrane or of thick mucus in the trachea, the tube should not be inserted at once, but the edges of the tracheal wound should be held apart for the child to freely cough out the contents of the air passages, and for the surgeon to clear them away and examine the surface of the trachea so as to pick off any visible membrane above or below the opening. Parker advises the systematic use of the dilator and swabbing out the trachea and larynx with a feather dipped in solution of carbonate of soda before putting in the tube.

The tracheal aperture may be held open either with the dilator or with artery forceps, or Golding Bird's dilator may be worn for a time.

In inserting the tube it is sometimes difficult to get it into the slitlike orifice in the trachea; under these circumstances the dilator is useful, or if one is not at hand, one edge of the opening may be depressed by the finger so as to make the aperture gape. A bivalve tube is of course the easiest to insert for this reason, though it is not by any means the best variety. The surgeon should never be satisfied that the trachea is properly opened unless free blasts of air are driven out on coughing, nor that the tube is in the wind-pipe unless air and mucus are blown out through the tube freely.

The instrument most commonly used to clear the trachea of membrane is a feather; some of the shorter tail feathers of a pheasant will be found the best; if the longer ones are used the end which is too flexible should be cut off. We have had some common brush pipe-cleaners tipped with coralline for this purpose and also a miniature bristle probang made to sweep out the trachea. Membrane can often be picked out with forceps. Aspirators of all kinds are of use chiefly if not solely for blood and the thinner form of mucus; adherent membrane and thick mucus cannot be drawn out by them; neither is sucking by the mouth any better, hence it is not worth the risk to the operator. Anyone who has tried it will know how impossible it is to suck out anything except the fluid material, and even for this suction is often unsuccessful. Parker, however, strongly advocates the use of aspirators after loosening and softening the membrane by instillation of carbonate of soda.<sup>1</sup> Where breathing has ceased or is becoming very feeble, artificial respiration should be performed, and if necessary a catheter may be passed down the trachea and the lungs inflated.<sup>2</sup>

Such are the more important points about the operation itself in cases

<sup>1</sup> Sodæ carbonat. ℥ij, glycerine ℥ij, water to ℥viij (Parker).

<sup>2</sup> Vide Jennings, *Arch. Pædiatr.* September, 1884.

where everything can be done deliberately and Trousseau's classical advice<sup>1</sup> followed. In many cases, however, if the operator is slow the child will be dead before the trachea is opened, and if not actually dead, the almost complete asphyxia will seriously add to the dangers of the case. Under such circumstances it is necessary to cut the steps of the operation short; a free incision through the skin, another down to the trachea, and the third upwards in the trachea itself. We have often had to operate in this way with three cuts, using no instrument except the knife and the tracheotomy tube; after the first two incisions the left forefinger is passed down to the trachea, which is steadied by it; the opening is made and the finger kept as a guide for the tube, which is at once inserted.<sup>2</sup> In some cases there is free bleeding for a moment or two from the engorged veins; this must be neglected, the tube put in at once, and the child instantly turned over on its face to prevent any blood from running into the trachea; as soon as air enters the lungs freely the circulation is re-established and the venous bleeding ceases without any treatment. The objection to this mode of operating is that it is of course more difficult, and there is some risk of blood getting into the air passages; it is however necessary in some cases. In very urgent suffocation the operation may even be done in one incision through skin and trachea upwards, but this can hardly ever be necessary, and has several objections, the chief being that in children the trachea can by no means always be felt through the skin and there is great likelihood of emphysema from insufficiency of the superficial wound.<sup>3</sup>

It is well to remember that venous bleeding in tracheotomy is always more formidable in appearance than in reality, and always ceases at once after the trachea is freely opened.

Emphysema occurring at the time of the operation is due to too small a skin wound or to opening up the cellular tissue in attempts to pass the tube; it may be very extensive and spread down into the thorax; in such cases it is sometimes fatal from pressure upon the lungs. Champneys has shown experimentally that there is serious danger of mediastinal emphysema and pneumo-thorax when artificial respiration or sudden violent inspiratory effort is made after division of the deep cervical fascia; hence the tube or dilator should be put in quickly and the fascia disturbed as little as possible.<sup>4</sup>

A possible danger from entry of air into a wounded vein need only be mentioned, instant pressure on the vein and rapid opening of the trachea are the remedies.

Opinions differ greatly as to the best form of tracheotomy tube for immediate use. The bivalve is the easiest to insert; the lobster-tailed tube of Durham is open to the objection that it is very difficult to clean; probably Parker's so-called angular tube is the best, and is certainly anatomically the most correct, it has also the advantage of being polished inside. It is, however, a matter

<sup>1</sup> 'Opérez lentement, très lentement.'

<sup>2</sup> The finger and thumb may be usefully employed to push back the tissues on each side and, as it were, press forward the trachea.

<sup>3</sup> St. Germain operates by one incision downwards, beginning by perforating the crico-thyroid membrane. Neither this plan nor operation with the thermo-cautery has anything to recommend it.

<sup>4</sup> *Med. Chir. Trans.* 1882. ○

of little importance what shape of tube is put in for the first few hours, provided it is of sufficient size and has a movable shield to allow it to lie evenly. The largest size that the trachea will admit should always be used to give as much breathing space as possible and to prevent play of the tube in the trachea. Parker has shown that the diameter of the windpipe is exceedingly variable and no rules for size in correspondence with age can be given. In any case it is advisable to change the tube after twenty-four or forty-eight hours, and this gives time for the substitution of a Parker's tube for any other that may have been used at the moment. After ninety-six hours the metal tube can often be replaced by a Morratt Baker's rubber one, or at least a metal tube of different length to that first employed, or better still the tube may be in favourable cases left out altogether.

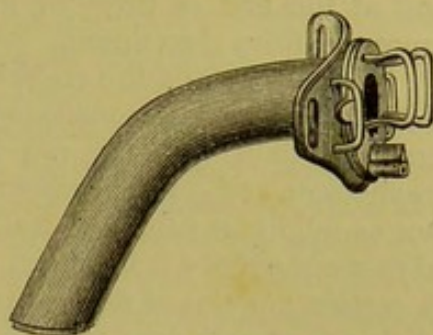


Fig. 17.—Parker's tube.

As soon as the trachea has been cleaned and the child has become quiet after the operation, i.e. usually in about half an hour or less, the child should be removed to the tent, the arrangement of which has been already described. The steam may be medicated with eucalyptus, sanitas, &c. if desired. Parker specially recommends creasote<sup>1</sup> and also the burning of small quantities of sulphur in the room.

The lower part of the wound should be dusted over with iodoform and a piece of gauze slipped beneath the shield of the tube to protect the skin and wound from it. If the edge of the shield cuts into the wound, the tube does not fit well and probably the inner end is pressing upon the tracheal wall; it is either too long in the straight part or the curve is wrong. A single layer of gauze wet with 1-40 carbolic or some other antiseptic solution should be laid over the mouth of the tube and removed when there is any coughing.

The child must be constantly watched, and at the least sign of dyspnoea or any cough the tube should be cleaned with a feather, and coughing excited, watching for the moment when mucus appears at the mouth of the tube to wipe it away before it is drawn in again. The inner tube should be put in as soon as the child has settled down, and taken out every half-hour or oftener at first to be cleaned. Special watch must be kept for any sudden plugging of the tube by pieces of detached membrane or thick mucus—a frequent cause of sudden death after tracheotomy—immediate removal of the tube and membrane is required in such circumstances.

*After management.*—Success in the results of tracheotomy cases depends more upon after management than upon anything else, and if surgeons could nurse their own cases the mortality after the operation would be much less. Constant watchfulness, *readiness to remove the tube altogether and clean out the trachea*,<sup>2</sup> the timely administration of stimulants, regulation of temperature and moisture are essentials, and can be only satisfactorily seen to by the surgeon

<sup>1</sup> Creasote promotes mucous secretion and hence loosening of the membrane; abundant discharge of mucus is a good sign in so far as there is less likelihood of there being any membrane in the trachea if free secretion occurs.

<sup>2</sup> If membrane continues to form this should be done at least once daily.

himself. Cocks<sup>1</sup> well insists upon this, and points out that sudden obstruction is most often due to inspissated mucus, not to membrane; this thick mucus is secreted generally about twenty-four hours after the operation, and at the end of three or four days the discharge becomes thinner and more puriform (Jennings).

It is well to feed the child by nutrient enemata for the first few hours, but if he is thirsty a few teaspoonsful of iced milk may be given. During the first few days, the milk not infrequently comes out in part through the tracheotomy tube from imperfect closure of the glottis during deglutition, and not as might be supposed from any accident to the œsophagus; on account of this occurrence it has been advised to give more solid food by the mouth. A certain amount of risk is incurred from this imperfect power of swallowing in that food may pass into the lungs and set up the so-called 'deglutition pneumonia;' any such danger may be avoided, as pointed out by Dr. Habershon, jun., by feeding the child through a soft catheter; from two to six oz. of milk may be given in this way every four hours,<sup>2</sup> but the plan is rarely required.

Stimulants and nourishment, peptonised beef-jelly and milk, brandy, carbonate of ammonia, quinine and iron should be given freely according to the requirements of each case, remembering that diphtheritic patients often die of asthenia; on the other hand a too abundant and too exclusively animal diet may in some instances do harm by throwing an extra strain upon damaged kidneys. Food should be given every two or three hours at first, and, if necessary, as already mentioned, should be given through a catheter which may be passed by the mouth or through the nares.

If the pharynx and nasal fossæ are covered with membrane, this should be thoroughly removed after swabbing or douching with the alkaline lotion,<sup>3</sup> and then some spray of creasote, carbolic, or eucalyptus used. Where from simple dislike to food or extensive ulceration or diphtheritic paralysis the child refuses food altogether, the catheter must be of course used for feeding.

If possible the tracheotomy tube should be removed altogether on the fourth or fifth day, but this must depend upon how far the disease has subsided; if membrane is still coming away, the tube must remain, and it may be the eighth or tenth day before the tube is got rid of. If, as not infrequently happens, the dyspnœa returns on closure of the orifice of the tube with the finger (always supposing that the tube has a perforation at the bend) or on its removal, the difficulty is due either to the presence of membrane or of granulation tissue which may form a polypoid mass springing from the site of some patch of membrane,<sup>4</sup> from the edge of the wound or from an ulcer due to the pressure of the tube.<sup>5</sup> Or the dyspnœa may be due to ad-

<sup>1</sup> *Archives of Pædiatrics*, January, 1884.

<sup>2</sup> *St. Bartholomew's Reports*, 1885.

<sup>3</sup> Sodæ carbonat. ʒij, Glycerine ʒij, water to ʒviiij (Parker).

<sup>4</sup> Granulation masses, according to Parker, are most common about the fourth to the eighth day, and may be expected if there are exuberant masses on the margin of the tracheal wound. Morell Mackenzie says they occur from the fifteenth to the thirtieth day, never after two months. Parker treats them by the application of nitrate of silver.

<sup>5</sup> Black patches seen on the outer tube when it is removed are said to indicate ulceration at the corresponding spot of the trachea, and should be looked upon as an indication for change of the tube to one of different length (Parker).

hesions in the larynx or possibly paralysis of the laryngeal muscles, inflammatory softening of the trachea or swelling of the mucous membrane.

Where then the tube cannot be removed entirely after the fifth day the metal one should be replaced by a rubber one, or frequent changes made in the *length of the tube*, and daily attempts made to dispense with the tube altogether. Should the obstruction continue, search must be made for its cause; the most common is the granulation mass which may sometimes be seen on using the dilator and be removed, its base being touched with nitrate of silver. Failing this, it is well to wait a week or so and allow the child to regain strength; it should then be examined under an anæsthetic and, failing the finding of granulations or other obvious cause, a flexible probe should be passed up through the glottis from below and a piece of silk carrying a small sponge be attached to it; the probe should then be drawn out through the mouth, and the sponge carried through the larynx sweeps it out, breaks down any adhesions, and clears away mucus or any granulations there may be. We have by this means succeeded in restoring the breathing powers after many attempts at doing without the tube for a long time.

The dangers then of the too prolonged retention of the tube are the possible development of granulation masses and ulceration of the trachea, which may either lead to hæmorrhage from perforating the innominate artery or vein or to subsequent tracheal stenosis from cicatricial stricture. Roger in 1859 and Heilly (*Le Progrès Médical*, November 29, 1884) estimated that in about one in five of the cases of tracheotomy there is ulceration of the trachea, but these results are from post-mortem observations. The ulceration may be either on the anterior or posterior wall of the trachea and gives rise to no special symptoms at the time, unless some important vessel is opened.

Sometimes mere nervousness and fear of suffocation prevent the removal of the tube; in such cases attempts must be gradually made by the use of a tube with a large fenestra to allow the passage of air through the larynx, while the external orifice of the tube is closed with the finger or a cork for gradually increased periods of time. Careful watch must always be kept upon these cases for fear of sudden asphyxia, which may come on after removal of the tube, as soon as the tracheal orifice becomes small, or even later than this from growth of granulations from the inner surface of the wound. In such cases the wound may require to be reopened and the tube to be inserted afresh. In some few cases the tube can never be dispensed with, and has to be worn permanently; but usually some cause of obstruction can be found. In any case where the tube has to be long retained, great care must be taken to avoid ulceration and to see that the tube is not corroded; it has several times happened that the tube has dropped off the shield and fallen into the trachea after long wear.

As to the application of lotions, &c., to the interior of the trachea after operation, the number of specifics is as great as that for the throat; the soda lotion and lime water<sup>1</sup> do, no doubt, soften the membrane and mucus, and

<sup>1</sup> Lime water is soon rendered inefficient by the  $\text{CO}_2$  of the expired air. Apomorphia (Jennings) and corrosive sublimate  $\frac{1}{10}$  to  $\frac{1}{24}$  gr. (Jacobi) taken internally every hour have been recommended for pseudo-membranous tracheitis, but their value is more than doubtful.

allow it to be more easily detached ; of the other remedies, the most that can certainly be said of them is that it does no harm to try them, and may do good. The applications may be made by a brush or spray-producer, or a drop or two may be instilled through the tube from time to time. Probably smearing the tube each time it is replaced with iodoform ointment is a good plan.

If there is any diphtheria of the wound, a mixture of equal parts of strong HCl and glycerine may be smeared over it, and the same solution may be applied once or twice daily to any patches on the fauces (Parker) ; St. Germain, however, strongly condemns this plan.

After the operation the child is greatly relieved, usually falls asleep, and all goes on well for twenty-four or forty-eight hours, and then in fatal cases death occurs, often suddenly. This sudden death may be due to various causes : blocking of the tube with detached membrane or mucus, extension downwards of the disease possibly, irritation of the vagus (Parker), simple asthenia or poisoning by the disease, pneumonia, or cardiac failure. Later, complications such as nephritis, paralysis, septicæmia, cellulitis of the neck, or simple exhaustion may prove fatal.

There is no doubt that the majority of cases of tracheotomy for diphtheria die ; the mortality varies with the epidemic, and with the operator, for necessarily the surgeon who will only operate in the most favourable cases will have a lower mortality than he who gives a chance of relief to less hopeful cases as well. Hence statistics are of no value. It is, however, roughly true that a large proportion of the cases described as croup recover after tracheotomy, while those classed as diphtheria mostly die.

Age has a very important bearing on the success of the operation. Children under two years comparatively seldom recover,<sup>1</sup> the feebleness of the child, the increased difficulty of the operation and of the subsequent management, all make the prospect at this age worse.

Archambault, in the Paris Children's Hospital, gives the following table of tracheotomy cases :

	Cases	Recoveries
1-3 years . . . . .	976	104
3-4 „ . . . . .	820	175
4-5 „ . . . . .	736	174
5-6 „ . . . . .	497	148
above 6 „ . . . . .	547	198

Apart from diphtheria or croup, tracheotomy may have to be considered in cases of *scalds of the glottis* usually the result of an attempt to drink from the spout of a tea-kettle. In such cases, as Dr. Wilks has shown, a false membrane may be produced exactly like that of diphtheria.<sup>2</sup> The symptoms usually come on immediately, and in slight cases soon subside if the child is kept in bed in a warm moist atmosphere. Sudden spasm, bronchitis,

<sup>1</sup> But Lindner, *Jahrbuch f. Kinderheilk.* B. xx. H. 2, records 38 per cent. of successes for 'croup and diphtheria,' and most of the successes were in the second year of life ; and Chaym, *Archiv f. Kinderheilk.* B. iv. H. 11, 12, has collected 220 successful cases under two years ; the youngest cases are six weeks and nine weeks respectively ; the latter, however, was for post-pharyngeal abscess.—*Berliner Klin. Woch.* 1880.

<sup>2</sup> *Guy's Reports*, 1860, and Bryant in the same number.

and pneumonia, and the formation of false membrane are the chief dangers. The treatment of such cases consists in keeping the child in a tracheotomy tent and giving antimony or an emetic. If the child is steadily getting worse tracheotomy should be performed. The tube may be removed usually on the third to eighth day. Scarification is often recommended, but is more easy to write about than to perform.

**Foreign bodies** often find their way into the air-passages of children. A bead, or grain of maize, or a plum-stone, or other foreign body is held in the child's mouth and a sudden inspiration may cause it to pass into the larynx. The body may lodge in the upper opening of the larynx or in the rima, or may pass into the trachea or either bronchus, usually the right.

If the body is in the larynx there will be dyspnœa and more or less loss of voice, with hoarse or ringing cough, and if in the trachea possibly a loose rattling sound may be heard on listening over the front of the neck indicating the movement of the body in the trachea. If the substance is lodged in the bronchus, there will be impaired breath sounds and possibly collapse of the lung on the same side.

If the history is clear, tracheotomy should be at once performed, as sudden asphyxia often comes on quite unexpectedly; hence, urgent symptoms should not be waited for. The opening in the trachea should be free, and the edges should be held apart to allow of the ready expulsion of the body, which is often blown out at once. If this does not occur, the larynx should be searched, a probe being passed in from below and the finger made to explore the throat from the mouth. If the body is lodged below the opening the child should be inverted and shaken, and if this is unsuccessful an attempt should be made to extract the substance with forceps or a brush passed down the trachea. Bronchitis and pneumonia usually speedily result if the foreign body is not removed.

Should the attempt at removal fail, if the body is in the larynx and cannot be pushed up into the mouth or removed from below, it is probably better to follow Holmes's advice and divide partially or wholly the thyroid cartilage so as to expose and remove the impacted mass; the operation is likely to do less harm than the retention of the foreign material. If the substance is lodged in the lungs it may possibly be removed at a second attempt or may become loosened and coughed up; occasionally such bodies ulcerate their way out and may even reach the surface of the chest. In other cases death results from pneumonia or pulmonary abscess.

Certain other conditions may demand tracheotomy in children—congenital syphilitic laryngitis, chronic simple laryngitis, papilloma, or, as already mentioned, pressure of pharyngeal abscesses.

**Intubation of the larynx** has been recently practised<sup>1</sup> by O'Dwyer, Waxham, and others, chiefly in America, as a substitute for tracheotomy. It has been urged in its favour that it is a less severe measure than that operation, and is likely to be permitted by friends when a cutting operation is refused; that it does not prevent opening the trachea later, should that become necessary, and that it is efficient, while it does not expose a raw surface to the diphtheritic poison nor allow unwarmed air to reach the lungs. A special set of instruments is required for this plan. From twenty to thirty per cent.<sup>1</sup>

<sup>1</sup> Vide Waxham, *Brit. Med. Jour.*, September 29th, 1888.

of successful results have been obtained, but several drawbacks to its use are admitted, such as the difficulty of the manipulation, the liability to displacement of the tube, its obstruction and so on. Our experience of trials with the somewhat complicated apparatus upon the dead subject showed that it is not an easy matter to insert the tube, but a little practice gets over this difficulty; it is much more difficult to remove the tube from the larynx. The small size of the tube, the difficulty of the operation, and the expense of the appliances will, we think, prove obstacles to the introduction of the method into general

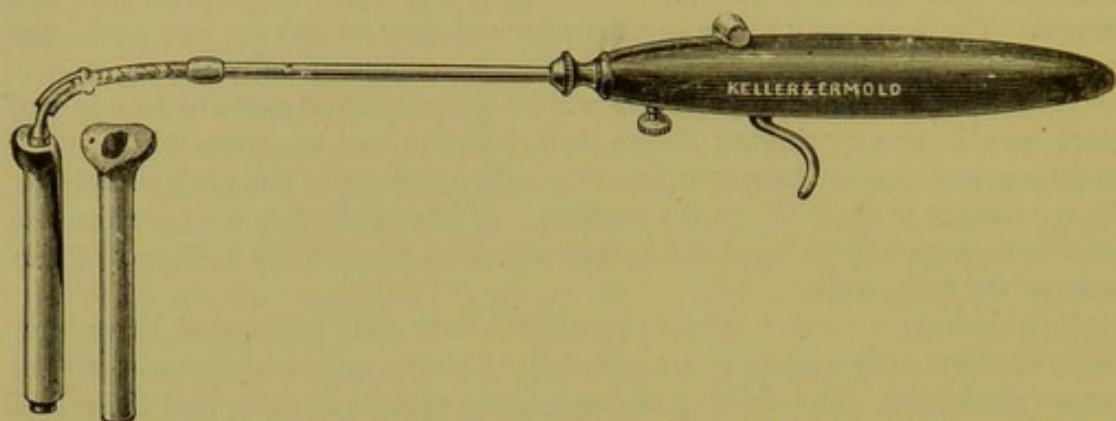


Fig. 18.—O'Dwyer's Intubation Apparatus. The figure shows the 'introducer' with a tube fitted on. A separate tube is also shown; these have recently been made with an 'artificial epiglottis.'

use. It seems, however, that several improvements might be made in the apparatus, and the method requires further investigation before it is adopted or condemned. Intubation, as suggested by Symonds, would be certainly useful in some cases where after tracheotomy there is a difficulty in getting rid of the tube. For further details we must refer to the 'Medical Chronicle'

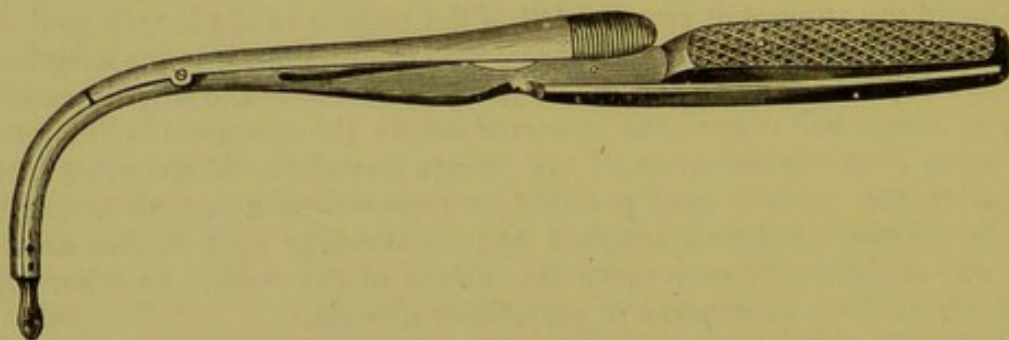


Fig. 19.—O'Dwyer's Extractor. The jointed beak fits into the tube and holds it firmly when the lever is depressed by the thumb of the operator.

for 1887, where abstracts of numerous papers on the subject will be found, also to the 'Archives of Pædiatrics' 1887, and to Waxham's paper already referred to.

In the only instance in which we have performed intubation upon a living child the result was disastrous: a portion of the membrane was pushed down before the tube, and the child instantly choked; it was only by immediate tracheotomy and the use of artificial respiration that breathing was restored. The operation appears best adapted for cases where there is little or no false membrane—i.e. certain cases of acute laryngitis, the less severe forms of

diphtheria, where tracheotomy is for any reason undesirable, and for use in cases where mechanical obstruction remains after tracheotomy, or results from cicatricial contraction in the larynx.

The apparatus used for intubation, and figured above, consists of a special tube with an 'introducer' and 'extractor.' The mouth is held open by a gag, a tube of proper size selected, threaded, and its pilot screwed on to the introducer; the left forefinger passed to the back of the throat pulls forward the epiglottis and serves as guide to the tube. As soon as the tube is in the larynx the introducer is withdrawn with the pilot, and if the tube is in position the thread is also withdrawn. The tube is then left in position for a time varying from a few hours to two or three days, according to the circumstances of the case. To remove it an anæsthetic is given, and the extractor introduced into the opening of the tube, which is then withdrawn. If too small a tube is used it may slip into the trachea. Without practice the tube is apt to be passed into the œsophagus.

**Chronic Laryngitis.**—Both infants and older children suffer from chronic hoarseness, with occasionally acute or subacute exacerbations, with croupy symptoms. Such cases may take their origin in a past attack or attacks of subacute laryngitis, a certain amount of thickening being left behind. Other cases are apparently syphilitic, especially in infants. Tubercular laryngitis may also occur, but it is certainly uncommon. The larynx is also sometimes affected in cases of chronic pharyngitis where the tonsils are enlarged and perhaps post-nasal growths also exist. If the symptoms do not yield to astringent applications or the use of caustics such as nitrate of silver, there may be so much progressive thickening and dyspnœa, that tracheotomy may even be required; this is, however, very rarely the case.

**Papilloma of the larynx** is a rare affection, consisting in one or more warty outgrowths from the neighbourhood of the true vocal cords. The symptoms are aphonia and usually intermittent but increasing dyspnœa coming on without obvious cause. Where laryngoscopy is practicable, inspection shows the warty mass or masses usually about the anterior part of the glottis. Sudden obstruction of the aperture may result from spasm set up by impaction of a pendulous growth between the cords, or gradual asphyxia may come on. Three modes of treatment are possible—removal of the growths by endolaryngeal operation, a method applicable only to late childhood and adults; the second is tracheotomy, with or without an attempt to remove the growths from the tracheotomy wound; and the third is thyrotomy, with excision of the warts when fully exposed. The latter plan, which is the simplest, is open to the objection that injury is likely to be done to the vocal cords and permanent aphonia may result. Several successful cases by Parker, Davies-Colley and others, have, however, been recorded. On the whole, in this disease, it is probably best to perform thyrotomy.

## CHAPTER XII.

DISEASES OF THE RESPIRATORY APPARATUS—*continued.*

**Bronchitis and Catarrh.**—Catarrh of the bronchial tubes is a common affection at all periods of life and in every social grade, but it is in early childhood that it is perhaps the most common, and it is at this period that it assumes the greatest importance from the diseases which are liable to follow in its train. In old age, when the lungs are damaged by emphysema, and the chest walls have lost their elasticity, bronchitis is apt to be a serious and often fatal disease; but not less so is it in the very young, in whom the chest walls are alike wanting in elasticity and rigidity, the bronchial tubes easily collapse, and the lungs very readily join in the inflammation. The greatest liability appears to occur during the first two years of life; certainly at this age it is most fatal. Exposure to cold is in a large number of cases the exciting cause; climatic influences are seen especially in late autumn or early winter in the larger number of cases of chest affections which occur at this period. That the larger number of cases should occur among the lower and worst-housed class is only what is to be expected, inasmuch as the lives of the infants and children are spent either in the foul and stuffy atmosphere of an overcrowded and ill-ventilated house, or exposed imperfectly clad to all sorts of weather in the streets. The predisposing causes are many; some children seem to inherit a tendency to bronchial catarrh, and who, in spite of the greatest care and the most constant 'coddling,' suffer every few months, perhaps for the whole of the winter, from bronchial catarrh or severe colds, which pass into bronchitis with the greatest readiness; dentition, rickets, measles, whooping cough, intestinal catarrh frequently play an important part in the production of a bronchitis. During the time that a tooth is being cut children seem very apt to suffer from catarrh, which in the winter affects the bronchial tubes and in summer the intestines. Pressure of the tooth on the gums seems to act reflexly in producing a catarrh, sometimes with more or less spasm, as the child becomes wheezy at night, sibilus being heard all over the chest, while in the morning it will be perfectly well. This may happen several nights in succession. Rickety children are specially prone to suffer from bronchial affections, and in them it is especially serious on account of the softness of the ribs, and the weakness of the muscles of respiration, resulting in deformed chests and collapsed lung.

*Symptoms and course.*—The attack is often preceded by a cold in the head, the infant sneezes, its nose runs, and it begins to cough. If the bronchial catarrh which follows be mild, and the catarrh do not extend beyond the trachea and large bronchi, the general symptoms are slight:

there is no distress, no dyspnoea, only a troublesome cough, perhaps some wheezing during respiration and a slightly elevated temperature at night. In the more severe attacks, in which the smaller bronchial tubes are involved, their mucous membrane being swollen and the secretion thick and viscid, dyspnoea from obstruction to the air entering the lungs will be present. The pulse is hard and accelerated, the number of respirations increased according to the amount of obstruction, the alæ nasi working, the skin hot, and the infant restless and thirsty. On placing the ear to the chest, dry hissing or snoring sounds will be heard during inspiration, as the air rushes through the pulmonary divisions of the bronchi, in the severer cases entirely obscuring the respiratory murmur. In the milder attacks rhonchi will only be heard with some respiratory movements, being more especially heard at the roots of the lungs. In infants and young children, especially if their ribs are softened in consequence of rickets, there is recession of the chest walls, especially at the epigastrium and lower lateral region of the chest, due to the imperfect filling of the lungs, the chest wall falling in, in place of the lungs expanding. In a later stage the sibilant or rhonchial sounds become mixed with moist rales: these are not distinctly and sharply crepitant as of bubbles passing through thin fluid, but indistinct bubbling sounds as of air forced through thick tenacious mucus. The moist sounds succeeding the dry, point to a freer secretion of mucus from the hitherto swollen and congested mucous membrane. In some cases in infants mucous bubbling rales are heard from the first. If convalescence is quickly established, the abnormal sounds are gradually replaced by the normal respiratory murmur, though rhonchi or rales may be heard for some days or weeks. Percussion of the chest walls during an attack of uncomplicated bronchitis shows the resonance normal, except perhaps there may be some hyper-resonance at the sub-clavicular regions from the presence of more or less emphysema.

In most attacks of bronchitis there is usually more or less disturbance of the digestive organs. The bowels may be confined and distended with flatulence, the tongue is coated, and there is often more or less vomiting.

The fever in uncomplicated cases is never high; there may be an evening rise of a degree or two, while the morning temperature may be normal or subnormal, especially in weakly children. The cough, which in the early stages is hard, in the later stages becomes looser, mucus is coughed up into the pharynx and then quickly swallowed, unless extracted by means of the nurse's finger. Children under five rarely expectorate—mucus is coughed up, but they have not the sense to spit it out.

An attack of bronchitis usually lasts a week or ten days and ends in recovery, leaving the child subject to a second attack.

*Complications.*—Bronchitis in infants and young children is frequently accompanied by one or more complications, the commonest being collapse of the lung, catarrhal pneumonia, and emphysema. In a fatal case it is almost certain that one, or mostly all three, of these complications will be found.

**Collapse of lung.**—During an attack of bronchitis or bronchial catarrh it is not uncommon to note that the respiratory murmur is weak or absent over a portion of lung, as, for instance, one or other base; then perhaps after a vigorous cough a plug of mucus is dislodged from a large bronchus and the breath sounds, with perhaps some loose rales, are heard over the same area.

At other times the breath sounds are absent, and by the next day the ordinary respiratory murmur will again be heard. In this case a plug of thick mucus lodged in one of the larger divisions of the pulmonary bronchi prevents the ingress and egress of the air from the lung, but is expelled and coughed up by an extra effort.

If, however, thick mucus is drawn into the smaller bronchi, perhaps filling up a series of small branches, the most powerful expiratory effort the child can make fails to clear the occluded bronchi, especially when the respiratory muscles are weak and the ribs are soft and easily bend. Two things now are certain to happen—the lung supplied by the occluded bronchi collapses and more or less dilatation of the bronchial tubes and emphysema of the neighbouring lung occurs, unless the chest walls fall in to take the room of the collapsed lung. The lung collapses in consequence of the absorption of the imprisoned air, the air entering the blood-vessels, as shown by the experiments of Lichtheim. It is clear that this collapse of lung and vicarious emphysema at least temporarily damages the lung, and if this should occur to any great extent in acute bronchitis, it adds considerably to the danger of death by asphyxia.

The symptoms to which collapse give rise are not always very definite, and unless tolerably extensive there may be no sign of its presence. In some cases it may supervene suddenly, possibly by the sucking in of mucus which has accumulated in the trachea during sleep, into the bronchial tubes, the dyspnoea becoming urgent, the child's lips blue; it rolls about in its cot struggling for breath, and convulsions come on which perhaps prove fatal. In other cases while the symptoms may be alarming for the time they quickly pass away, a result due to the mucus being expelled. If the collapse is scattered in patches throughout the lung, especially if accompanied by emphysema, it will be impossible to detect it by any physical signs; there may be hyper-resonance due to the emphysema, weak breath sounds, and perhaps some moist rales. If any extent of lung is involved as part of an apex or base, there will be some loss of resonance, but this is rarely well marked, unless some broncho-pneumonia be associated with it, a pneumonic patch and a collapsed patch lying side by side. The respiratory murmur over the collapsed patch is weak and rhonchus or moist sounds may be heard. In some cases there appears to be a mixed condition of collapse with much congestion of the vessels and œdema, or possibly as some authors believe the collapsed lung becomes the seat of a low form of pneumonia with exudation into the collapsed air-sacs.

**Bronchiectasis and Emphysema.**—Dilatation of the bronchi frequently takes place during acute bronchitis, the walls of the medium-sized and small bronchi being thin and their calibre increased, a result no doubt due to inflammatory softening of their walls. Emphysema is also constantly present in association with dilated bronchial tubes. The chest walls during an acute attack assume the position of inspiration and particularly the infraclavicular region, become hyper-resonant, while the expiratory murmur is prolonged. As already remarked, compensatory emphysema is constantly present in association with broncho-pneumonia and collapse. Bronchiectasis takes place in association with chronic pleurisy and fibroid conditions of lung.

**Broncho-pneumonia.**—In the majority of cases the attack begins with a

bronchial catarrh and passes on into a broncho-pneumonia, the inflammation extending from the bronchi into the air cells. In other cases the bronchial

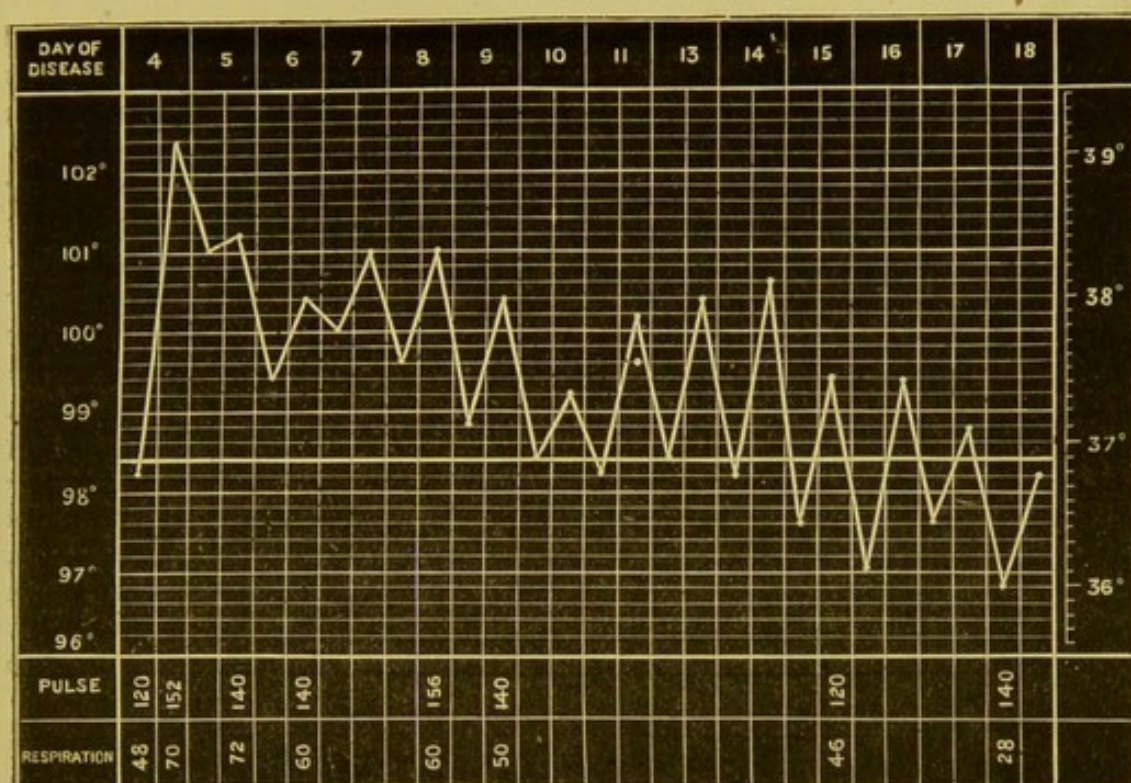


Fig. 20.—Temperature Chart of a case of Bronchitis, with disseminated patches of pneumonia. Boy of 5 years. Recovery.

symptoms may be slight or absent and the attack may closely resemble a croupous pneumonia. Between these two types all gradations may be met with. When the pneumonia occurs secondarily to bronchitis, all the symptoms become exaggerated, the child is restless, the cough shorter and more, hacking, the skin hot and dry, the evening temperature usually reaching 103° or 104° with morning remissions of several degrees, so that the fever assumes a remittent type; sometimes there are evening instead of morning remissions, the temperature being at its lowest in the evening—the dyspnoea is usually great, the respirations numbering 40 or 50, but varying with the amount of fever and extent of lung involved. If the pneumonia is extensive the face wears a distressed expression, the alae nasi work vigorously, the child lies weak and helpless in its mother's arms, too feeble to cry, or if it resists examination for awhile it is soon exhausted and passively submits.

An examination of the chest, if made when the attack is fully developed and severe, shows that the accessory muscles of respiration are brought into play, the respirations are rapid and shallow, with recession of the epigastrium and intercostal spaces. The percussion note varies according to the position of the consolidated lung; this may involve an extended portion at one or both bases, at an apex, or be scattered in patches over the lungs. To detect the pneumonic portions both light and strong percussion should be practised, carefully comparing any spot where the resonance appears impaired with the opposite side. There may be hyper-resonance, especially anteriorly, from

the presence of emphysema. A considerable amount of pneumonia may exist if diffuse or patchy without any definitely impaired resonance. There is never complete dulness in pneumonic consolidation, unless much lymph or some fluid be present. On auscultation rhonchi are usually heard over the chest, while over the pneumonic portions rales of a consonant or ringing character are heard, which contrast with the subcrepitant rales of a simple bronchitis, inasmuch as they are more intense, from the fact of their travelling to the ear through consolidated lung. Even though no consolidated lung can be detected by percussion, the presence of consonant intensely ringing rales with a temperature of  $103^{\circ}$  or  $104^{\circ}$  points almost certainly to pneumonia.

In the early stages the respiratory murmur is weak, later there is mostly well-marked bronchial breathing over the dull area. If a fatal result is about to occur, the respirations become more hurried, the distress greater, and the pulse weaker and weaker; rales and rhonchus are heard over the whole chest, the heart flags, and the child becomes pallid and comatose, death taking place with symptoms of toxæmia on account of the lungs becoming choked and consolidated. The temperature usually falls towards the close; the child is frequently convulsed. If, however, the attack takes a favourable turn, towards the end of the first week or earlier the temperature approaches normal, the breathing is easier, and the child, instead of concentrating his whole attention on himself, begins to notice those about and to play with



Fig. 21.—Temperature Chart of a case of acute Broncho-pneumonia in a boy of  $2\frac{1}{2}$  years; death 15th day. At the post mortem both bases of lungs showed generalised broncho-pneumonia with *graines jaunes*.

his toys. The physical signs change but slowly, the bronchial breathing and rales being heard perhaps during the second or even the third week.

While the above is the description of a typical attack, the pneumonia may be of much less well-marked character. The child may seem ill with little or no cough, while there is loss of appetite, coated tongue and feverishness, especially well marked during the afternoon or evening. An examination of the chest may at first yield no positive result, yet in a day it will be noted that there is a patch of lung at the extreme base, axilla, or near the root where the air does not enter well, and the respiratory murmur is replaced by breathing of a distinctly bronchial character. In a few days or a week the temperature may again become normal.

Sometimes an attack of broncho-pneumonia closely simulates the croupous variety and there may be a doubt as to which category to refer it. The onset may be sudden, accompanied by a convulsion or series of convulsions, the temperature may rise to  $104^{\circ}$  or  $105^{\circ}$ , the physical signs may point to an extended portion of lung being involved, and only the course of the attack, the temperature becoming intermittent, and reaching normal gradually by lysis, would seem to indicate that the attack is rather of the catarrhal than the croupous variety. Some cases may from first to last be open to doubt.

*Prognosis.*—Broncho-pneumonia is always a dangerous disease, but more especially so in children under two years of age who are rickety or weakly. The prognosis is necessarily serious if the pneumonia follow any other disease, as measles, whooping cough, or summer diarrhoea, or when it occurs in scarlet fever through the extension of the inflammatory process in the throat. In any severe case the danger depends upon the amount of lung involved and the softness of the chest walls. It must also be remembered that a young child may struggle through the bronchial affection, only to pass into a condition of atrophy, the result of a gastro-intestinal catarrh. The pneumonia may become chronic and tuberculosis supervene.

*Morbid anatomy.*—The appearances found post mortem in the bodies of children dying of bronchitis and broncho-pneumonia are very various and are apt to puzzle those unaccustomed to the autopsies made in children, and

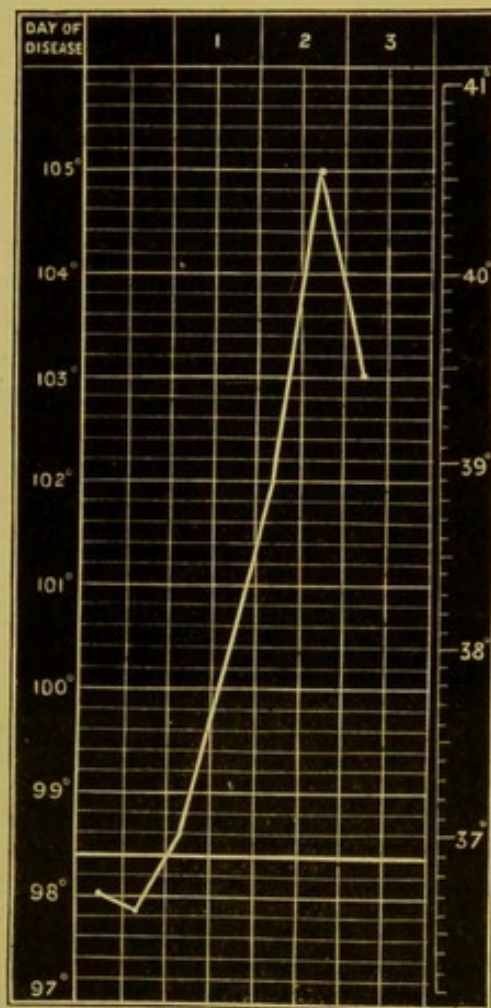


Fig. 22.—Temperature Chart of a case of acute lobar pneumonia in an infant of 9 months; death on 3rd day. The whole left lung except a small part of upper lobe, which was emphysematous was solid; section of lung not so solid as red hepatization; lobules distinct, of a pink and greyish colour.

much confusion has existed in the past in reference to them, especially in confounding the various forms of pneumonia and carnification of the lung with collapse. Collapse of the lung is mostly patchy in its distribution, rarely affecting any continuous extent of lung or involving the whole thickness of a lung. It affects the anterior and inferior edges of the lungs, especially the anterior edge of the middle lobe of the right side and tongue of the left which covers the heart; it is sometimes present along the posterior border of the lung; the collapsed portions are depressed below the surface, purple in colour and airless. Taken between the finger and thumb there is no substance to be felt as in pneumonia. The collapsed portions can be inflated through the bronchi. The collapse is brought about in at least two ways, either from occlusion of a small bronchus by thick mucus, the air being first imprisoned and then absorbed by the capillaries, or by feeble inspiratory power aided by obstruction to the entrance of air, especially when the ribs are soft as in rickets; in this case the chest falls in during inspiration, instead of the lungs becoming distended; it is in this way that collapse is produced along the anterior edges of the lung. The collapsed portions become oedematous from the stagnation of the circulation; according to some they become pneumatic.

What happens to the collapsed portions of lung in the long run is not clear, in most cases apparently recovery takes place, but we believe in some cases fibroid changes are set up, as evidenced by those chronic cases of bronchitis and dilated tubes, the latter surrounded by indurated lung. Acute emphysema plays an important part in the acute lung disease of children. It is sometimes produced very rapidly; thus a child may die of acute broncho-pneumonia complicating measles in three or four days, and extensive emphysema may be present, no doubt produced during the period and contributing very materially to the fatal result (see p. 231). The bases of the lungs are in an early stage of pneumonia and collapse, the upper lobes are overworked, the constant coughing consequent on the acute bronchitis produces emphysema, and the only remaining normal lung is thus damaged and a fatal result quickly ensues.

The chief types found may be described shortly in the following groups.

1. **Acute Bronchitis involving the smaller tubes, collapse of lung, vicarious emphysema.**—On opening the chest the lungs are found to be in a condition of deep inspiration, their surfaces are studded over with clusters of lobules which are depressed and purple in colour (collapse) and with raised portions which are of a pale pink colour (emphysema). On section, thick semipurulent frothy mucus exudes from the large and small bronchi, the latter sometimes contain a semi-membranous exudation. The cut surface of the lung exudes much blood-stained frothy fluid due to congestion of the lung; the lungs are crepitant except where collapse has taken place. The large veins and right heart are much engorged.

2. **Disseminated Broncho-pneumonia.**—The bronchial tubes contain much frothy fluid, one or both lungs, especially the lower lobes posteriorly, have a semi-solid feel, but crepitate, and perhaps some nodules of various sizes may be felt. The section exudes much serum, purulent mucus exudes from the small bronchi, the cut surface of the lung has a mottled appearance, caused by clusters of lobules which are grey or pale pink and have a firm

feel and bright red portions of crepitant lung. The paler portions are pneumonic and solid, the red portions are air-containing congested lung, which surround the pneumonic portions. Portions of lung which are removed will float in water, but easily break down on thrusting in the finger. The upper lobes are emphysematous.

3. **Acute Generalised Broncho-pneumonia.**—The posterior inferior or whole of one or both lobes has a semi-solid feel, though less solid than in croupous pneumonia, with but little or no sense of crepitation. The surface is purplish in colour, the pleural covering may have minute hæmorrhages on its surface or be roughened from the presence of lymph. The cut section has a solid feel, yet is not granular as in true croupous pneumonia, but easily breaks down on pressure with the finger and sinks in water. It has a mottled appearance in consequence of the lobules surrounding the terminal bronchi being paler in colour and in a later stage of consolidation than the intervening portions of lung. There will probably be collapse of the anterior and inferior edges, as well as acute emphysema in the same positions; some of the vesicles are frequently distended to the size of millet seeds or even peas and perhaps one here and there is ruptured. In a still later stage, especially if the inflammation is intense as in measles or scarlet fever, a lobe may be solid and on the surface beneath the pleura there are a number of yellow spots the size of millet seeds or larger, which on pricking yield a drop of thick pus. On section these yellow spots are seen scattered through the lung; they are the 'graines jaunes' or 'abscess peri-bronchite' of French authors, and are in fact minute abscesses surrounding the terminal bronchioles formed by the softening of the pneumonic lobules.

4. In **infants under six months** a form of pneumonia is sometimes found which does not agree with the above description. A lobe, generally one of the lower, is semi-solid, its surface depressed and purple, surrounded perhaps by raised emphysematous vesicles. The cut section is smooth and of a uniform plum colour, the lobules indistinct and airless, but the lung has not the solid feel of red hepatisation.

5. In some cases **nodules of fibrinous pneumonia** as large as hazel nuts or walnuts, hard, and with a granular surface, may be found. We have seen this condition in connection with measles.

It has already been remarked that clinically broncho-pneumonia sometimes so closely simulates croupous pneumonia that it is difficult to say to which variety it is to be referred. The same difficulty may occur in the post-mortem room, as some lobular pneumonias have almost the solid feel found in croupous pneumonia, and a microscopic examination shows the air-vesicles to contain fibrin, and yet the section to the naked eye is not granular as it is in red hepatisation, but mottled, the clusters of lobules varying in tint and more closely resembling in appearance the condition of broncho-pneumonia.

*Diagnosis.*—A clinical distinction between the above conditions is often impossible, inasmuch as bronchitis, collapse, emphysema and catarrhal pneumonia may all exist in the same lung, and more or less mask one another. However, a few points may be emphasised. In simple bronchitis the temperature is rarely high, there is no impairment of resonance, and the moist sounds if present are indistinct and distant. In broncho-pneumonia the temperature is higher, usually there is impaired resonance, perhaps whiffy or

bronchial breathing, and the moist sounds are clear, sharp and ringing. The diagnosis of collapse is much more uncertain unless much lung is involved, then there is impaired resonance and weak and distant bronchial sounds.

In all cases of broncho-pneumonia we must bear in mind the possibility of some localised collection of pus being present over a dull patch, and also that the case may be one of miliary tubercle as well as broncho-pneumonia.

*Treatment.*—The colds in the head and bronchial catarrhs of children call rather for careful hygiene than active treatment. Confinement to a well-warmed and ventilated room or suite of rooms, as long as the symptoms of a cold are present or rhonchi are heard in the chest, with a light mostly fluid diet, will in many cases be all that is necessary. Merely to confine a child to the house and let it run about in cold passages and stand in draughts is useless, and likely to give rise to another cold before the first has completely passed away. Some children are exceedingly liable to take cold, and bronchitis to follow very readily, and with these extra care must be taken and the last trace of a cold must have disappeared before they are permitted to go out. In those cases where there is a laryngeal or tracheal catarrh the cough is often troublesome, especially keeping the patient awake at night and disturbing the whole household. Among the household remedies for coughs which are useful are black currant jelly, glycerine lozenges, liquorice, and jujubes simple or medicated. A hot cup of beef-tea or cocoa the last thing at night will often soothe a troublesome cough. In many cases it will be necessary to give small doses of some sedative, especially in the case of older children. Morphia, codeia, aconite, hyoscyamus, bromide of ammonium may be given for this purpose, made up in the form of a linctus with syrup of orange or tolu or glycerine. The morphia and ipecacuanha lozenges of the B.P. made with fruit paste or glycerine jelly are very convenient. Codeia jelly acts exceedingly well in soothing irritable coughs.

The diet should consist largely of fluids, milk, beef-tea, light puddings; lemonade, barley water, linseed tea, to assuage thirst and tend to produce free action of the kidneys and skin, are likely to be useful; salines such as citrate of ammonia or potash; liq. ammon. acet. may also be given.

The prevention of attacks of bronchial catarrhs and colds is a matter of much importance, especially in the case of those who are liable to bronchitis or asthmatic attacks whenever they take cold. A house in a dry and bracing situation, with well-warmed living-rooms, passages and bedrooms,—while the ventilation and sanitation are carefully looked after,—is a first necessity in the prevention of colds. Care must be taken that such children are properly clothed with well-fitting woollen under-garments, that they have plenty of exercise in the open air whenever the weather is suitable, while cold sponging or the tepid douche in the morning whilst standing in warm water is of much service in promoting the circulation in the skin and preventing chills.

Are 'colds in the head' infectious? It is a common experience that almost a whole household is affected at the same time or in succession, and there can be little doubt that in some cases a nasal catarrh passes from one child to another without the latter having been exposed to any chill. Other conditions favouring these attacks may be present, but of these next to nothing is known. Possibly a chill may predispose the mucous membrane

to take on inflammation or become a suitable nidus for the cultivation of bacilli or other organisms present in the atmosphere.

If the catarrh passes downwards from the trachea into the smaller tubes, and the child in consequence 'wheezes' and rhonchi are heard all over the chest, the child should be confined to its bed or cot, care being taken to have it warmly clothed and in a situation free from draughts. In the more severe cases of bronchitis and catarrhal pneumonia, especially in small children, a sort of tent should be rigged over the cot, or one or two clothes screens placed around with sheets hung on them so as to form sides and a roof will answer very well. The atmosphere must be kept moist by means of a bronchitis kettle or the sheets which form the walls of the tent may be kept moist. The temperature in the cot should be maintained at  $65^{\circ}$ - $70^{\circ}$  night and day. The diet should consist entirely of fluids if the attack is at all acute. Milk diluted with whey or barley water or soda water in proportion of one third or one fourth should form the principal form of nourishment; a cup of beef-tea once or twice a day may be allowed. Moist hot applications to the chest are soothing to the patient and may be applied in the form of linseed poultices or fomentations. It must however be borne in mind that poultices made by unskilled hands may, especially in the case of infants and young children, do more harm than good; to surround the chest of an infant with a heavy poultice when the bronchial tubes are choked with thick mucus and patches of lung are in a state of collapse is simply to invite death by suffocation. The poultices should be well mixed, not too heavy nor applied too hot (placing them against one's cheek is the best guide), being carefully kept in position by means of a flannel binder, and renewed at least every four hours. A mustard poultice is often of great service in the early stage; one tablespoonful of mustard to four or five tablespoonfuls of linseed meal may be used, the poultice remaining on three or four hours. This strength is not sufficient to produce more than some redness, and it can be renewed or replaced by a simple poultice according to circumstances. For infants and young children hot fomentations applied by means of spongio-piline or flannel are preferable to poultices; they are much more cleanly and harm is less likely to be done by their application. Several layers of flannel may be used wrung out of water, or if need be mustard and water, and covered with a piece of oiled silk, the whole being surrounded by cotton wool. Poultices and hot applications are of most service in the early stages, when the mucous membrane is swollen and dry and the secretion scanty; in the later stages they are also useful if the secretion is thick and coughed up with difficulty.

In the early stage of bronchitis if there is much wheezing, dyspnoea and distress, an emetic is of much service, more so perhaps in bronchitis than in catarrhal pneumonia. Pulv. ipecac. in five-grain doses in syrup of orange peel may be given to a child under two years of age and repeated in a few minutes if it fail to act. The act of vomiting especially after ipecac. will probably be attended by a freer secretion of mucus and relief to the breathing. At this period the depressant expectorants which appear to diminish tension in the vessels and thus relieve the congested mucous membrane are mostly used. Of these antimony, ipecac. and aconite are more frequently used than any others. In this stage, when the cough is hard and sibilus is

heard in the chest, antimony in small repeated doses, short of producing nausea and depression, is of much service.

( 22A )

Wine of antimony . . . . .	℥v
Tartarated soda . . . . .	gr. v
Syrup of lemons . . . . .	℥ss
Water . . . . .	to ℥j

*Every two or three hours to a child a year old.*

In catarrhal pneumonia aconite in half-minim or minim doses is preferable. The drug may be continued for several days, as long as the fever lasts or the secretion remains scanty or is coughed up with difficulty. Given with caution and in small doses there is little fear of its producing too great depression; in feeble children however it may be well to give small doses of alcohol at the same time. Many prefer to give ipecac. instead of antimony, especially in the feeble and cachectic patients so often met with in the out-patient room. Some believe ipecac. combined with alkalies such as bicarbonate of potash to be of especial value when mucous rales are heard in the chest and the infant or child has much difficulty in coughing up the thick secretion which is formed. Simple salines are preferred by some. Dr. Lewis Smith recommends tr. veratri viridis in half-minim or minim doses every second hour. As long as the cough remains hard, the mucous secretion scanty or difficult to expel, the antimony or ipecac. should be persevered with, and is far more likely to be of service than the stimulating mixtures so often prescribed. It is when the catarrh continues, the cough becoming loose, the secretion liquid, and the fever mostly gone, that carbonate of ammonia, squills, and terebene are most likely to be useful. At this stage the fomentations and poultices should be given up in favour of a warm cotton-wool jacket or stimulating applications may be applied to the chest walls. Ammonia may be usefully combined with digitalis and squills, as in the following mixture:—

( 23 )

Carbonate of ammonia . . . . .	gr. j
Tincture of digitalis . . . . .	℥ss
Syrup of squills . . . . .	mxx
Dill water . . . . .	to ℥j

*Every four hours or three times a day.*

Among stimulating applications to be rubbed into the chest wall the following are useful in producing slight redness without being too severe:—

( 24 )

Oil of mustard . . . . .	℥v to ℥x
Camphorated oil. . . . .	℥j

( 25 )

Tincture of capsicums
Liniment of soap, equal parts

The lin. potass. iodidi c. sapone B.P. may be used in a similar way.

( 26 )

Powdered capsicums . . . . .	℥j
Lanoline . . . . .	℥j

Forms a good stimulating application, which may be applied daily

Iodide of potassium is often useful in the subacute or chronic stage, and nitric acid and nux vomica are of much service during convalescence.

In bronchitis pure and simple the temperature is never so excessive as to require any antipyretic treatment, but in some cases of acute broncho-pneumonia, especially where it approaches the croupous type, or when it accompanies hooping cough or measles, the temperature is apt to take high flights. Sponging with tepid water, 'packs,' or when there is drowsiness or convulsions the warm bath gradually cooled down by adding cold water so as to reduce it to  $60^{\circ}$ , may be used. Antifebrin or antipyrin may be used for the same purpose with care, beginning with a small dose, two grains of the former for a child of two or three years of age. Both of these antipyretics have been used in small doses frequently repeated both in acute bronchitis and broncho-pneumonia. An excessively high temperature,  $104^{\circ}$ – $105^{\circ}$ , is sometimes present in an early stage of pneumonia, accompanied by convulsions or coma; in such cases no time should be lost in resorting to baths or packs while giving stimulants if necessary by the rectum.

Death usually threatens in bronchitis or broncho-pneumonia from mechanical interference with the air entering the lungs, asphyxia being produced, with great depression of the heart's action. This occurs especially in young infants by a blockage of the medium-sized and small tubes by thick mucus which it is powerless to expel, or is due to capillary obstruction, collapse of lung, acute emphysema, or a large tract of lung becoming involved in the pneumonic process. In young infants with obstructed bronchial tubes, all tight binding up of the chest walls by poultices or bandages must be avoided; its position must be varied from time to time so as to give each lung full play in turn, and an occasional emetic of alum or squills will help to get rid of the excessive and tenacious secretion. The nurse's finger may be usefully employed in removing the secretion from the back of the throat after a fit of coughing. In suddenly-produced dyspnœa either from collapse of lung or acute pneumonia, when the circulation through the lungs is obstructed and the right heart over-distended, local bleeding by means of a leech or two is often of the greatest service, and may be the means of saving life. One, two, or three leeches may be applied at the tip of the sternum, and after falling off the bleeding may if necessary be encouraged by warm applications. Mustard baths, or mustard fomentations, or turpentine stupes applied to the chest are likely to be useful in those cases where there is extensive pneumonia, with much dyspnœa and cardiac depression—turpentine must be used cautiously. Ammonia and digitalis must also be freely given under similar circumstances. Oxygen-inhalation may be resorted to.

The question of the administration of emetics, alcohol and opium, is of importance. Emetics are mostly of value in the early stages of laryngitis or bronchitis when the cough is hard and the breathing difficult on account of the swollen condition of the mucous membrane; a freer secretion follows the administration, and moreover the unloading of the stomach of the accumulated mucus and undigested food seems to have a good effect; ipecacuanha or sulphate of zinc answers best at this stage. Emetics are sometimes useful in a later stage of bronchitis and collapse when the bronchial tubes are choked with mucus, provided there is no pneumonia or cyanosis; ten to thirty grains of alum in a teaspoonful of syrup of squills is preferable to

ippecac. or zinc at this time. In small babies alum and honey may be given on a small brush. The administration of alcohol is unnecessary in the early stages and should always be used with caution in the later stages, for like opium it soothes the cough and in large quantities its effect is narcotic; it is therefore contraindicated except in small doses if there is any tendency to cyanosis. Opium in the form of Dover's powder is often of great value if the child is restless and its cough irritable, but it is perhaps needless to say it should on no account be given if there is much dyspnoea due to the accumulation of mucus in the bronchial tubes or much lung involved.

During an acute attack of bronchitis or pneumonia the digestive organs are very apt to suffer; there may be vomiting, flatulence, and diarrhoea. This impaired digestion must always be borne in mind when the question of dieting is being discussed, and care must be taken not to overload the stomach and bowels with too large a quantity of milk, beef-tea, &c. An occasional laxative dose of calomel or rhubarb and soda may be useful.

It is well to bear in mind the possibility that an infant may recover from an acute attack of bronchitis, to finally succumb to a gastro-intestinal atrophy dating from the acute bronchial attack.

**Chronic Bronchitis and Bronchiectasis.**—Children and infants like adults suffer from chronic bronchial catarrh; they recover slowly and then perhaps within a few weeks another attack supervenes. Some children show such a tendency to these attacks that they have to be kept prisoners almost all the winter, as exposure to even slight cold is sufficient to lay them by for weeks. Frequent and long-continued attacks of bronchitis are certain sooner or later to produce emphysema, dilated bronchial tubes and dilatation of the right side of the heart and the veins which empty into it. Such children present a typical picture; they are mostly thin, with rounded drooping shoulders, barrel-shaped chests, enlarged superficial jugular veins and often injected capillaries on the cheeks. In the milder cases such children with care improve greatly and frequently by puberty lose their tendency to bronchial troubles, and grow up, if not strong, at least not with impaired health. On the other hand, there is always the risk of an intercurrent and perhaps fatal pneumonia; we have seen children of this class with marked emphysema come regularly into hospital perhaps twice in a winter with attacks of croupous pneumonia. There is a risk of chronic bronchitis passing into a chronic broncho-pneumonia, the lung tissue around the dilated bronchi becoming caseous and indurated. There is also the risk of tuberculosis, though we have not often been able to trace a connection between chronic bronchitis and tubercle, though those suffering from chronic bronchitis are often mistaken for phthisical subjects.

**Chronic Broncho-pneumonia.**—Attacks of broncho-pneumonia are apt to become chronic in consequence of an imperfect clearing up of the lung and the resulting caseous degeneration. Catarrhal pneumonia following measles or whooping cough is very apt in an unhealthy child or one who inherits tubercular tendencies to take a subacute course; a base or less often an apex of a lung remains more or less dull, the breath sounds are bronchial, moist sounds are heard, and the evening temperature rises to 102° or 103° F. with night sweats and emaciation. This state of things may go

on for weeks, and it may be impossible to say if the caseous changes are progressing or not. The risk in such cases is undoubtedly that, although the lung may clear up, the bronchial glands may become caseous, and a general tuberculosis of the lung or perhaps tubercular meningitis follow. Most cases of chronic broncho-pneumonia terminate either in recovery or tuberculosis, though in some instances they run a very chronic course resembling a chronic phthisis, and at the post-mortem, dilated bronchi and caseous and fibroid changes are found, but no tubercle, at least no grey granulations. Such cases during life are mostly regarded as chronic or fibroid phthisis; they present in their later stages the signs of consolidation of a portion of lung at an apex or base, the chest wall is probably retracted, there is bronchial breathing, sharp ringing rales, and very foetid expectoration, which is coughed up in large quantities. They are thin, anæmic, are easily put out of health, have clubbed fingers and dilated right hearts. They linger long, but finally die exhausted. At the post-mortem there is found dilated bronchi filled with thick foul secretion, cheesy nodules around the bronchial tubes, much fibroid and indurated lung tissue and emphysema. In some cases there is gangrene of the lung before death. Children liable to bronchitis or who suffer from it in the chronic form require to be warmly clothed and protected from cold. Residence in a warm climate and pure atmosphere during the winter and at high altitudes during the summer should be insisted on where possible. A warm house is necessary if they have to winter in this climate. Every means must be employed which will improve their general health.<sup>1</sup>

**Pleurisy and Empyema.**—That pleurisy must be a common disease in children is shown by the frequency with which the lungs are found adherent to the chest walls when making autopsies on children who have died from various diseases. Here, as in the case of adults, the evidence of a past pleurisy is conclusive. Yet it cannot be said that pleurisy is diagnosed and treated with any great frequency during life, the reason no doubt being that young children are not able to localise attacks of pain, that when fretful it is not easy to thoroughly examine their chests by auscultation, and moreover the symptoms may be masked by other diseases in which the pleural lesion plays but a secondary part.

Pleurisy, primary and acute, occurs at all ages during infancy and childhood, the first year of life being by no means exempt. It is apt to follow exposure to cold or not unfrequently an accident, such as a fall or blow on the chest. It is however far more commonly associated with a croupous, catarrhal, or septic pneumonia. It occurs very frequently in connection with tuberculosis of the lung.

**Symptoms.**—Pleurisy may begin suddenly and run an acute course, though more often it is subacute. The attack begins with a short cough, fever, shallow respiratory movements, the affected side moving less than its fellow, accompanied by sharp pain, which the child, if old enough to do so, refers to the side or very often the epigastrium. In infants the attack may be ushered in by convulsions and its course marked by screaming fits, especially on disturbance. If the pleurisy be extensive and acute, an examination of the chest shows the respirations to be shallow, and the movements of the affected

<sup>1</sup> The treatment of dilated bronchi by incision and drainage has not been successful in our hands.

side extremely limited, while percussion over the latter or pressure in the intercostal spaces with the finger gives rise to expressions of acute pain. On auscultation while the breath sounds are loud and clear on the normal side, they are weak on the affected and perhaps accompanied by a friction sound. The pulse is quickened and there is fever, perhaps  $100^{\circ}$ – $102^{\circ}$ , unless pneumonia is present, when it is probably higher. The further course of the attack varies according to whether effusion of serum occurs or not. In the latter case in the course of a few days the fever subsides, the friction sounds disappear, though perhaps some 'stitch,' stabbing pain in the side, remains for awhile. In many cases apparently a local pleurisy takes place during the course of a bronchitis or bronchial catarrh in which little else than a sharp pain in the side or abdomen is present.

In pleurisy occurring between the diaphragm and lung the symptoms are generally obscure, there is pain and tenderness in the epigastric or hepatic region, with thoracic breathing, the abdominal muscles and diaphragm being kept as quiet as possible. Should effusion take place in any quantity, signs of its presence quickly appear. The child will probably lie on the affected side, so as to give full play to the lung on the sound side; the infant, as Henoch points out, with fluid in the right pleural cavity takes only the left breast of its mother for a similar reason. On inspection it will be noted that the side containing the effused fluid moves less freely than the other, and if the fluid is in the left chest, the cardiac impulse is displaced towards the right side. In large pleural effusions on the right side, the impulse may be moved towards the left. This displacement of the cardiac impulse is of special value in the diagnosis of fluid in the chest in children, on account of the uncertainty and small value of some of the other physical signs; as, for instance, the vocal resonance and fremitus, which yield valuable information in adults. The position of the heart's impulse is best ascertained by placing the surface of the hand on the chest wall, and if necessary by determining by auscultation the position of the heart by the comparative loudness of its sounds. It is necessary however to remember that the heart may be displaced without any fluid being present at the time of examination, as it may have been pushed on one side by a former effusion and have become fixed in an abnormal position by fibrous adhesions; in this case the lung also will probably be adherent and a dull note may be elicited over it which suggests the presence of fluid. The heart may also be pulled on one side or upwards by a fibroid condition of lung or chronic pleurisy.

On percussion of the chest, a dull or much impaired resonance will be detected over the area occupied by fluid, while in most cases the sub-clavicular region and frequently also the supra-spinous fossa and possibly a strip between the base of the scapula and the spine will be resonant, mostly hyper-resonant. If the effusion be great the whole side will be completely dull and give a sense of resistance on percussion. On auscultation the breath sounds are weak and distant, but usually of a distinctly bronchial or tubular character. In the earlier stages of effusion the expiratory murmur is especially accentuated and bronchial, the air from the compressed lung being as it were expelled with difficulty. The breath sounds on the healthy side are exaggerated. The vocal resonance and fremitus may be absent or weak, but it may be impossible to elicit any information in this way, as the

voices of children, especially girls, are weak, and moreover they may not be old enough to understand what they are wanted to do. During crying information of value may sometimes be obtained by placing the hand on the chest. Comparative measurements of the two sides show the affected side in recent cases to be larger than the other; but too much value must not be attached to measurements, as in chronic cases some amount of retraction may have taken place. Of more value is the cyrtometer tracing; this, as pointed out by Dr. S. Gee, shows a change of shape from the elliptical to the more circular form without the circumference necessarily being increased.

Should a large amount of fluid be poured out in a short space of time, it will necessarily give rise to dyspnœa; the child will turn over on to the affected side or lie upon its back; the alæ nasi work and the number of respirations are increased perhaps to 40 or 50. If the amount of fluid is smaller in quantity, the child may be tolerably comfortable while lying at rest, but there is dyspnœa on the slightest exertion. The amount of feverishness varies, during the inflammatory stage before or during the period the serum is being poured out the temperature is usually raised two or three degrees, in the course of a few days a gradual fall takes place and there may be no fever or only a slight elevation at night.

Under favourable circumstances in a healthy child, the serum effused begins to be reabsorbed; this it usually does in the course of a few days, the heart if displaced returning by degrees to its normal position, the level of the fluid becoming lower and lower, till the side regains its normal resonance, or, what is much more likely, a somewhat impaired resonance which it retains for many weeks. The reason of this is doubtless that the re-expanded lung remains for some time in a sodden and congested state and not improbably its pleural surface contracts adhesions with the chest wall. During the stage of reabsorption friction and moist rales are frequently heard in the lung and the breath sounds are weak. In some cases however this desirable reabsorption does not at once take place. The child's health is impaired, he is anæmic and depressed, perhaps thick layers of lymph are covering the pleural surface of the lung and chest wall, and conditions are not favourable for the reabsorption of the fluid after the inflammation has subsided; or possibly the absorption may go on extremely slowly, *pari passu* with the organising of the lymph which has been poured out. Under these circumstances much damage may be done, the heart may be fixed in a malposition, the lung may become tied down by a thick layer of fibroid tissue which contracting holds the lung in its grip, while the chest falls in and the spine becomes curved.

But besides a quick reabsorption of the serum, and a chronic pleurisy with its slow course, another result may follow, and that is, at least this is what is usually believed, the serum may become pus; this however is not a common result if the fluid effused is at first serum, and it rarely happens that it remains so for some weeks and then finally becomes converted into pus. An empyema as a rule is an empyema from the first, at least the fluid effused is turbid looking at first, in other words it is thin pus and later it becomes thick pus. It is no doubt most common to find that where there is reason to believe fluid has existed in the chest for some weeks or months, that the fluid is pus and not serum, but then in all probability the fluid has been

pus from the first and has failed to be absorbed, whereas had it been serum it would have been. Serum may undoubtedly remain in the chest unaltered for many weeks, perhaps months, but this is uncommon except in cases of tubercle, or new growths in the lung or in cardiac disease. An empyema is, in the vast majority of instances at any rate, an empyema from the first, and the result rather of a pleuro-pneumonia than a simple pleurisy. The more intense the inflammation the more likely is it that pus, not simple serum, is poured out, or that the serum poured out quickly becomes pus. This is especially likely to happen if a pleuro-pneumonia follow scarlet fever, measles, or hooping cough, or indeed any pneumonia of the croupous type. The symptoms given by an empyema are by no means distinctive as between pus and serum, and often no definite diagnosis can be made until an exploratory puncture has been made. In favour of pus in acute cases would be its occur-

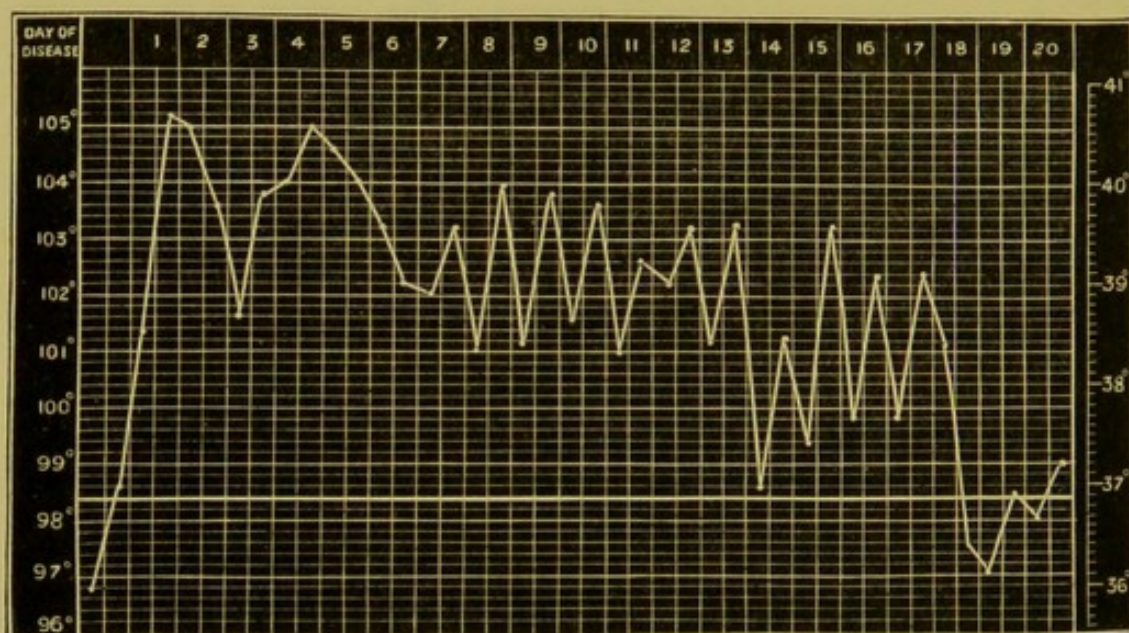


Fig. 23.—Temperature Chart of a case of Pleuro-pneumonia followed by Empyema, in a girl of nine years. Signs of fluid were discovered on the sixth day, pus on the eleventh day ; on the seventeenth day the chest was incised.

rence as a sequel of a zymotic disease, especially in a weakly child ; in chronic cases the presence of hectic, diarrhoea, a sallow earthy complexion, the 'pointing' of a collection of fluid in connection with the chest. A collection of purulent fluid may be present in the chest and give very few signs of its presence, except the physical signs. It may be remembered that in any chronic case of fluid in the chest in a child, that fluid is probably pus but not universally so. The early history of an empyema is generally that of an acute pneumonia which does not clear up, and the presence of pus in the chest is likely to be thought to be consolidation of the lung, especially as there may be well-marked bronchial breathing. As an illustration of this the following case may be cited. A girl of nine years was convalescent from scarlet fever. On the thirty-eighth day the temperature rose to 105°, there was intense pain referred to the left side of the chest and epigastrium, especially felt when she turned in bed, there was also some want of resonance at

the left apex. On the third day of the attack there was diminished resonance over the whole left side with bronchial breathing, no displacement of the heart. On the sixth day there was slight displacement of the heart to the right; the dulness over the left chest was much more marked, the breath sounds were faint and bronchial. On the eleventh day the signs of fluid had increased, the heart's impulse being felt at the left border of the sternum, an exploratory puncture showed the presence of pus. On the seventeenth day the chest was incised antiseptically, pus and much lymph escaped, a tube was inserted and complete recovery ensued (see fig. 23).

It must always be borne in mind that if a croupous pneumonia does not clear up and the dulness disappear, or the temperature remits instead of falling when the time for a crisis comes, that pus may be present in the chest. In such cases the signs of consolidation of lung are gradually replaced by those of fluid, the latter accumulating as the pneumonic consolidation disappears.

Pus may be present in the chest, yet not free in the pleural cavity, but confined by adhesion between the lung and chest wall or diaphragm. More than one localised empyema may be present on the same or opposite sides. Such localised collections may be present in any part, as at the apex in front, the base behind, or in front between the pericardium and anterior edge of the left lung, or between the lung and the diaphragm. These small empyemas are often associated with broncho-pneumonias and chronic tuberculosis of the lung. It is perfectly obvious that if these collections of fluid are not large, and are surrounded by and backed up by crepitant lung, diagnosis will be by no means easy, and it is not surprising that such may be found on the post-mortem table which had escaped discovery during life. In these cases the physical signs are not distinctive; there will mostly be a patch of dulness, with more or less resistance, but an adherent lung with thick fibroid tissue between it and the chest wall will give a similar note. The breath sounds are weak, perhaps bronchial. When in doubt it is wise to explore, not using too fine a needle, as if the bore is too small it is apt to become blocked with a flake of lymph or pus. If the layer of pus is not thick the needle may pass through the pus into lung beyond.

*Diagnosis.*—The distinction between the consolidation of pneumonia and pleuritic effusion in typical cases is made readily enough. The intense bronchial breathing, with the clear, ringing rales and impaired resonance of pneumonic consolidation, form a marked contrast to the weak distant breath sounds, wooden dulness, and displaced heart distinctive of a large effusion of fluid. In many cases however no diagnosis is possible without an exploratory puncture, and even then a negative result does not definitely settle the matter, as it is quite possible to miss the fluid. A pneumonic lung covered with a thick layer of lymph, or a sodden lung covered with fibroid tissue and adherent to the chest wall, gives a wooden dulness and resistance closely resembling that of fluid. On the other hand when fluid is present the bronchial breathing is sometimes loud and even intense. A good rule to follow is, whenever there is a patch of dulness that does not clear up, especially where there is a hectic or elevated temperature, always to explore by means of the subcutaneous syringe. The diagnosis between a local or small collection of fluid at a base and chronic pneumonia, caseous pneumonia, and tubercular consolidation, is often far from easy, and indeed is

generally impossible without exploration. There may be dulness and a hectic temperature, moreover there may be a patch of impaired resonance in the axilla while the apex and base is resonant, and both sides may be affected.

*Morbid anatomy.*—It is not often that an opportunity occurs of examining the chest of a child that has died of uncomplicated pleurisy or empyema, though it is common enough to find both in association with pneumonia or tuberculosis. The pleurisy differs much in degree, from a simply roughened surface to a layer of thick lymph; the adhesions which result from the organising of the lymph also varying greatly in toughness and thickness. Serum in varying amount, perhaps in greater quantity than was suspected during life, may be found in association with pneumonia, especially in such diseases as nephritis, septicæmia, and scarlet fever. The lung corresponding to the position of the fluid is collapsed and airless. The result of a past pleurisy, especially when this has been chronic, is sometimes seen at the post-mortem in the shape of thick fibroid adhesions which completely surround and infiltrate the lung. The latter is completely surrounded, airless, in a condition of cirrhosis, traversed by bands of fibroid tissue and occupying a position at the posterior aspect of the chest in contact with the spine. In other cases there may be found adhesions connecting both lungs with the chest wall and diaphragm, and on cutting through the lungs they appear to be riddled with cavities, which are in reality dilated bronchial tubes. The relation between empyemas and tuberculosis is interesting and important. It is believed by some that the subjects of chronic empyemas are apt to become tubercular; in other words, patients who suffer from a chronic empyema are likely to die of phthisis. We do not think, at least as far as our experience goes, that there is any post-mortem evidence to support this. That chronic pneumonia may terminate in tuberculosis by the mediastinal glands becoming caseous is an almost everyday experience, but this certainly does not apply to empyema. Barlow and Parker however state that they have met with cases where they believed a tuberculosis was secondary to a chronic empyema.<sup>1</sup> Localised collections of pus may sometimes be found in connection with chronic tuberculosis, but in these cases the pus is apparently secondary to the tubercular process.

Suppurative or simple pericarditis may take place by extension of the inflammation from the pleura.

*Treatment.*—In the early stages of dry pleurisy where the pain is severe the child is necessarily placed in bed, small doses of an anodyne being given and hot applications applied to the chest. Small doses of opiates relieve the pain best, such as Dover's powder or  $\frac{1}{12}$  —  $\frac{1}{20}$  grain of morphia given subcutaneously; the latter may be administered to children over four years, but not to infants. Hot poultices may be used with less fear than in pneumonia where much lung is involved. Strapping the chest on the affected side with strips of belladonna plaister is often very useful.

The natural course of a dry pleurisy is towards recovery, the inflammatory condition of the pleura subsiding, the lymph effused being organised, and the lung becoming adherent to the chest wall. The adhesions thus formed differ very much in their firmness and strength, the lung being perhaps only loosely attached to the parietes, so that its movements are only

<sup>1</sup> Dr. Hutton has also seen such cases.

slightly if at all impaired, or firmly attached by thick leathery adhesions so that it cannot be torn away without damage. In the latter case the adhesions are extensive, the movements of the lung are impaired, it never properly empties itself of air, and it is in consequence always more or less in a congested or œdematous condition, and possibly becomes infiltrated with fibroid tissue while the bronchial tubes become dilated. Such cases are probably the result of chronic or subacute pleurisy; the chest may also contract and fall in. When an effusion of fluid has occurred, in the vast majority of cases reabsorption takes place after the inflammatory condition of the pleura has subsided, and the tension of blood in the vessels has become reduced to normal. Life however may be threatened from the excess of fluid thrown out; under these circumstances nearly the whole of the blood in the body is passing through the sound lung; it is consequently intensely congested and may become œdematous. Moreover the right side of the heart is over-distended, and as a consequence sudden death is apt to ensue. For this reason no time should be lost if the dyspnœa and distress become great, in relieving the chest by the withdrawal of some of the effused fluid. On the other hand, the mere presence of fluid in the chest, if there are no signs of distress, does not necessitate operative interference, as in the great majority of cases absorption takes place in the course of a few days or a week. Operative interference, therefore, is called for in all cases where there is dyspnœa or orthopnœa when lying quietly in bed, or where there is much displacement of the heart. In those chronic cases where the fluid is not absorbed or is not diminishing in quantity after the lapse of a few weeks, the serum may be removed from the chest by means either of the aspirator or by trocar and cannula, the small ones introduced by Dr. Southey for the removal of the fluid in ascites answering very well. Whatever method is selected, the fluid should be removed slowly and there is no necessity to remove all that can be aspirated. Too rapid aspiration of the fluid is apt to lead to bleeding into the chest from rupture of some of the capillary vessels and may possibly cause emphysema of the lung on account of one part of the lung expanding faster than the other. On the whole, we believe the best results are obtained by the use of Southey's trocar and cannula. One of these may be introduced without difficulty and without pain if local anæsthesia be produced, a piece of fine india-rubber tube attached and the fluid allowed slowly to drain away for a couple of hours or so, ten to twenty ozs. being thus withdrawn; if necessary two cannulæ can be inserted. In those cases where the dyspnœa is extreme, relief is more quickly obtained by aspiration. It may not improbably happen that the pleural cavity in part fills up again and a second or a third removal be required. In the less acute cases where there is no urgency and no removal is attempted, the child should be confined to bed in a warm room and carefully protected from cold. It may be doubted if any drug materially aids the reabsorption of the effused fluid, though the usual treatment in such cases—namely, giving iodide of potassium internally and painting liniment of iodine mixed with an equal quantity of glycerine externally—appears to be useful. The *lin. iodi* by itself requires using with care, especially in young or weakly children. (See p. 209.)

The natural course of an empyema differs from that of a simple serous effusion. In a minority of cases, especially where the empyema is small

and confined by adhesions, it may dry up, and the inspissated pus in time become cretaceous. But this event can hardly be expected, and should it take place, especially if the empyema be a large one, the result, accompanied as it is by retraction of the chest and compression of the lung, is anything but satisfactory. The presence of pus in the chest is inconsistent with good health, to say nothing of the risks the patients run of its burrowing in various directions. The child with a chronic undrained empyema probably suffers from hectic fever, is anæmic and sallow, the skin becomes rough, the fingers clubbed and the child emaciates. Various other results may follow; the pus may form an abscess, find its way through the intercostals, and point in the fourth or fifth space; it may find its way through the skin and a chronic discharge take place. It may open through the lung into a bronchial tube and the pus be gradually coughed up; in this way recovery may eventually take place, though the process is a slow one; or an abscess or abscesses may form in the lung. An empyema on the right side may, either by contiguity or by opening through the diaphragm, give rise to an abscess in the liver. It may open into the abdomen by finding its way through the diaphragm and set up peritonitis. The pus may burrow any distance, opening through the abdominal walls or simulating a lumbar abscess.

Directly a diagnosis of pus in the chest is made, arrangements should be made to evacuate it, and this in the vast majority of cases should be by free incision and drainage. Aspiration may be tried once or twice in local empyemata, especially in infants and small children, but it is only in the minority of cases that it will succeed, as the cavity usually fills up again and separates the parts which should be kept in contact if a cure is to result.

The surgical treatment of suppuration within the pleural cavity is based on the ordinary principles guiding us in the management of abscesses elsewhere. Hence, although it occasionally happens that pleural abscesses dry up and do not discharge at all, or discharge through the lung or elsewhere and then heal, none of these possibilities should be looked for and the treatment practically resolves itself into tapping and free incision.

Tapping an empyema with a simple trocar and allowing the fluid to drain away through a tube into an antiseptic lotion is a mode of treatment that is successful in certain cases, but is open to several objections. The cases for which it is suitable are those where the empyema is recent, of small size, contains no masses of lymph or caseous material, and where the lung is not bound down by firm adhesions but is ready to expand on removal of the compressing fluid; further it is important for the successful employment of this plan that the pus be contained in one cavity only and not be loculated. The dangers of tapping are the risk of wounding the lung by thrusting the trocar too far inwards on the one hand, and on the other the possibility of pushing the thickened pleura or a layer of lymph before the trocar so that the abscess cavity is not opened. There is also the likelihood of the cannula becoming blocked with lymph or caseous material, and of incomplete emptying of the cavity because it is loculated or because the lung cannot re-expand.

Aspiration is open to the same objections, with the additional one that if too powerful suction is employed there is likely to be bleeding from the surface of the lung or the pleura, and the cavity may become partially filled with clot which readily decomposes.

The difficulty of emptying the cavity when the lung cannot re-expand has been met by Mr. R. W. Parker by the plan of injecting aseptic air into the pleura to replace the pus as it flows away, or lotions may be used with the same object; but the plan has not met and is not likely to meet with general approval. Aspiration then should be employed for small, single, recent empyemata, and in some few of such cases after one or two tapplings the pus will cease to be secreted. Should there be chronic disease of the lung, caseous material, glandular or other, or disease of the ribs or spine, since the source of irritation remains, pus formation will go on and aspiration cannot be sufficient. Failing then tapping or aspiration, the remaining resource is free incision and drainage of the abscess. The general plan of operation may be described first and certain special points alluded to afterwards.

The incision should be an inch or more in length, and should be made along the lower margin of the space selected, so as to avoid injury to the intercostal vessels. The tissues should be gradually cut through until the pleura is reached, all bleeding being arrested before the pleura is opened. If the membrane is not much thickened, a sharp director may be thrust through it and used as a guide for the knife; if, however, it is very tough and thick, as may be the case if the disease is of long standing, it is better to incise it at once with the knife. As soon as the cavity is reached a pair of dressing or sinus forceps should be passed in, opened, and the pus allowed to escape freely. The drainage tube is then to be inserted and secured by a thread round the chest unless a special tube is employed. Possibly the dressings will be soaked and require changing in a few hours; if however the cavity is fairly emptied and thick wood-wool pads are employed this is not necessary.

The special points to be considered are the position of the incision, the drainage tube, the management of adhesions, and the washing out of the chest.

First, then, the position of the incision. Where the empyema is local the incision must of course be made over it and the lowest convenient spot for drainage should be chosen. Where the whole pleural cavity is filled with pus a difference of opinion exists as to the most suitable spot for the opening. Mr. Marshall advocates an incision in the front of the chest, others prefer the axilla. We think however, on the whole, the best place is just behind and below the angle of the scapula in the eighth interspace; this spot affords good drainage when the patient lies on his back or side, it is not quite so convenient for dressing, but it is nearly at the lowest point of the cavity, yet not so low as to risk injury to the diaphragm, which is liable to be drawn up to take the place of the shrunken lung.<sup>1</sup> Unless the incision is made too far back there is no great thickness of muscle to cut through.

As to drainage, though in some cases where the chest is very full of fluid the intercostal spaces may be widened and bulging, yet often this is not so, and the ribs are so close together that it is difficult to get a tube into the chest, and when inserted it is liable to be nipped by pressure of the ribs. In such cases the ribs should be prised apart with dressing forceps and a

<sup>1</sup> The objection that an empyema usually heals up at the back first, and that therefore a cavity is likely to remain unclosed in front, has not in our experience proved a valid objection to the posterior incision.

rigid tube, such as a silver or vulcanite tracheotomy tube, employed. The tube should not project far into the pleural cavity, but only just enough to be clear of the thickened pleura, otherwise it will fail to drain the cavity and may be blocked by pressure against the lung. A double tube, or two pieces of tubing fixed together side by side (Battams), are preferred by some surgeons; the plan is useful if it is intended to wash out the chest, but in many cases is open to the objection given above.

After opening the chest a finger should be passed in if possible to ascertain the size of the cavity and to break down any adhesions shutting in localised collections of pus,<sup>1</sup> as well as to remove any masses of lymph or solid material in the cavity. If the pus is foul or thick and flaky, as large a tube as possible should be put in and the chest washed out at once with sanitas, eucalyptus, or boracic lotion, till it is quite clear. Should any bleeding occur from the intercostal vessels, they may be picked up or secured by a catgut ligature passed round the rib including the vessel; this is easily done with an aneurism needle. Bleeding from the granulating surface of the pleura after exploration soon ceases of itself, but all clots should be washed out.

During the operation careful watch must be kept by the anæsthetist that the child does not suffer from having to lie upon the sound side, and at any sign of failing pulse or respiration the child must be turned upon its back or towards the affected side. The after-treatment of empyema consists in keeping the cavity aseptic and well drained; obstruction of the tube is most likely to be due to flakes of lymph if a rigid one is used, to nipping of the tube by the ribs if rubber is employed. As regards washing out the chest it must be remembered that there is a certain amount of danger in it; cases of sudden death during the process have several times been recorded, possibly from irritation of cardiac nerves in the wall of the cavity or from sudden dyspnoea; this, though a rare occurrence, should deter us from washing out an empyema unless the discharge is foul, and it should lead to caution and the avoidance of any distention of the cavity or the use of irritant lotions even in such cases. In free incision of the chest the opening is of course large enough to admit air readily, hence there is no obstacle to complete emptying of the cavity. The tube should not be left out until the discharge has nearly or quite ceased, and exploration with a probe has shown that the cavity is filled up; often, though there is but little discharge, a good-sized cavity or a long sinus remains, and if the external wound is allowed to close, fresh collections of pus will take place. In a certain number of cases the empyema will be pointing externally when the case is first seen; such pointing most commonly occurs in the front of the chest from the second to the fifth space. If the skin is already thinned the pus should be let out at this spot and the case managed as usual; if however the cavity does not drain freely, a long probe should be passed through the anterior orifice, and cut down upon at a more dependent spot, and a drainage tube inserted there. While admitting that the successful management of empyema is not simply a question of drainage as in other abscesses, we think a dependent opening is a highly important matter.

Sometimes the pressure of the drainage tube causes ulceration of one of

<sup>1</sup> Dr. Fagge states that loculation is very rarely found post mortem.

the ribs ; this is however a matter of little importance, since the rib usually recovers after removal of the tube.

In a certain proportion of cases after drainage of the empyema the cavity does not become obliterated but remains as a pus-secreting sac ; this is due either to imperfect expansion of the lung or insufficient compensatory falling in of the chest wall. Under such conditions the discharge may go on indefinitely and cause lardaceous disease and hectic fever ; it is then necessary to find other means of allowing the surfaces of the abscess sac to come together. For this purpose resection of one or more ribs (Estlander's operation<sup>1</sup>) has been devised. Although in children, from the softness and flexibility of the ribs and spine, the chest generally falls in readily, this is by no means always so, and the operation should be done as soon as it is clear that progress is not being made or the child's health is failing. Where there is an insufficient opening for drainage, it is also necessary in some cases to provide a larger orifice by removal of part of a rib. The operation is a simple one; to remove a single rib, the lowest one in the cavity should be chosen, usually the seventh or eighth. An incision is made along it down to the bone, the periosteum is readily peeled back with a raspator, and about an inch or more of the rib is cut out with bone forceps; the periosteum and pleura are then incised parallel with and avoiding the intercostal vessels ; if the artery is wounded however it is easily secured now that the rib is gone. When the resection is done to allow collapse of the chest wall, from two to five ribs may have to be resected, two or three inches of bone being taken from each ; in such case a quadrilateral flap of the soft parts should be turned forward and the ribs removed one after the other. Though it is perhaps better in such cases to remove the bones subperiosteally the periosteum should be cut away before closing the wound, otherwise it often happens that ossification rapidly takes place and fills up the gap in the chest wall and so prevents the desired collapse. We have sometimes found the intercostal vessels obliterated in these cases and there has been no arterial bleeding at all. Marshall has divided the costal cartilages subcutaneously with the same object, but resection is the more complete operation and it sounds and looks more formidable than it is. The subsequent management of the wound requires no description. Unless an empyema speedily recovers, more or less retraction of the side necessarily results, and from this a lateral or rather, as Lane has pointed out, a true rotato-lateral curvature of the spine follows ; this of course is largely irremediable, but some improvement may be obtained by treatment (*vide* Lateral Curvature).

Inasmuch as the ribs are less yielding near the angles, it is better to remove the bone as far back as possible up to the edge of the erector spine. We have tried osteotomy of the rib at the posterior part at the same time as resection to allow more complete falling in of the chest wall, but found little was to be gained by this means, since the rib is held firmly in place by the surrounding soft parts.

<sup>1</sup> Estlander's operation is strictly the removal of a sufficient part of the chest wall to allow of complete collapse.

## CHAPTER XIII.

## DISEASES OF THE RESPIRATORY APPARATUS—(continued).

**Croupous Pneumonia.**—Croupous pneumonia in its typical form is a common disease in children over three years of age, and does not differ either in its course or morbid anatomy from the attacks in young adults, though the mortality is much less. Reference has already been made to the acute lobar pneumonias of infancy and childhood, which are frequently classed amongst the fibrinous or genuine croupous pneumonias on account of the extent of lung involved and also of their termination by crisis. That many of them are fibrinous to some extent is certain, as effused fibrin may be seen in sections prepared for the microscope, but in our experience such lungs when seen on the post-mortem table are more spongy and lack the complete solidity of the red hepatisation of true croupous pneumonia, and the outlines of the lobules are readily seen in consequence of their differing from one another as to the extent to which they are affected. Moreover, while they may contain fibrin, the cellular element largely predominates. Fortunately it is of little practical moment under which division these attacks are classed, hybrid cases are certain to come under observation both in infancy and childhood, and we have frequently to be content with describing attacks as being of the 'croupous type,' or of the 'catarrhal' or 'broncho-pneumonic type,' according as their symptoms resemble typical attacks of either the one or

*Table showing the ages and mortality of 401 cases of Croupous Pneumonia.*

	Under 2 yrs.		2 to 5 yrs.		5 to 10 yrs.		10 to 14 yrs.		Total	Deaths
	Total	Deaths	Total	Deaths	Total	Deaths	Total	Deaths		
1878	2	—	15	3	14	—	2	—	33	3
1879	3	1	16	1	14	—	3	—	36	2
1880	—	—	5	1	6	1	3	—	14	2
1881	1	1	18	3	20	1	5	—	44	5
1882	3	—	14	1	25	1	8	—	50	2
1883	2	—	17	—	26	1	12	—	57	1
1884	—	—	7	1	37	—	12	—	56	1
1885	—	—	16	—	24	1	19	—	59	1
1886	1	—	9	3	9	—	4	—	23	3
1887	—	—	6	—	18	—	5	—	29	—
	<b>12</b>	<b>2</b>	<b>123</b>	<b>13</b>	193	5	73		401	20

the other. It is the difficulty of classifying hybrid cases that makes the statistics of one hospital or one year or the mortality of the disease liable to error when compared with that of other hospitals or years.

The statistics (given in the table on p. 194) of our own hospital of the cases entered as croupous pneumonia during the ten years 1878-1887 illustrate the comparative frequency of the disease at different ages. In this series of cases the total mortality amounted to 5 per cent., the highest being among children under two years of age.<sup>1</sup>

The *etiology* of croupous pneumonia is not perhaps quite as simple as it seems at first sight. A schoolboy is exposed to a cold east wind after getting hot, or is chilled by a fall into water, and a few days later develops an acute pneumonia; in such cases there can be little doubt that pneumonia is the result of a chill. In connection however with this, our own hospital statistics do not show much difference in the number of cases admitted during the different months of the year, though there is a slight preponderance in favour of March.<sup>2</sup> Attacks certainly occur at all times of year, in the warmer as well as in the colder months. On the other hand, it is quite certain that croupous pneumonia is at times epidemic and also infectious, affecting several members of the same household or the same street, and in a few instances there have been widespread epidemics. Epidemics of pneumonia associated with tonsillitis have occurred in schools and other large institutions where the sanitary arrangements have been found faulty. It may be taken for certain that while there is a form of pneumonia of the croupous type due to cold, 'pneumonia a frigore,' other causes may produce it, such as infection by the inhalation of the 'pneumonia micrococcus,' or it may be part of some general septic poisoning, produced by sewer gas, or other form of poisoning. There is much reason to believe that there is a catarrhal tonsillitis due to exposure to cold and a tonsillitis due to infection or septic poisoning, and in the same way pneumonias, membranous croups, and intestinal catarrhs may be due to a chill or dyspepsia at one time and to infection or the reception of some poison at another. In some instances acute pneumonia has followed injury; a blow on the chest or a fall on the head has been followed a few days later by a pneumonic attack.

In different epidemics or in different years or localities attacks of pneumonia appear to vary in their character, sometimes being of the sthenic, sometimes of asthenic type; this has been specially described by Foxwell ('Practitioner,' July, 1886).

*Symptoms and course.*—The onset is sudden, with symptoms not unlike those of scarlet fever; there is high fever, dyspnœa, rapid pulse, headache, pain in the side or abdomen, short cough, and perhaps vomiting and diarrhœa. In children under three years convulsions are not uncommon at the onset, but these are rare in older children; the convulsions may prove fatal before the attack of pneumonia has fully declared itself. Delirium may be an early symptom, especially if the fever is high. By the time a medical

<sup>1</sup> These figures closely correspond with those given by Von Dusch; in 331 of his cases of croupous pneumonia in children under ten years of age, the mortality was 4·8 per cent.

<sup>2</sup> In 628 cases of croupous pneumonia during the years 1857-1885, Durasz found a slight excess in April and May.

examination is made the child is usually too ill to be about, and is either in bed or being nursed in its mother's arms; the cheeks are flushed, the alæ nasi are working, the respirations are perhaps doubled, being possibly 40 per minute or more, the pulse 120 to 140, there is a temperature of  $104^{\circ}$  or thereabouts, the tongue is dry and brown, and there may be herpetic vesicles on the lips and nose. An examination of the urine shows it to be dark in colour, concentrated, containing albumen and an excess of urea, and deficient in chlorides. The cough is dry and hacking, and pain is often complained of during the act; in young children there is no expectoration, in older ones there may be the usual rusty sputa. The fever and dyspnœa continue, the child remaining very ill till the end of the week, when, usually between the sixth and ninth day, the fever suddenly abates and a marked improvement takes place in all the symptoms, so that it is evident to all that the crisis has come. The crisis is sometimes marked by collapse, the child becoming cold and clammy, with a subnormal temperature.

*Physical signs.*—An examination of the chest on the first or second day of the attack will usually lead to the discovery of more or less consolidated lung. Careful percussion, striking now lightly, now more forcibly, will elicit a certain high-pitched note or impaired resonance over some part of the chest wall, as in the infra-clavicular, axillary, or scapular region, or over the root or base of the lungs; on listening over the affected area some departure from the normal breath sounds will probably be heard. There may be simply weak or distant breathing, as if the air was not entering freely into some part of the lung; there may be distant or intense bronchial breathing, or various abnormal sounds, as a pleuritic rub, rhonchus, or more often, subcrepitant or loose ringing rales, the fine crepitation so common in adults being usually absent. There is usually increased vocal resonance and fremitus, though it is not always possible to elicit these signs unless the child cries. If there is much lung affected, loud or harsh breath sounds are heard over the non-affected lung, and care must be taken not to mistake these signs of an overworked, for those of an affected lung.

The position of the consolidation varies considerably and does not necessarily correspond to a lobe, but may occupy the whole extent of lung anteriorly or posteriorly; or the most marked signs may be first detected over the root of the lung or behind in the axilla. The left base and right apex are favourite spots to be attacked, but any part of the lung may be involved, though it may be borne in mind that the apices are more apt to be affected in children than in adults, and it is just at this spot that early signs are apt to be overlooked. In the course of a day or two, sometimes not for several, the physical signs become more marked, the dulness cannot be mistaken, the bronchial breathing becomes whiffy and intense; in a few days more, usually after the crisis has arrived, coarse loose crepitant rales are heard which mark the resolution of the pneumonic lung. The dulness and bronchial breath sounds and rales disappear, but some want of resonance is apt to remain for many weeks, as the lung remains in an œdematous state. While such is the usual course of events in an ordinary case, there are marked differences with regard to the time when the physical signs make their appearance, there being frequently a delay of several days, perhaps appearing as late as the 5th. It is important to remember this, for a mistake in

diagnosis is easy, as a most careful examination of the whole chest may reveal nothing suggestive of pneumonia. In such cases there is a strong presumption that the pneumonia is centrally situated, perhaps at the root of the lung, and takes some time to approach the surface; or possibly there may be an acute inflammatory congestion of a portion of lung and a delay in the transudation of fibrin into the air-sacs. Often a sub-tympanitic note to percussion and weak bronchial breathing, or simply distant respiratory sounds, may be all there is to be heard for a day or two. In a few cases the crisis may come and the child recover without the classical signs of pneumonia ever being present.

*Temperature.*—The temperature usually goes up suddenly at the onset to  $104^{\circ}$  or thereabouts, and during the course of the attack continues high, with slight morning remissions, till the crisis, when the fall is sudden (see fig. 24), perhaps  $4^{\circ}$  or  $5^{\circ}$ , to a subnormal temperature; the latter may last for a few days and then the normal line be regained. The day on which the crisis takes place varies greatly; the attack may end about the 4th or 5th day or earlier, but usually the crisis is delayed till the 7th or 8th, and in the creeping form till the end of the second week or later; a post-crisial rise often occurs (see fig. 25), the temperature rising a few degrees the following evening, becoming normal the next morning. Post-crisial hectic, prolonged for some days or weeks, suggests the presence of an empyema or other complication. In the minority of cases the temperature falls by lysis.

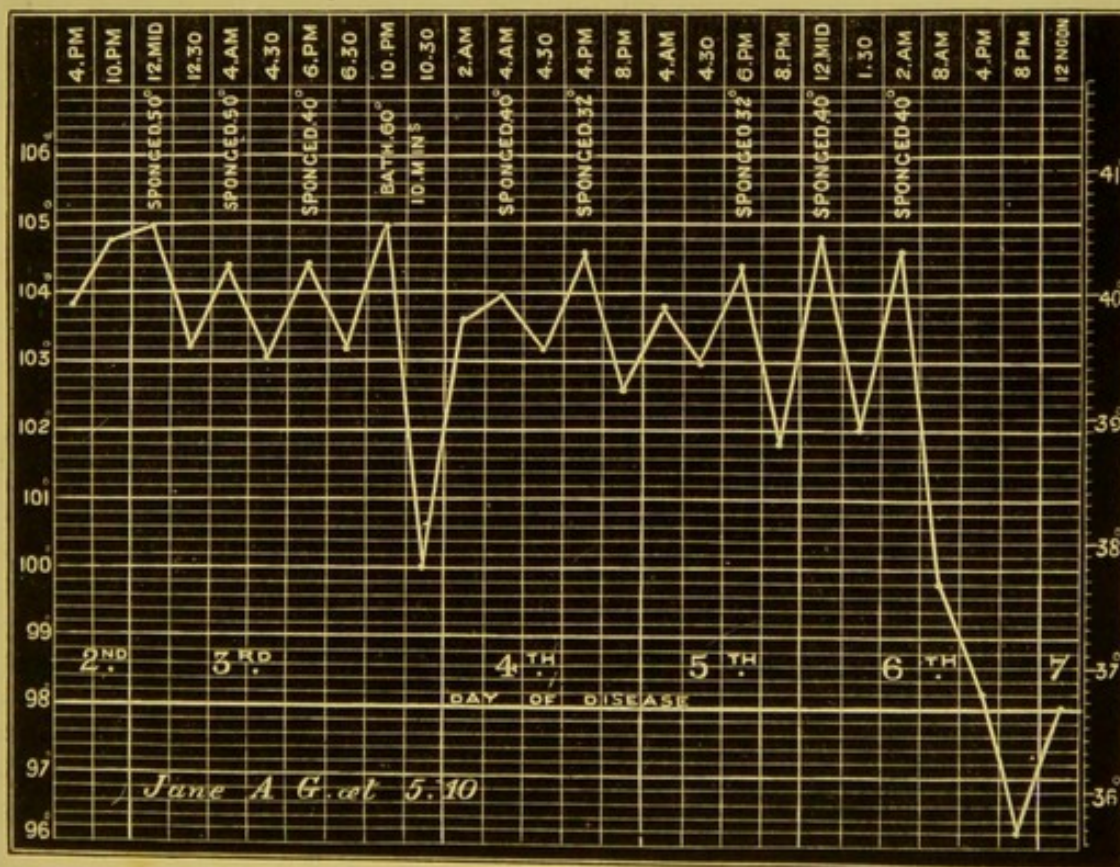


Fig. 24.—Temperature Chart of a case of Croupous Pneumonia of left apex in a girl of five years. Crisis 6th day. Recovery.



abdominal pain, and it is only after a day or two, when the classical signs of pneumonia appear, that a diagnosis of pneumonia is made. The attack may simulate gastro-intestinal catarrh or peritonitis, the abdominal pain being due to diaphragmatic or costal pleurisy. (5) **Pleuro-Pneumonia**.—In these cases the signs of pleurisy predominate; there is sharp stabbing pain, tenderness on percussion, and the child screams when it coughs or turns over in bed. Signs of consolidation are succeeded by those of pleuritic effusion or an empyema possibly results.

*Complications and sequelæ*.—**Pleurisy** frequently accompanies croupous pneumonia; percussion over the dull area, and deep pressure gives pain and friction sounds are frequently heard; the pleurisy is apt to become suppurative in weakly children, especially if the pneumonia occurs in the course of scarlet fever, measles, or whooping cough (see page 185). **Pericarditis** sometimes occurs. **Hyperpyrexia**, a temperature of  $105^{\circ}$  or  $106^{\circ}$  occasionally taking place, accompanied by cerebral symptoms, convulsions in young children, stupor and delirium in older ones. **Meningitis** is rare, though it occurs occasionally simultaneously with the pneumonia or follows as a sequela, being most common in young children. **Nephritis** also occurs in association with pneumonia; usually the latter is secondary to the former. **Jaundice** sometimes accompanies pneumonia, especially of the right base. **Gangrene of the lung** occasionally supervenes and brings about a fatal result; this seems mostly to occur either in pneumonia, secondary to nephritis, or when pneumonia occurs in a subject who has emphysematous lungs. The possibility of the lung being adherent to the chest and undergoing an indurating or fibroid process must be kept in mind. A chronic condition of **caseation** may remain, but this is much commoner after catarrhal than after croupous pneumonia. **Diphtheria** of the fauces may complicate it; once or twice we have discovered to our surprise, late in the attack or on the post-mortem table, false membrane on the fauces.

*Prognosis*.—The prognosis is favourable in cases of croupous pneumonia when it is primary and attacks healthy children over three years of age; among such the mortality is small. Double pneumonia is necessarily more fatal than single, but here the amount of lung involved at one time is not necessarily great, as usually while it is advancing on one side it is receding on the other; the danger depends on the amount of lung involved, and the respirations give a more or less useful indication of this. In a child who already suffers from chronic bronchitis and emphysema or cardiac disease the prognosis is much worse. Secondary pneumonia when it follows or complicates scarlet fever, measles, whooping cough, nephritis, or follows operations or is connected with septicæmia, is necessarily a serious and often fatal disease. When much pleurisy accompanies the pneumonia, especially in young children, the prognosis is less favourable than in cases of simple croupous pneumonia.

*Diagnosis*.—In those cases of croupous pneumonia which begin with vomiting and high fever, and where the physical signs are delayed, there is a certain superficial resemblance to scarlet fever. That such cases are liable to be mistaken for scarlet fever is shown by the fact that not uncommonly cases of acute pneumonia are sent into fever hospitals certified as suffering from scarlet fever. A careful examination of the patient, and if necessary a

delay of twenty-four hours before coming to a decision, will prevent, in the large majority of cases, such an error. In the first twenty-four hours in a sharp attack of scarlet fever there may be high temperature, vomiting, diarrhœa, rapid pulse, often 150, tonsillitis more or less developed, no pain in the chest or cough. The rash usually appears at the end of twenty-four hours. In acute pneumonia there may be high fever, headache, pain in the chest or abdomen, dyspnœa, pulse perhaps of 120, perhaps some physical signs in the chest, not often vomiting, diarrhœa, or tonsillitis. There is no rash. Acute pneumonia with marked cerebral symptoms, such as delirium, stupor, headache, sordes on the teeth, and high fever may be taken for typhus. A careful examination of the lungs would generally decide; in typhus there may be evidence of bronchitis, in pneumonia there would usually be some want of resonance at an apex or base, with some distant or bronchial breathing. The presence of a characteristic rash on the third or fourth day would decide the diagnosis; it is well to remember that in children typhus is usually a mild disease. In young children an acute attack of croupous pneumonia, with high fever, convulsions, drowsiness, or coma, may be mistaken for acute meningitis, or as a matter of fact pneumonia and meningitis may co-exist. We should however hesitate in the presence of pneumonia and a temperature of  $104^{\circ}$  or  $105^{\circ}$  to diagnose meningitis, the cerebral symptoms being due to the high temperature and poisoned blood. In all cases where a young child is suddenly taken with convulsions and high fever, pneumonia should be suspected and a careful examination of the lungs made. The diagnosis between croupous pneumonia and generalised broncho-pneumonia is often not easy during life; we cannot usually do more than say such and such an attack approaches more nearly to the croupous type when there is a sudden onset, a local portion of lung involved, a continuous temperature and a crisis; that it is more of the catarrhal type when there is much bronchitis, an intermittent temperature, and gradual subsidence of the fever. The difficulty does not always end in the post-mortem room, as typical fibrinous pneumonia in patches or more widely distributed may be found in one lung and undoubted lobular pneumonia in the other, or both varieties may be present in the same lung.

*Pathology.*—In croupous pneumonia the first stage is that of an inflammatory engorgement of an extended portion of lung, the vessels are full, the capillaries are tortuous and distended, encroaching on the air-space in the sacs; in the second stage the engorged vessels relieve themselves by pouring out liquor sanguinis and some corpuscular elements into the air sacs, which become blocked with fibrine, and a condition of red hepatisation results. This red hepatisation, when seen at the post mortem, differs from the lobar variety of catarrhal pneumonia in that it is more solid to the touch, presents a uniformly coloured surface on which the outlines of the lobules cannot be distinguished; in children it is less often granular than it is in adults. In a later stage grey hepatisation is present, the lighter colour being due to a greater number of corpuscular elements being present.

*Treatment.*—An uncomplicated case of croupous pneumonia in a child does not require active treatment, as the course is short and the heart and arterial system, unlike what is often found in adults, are free from degenerations and able to stand the strain imposed upon them. The child should of

course be confined to his bed in a well-warmed and ventilated room ; he should be allowed only fluid nourishment, such as milk, barley water, or soda water. A piece of spongio-piline or flannel doubled several times may be wrung out of hot water and applied to the chest. Poultices may be used and retain the heat better than anything else, but they are very liable to slip out of place, and are unsuited for infants on account of their weight. In the early stages aconite is of service, one or two drops of the tincture being given every two or four hours, being watched carefully lest it produce too much depression. In many cases no other treatment is required, the aconite being stopped when the crisis comes. If the temperature is not excessive, not much exceeding  $103^{\circ}$ , no special methods of reducing it need be used, as the course of the disease is short, and often after the first day or two it takes a lower range ; the initial fever in the case of infants and young children is in some cases high, and is apparently the cause of the cerebral symptoms, such as convulsions and coma, from which they suffer and which sometimes prove fatal. When this is the case no time should be lost in reducing temperature, by cold sponging, packs, baths, the application of ice, or by the administration of antipyretics. If the temperature is high— $104^{\circ}$  or  $105^{\circ}$ —there is no need to fear any harm accruing from cold water, the simplest method of applying it being by sponging the patient over with cold water, or, what is more effectual, a pack at  $60^{\circ}$  or  $70^{\circ}$  ; this latter can be applied by wringing a towel out of cold water, folding and applying it round the chest, or enveloping the whole body in a wetted sheet. The process may be repeated at intervals of an hour more or less. If these means prove inefficient, or if, as in the case of convulsions, there is no time to lose, the cold or graduated bath should be resorted to ; the child being placed in a warm or lukewarm bath and the temperature of the water gradually lowered to  $60^{\circ}$  F. by addition of cold water or ice ; if the patient becomes blue and cold he should be removed at once. Another effectual method of reducing temperature is by means of a bag of ice placed on the affected side and secured in position by a flannel binder.

The best antipyretics are quinine and antifebrin, either being given in two or three grain doses to a child of three years every four hours ; the latter is apt to produce considerable depression, which however quickly passes away ; large doses of quinine are apt to produce dyspepsia. The effects of aconite on the pulse should be carefully watched ; any signs of intermission or irregularity should be the signal for omitting it, for awhile at least, and substituting some simple saline, as liq. ammon. acet. or citratis ; alcohol and stimulant expectorants are best avoided, after the crisis, but two or three drop doses of tr. digitalis, given every four hours, are often useful if the pulse is poor ; citrate of caffeine or sulphuric ether may also be given.

In cases where the crisis is delayed on account of the inflammatory process extending, as in the creeping form, and the child seems low and weak, there is always a temptation to give ammonia and stimulants, and these may in some cases be needed ; but our impression is, that patients do better in the inflammatory stages, when the process is still extending, on small doses of aconite, antimony, or salines, than they do on a too stimulating treatment. An occasional dose of alcohol may do good when a continuous dosing is harmful ; alcohol in large doses acts as a narcotic, and is apt to add to the drowsiness and tendency to delirium. Opium in the form of 'nepenthe' or

Dover's powder is of great value in calming the delirium and sleeplessness as well as soothing the irritable cough and relieving pain when this is a marked feature, as it is in the pleuritic complications. One to three drops of nepenthe or half to two grains of Dover's powder may be given at night to procure rest and sleep. In double pneumonia, where there is much depression with a failing pulse, ether and digitalis must be resorted to. Ether may be injected in three to five drop doses subcutaneously or *sp. etheris* and *tr. digitalis* may be given every few hours. Champagne is a good restorative under these circumstances, but it may cause vomiting if given too freely, and it will be well to dilute it with soda-water in the case of young children.

**Gangrene of the lung.**—Croupous pneumonia when it attacks children already the subject of chronic bronchitis and emphysema is apt to terminate in gangrene of the lung; this we have seen on several occasions. It is apt to follow pneumonia secondary to scarlatinal nephritis and also whooping-cough. The principal diagnostic symptom is the exceedingly foul breath; the temperature is usually high, sometimes hectic, suggesting pus, and the pulse is rapid. The lung is found at the post mortem in a state of grey hepatitis, breaking down into ragged cavities and smelling offensively.

**Abscess of the lung.**—Purulent collections in the lungs are mostly the result of septic embolism from some distant suppurating centre, as in an otitis or some other bone lesion, and associated with pyæmia. They are usually small and situated on the surface. Small abscesses may be secondary to an empyema, the latter finding its way *viâ* a small abscess into a bronchial tube. Minute abscesses are sometimes a sequence of a broncho-pneumonia secondary to scarlet fever, measles, or whooping cough, suppuration taking place in the lobules immediately surrounding the terminal bronchioles; here small centres containing pus may be found (see p. 177).

**Asthma.**—Spasmodic asthma is by no means uncommon among children. Bronchial spasm is sometimes secondary to dentition; a child when cutting a tooth, especially towards evening, begins to wheeze, and on placing the ear to the chest sibilus may be heard. A condition of asthma or urgent dyspnœa is frequently present in the uræmia of scarlatinal nephritis and in the rare cases of contracted kidney which occur in children; it may be open to doubt if in such cases the origin is not cardiac, rather than being due to any bronchial spasm. Hysterical children sometimes have attacks resembling asthma. The commonest form, however, is bronchial or spasmodic asthma, resembling the asthma of adults; such children are exceedingly liable to bronchial catarrh. In most of these cases it is hereditary and may begin as early as two years of age. The attack begins with the symptoms of a bronchial catarrh lasting for a few hours or days, then an attack of dyspnœa occurs, perhaps at night-time; the child sits up in bed and fights for his breath, the breathing is quick, the *alæ nasi* work, the lips are blue; the attack lasts from a few minutes to an hour or two, and is followed by freer secretion and relief. Some attacks are associated, not with bronchial catarrh but with dyspepsia, and have been termed *asthma dyspepticum* by Henoeh, the child having an asthmatic attack when suffering from dyspepsia or having taken improper food. Instances have occurred in which enlarged tonsils and post-nasal adenoids have appeared to have had a hand

in producing such attacks. The treatment must be directed to prevent children from taking cold or becoming dyspeptic. Some high, bracing, dry, inland site, usually suits such children better than the sea-side. The east winds of spring are especially liable to excite an attack. A house uniformly warmed throughout, so that the child, who is necessarily confined much to the house, can wander from one room to another without the risk of cold, is a great advantage. An attack may usually be relieved by the burning of nitrate of potash papers, and by lobelia. Arsenic is the best remedy, with cod-liver oil between the attacks. The bowels require attention; Carlsbad salts or some other saline aperient being useful for this purpose.

**Diseases of the Bronchial Glands.**—The tracheo-bronchial glands are situated in the middle mediastinum in close relationship with the trachea and bronchi; they are some ten to twelve in number, and are arranged in three groups; one set surrounds the trachea, another group is situated at the bifurcation, and a third around the right and left bronchi. The pulmonary glands are situated at the root of the lung and accompany the bronchi into the substance of the lung. These glands, which receive the lymphatics of the lungs and bronchi, and like other lymphatic glands readily become inflamed and swollen during attacks of bronchitis and broncho-pneumonia, especially after measles and whooping cough, are apt to remain chronically enlarged and further to become **caseous** and to **suppurate**. During this inflammatory process more or less thickening and matting often takes place in surrounding parts, so that the glands may become adherent to the trachea or bronchi or œsophagus. The glands and connective tissue in the anterior and posterior mediastinum may also become affected, so that the anterior-internal edges of the lungs and the whole contents of the mediastinum may become thickened and matted together.

Caseation of the mediastinal glands is exceedingly common in children, and they may be found in this condition in the bodies of children dying of various diseases, but they are almost universally caseous in those dying of pulmonary tuberculosis or chronic catarrhal pneumonia. In many cases of acute or chronic tuberculosis it is clear that the disease in the glands is older than the tubercle in the lungs, and has spread from the former to the latter. In such cases the glands have become enlarged secondarily to some bronchitis or pneumonia, have undergone caseation, and the lungs have been infected in consequence of caseating bronchial or pulmonary glands, the tubercular disease spreading into the lungs from the root.

**Symptoms.**—In the large majority of cases there are no distinctive symptoms of caseating mediastinal glands, and *per se* they are not more likely to give rise to symptoms than caseating glands in the neck; but, inasmuch as they are so frequently associated with early or chronic tuberculosis of the lungs, the subjects of them are hardly likely to present the appearances of health. Occasionally however they are found unexpectedly in the bodies of children dying of other diseases. With regard to physical signs, it must be clear from a consideration of the anatomy of the mediastinum that the glands lie too deeply to be detected by percussion unless they are enormously enlarged; this may take place in sarcomatous enlargement, but rarely in tuberculosis. It has been asserted that when enlarged they can be detected by a diminished resonance in the interscapular region, corresponding to the third

to the first vertebræ ; but, inasmuch as the thick posterior edges of the lungs, besides the aorta, œsophagus and a mass of muscle, intervene between the glands and the surface, it is certain that the enlargement must be very considerable to modify the percussion note in this position. Enlarged glands are more likely to modify the resonance behind the upper part of the sternum and adjacent cartilages, but in infants and young children the anterior mediastinum is occupied by the thymus, which would mask any enlargement of the lymphatic glands ; and in older children, where the thymus is small, lymphatic glands must be very much enlarged to come to the surface and give rise to any dulness, covered as they are by the anterior edges of the lungs. Error may easily arise from a dulness due to a past pleurisy and consequent adhesion along the anterior edges of the lungs. If the results of percussion are uncertain, those derived from auscultation are necessarily more so, except in considerable enlargement of glands. Of the pressure signs, the most reliable is weak breathing in one of the lungs in consequence of pressure on the right or left bronchus ; this sign is of undoubted value, but as there is usually some tubercular lesion in the lungs, this symptom may readily be masked. Attacks of paroxysmal dyspnoea, and cough with stridulous breathing, may also be present on account of the nerves being involved. Swelling of the face and distention of the jugulars have also been described, but these are far more frequently due to constant coughing than to any pressure on the large veins in the chest. A caseous gland not infrequently becomes adherent to the trachea or one of the bronchi, ulcerates into it, and caseous matter may be coughed up ; in a few instances it has happened that this takes place suddenly and death results from plugging of the windpipe. In other instances the glands may form an abscess which points in one of the intercostal spaces close to the sternum, as in a case under the care of Dr. Eustace Smith, or may open into the œsophagus. In one of our own cases a **mediastinal abscess** pointed near the left edge of the sternum, low down.

The pulmonary glands which accompany the small bronchial glands into the lungs may become caseous, soften and form cavities, more especially in the lower lobes. It must be acknowledged that caseous glands can rarely be diagnosed during life with anything like certainty, partly on account of their lying deeply, and partly from the fact that they are so commonly associated with chronic lung disease. They rarely attain any large size, and consequently do not modify the percussion note or press on the veins, bronchi, or nerves.

When however the mediastinal glands become the seat of a new growth, such as **lymph-adenoma**, the case is different ; they may become enormously enlarged surrounding the veins and bronchi, giving rise to marked dulness over the sternum and adjoining rib-cartilages, and pressure signs from involving the vessels. Attacks of paroxysmal breathing are common on account of pressure on the recurrent laryngeal and other nerves. The course of the disease usually extends over a few months only, the patient getting progressively worse. Among the early symptoms will usually be those of disturbed innervation. There are attacks of paroxysmal cough, with a metallic ring and stridulous breathing and orthopnoea, so that the child has to be propped up to get its breath ; in the later stages the distress is often very great. The voice is altered, perhaps reduced to a whisper. The return of

blood to the chest may be interfered with on account of the superior vena cava being compressed, giving rise to a distention of the jugular or axillary veins, and swelling of the face or arms. Fluid may be present in one or both pleural cavities from pressure on the azygos veins. If the tumour is of any size, there will be dulness over the sternum or in the adjoining region, particularly to the left edge of the sternum in the upper intercostal spaces. Intense bronchial breathing may be heard here. The lung may be pushed to the left by the encroachment of the tumour, which may bulge forward the sternum and ribs.

**Chronic Tuberculosis of the Lungs.** *Infancy and early childhood.*—No age is free from liability to be affected with tubercle, thus Demme has found tubercular disease of the intestine in an infant of twenty-nine days.

Tubercular disease is not common in infants of a few months old; at this period gastro-intestinal atrophy is exceedingly common and is liable to be mistaken for tubercular disease on account of the wasting which takes place. Tuberculosis in young children rarely begins as does the phthisis of adults by a growth of tubercle and a condensation at the apices of the lungs, and a gradual extension downwards taking place, but is apt to be far more widespread in its distribution both in the lungs and in the body. It is therefore far more difficult to diagnose by means of physical signs which are less distinctive than are those of adults. It is needless to say that the same general appearances are found in the bodies of children as in adults dying of tuberculosis; grey tubercle, caseous masses, iron-grey infiltration and fibroid tissue in excessive quantity, and irregular cavities. The distribution however mostly differs, one of the chief differences being that in adults the tubercular processes appear to have a special affinity for the apices; in early childhood there is no such predilection, the hilus of the lung or base being more frequently affected before the apex. The bronchial glands are almost constantly found caseous, with also the small pulmonary glands which accompany the bronchi, the latter suppurating and forming small cavities near the root of the lungs. In this way a tuberculosis may spread into the lungs from the hilus. Not infrequently one or both bases are semi-solid from caseating pneumonia with ragged cavities, at other times a similar state of things is found at the apex. In other cases both lungs are stuffed with clusters of grey or yellow tubercles surrounding the terminal bronchi. There may be tubercle on the surface of the pleura, with more or less pleurisy or small local empyemas. The abdominal organs are exceedingly apt to be affected; cheesy masses are frequently found in the liver, spleen and kidneys; cheesy mesenteric glands and ulceration of the intestines are very common in cases of general tuberculosis. Tubercles are not infrequently found on the peritoneum and other serous membranes, as the pleura and meninges of the brain. Tubercular disease of bone may be associated with a general distribution of tubercle throughout the body.

The changes found post mortem in young children suffering from chronic or subacute tuberculosis compared with those found in the chronic phthisis of adults may be summed up as follows:—

1. Frequency with which the lungs (in children) are invaded with tubercular deposits from the root of the lung in consequence of an infection from caseating bronchial glands.

2. Frequency with which the lymphatic glands of the body become tubercular.
3. Frequency with which *caseous* degeneration takes place in the lungs, &c., grey tubercle being less common.
4. Frequency with which the liver, spleen, kidneys, mesenteric glands, peritoneum and intestines are the seat of tubercular changes.
5. Frequency of tubercular meningitis and of caseous tubercle in the brain.

*Symptoms.*—If the diagnosis of phthisis in the early stages is difficult in adults, when it is possible to carefully auscultate and percuss the apices of the lungs, examine the sputa for bacilli and cross-question the patient concerning the symptoms presented, it is necessarily much more difficult in the infant or young child, where the symptoms are rarely definite and where the lesions are so widely spread throughout the body. The younger the subject the more likely are the symptoms to be wanting in distinctiveness and the diagnosis to be consequently difficult, frequently wasting and a family history of tuberculosis being nearly all there is to go by. The temperature is usually hectic, normal or perhaps subnormal in the morning and reaching  $102^{\circ}$  or  $103^{\circ}$  in the evening, though this may be reversed. There may be diarrhoea without apparent cause, and various dyspeptic troubles; cough, though this may be absent; perhaps enlargement of some external glands. An examination of the lungs may reveal very little, perhaps some want of resonance over the base or apex or in the interscapular region or axilla, with some ringing consonant rales or crepitation. There is progressive wasting, which in a child of over a year or eighteen months is more suspicious than in an infant a few months old, where wasting is more often due to chronic intestinal catarrh than to tuberculosis. In those cases where wasting and hectic follow measles, or whooping-cough, bronchitis or bronchopneumonia, there is a strong suspicion of tuberculosis, even though there may have been a period of comparative health intervening between the acute attack and the hectic supervening; a family history of phthisis would make the case look still more threatening. In the later stages the symptoms become more decisive. The hectic continues, the wasting is progressive, the cough is troublesome, the diarrhoea perhaps is still present, parasitic stomatitis makes its appearance, the feet, hands, and face become œdematous, and the child is anæmic and very weak. Examination of the chest will now show some marked dulness or loss of resonance over some portion of lung, apex or base, with bronchial breathing and sharp consonating rales; often one is surprised to find how little can be detected in the chest, even when it is evident that the child is far advanced in tubercular disease. The typical signs of a cavity can rarely be elicited, inasmuch as the cavities in the lungs of infants and young children are not often larger than marbles or walnuts; most frequently they have irregular and ragged walls. A cracked-pot sound may sometimes be elicited in front, but on account of the yielding nature of the chest walls in an infant it is of no diagnostic value as regards a cavity.

*Diagnosis.*—Whenever wasting occurs as a prominent symptom during infancy and childhood, tuberculosis is certain to be thought of; wasting occurs in all dyspeptic diseases during infancy, and it may simulate the

wasting of tuberculosis when it occurs in connection with empyema or broncho-pneumonia in young children. An empyema may readily be mistaken for tuberculosis of the lungs if a careful examination of the lungs is not made, aided if necessary by an exploratory puncture, as there is wasting, hectic, and cough. The difficulty in deciding may be great without exploration if the empyema is localised or there is more than one. A chronic effusion in the pericardium may be mistaken for tubercular disease. It is often difficult in cases of chronic broncho-pneumonia, the chronic condition following an acute attack, to decide if a tubercular process is going on. There may be wasting and hectic, and yet after some weeks the temperature will gradually fall, the lung clear up and the child perfectly recover. In most cases only the progress of the case will decide.

*Older children.*—After the age of six years—in other words, after the commencement of the second dentition—chronic tuberculosis much more frequently resembles the chronic phthisis of adults than it does before this era. As the child gets older the resemblance becomes still more close. Children before this age rarely suffer from chronic tuberculosis of the adult type. The early symptoms are those of cough, loss of appetite, diarrhoea, wasting, night sweats, and hectic; progressive weakness; the symptom which we miss for the most part is hæmoptysis, which, though sometimes present, is much more frequently absent in children than in adults, and less is expectorated. An examination of the chest may perhaps disclose some loss of resonance at one apex (usually the right), with perhaps some rhonchus or moist sounds, or there may be no loss of resonance, only the signs of a chronic or subacute bronchial catarrh localised in the apex of a lung; or there may be impaired resonance only due to the presence of a thickened pleura and adherent lung. In this stage children perhaps more often than adults improve under treatment and a careful hygiene, and may be restored to perfect health; there is abundant evidence to demonstrate this. If the disease progresses the hectic and wasting continue, the child becomes pallid and weak, the diarrhoea frequent and troublesome, especially following meals; the physical signs show an extended area of lung involved, the tubercular infiltration travelling from the apex towards the base, and giving rise to caseous degeneration, fibroid changes and cavitation. The progress of such cases is apt to be more rapid than the corresponding cases in adults, four to six months being a common time. In the last stages the emaciation is extreme, the feet œdematous, bed sores are apt to form, and while the patient may linger for a while if no intercurrent affection brings the end quickly, it must be borne in mind that such cases are exceedingly apt to be brought to a conclusion by tubercular meningitis in any stage early or late. The abdominal organs are also apt to join in a more extensive spreading of tubercle than is the case later in life; mesenteric disease, extensive ulceration of bowels, peritonitis subacute or acute, are apt to be present, and necessarily influence the course of the disease. Hæmoptysis, which may be fatal almost immediately, occasionally occurs; in other cases blood may be expectorated in considerable quantities.

Sometimes an **acute phthisis** takes place without miliary tuberculosis being present; the tubercular process taking the form of clusters of grey tubercle surrounding the bronchi, the process beginning at the apex and

travelling towards the base, the symptoms being those of a rapid phthisis, perhaps extending over a month or two.

On the other hand, a **fibroid phthisis** essentially chronic in its course may take place, appearing at times to be stationary, or the patient undergoes considerable improvement. In these cases there is much fibroid change and iron-grey induration of lung with retraction. The physical signs develop slowly, there is dulness of an apex, which gradually becomes almost absolute, intense bronchial breathing, consonant rales and gradual retraction of the affected side. The child may fatten and appear to flourish and present a normal temperature, but it is easily exhausted, suffers from dyspnoea on exertion, its face and lips are turgid and the fingers become clubbed. In a few cases there is hæmoptysis, but this is the exception. It is possible that the process may become arrested, the lung being converted into fibroid tissue. In the majority of cases, the disease is progressive, and the opposite apex becomes affected. The whole course may extend over several years, unless bronchitis or some other intercurrent disease supervenes.

The principal clinical differences between chronic phthisis in older children and adults may be summed up as follows :—

1. Frequency with which children in the first stage recover.
2. Frequency with which the disease is brought to an abrupt termination by some acute affection, as tubercular meningitis, pleurisy, peritonitis, or acute miliary tuberculosis.
3. Comparative rarity of hæmoptysis in the early stages and of laryngitis in the latter stages.
4. Frequency of complication with abdominal tuberculosis.
5. Comparative rarity as compared with that of adults of extensive cavities in the lungs.

The *post-mortem appearances* are mostly similar to those found under similar circumstances in adults. Irregular ragged cavities, varying in size from a hazel-nut to a walnut, most numerous in the upper lobes, with cheesy masses and fibroid indurations; the same condition in the lower lobes in an earlier stage, with more or less crepitant lung. As a rule there is not much grey tubercle, but caseous masses, sometimes associated with peri-bronchial grey or yellow tubercles. There are not often cavities of large size, but these occur at times; in one case, a boy of eight years, who had suffered for six months, there was a cavity in the upper two-thirds of the left lung as large as an adult's clenched fist. Pleurisy and small collections of pus are not uncommon. The bronchial glands are almost invariably enlarged and caseous.

Instead of the above, especially in the more acute cases, the lungs are everywhere infiltrated with clusters of peri-bronchial tubercles, which crowd the upper lobes, where ragged irregular cavitation is commencing, while they are more sparsely scattered through the lower lobes.

In fibroid phthisis an extensive portion of one or both lungs is cicatrised and solid, bands of fibrous tissue run across, there is much grey infiltration, dilated bronchi, caseous glands and perhaps small ragged cavities. Other portions of lung are hypertrophic or emphysematous, perhaps containing scattered clusters of peri-bronchial tubercles.

Cheesy tubercles are met with constantly in other organs besides the lung,

especially in the liver, spleen and kidneys ; caseous mesenteric glands and ulceration of the intestines may also be associated.

*Treatment.*—The treatment of enlarged and caseous glands is necessarily the same in large measure as that of early tuberculosis. If a child, say one from three to six years of age, suffers from a hacking paroxysmal cough, is slightly feverish at night, remains in a condition of ill-defined malaise, especially if he have recently suffered from bronchitis, whooping cough, or measles, the suspicion will be raised that there is either caseation of the bronchial glands or an early tuberculosis of the lungs. There can be no certainty about the diagnosis, but if the family history points to tuberculosis there is only too much reason for anxiety. The indications for treatment which suggest themselves are to place the child under conditions in which there will be the least possible irritation of the lungs and bronchial tubes, and to supply him with nourishment in suitable quantities and in the most digestible forms. It is needless to say that these indications are fulfilled with difficulty or only partially. Residence in the smoke and dirt of large towns, or on damp clay subsoils, is alike bad, and if possible the child should be removed to some breezy moorland site or bracing sea-side place. Fresh air when it can be taken without risk of cold is of the greatest possible advantage in bracing up the digestive organs. In winter, if it be impossible to seek a warmer climate, thoroughly warm and well-ventilated apartments free from draughts must be secured. A well-warmed but not 'stuffy' house is a great advantage, as the child may in such a case have the 'run' of the whole house without being exposed to cold passages and open windows. A nourishing, easily assimilated diet should be prescribed, a variety being introduced in order to tempt the capricious appetite often present. A cup of beef-tea the last thing at night will often ease the cough and soothe the child to sleep.

Of special medicinal treatment, cod-liver oil, malt extract, mineral acids with cinchonine and the hypophosphites may be prescribed with advantage. Counter-irritants are useful ; they are hardly likely to have much effect on glands which are actually caseating, but they undoubtedly favourably influence chronic catarrhs of the bronchial mucous membranes. Among the milder ones, the lin. pot. iodid. c. sapone may be rubbed into the chest every evening, a piece of 'swansdown' or layer of cotton wool being applied. A stronger application may be made by diluting lin. iodi with glycerine and water—

( 27 )

Liniment of iodine	.	.	.	.	.	.	.	3ss.
Glycerine	.	.	.	.	.	.	.	3ij.
Water	.	.	.	.	.	.	.	to 3jss.

and applying it to the sternum or the subclavicular region every night and covering it over with a layer of cotton wool. Care must be taken not to render the skin too sore by applying it too frequently on the same spot.

The more urgent symptoms often present when the nerves are involved by a mediastinal tumour, and which are often very distressing, may be relieved in many cases by warm applications, such as fomentations, and small doses of nepenthe or morphia. Relief will probably be obtained from opiates combined with ether or chloroform if the dyspnoea is due to spasm. Inhalations

of chloroform, ether or nitrite of amyl, usually relieve. Small doses of morphia given subcutaneously may be tried.

Much that has been said applies to the early stages of all forms of chronic tuberculosis of the lungs. It is of the greatest possible importance to recognise the disease in its early stages when there is a fair probability that it may be arrested or undergo a natural cure if the conditions are favourable. To this end an equable temperature, a pure bracing air, protection from cold and damp and rapid temperature changes are of the greatest importance. The presence of tubercle in the lungs naturally predisposes to catarrhs and local pneumonias, and exposure to unfavourable conditions likely to favour their development is certain greatly to aggravate the disease. Great care must also be taken in the food which the child takes and in treating any departure from a healthy condition of the child's digestive system. A condition of catarrh of the bowels is very often present in tubercular diseases apart from any local lesion, and is an important factor in producing the wasting which accompanies tuberculosis.

## CHAPTER XIV.

## THE SPECIFIC FEVERS.

**Feverishness.**—Children more often than adults are apt to suffer from attacks of feverishness, the temperature perhaps rising suddenly without any obvious cause, remaining raised for a day or two, much to the alarm of the friends and the medical attendant, and returning to normal without any clue having been obtained as to its cause. Perhaps the feverishness is less acute, but continuous for some weeks, rising in the evening and falling in the morning, without any diagnosis being made. It is hardly needful to insist that in any given case no effort should be spared to find out the cause of the fever, and to effect this the child should be carefully examined, its chest being stripped and any sign of pneumonia carefully looked for, while the skin and throat should be minutely scrutinised in a good light. Inquiries should be made as to what the child has taken in the way of food, prior to the attack. If the attack is sudden, the temperature rising to  $103^{\circ}$  or  $104^{\circ}$  or more, acute pneumonia, scarlet fever, acute tonsillitis, or acute dyspepsia will doubtless suggest themselves. In children under three years of age, a high temperature with convulsions may be due to acute pneumonia, and a careful examination of the lungs should be made; in older children there may be no convulsions, but usually, if the physical signs are not distinctive, there is some stitch in the side felt on coughing, with more or less dyspnoea. In scarlet fever there is usually vomiting and often diarrhoea, and the appearances in the throat and skin soon become distinctive. During the first twelve or twenty-four hours it may be difficult to distinguish between scarlet fever and an acute diarrhoea or gastro-intestinal catarrh the result of improper food, as sometimes a gastric attack will produce severe symptoms of vomiting, diarrhoea, and fever. Or there may be no diarrhoea or sickness and only feverishness. In many of these cases it is wise to wait before giving a definite opinion. In some feverish attacks we have noticed an enlargement of the cervical glands, either the deep cervical at the angle of the jaw, or the glands on the upper part of the sterno-mastoid, without any appearances of irritation in the tonsil or pharynx; possibly there may be such a disease as an acute idiopathic adenitis, or some poison may perhaps be absorbed from the pharynx and enter the glands without setting up any local lesion at the absorbent surface.

Acute cerebral congestion or 'sunstroke' may be accompanied by high fever, quickly followed by death. In many cases where there is a high temperature and cerebral symptoms such as coma, delirium, or torpor, it is often difficult to say whether there is some cerebral disease, or whether the

high temperature and poisoned blood are not causing the cerebral symptoms, the brain itself being normal. When the temperature rises more slowly, taking several days to reach its greatest elevation, as is the case in measles, typhus, typhoid, and small-pox, a diagnosis cannot be made for a few days till characteristic symptoms develop. The hard cough, suffused eyes, and rash of measles, the headache, delirium, and coma of typhus, the backache and papules of smallpox, settle the diagnosis. The diagnosis as to the cause of fever is often very difficult when the fever assumes the intermittent or remittent type, going on for some days or weeks without any characteristic symptoms developing. A sub-acute or chronic gastro-intestinal catarrh, a patch of chronic pneumonia, a low form of enteric fever, a tubercular peritonitis or a miliary tuberculosis, may be present. There may be, as Dr. Foxwell suggests in these cases, a condition of general catarrh, including both alimentary and respiratory tracts. In all such cases a most careful examination should be made of the chest, abdomen, and retina for miliary tubercles, in the hopes of detecting something which will throw light on the attack. The possibility of an attack of fever due to suppuration in the middle ear must not be forgotten.

**Scarlet Fever.**—Scarlet fever is a specific fever of a highly infectious and dangerous character which occurs in epidemics, but is always more or less endemic in large populations. It is easy to understand the occurrence of epidemics in a small population where the fever exhausts the soil as it were, by attacking all those susceptible to its influence and then disappears for a while, to prevail at a later period, when the infection is re-introduced and the population contains again a number of the unprotected. It is more difficult, however, to understand the cause of epidemics in large cities where the infection is always present, unless we assume the existence of some unknown influence which favours the spread of the disease at one time more than another by rendering those who are unprotected by a former attack more than usually susceptible to the infection. Thus epidemics of scarlet fever are more common and widespread in the autumn than at any other period, and it would appear that at this season either the poison is apt to be more intense or individual susceptibility greater. Individual susceptibility varies greatly with age; infants under six months of age are rarely attacked, during the second year the susceptibility is greater, while children during their fourth and seventh years are most often attacked. The susceptibility then appears to diminish as age increases, though, as already remarked, varying strangely from time to time. Thus it may happen that a medical man or nurse may come in contact with scarlet fever cases for weeks or perhaps months without contracting the disease and yet finally take it. In one case which came under our notice a probationer-nurse was engaged in nursing in a scarlet-fever ward for six months without being attacked; many months after, while nursing in a surgical ward at another hospital, she contracted a smart attack of scarlet fever from a sporadic case arising in the ward.

Scarlet fever is apparently not so infectious as measles, a larger number of children and adults escape being attacked; thus Biedert found in an epidemic which prevailed in an isolated village (Neunhofen) where the inhabitants freely mixed with one another, and where no isolation of the fever patients was possible, that about 58 per cent. of the children unprotected by a former

attack contracted the disease, though only about two-thirds of these had well-marked symptoms, the rest having sore throats only. In different epidemics the numbers attacked varies extremely.

The *mortality* varies in different epidemics ; thus, in the fever ward of the Children's Hospital, Manchester, it has varied from 6 to 25 per cent. in different years during the last ten years, the average mortality among 1,598 cases treated being 11·8 per cent. This average mortality closely corresponds with the figures given by Collie of the mortality in the London, Stockwell, and Homerton fever hospitals, where, in upwards of 10,000 cases of scarlet fever, the mortality was 12·5 per cent. As in all probability many of the milder cases of fever never come into hospital at all, 10 per cent. mortality given by W. Squire as the average appears to be as nearly correct as possible. Age influences the mortality very considerably ; the mortality is high during the first three or four years of life, amounting to 25 to 30 per cent. ; it continues high till the age of six or seven years is reached, declining after this till the age of twenty-one, again increasing after this epoch.

Are there any morbid conditions of body which predispose to scarlet fever ? Very little is definitely known about such conditions ; individual susceptibility varies in the most erratic manner, at least is governed by no known laws, and it cannot be said that ill health in any way either favours or protects from attacks. To this however must be added, that it is our experience that operation cases and surgical cases with open wounds are more liable to contract the disease than are healthy persons. The so-called **surgical scarlet fever** is simply scarlet fever occurring in a surgical case (*vide infra*).

The strong and healthy appear to be as frequently attacked as the weakly and the attacks are often fatal to such ; it is by no means uncommon to see on the post-mortem table children who have succumbed to malignant scarlet fever looking fat and plump, and who were apparently in the best of health when attacked.

The *transference of infection* from the sick to the healthy takes place in various ways ; it may be by direct contact, the breath or the exhalations from the fever patient may be inhaled, or it may be carried by means of clothes or wearing apparel or bedding which has been in contact with the sick. It is highly probable also that the excretions of the patient are infective, the urine, fæces, and discharges from the ear or nose. From the investigations of Power and Klein it seems that the fever may pass from cattle to man by means of the milk of cows suffering from a form of bovine fever known by the name of 'sore teats.' The poison of scarlet fever appears to retain its vitality for many months, fever breaking out again and again in houses which have been imperfectly disinfected.

Second attacks are rare. Reinfection or relapses are said to take place in some instances ; in cases coming under our notice which have had an attack of genuine scarlet fever after admission to our fever ward, there was considerable doubt as to the correctness of the original diagnosis.

*Incubation.*—Mostly two to five days, though it may be much less, perhaps only a few hours ; 48 to 72 hours is a common period, but in many cases where slight sore throat precedes for some hours the more definite symptoms, it is impossible to state the period of incubation with exactness. In the majority of cases, if the initial vomiting be taken as the first symptom, it will be found

that the incubation is under three days. It cannot be said with certainty that it may not be more than five days, but such cases must be very exceptional.

*Premonitory symptoms.*—The invasion in the case of children is usually sudden, the first symptom being nearly always vomiting; this may come on after a hearty meal. There may also be diarrhoea. In older children and in adults there is usually nausea if not vomiting, sore throat, headache, shivering and loss of appetite. 'Sore-throat' with diarrhoea in a child or adult is extremely suspicious of scarlet fever, especially if fever is present. The tempe-

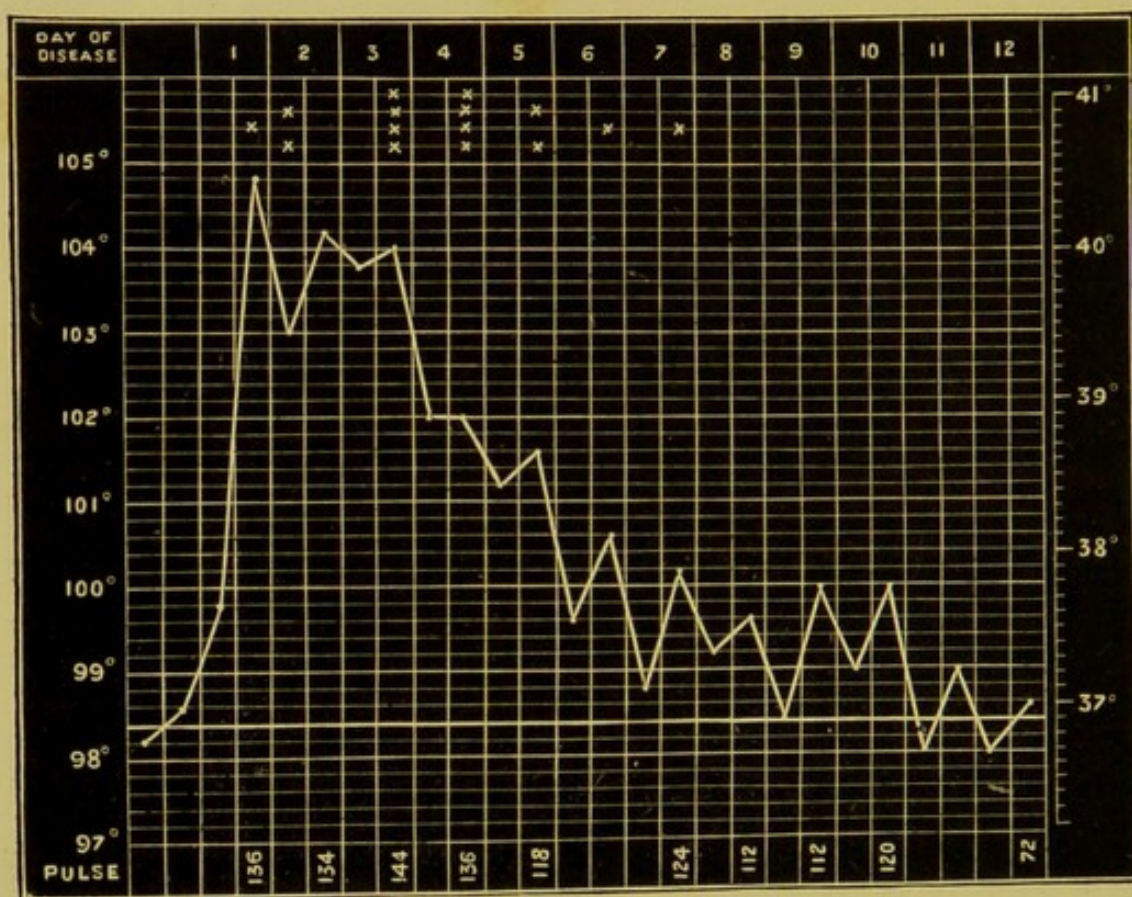


Fig. 26.—Temperature Chart of a case of Scarlet Fever, medium attack. M. K., aged 13 years.  
°, Rash present.

perature usually runs up quickly to 103° or 104° and perhaps the patient sits over the fire on account of feeling chilly; in some cases there is slight delirium.

An attack of vomiting and diarrhoea coming on suddenly with feverishness (103°–104 F°.) is very probably the commencement of scarlet fever.<sup>1</sup>

*Symptoms and course. Medium forms.*—The premonitory symptoms are usually followed within twenty-four hours by the characteristic rash. This is said to make its appearance first about the neck, but there is no certainty about this, and traces may be seen of it on the backs of the hands and wrists, or on the thighs or abdomen, when it is present nowhere else. In some cases it is first visible on the back. At first the rash is faint though perfectly characteristic, taking two or three days to reach its height. In other cases it disappears in the course of twenty-four or forty-eight hours,

<sup>1</sup> In such cases death may take place within twenty-four hours of the onset.

having at no time been more than a fine faint rash. When typical it cannot be mistaken for any other rash. Viewed from a short distance, the whole body excepting the face is of a uniform bright red colour; examined closely, it consists of a multitude of red points which correspond with the hair-follicles; these points are surrounded by zones of erythematous redness which joining with one another give a general diffuse red appearance to the skin. Sometimes the rash consists of the points only without the erythema; in this case the redness is necessarily less vivid. In rough skins the rash may be coarsely punctiform; that is, there is a condition of 'goose skin,' each point being large and the rash therefore coarse. Sudamina are not uncommon. In other cases the rash is patchy on the limbs, and when this is so, the case may simulate measles; the patches consist of clusters of fine papules or points with much surrounding erythema, while normal skin is present between the patches. Towards the end of the first week the rash, which has been fading for several days, is succeeded by desquamation, which is free or slight according to the intensity of the rash. This exfoliation of the epidermis generally goes on for many weeks, being present longest about the hands and feet. The tonsils are red, swollen and covered with an excess of mucoid secretion, yellow points corresponding to the tonsillar crypts are usually present, sometimes there are patches of yellow exudation; the soft palate, uvula and pharynx are more or less congested. The nasal mucous membrane is frequently involved, so that there is much discharge from the nose. The deep cervical glands at the angles of the jaw are usually enlarged. The tongue is coated with a thick white fur; not infrequently there is a dry glazed central band on the dorsum; in the course of a few days the tongue cleans, leaving a red clean glazed tongue with prominent fungiform papillæ—*i.e.* 'the strawberry tongue.' The eyes are often suffused and the conjunctiva injected, and with this there is often sleeplessness or delirium, no doubt due to a congested state of the membranes of the brain.

The pulse is quick, varying from 120-150, often faster, than the temperature or the general state of the child would have led one to expect; the temperature varies, mostly reaching 103° or 105° in a moderately sharp attack (fig. 26). The urine is scanty, high-coloured, and often contains a small quantity of albumen. In the course of a few days, perhaps by the end of the third or fourth, the attack has reached its height, and the symptoms begin to decline. The rash gradually fades, the temperature falls, the evening rises being smaller and the morning remissions more marked; the tongue cleans, the fauces are less injected and the appetite returns. By the end of the first week the temperature has reached normal; any feverishness which continues after this suggests some complication, the commonest being an ulcerating or sloughy process going on in the throat, inflammation of glands, and otitis. It must however be added that attacks of scarlet fever are extremely unequal and no two cases are exactly alike.

**Mild Scarlet Fever.**—In some cases the premonitory symptoms are absent or the fever is only slight and easily overlooked, and the first thing to call attention to the attack is the rash. It not unfrequently happens, even in hospitals where the children are under observation, that the discovery of a rash is the first thing noted. The child may seem to be in its usual health, make no complaint of sore throat, and appear to take its meals well, with

an evening rise and a morning remission of temperature, and yet be suffering from a mild attack of scarlet fever (fig. 27). The rash in such cases is rarely well marked, but if it is diffuse and punctiform and remains visible for twenty-four or forty-eight hours, the attack is unmistakably one of scarlet fever. There is usually slight tonsillitis. The most difficult cases to diagnose are those where there is sore throat without rash, inasmuch as there is nothing characteristic about a scarlatinal tonsillitis.

**Malignant Scarlet Fever.**—In some cases death occurs very rapidly, perhaps within twenty-four hours, though this is rare. The most rapid case which has come under our notice was that of a girl of twenty months; she was noticed not to take her dinner well and vomited after her tea, her temperature, which had been normal in the morning, had risen to  $103^{\circ}$  by 5.30 (fig. 28 *a*); at 7 P.M. the pulse was 160, the tonsils were enlarged, and there was a very faint rash over the body; she was removed the same evening by

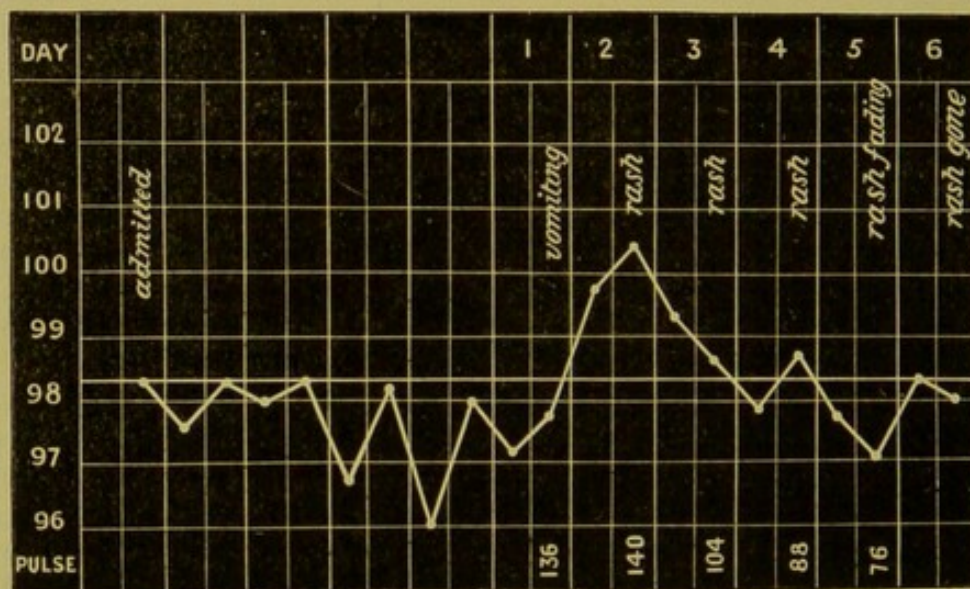


Fig. 27.—Temperature Chart of a Mild Scarlet Fever. B. W., aged 6 years. Attack contracted in scarlet fever ward.

the resident medical officer, Dr. Kershaw, to the fever ward. Next morning the rash had disappeared, the tonsils were enlarged with a patch of exudation on one of them, her pulse and respirations were rapid, but she did not seem extremely ill. She gradually became worse, the face cyanosed, respiration gasping, and pulse failing; she died soon after 5 P.M., twenty-four hours after the initial symptom of vomiting. At the post mortem one tonsil was sloughing and soft. Death in this case, as in most rapidly fatal cases, took place through the heart failing under the influence of the poison; they may not appear for a few hours in actual danger, then symptoms of cyanosis and collapse set in, quickly followed by a fatal result. In the great majority of acute cases death does not take place till the fourth or the seventh day (fig. 28 *b*); in these the temperature is high, perhaps  $105^{\circ}$  or  $106^{\circ}$ , there is much diarrhoea, often extreme restlessness, followed by coma; the tonsils are much swollen and covered with foul secretion, there is much nasal discharge, the glandular swelling and cellulitis is great, the neck being hard and tense

to the touch ; the skin is of a dull lurid colour, the extremities cold, and the heart gradually fails. If life is prolonged for a few days, the tonsils and soft palate slough and the lungs become the seat of septic pneumonia. In another class of case in which life is prolonged to the end of the second or third week a condition of **septicaemia** is set up. The tonsils ulcerate, sloughy patches appear on the fauces, the glands become enlarged and brawny, the nasal mucous membrane discharges a purulent secretion, and the conjunctivæ become affected ; the temperature is remittent but continues high, the urine albuminous, pus wells out from both ears, the child gradually

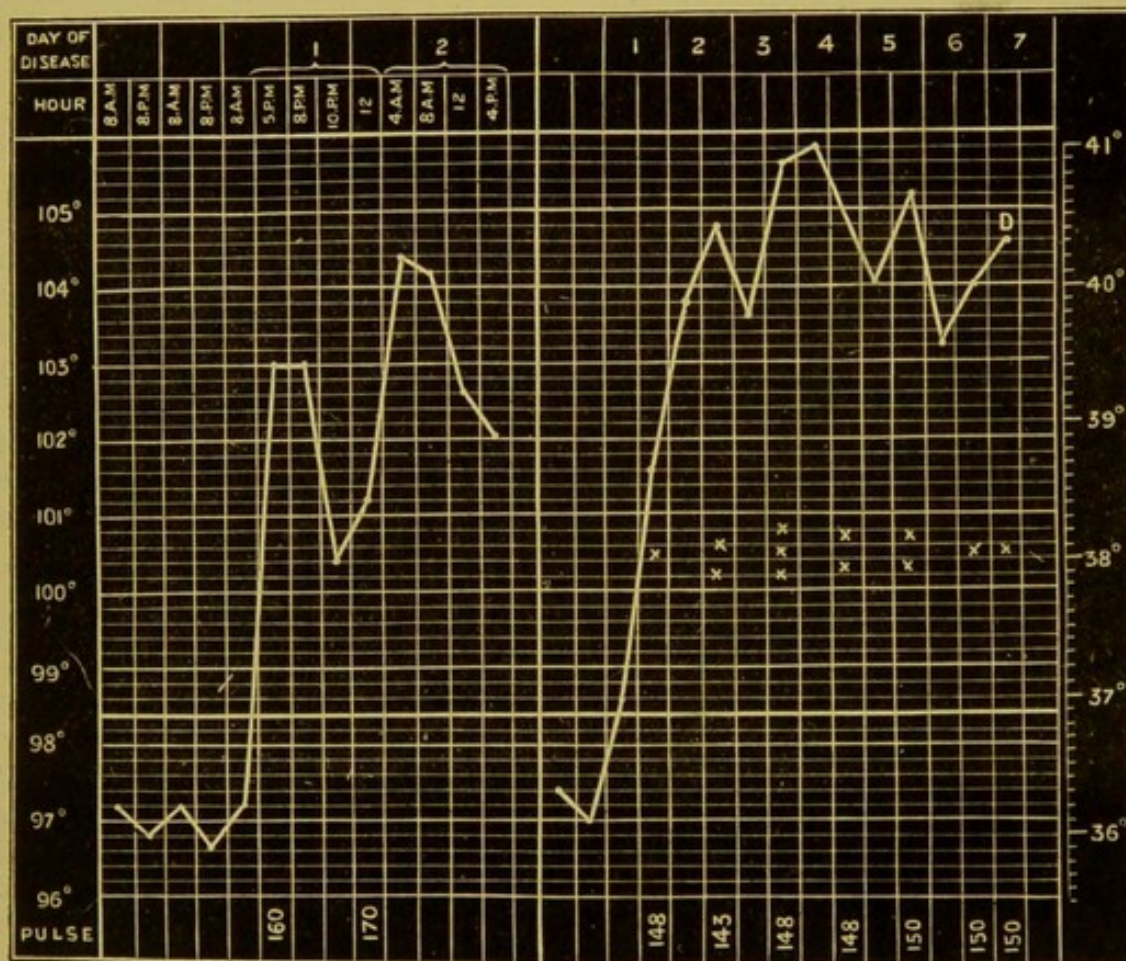


Fig. 28a.—Temperature Chart of Malignant Scarlet Fever. Death in 24 hours.

Fig. 28b.—Temperature Chart of Malignant Scarlet Fever. Death 7th day. x, Rash.

wastes and dies in the course of ten or fourteen days. At the post mortem there is found extensive sloughing about the fauces, pleuro-pneumonia, and large hæmorrhagic kidneys with minute abscesses. In some cases the temperature remains high during the second or even third week without any local lesion being discoverable to account for it. In all such cases the lungs should be carefully examined and the possibility of some septic inflammation going on in the kidneys be borne in mind.

*Prognosis.*—A guarded prognosis must always be given in the case of young children, the throat complications in these being generally serious. The tonsils are apt to slough, and they have so little power to get rid of the foul

secretion which rapidly forms in the pharynx and nose that they are extremely liable to pneumonia from extension from the pharynx and glandular inflammation. Diarrhœa is always a serious symptom ; when present at the onset it points to a sharp attack, in the later stages it is also of evil augury, and if a marked symptom it usually presages a fatal result. Drowsiness at the onset and during the course of the attack is an unfavourable symptom, as it usually accompanies a high degree of fever and a severe course. In all cases where the temperature is maintained during the second or third week, the prognosis must be exceedingly guarded and the possibility of a fatal nephritis supervening must be borne in mind.

*Complications and sequelæ.*—Many of these have already been referred to—

(1) The **tonsils** may become deeply excavated, the soft palate may slough, a small hole appearing through the velum, to be followed perhaps by an almost entire destruction of the soft parts ; in the rare cases when recovery follows, cicatrization and deformity of the soft palate is the result. The inflammation may spread to the epiglottis and larynx, and croupy symptoms become so urgent that tracheotomy is required. The fauces and larynx may become the seat of false membrane. In rare cases the ulcerating process in the throat may reach and enter the internal carotid or jugular vein and death follow from hæmorrhage.

(2) The **nasal and conjunctival mucous membrane** may be the seat of inflammation or a fibrinous exudation. A chronic discharge from the nose and a consequent eczematous condition of the upper lip may be left after the fever.

(3) **Otitis.** The inflammation may spread along the Eustachian tube to the middle ear, and pus be formed in the tympanic cavity, which finds its exit by perforation of the membrane. This may happen during the fever or during convalescence. Suppuration in the tympanum is one of the common causes of a continued elevated temperature after the disappearance of the rash ; the child may suffer very little pain, and the presence of pus in the external meatus or staining the linen may be the first thing to call attention to this complication. At other times the child will put its hand to its ear and frequently shake its head, as if to get rid of some source of irritation. Pyæmia and abscesses in the lungs may follow if thrombosis of the lateral sinus occurs.

(4) The **cervical glands** frequently become enlarged and suppurate, either during the course of the fever or when the child is convalescent. In some cases, more especially in weakly children, much sloughing may go on about the neck, deep ragged ulcers being formed, exposing the large vessels ; fatal hæmorrhage may occur from the latter.

(5) **Broncho- or pleuro-pneumonia** occurs very frequently in cases dying during the second week, and is due to extension downwards of the lesion from the throat. Pneumonia followed by empyema may take place during convalescence.

(6) **Synovitis and Rheumatism.**—The joints are apt to become swollen and tender at the end of the first or beginning of the second week ; those most frequently affected are the wrists and small joints of the hand, whilst sometimes the synovial sheaths of the tendons at the back and in the palms

of the hands are attacked. The knees, ankles, soles of the feet, elbows, and joints of the cervical vertebræ may be affected. Movement of the affected joints causes pain, and they are mostly swollen, red and tender. The affection is rarely severe, being fugitive, and seldom returning to the same joint. The knee-joints sometimes remain swollen for some weeks from effusion into the joints. The cases complicated with synovitis are usually severe, though exceptions occur; peri-endocarditis much less frequently occurs than in the ordinary form of rheumatism. Synovitis sometimes occurs in association with nephritis during the second week. Attacks of true rheumatism are apt to occur during convalescence, but such are more common in young adults than in children; these attacks differ in no particular from ordinary rheumatism, the heart being frequently involved. An attack of scarlet fever during convalescence from rheumatism not infrequently causes a relapse.

(7) **Pyæmia and suppuration in the joints** occasionally occurs; any joint may be affected. Such cases are mostly fatal, though not invariably so.

(8) **Nephritis.**—No complication of scarlet fever can vie in importance or interest with nephritis; and this condition often gives rise to much anxiety in an otherwise mild and favourable case. The 'initial' albuminuria which frequently accompanies the febrile state in the first week of the disease is not of much importance, as it is usually temporary and not due to any important lesion of the kidneys, and quickly disappears as the fever subsides towards the end of the first week. Apart from this febrile albuminuria, there are two forms of nephritis which, it is important to bear in mind, are distinct from one another, though they have frequently been confounded and much confusion has arisen in consequence. They may be distinguished as (1) Septic nephritis, (2) Post-scarlatinal nephritis.

1. **Septic Nephritis.**—In the severe forms of fever complicated with sloughing tonsils and soft palate and much glandular swelling, the urine is albuminous, frequently highly so; but it rarely contains blood in appreciable quantities or casts; there are indeed no renal symptoms, or if there are, they are so masked by the general condition of septicæmia that it is difficult or impossible to differentiate them. There is no dropsy or uræmic phenomena. If the patient survive till the end of the second or third week, a more or less typical pyæmic kidney is found at the post mortem. The kidneys are enlarged, frequently very much so; they are flabby, of a cream colour on the surface, with minute hæmorrhages and mostly minute abscesses. On section the cortex is of the same cream colour mottled with injected vessels and points of fluid or inspissated pus. This condition of kidney forms part of a general condition of pyæmia and is chiefly of interest in demonstrating that the kidneys suffer during the course of the disease itself, and consequently in cases which recover are in a condition which predisposes to inflammatory affections during convalescence.

2. **Post-scarlatinal Nephritis.**—This is the form which is liable to supervene during the third or fourth weeks and which is known generally by the name of scarlatinal nephritis. There can be little doubt that the kidneys are actively engaged during the course of the fever itself, and for the succeeding week or two, in carrying off the waste-products formed during the fever, and are in an irritable condition and prone to take on inflammatory action, in the same way as the bronchial tubes and lungs are left in an irritable con-

dition after measles and are apt to suffer from inflammatory attacks : and while it is possible in both cases that nephritis and pneumonia may supervene in spite of the greatest care, yet any chill or exposure to cold is extremely likely to produce or determine such an attack. The number of those who suffer varies in different epidemics, and also according to the season and the care which is taken of them during convalescence. Taking an average of several years, we find about six per cent. of our hospital patients have suffered from post-scarlatinal nephritis. Patients who have had the primary fever both in a severe and mild form may be attacked ; in the former class of cases, especially where there has been no period of apyrexia, it is mostly fatal ; in the later class—as least in hospital—it is rarely so fatal. The prognosis is usually bad in those cases where the temperature continues elevated during the second week, in consequence of severe pharyngeal or glandular inflammation, and which contract nephritis in the third week, the latter complication supervening on the throat lesions. From the fourteenth

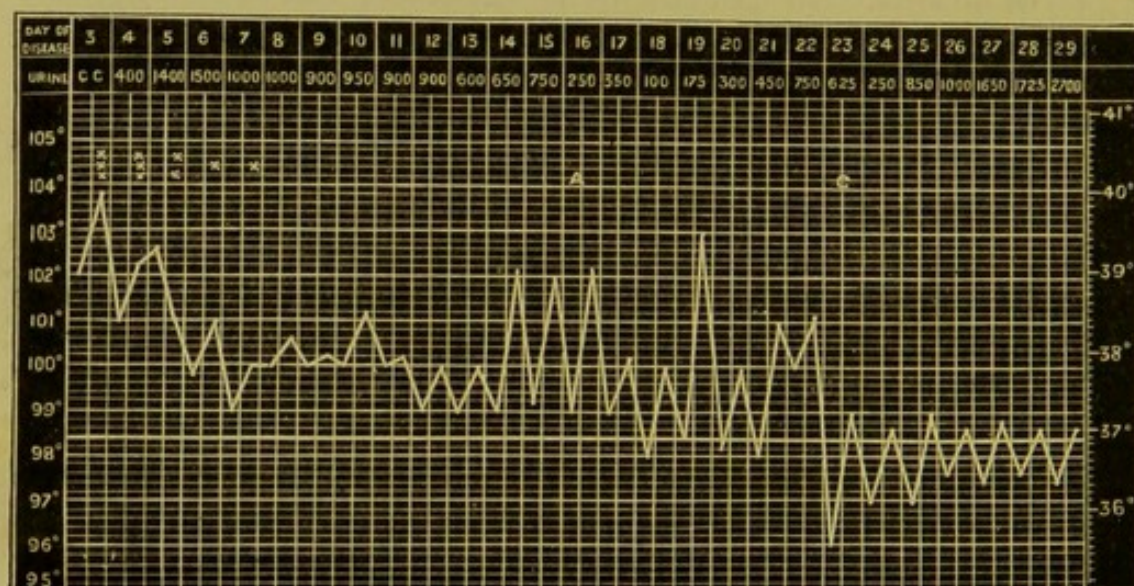


Fig. 29.—Temperature Chart of Post-Scarlatinal Nephritis. °, rash ; A, albumen ; c, uræmic convulsions. Recovery.

to the twenty-sixth day is the commonest time for nephritis to supervene, but as it usually begins insidiously, traces of albumen being present for a few days before blood and larger quantities of albumen appear, it is often impossible to determine the exact date of the commencement of the attack. In well-marked cases it is noticed by the attendants that the child which, since the subsidence of the fever, has been practically well, becomes restless, feverish at night, thirsty, has a quick perhaps hard pulse, and passes small quantities of dark-coloured urine. If particular attention has been paid to the urine, it will probably have been found that it has been diminishing in quantity, and has contained small quantities of albumen for a few days prior to the dark urine being passed. Sometimes puffiness about the face precedes the appearance of albumen in the urine. The urine may be dark red, but usually it is 'smoky,' and on allowing it to stand in a tall glass, deposits a dark flocculent precipitate, not unlike the flocculi in beef-tea. This

precipitate consists of blood corpuscles, epithelium and fibrinous cylinders which have been formed in the tubules and consequently may contain corpuscles and epithelium. The supernatant liquid contains a variable amount of albumen, sometimes becoming almost solid on being boiled, more often a half to a sixth of its volume of coagulated albumen precipitates by boiling. It may not contain any blood. For a few days the urine continues dark and albuminous and of high specific gravity (1020-1025), and diminished in quantity, perhaps only a few ounces per diem; the face becomes pale and puffy, there may be œdema of the feet and scrotum, and more or less vomiting, then perhaps at the end of a week an improvement takes place, large quantities of urine are passed with diminished quantities of blood and albumen, and the child becomes again convalescent, though the urine may contain some albumen for weeks or even months, and the anæmia may continue for a like period. On the other hand, in a minority of cases the nephritis is prolonged and symptoms of **uræmia** may supervene, the pulse become slow, the temperature subnormal, the tongue dry and brown. Often there is frequent vomiting, sometimes diarrhœa (see fig. 29), hæmorrhages may take place from various surfaces, especially the nose; there may be amaurosis, muscular twitchings, and perhaps general convulsion.

In all cases of nephritis particular care should be taken to examine the heart, inasmuch as a fatal result is more often brought about in consequence of cardiac failure than directly through uræmic convulsions. One of the effects of nephritis is to raise the tension in the blood-vessels, and this, if continued for any considerable time, is followed by **dilatation of the heart**, the tension in the arterial system in combination with malnutrition being responsible for this result. Another not uncommon result is **endocarditis** or **pericarditis**, and possibly **embolism**. The possibility of **death occurring suddenly** during the course of an acute or subacute nephritis must always be borne in mind; the patient may appear to be doing fairly well, perhaps sitting up in bed and playing with his toys, when an attack of dyspnœa comes on, the face becomes livid or pallid, the pulse disappears, and death quickly takes place. Sometimes attacks of dyspnœa may precede by a day or two the fatal event. Such cases have been often described as being fatal in consequence of œdema of the lungs, the dilatation of the heart having been overlooked; œdema of the lungs is present, but it is secondary to the cardiac failure. The pathology of such cases is tolerably clear; acute nephritis, running a very rapid course in consequence of the kidneys being almost completely choked, usually terminates with uræmic phenomena; if it runs a slower course, the tension in the blood-vessels throws additional work upon the heart, the left ventricle struggles with the increased work thrown upon it, the blood becomes impoverished and nutrition impaired, the cavities of the heart dilate, and finally that organ gives way, often suddenly at the last. The amount of dilatation present should be carefully noted by the position of the apex beat, and the increase of impaired resonance.

**Pneumonia, pleurisy, and peritonitis** may occur in the course of nephritis. Pleuro-pneumonia, ending in gangrene, may take place. In a few cases the attack is exceedingly acute, the temperature being high, 104°

to 105°, the tongue dry and brown, the urine containing much blood and albumen, and death rapidly taking place. In such cases there is usually coincident pneumonia. In a large number of cases the attacks are mild, a small quantity of albumen, perhaps without any blood, making its appearance during the third week, the face becoming puffy and the child anæmic, the albumen disappearing in the course of a week or two, and the child after a prolonged convalescence slowly regaining its health.

Total suppression of urine is not common, a few ounces daily being usually passed; in one of our cases only three ounces of pale albuminous urine was passed in the four and a half days which preceded death; there were no convulsions. Life is rarely prolonged beyond the fifth day if there is total suppression. Death takes place in many cases without convulsions, in others convulsions may supervene and recovery follow; the convulsions are not dependent only upon retained urinary products, but also upon the stability of the nervous centres, which differs markedly in different children.

*Diagnosis.*—The diagnosis of mild cases of scarlet fever often presents extraordinary difficulty, and yet the importance of making a diagnosis is often great. In hospital or dispensary practice cases have mostly to be treated as infectious or non-infectious; as there is often no opportunity of taking a middle course, they must be sent into a fever ward with the risk of contracting the disease if the diagnosis is at fault, or of infecting others if treated with non-infectious cases. In private practice among the wealthier classes it may be possible to isolate all suspicious cases, but such are always a source of anxiety. It cannot be too forcibly impressed that diagnosis in some instances is impossible, and that errors will occasionally be made by the most experienced, though at the same time it must be acknowledged that mistakes are more frequently made through carelessness than from any want of knowledge. The most characteristic phenomenon is of course the rash, and if this is well marked, being diffuse and punctiform, and lasting at least twenty-four or forty-eight hours, even in the absence of tonsillitis or a high temperature, there can hardly be a doubt about the diagnosis. A measles rash can hardly be mistaken for it, except in those cases where the rash is patchy about the limbs, but in these it is usually diffuse and characteristic on the trunk. A scarlet fever rash however faint usually lasts for twenty-four hours at least, in this respect differing from erythematous rashes, which may be present in the evening and gone before morning. It is always well when called to see a rash by artificial light to wait for daylight to give a definite opinion. It is important to bear in mind that a rash resembling scarlet fever occurs in some cases of pyæmia and also in rubella (*see* p. 235). To distinguish between scarlatinal and simple tonsillitis is mostly impossible in the absence of a rash; the 'strawberry' tongue is generally absent in cases unattended with a rash. Cases of tonsillitis where the nasal mucous membrane becomes involved, or where there is excessive exudation on the fauces or sloughing of the soft palate, if diphtheria can be excluded, are probably scarlatinal. If the lymphatic glands at the angle of the jaw become enlarged and tender, scarlet fever is probable. Acute nephritis occurring after an anomalous rash or sore throat makes it practically certain that the primary attack was scarlet fever.

*Morbid anatomy.*—In the bodies of those dying during the first few days

of the disease, no gross lesions except those in connection with the throat can be detected. One or both tonsils are ragged, perhaps sloughy, the glands are enlarged, perhaps beginning to suppurate, the internal organs are gorged with blood, there are minute hæmorrhages on their surfaces. The heart, liver, and kidneys are pale, the Peyer's glands are swollen, and the mucous membrane of the intestines injected. If the child has survived a week or more, usually septic changes are present; the lungs are in a condition of pneumonia more or less advanced, which is secondary to the sloughy throat, and the glandular inflammation and cellulitis in the neck; marked changes are also found in the kidneys if the child has survived two or three weeks. In typical cases these are much enlarged, flabby, pale on the surface, with minute hæmorrhages and injected capillaries; on section minute abscesses may often be seen at the base of the pyramids. On microscopical examination large tracts of kidney substance will be found infiltrated with leucocytes, and micrococci will be detected in the capillaries.<sup>1</sup> If death has been the result of post-scarlatinal nephritis, in the early stages the kidneys will be gorged with blood and deeply stained in consequence of the tubules being choked with casts and the capillaries distended to their utmost. In a later stage the kidneys are enlarged and pale, dripping urine on section, and on close examination it will be noted that the Malpighian bodies are enlarged and pale, standing out prominently like grains of sand dusted on to the cortex. On microscopical examination it will be found that the glomeruli are enlarged in consequence of containing an increase in the number of their nuclei, in some cases fibrinous thrombi, and in a later stage being surrounded by a fibro-cellular growth which completely strangulates them and produces complete obstruction. When nephritis is present the cavities of the heart are found dilated, sometimes there is peri-endocarditis, peritonitis, or pneumonia.

*Treatment.*—As soon as scarlet fever is suspected, means must be adopted to prevent the spread of the disease in the household by isolating the patient as far as it is possible to do so. It is obviously impossible to effect this in the smaller class of houses, and indeed even in large and well-appointed houses nothing like perfect isolation can be carried out, the removal of the patient to a fever hospital being in all cases the wisest course when it can be managed. To diminish risks of infection as far as it is possible, a room on the upper story should be secured, or still better the whole of the top landing should be devoted to the patient, and those of the household who are in attendance on him. Every article in the room which can be spared, especially curtains, carpets, and other woollen goods, should be removed, only retaining such as are required for immediate use. The bedding should consist of a horse-hair mattress and warm but light coverings. The sick-room should be large and airy, the more cubic space the better, provided it can be kept at a moderate temperature, and all draughts avoided. The attendants on the sick should not mix with the other members of the household, but devote themselves entirely to the work of the sick-room. If there are children in the house who have not had scarlet fever, the question will arise what is best to be done with them. In the first place, it is clear that they must not attend school or mix with other children; the question of sending them away must

<sup>1</sup> These micro-organisms are similar to those found in septicæmia and are quite distinct from the bacilli described by Edington.

depend upon various circumstances. Remaining at home unquestionably involves a risk, and at any time so long as the house remains infected they may be attacked. Sending them away involves the risk of their being incubating at the time, and of conveying the infection to another household. The best course, if it can be taken, is to send them away to some household where there are no children, and where they can be brought back if they are attacked after removal. To send them away to distant sea-side lodgings could not be sanctioned under any circumstances : it is better to run the risk of infection at home, than have them sicken away from home among strangers, and become the source of an outbreak elsewhere.

As soon as the diagnosis of scarlet fever is made the child should be put to bed, and remain there as long as there is fever, or still better for three weeks, though this, in mild cases especially, is difficult to enforce in private practice. In hospital practice three weeks in bed is the ordinary rule ; the object of this being to obviate the risk of catching cold, and it is better to be over-cautious in this respect. The diet for the first few weeks should consist largely of fluids ; it is most important that the digestive organs should not be overtaxed and that the excretory apparatus, especially the kidneys, should be active, inasmuch as the waste products are increased during fever, and the poison also passes out of the body in this way. During the febrile period, milk and barley water or milk and soda water is the best food that can be given ; feverish children rarely care for beef-tea, and all jellies and meat extracts are unnecessary. One to two pints of milk suitably diluted during the twenty-four hours will be quite sufficient ; if more is attempted, sickness may not unlikely be produced. Daily sponging with tepid or cold water, to which some Condyl's fluid or other deodorant is added, is of much service. Caution should be exercised in giving baths, and unless the bath can be brought to the bed-side, they had better be avoided until convalescence is well established. Whilst desquamation is proceeding, after the spongings or warm baths the skin should be gently anointed with glycerine and starch, carbolic oil, or an ointment containing carbolic acid (1-12).

The application of topical remedies to the throat and nasal mucous membrane is frequently a matter of great difficulty in children and much adroitness and firmness will be often required. In mild cases where there is only a slight congestion and swelling of the tonsils, no local treatment need be attempted, except perhaps the sucking of pieces of ice or iced milk. In older children the throat spray may be used if the patient is sufficiently docile, but young children are almost certain to offer a certain amount of resistance when their throat is being attended to, and under these circumstances spraying is useless, as the spray is rarely properly directed. Here mopping by means of a large paint-brush or with lint secured at the end of a piece of stick will have to be resorted to. Syringing the fauces is also useful to clear away the mucus which is so apt to accumulate both in the fauces and nasal passages. In selecting an antiseptic which is to be used freely as in syringing or spraying, it is well to remember that some of it may be swallowed, and consequently it should not be very poisonous, while for mopping or painting a caustic or more active poison may be used. In severe cases the frequent cleansing of the throat is a matter of great importance and one upon which we are inclined to lay much stress ; it is however often attended

with exhausting struggles for the patient, and can only be done by properly trained nurses, the friends rarely having the necessary skill or firmness. The actual antiseptic selected is of less importance than the manner of using it, the object being to prevent the mucus and products of decomposition from accumulating in the fauces and being drawn into the air passages or being absorbed. For syringing or mopping, solutions containing chlorine, as liq. sodæ chloratæ (1 to 20), sulphurous acid (1 to 10), boracic acid (1 to 15), boroglyceride (saturated solution in glycerine), sanitas (1 to 40), permanganate of potash (1 to 40), answer very well. The sulphurous acid has the disadvantage of frequently containing sulphuric acid, and consequently giving rise to smarting, if there are many cracks in the lips or excoriations about the nose. These can be used every four hours, or more frequently according to the severity of the case. Where there is much exudation, or sloughing of the tonsils or fauces, some strong caustic solution, as glycer. acid. carbolici, or chinolin 2 to 5 p.c. in alcohol. Nitrate of silver may be applied once or twice a day, having first syringed away the mucus; a saturated solution of salicylic acid in sp. vini rect. is a good preparation for painting on. There is but little reason to believe that the course of the fever is much influenced by internal remedies; in mild cases a saline such as chlorate of potash is useful, giving it only in moderate doses, as 2 to 5 grs. every four or six hours; in larger doses it is apt to be deleterious. In more severe cases the treatment must be adapted to the symptoms, stimulants being usually required on account of the depression which is so often present. Carbonate of ammonia, digitalis, cinchona bark, separately or in combination, are the most useful drugs. Diarrhœa, if excessive, must be kept in check by opium enemata; if moderate, it had better be left alone. Sleeplessness, headache, delirium, are best relieved by an ice-bag to the head and full doses of bromide. When the temperature continues high, being  $104^{\circ}$  to  $105^{\circ}$  quinine in 1 to 3 gr. doses, and repeated packs, so as to get the skin to act, have appeared to us the most useful form of treatment. The child should be wrapped up in a sheet wrung out of water at  $60^{\circ}$  and rolled up in a blanket for an hour. This must be repeated if the temperature continues high. Cold spongings are also useful. Cold baths require great care on account of the depression they are apt to produce; if used at all, they should consist of the graduated bath—that is, the child should be placed in a bath at  $90^{\circ}$ , the temperature being gradually reduced to  $60^{\circ}$  by the addition of cold water. Antifebrin or antipyrin may be used, but their effect is temporary only, and they are apt to be accompanied by considerable depression of the heart. The former may be given in 3 to 5 gr. doses in sherry or tincture of orange peel, as it is insoluble in water. Oxygen gas has been used with apparent advantage.<sup>1</sup>

It must however be admitted that the treatment of the severer forms of scarlet fever is disappointing and often disheartening: in spite of the most devoted nursing, stimulants freely given, antipyretics, liquid nourishments of all kinds, antiseptics to the fauces, they go from bad to worse, apparently uninfluenced by all that has been done for them. On the other hand, it sometimes happens that cases which at first are most unpromising are apparently saved by careful nursing and appropriate treatment, and this fact should encourage every effort. In rare instances sloughing fauces will mend, pneu-

<sup>1</sup> See Gresswell, the *Practitioner*, October 1888.

monias clear up, temperatures which have been high for two or even three weeks gradually fall, and complete recovery ensue.

The otitis which so commonly occurs is usually suppurative from the first, the tympanic membrane quickly gives way and a free discharge follows. Earache should be treated by the instillation of warm camphorated oil, to which a drop or two of laudanum has been added, and hot fomentations may be applied externally. A single drop of glyc. acid. carbolic (B.P.), carefully dropped into the ear so as to reach the membrane, usually gives relief. If, on examination by the speculum, pus is seen bulging the membrane, an incision should be made; but nature usually anticipates the surgeon in this matter, and so quickly that the operation is seldom necessary, except in those cases where the membrane fails to give way early. The pus which forms in scarlet fever appears to penetrate the membrane more quickly than the pus formed in non-febrile cases. When a discharge exists, care should be taken to keep the ear syringed out and some antiseptic powder, such as iodoform and boracic acid, blown in. The after-treatment of chronic otitis need not be gone into here.

The preventive treatment of post-scarlatinal nephritis consists in the greatest care being taken during the second and third weeks to avoid cold and to keep the skin acting, and avoiding a stimulating diet and any overfeeding. The child should be sponged daily or bathed, provided there is no risk of chill; the diet should be largely fluid, milk, light puddings and sops, and the bowels should be acted upon if necessary by laxatives or salines such as tartrate of soda or Glauber's salts. On the appearance of albumen a smart purge of senna or jalap should be given and the child dressed in a flannel night-shirt and placed between the blankets; salines such as citrate of potash, liq. ammon. acet., or tartrate of soda, being given. The diet should consist entirely of barley-water and of milk, or of fluids at any rate. Hot packs, a blanket wrung out of hot water being used, or hot vapour baths given by means of Allen's apparatus, or warm baths, are always useful in acting on the skin and drawing away the blood from the kidneys and so relieving the inflammatory congestion present. The smaller the quantity of urine passed the more vigorous should be the packs or baths. Ten grains of jaborandi leaves, made into an infusion with hot water, or one-tenth of a grain of nitrate of pilocarpine subcutaneously, may be given before the packs once or twice a day. Children bear pilocarpine well, but its use requires care on account of the cardiac depression it is apt to produce. Poultices to the loins should be applied between the packs. Dry-cupping seems sometimes to be useful and may be tried. If the kidneys fail to act, and no urine or only a small quantity is secreted, large enemata of hot water will sometimes give relief, urine being passed as the enema is being expelled.

During the course of a nephritis the condition of the heart must be carefully watched, as also must any tendency to muscular twitchings about the face or hands. Any attacks of dyspnoea or evidence of cardiac dilatation must be met by the administration of digitalis, two to five drops every two hours. Solution of nitro-glycerine in drop doses, inhalation of chloroform, or nitrate of amyl may be tried if convulsions supervene.

*Quarantine.*—Six weeks at least—better two months—reckoning from

the first day of the fever should elapse before a child convalescent from scarlet fever can be allowed to rejoin his companions or go to seaside lodgings; and not then if the desquamation is incomplete or there is a discharge from his nose or ears. In so important a matter as discharging a convalescent scarlet fever patient, it is wise to err on the side of caution.

**Measles.**—Measles is an acute infectious disorder characterised by coryza and fever in the prodromal stage, followed by a peculiar papular eruption on the face and body.

Measles, like hooping cough, prevails in widespread epidemics, though its epidemics are of shorter duration; but sporadic cases are always occurring in large centres of population. This epidemic prevalence occurs in large cities every eighteen months or two years, though the epidemics differ very much in their extent and fatality. In these epidemics, when once the disease enters a household, or indeed a street or alley, hardly anyone escapes who is not protected by a previous attack, the sufferers in nearly all cases being young children; the older children and adults having suffered in previous epidemics. Communities removed from frequent contact with civilisation, and where there has been no epidemic prevalent for some time previously, invariably suffer severely when the poison of measles is introduced, adults being affected as well as children. The most notable instance of this in recent times is the epidemic of measles in the Fiji Islands in 1875, which raged for four months, 40,000 natives dying out of a population of 150,000,<sup>1</sup> equal to upwards of one in every four of the population, whereas in London in 1886, which may be taken as an average year, the deaths from measles were five in every 10,000 living (at all ages). The same virulence of an epidemic may be seen in a lesser degree in populations, more especially among children, in villages or isolated places where there has been no epidemic for some time previously. The susceptibility to measles is exceedingly great in unprotected subjects; thus Biedert,<sup>2</sup> in a small epidemic in an isolated village, found only 14 per cent. of the children who were unprotected escaped after being exposed to the infection. In the Faroe Islands under similar conditions only 4·5 per cent. and 1 per cent. escaped.<sup>3</sup> The same experience obtains in schools and in the wards of children's hospitals, where, if a child has been admitted incubating and remains till the rash appears, an epidemic follows which it is difficult to stop until nearly all of the unprotected have been attacked. The epidemics are independent of season and occur in winter as in summer.

The disease, like most other specific fevers, spreads by contagion, but the nature of this has not been satisfactorily determined, though micro-organisms have been obtained from the breath and secretions of patients suffering from measles by A. Ransome, and also by Braidwood and Vacher.

The poison is apparently given off in the breath and other secretions, and may be conveyed to a distance by its adhering to the clothes or person of a nurse or others coming in contact with the sick. The poison, however, appears to be more diffusible or more readily destroyed than the poison of small-pox or varicella, as it rarely if ever in our experience is introduced into a ward, except by those who were admitted incubating, it being unlike variola

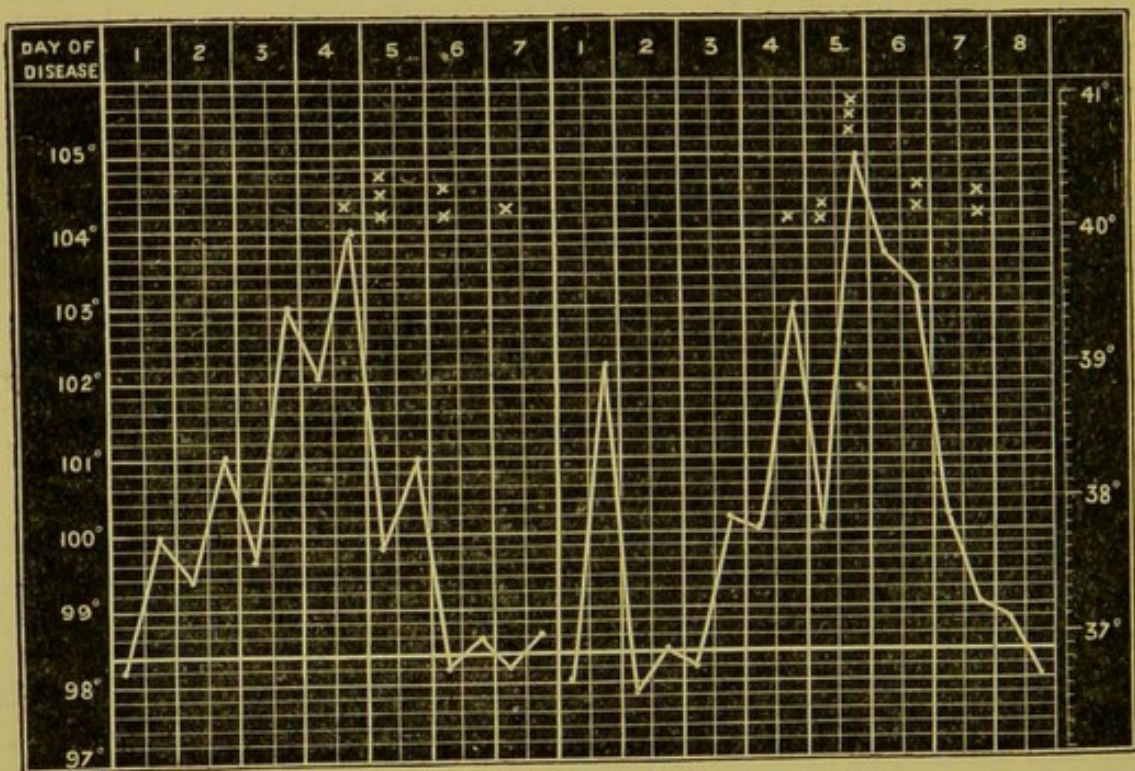
<sup>1</sup> Corney quoted by Collie.

<sup>2</sup> *Jahrbuch für Kindheilkunde*, vol. xxiv. p. 94.

<sup>3</sup> Madsen, *Panum*.

or varicella poison in this respect, infection in the latter case appearing to be brought in by visitors. The poison is known to be given out from the patient very early in the attack—that is, from the first appearance of definite symptoms, as coryza and fever—but there is good reason to believe that Mr. Vacher is right in believing that measles is infectious during the incubative stage, as well as during the febrile and eruptive stage. Several instances which point strongly to this conclusion have come under our notice.

The mortality differs enormously according to the circumstances under which the attacks develop and also in different epidemics. In healthy children among the well-to-do class the mortality is practically *nil*; in the tubercular and wasted children to be found in workhouses, hospitals, and among the lower classes, the mortality is enormous, no disease more certainly being attended with a fatal result. William Squire places it in crowded wards



Figs. 30a and 30b.—Temperature Charts of cases of Measles. \*, rash.

at 20 to 30 per cent. of those attacked. Among dispensary patients the mortality generally amounts to 9 or 10 per cent. In our own dispensary, during the six years 1880–1885, 1395 cases were treated, with 128 deaths, making a mortality of 9 per cent. Of the fatal cases 73 per cent. were under two years of age and 9 per cent. under six months of age.

Second attacks of true measles are not uncommon. In many cases where there has said to have been a recurrence of measles, one of the attacks has no doubt been rubella.

*Incubation.*—When inoculated this appears to be seven or eight days, when contracted in the usual way it is mostly ten to twelve days, the rash appearing on the fourteenth or sixteenth day.

*Symptoms. Prodromal stage.*—The early symptoms are those of a feverish cold. The child sneezes, waters at the eyes, there is catarrh of the nasal membrane, with usually a hard hacking or perhaps croupy cough. Sometimes the symptoms are those of a catarrhal laryngitis or bronchitis. On everting the eyelids the palpebral conjunctiva is seen to be red and congested, and the fauces and tonsils are hyperæmic with excessive secretion. The child is feverish, often acutely ill, the temperature rising in the evening a degree or two and usually falling again in the morning; this continues, though becoming increasingly marked, till the rash is fully developed. Sometimes there is a marked remission on the second or third day (see fig. 30*b*). Often a blotchy redness about the face precedes the papular eruption. Earache occasionally occurs.

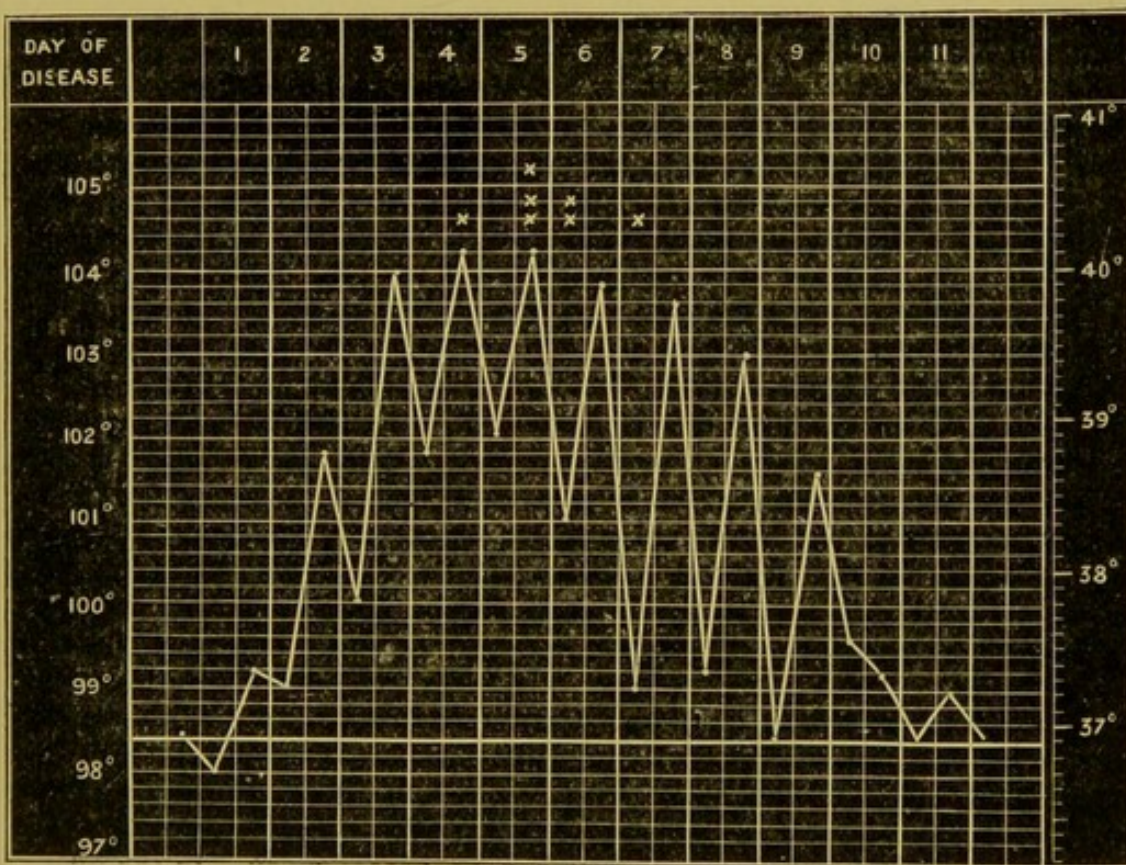


Fig. 31.—Temperature Chart of a case of Measles, complicated with Broncho-Pneumonia \* , rash

*Eruptive stage.*—The characteristic eruption usually makes its appearance at the end of the fourth day, on the forehead, face and neck, and fauces. The child's appearance at this time is so characteristic that in well-marked cases a glance is sufficient to establish the diagnosis. The face is flushed, the eyes red and watering, there is a short cough, the forehead, nose and cheeks are covered with crops of dusky red papules, surrounded by a zone of erythema which contrasts with the normal skin between the groups. The papules can be distinctly seen and felt, and though not 'spotty' to the touch, yet they have often a distinct feeling of hardness. The rash on the face is usually both patchy and discrete, the

patches being made up of confluent papules, the latter of small groups or single papules arranged at times in small crescents or semicircles. In the course of a day or two the rest of the body is more or less covered with the rash; it is apt to be confluent with much erythematous redness on the dependent surfaces, as the extensor surfaces of the arm and thigh, the back and buttocks, and more discrete or spotty on the chest and rest of the body. By the fifth or sixth day the eruption is at its height, and commencing to fade first on the face and later on the body and limbs, to be followed, especially on the face, by a fine desquamation. By the seventh or eighth the rash has completely disappeared, leaving at most only an indefinite mottling or staining over the body. The temperature, which has probably reached  $103^{\circ}$ – $105^{\circ}$  by the sixth day, quickly falls to normal or thereabouts, and the headache and discomfort is gone and the child seems greatly relieved. In severe cases in weakly children the crisis may be accompanied by much exhaustion, but this rarely happens. The temperature remaining high indicates some complication such as bronchitis or pneumonia (see fig. 31).

**Mild or ill-defined Measles.**—Very often all the symptoms are milder than those just described, but at the same time are perfectly characteristic. On the other hand, the attack may be so light as to be recognised with difficulty. There may be almost entire absence of symptoms in the prodromal stage or a temperature only reaching  $100^{\circ}$  or  $101^{\circ}$ , the coryza and catarrh being insignificant, while the rash is represented by ill-defined and characterless papules about the neck, back of hands and thighs. In other cases probably the catarrh and laryngeal symptoms are well marked, the child evidently suffering from a laryngitis; this is followed by an indefinite mottling about the neck and hands as the laryngeal symptoms abate.

**Severe and complicated Measles.**—Epidemics of measles differ greatly in the severity of the individual attacks. Most of these fatal attacks are characterised by high fever, dry brown tongue, delirium, convulsions due to an intense hyperæmia of the internal organs, more especially the lungs and brain. The heart's action is depressed, the rash ill-defined, the skin being dusky, in some cases petechial. In such cases death may take place on the third or fourth day, or improvement commences at the end of the week. In the majority of cases measles threatens life through the tendency to inflammation of the lungs. The lung symptoms may be prominent from the first, or the presence of pneumonia may delay convalescence or supervene when the acute symptoms have passed away. In the former case the symptoms are those of acute broncho-pneumonia, the temperature continues high, perhaps  $105^{\circ}$  or  $106^{\circ}$ , there is marked dyspnœa, sibilant sounds are heard over the whole chest, the air does not enter the bases freely, the rash is scanty, perhaps only an ill-defined mottling, delirium followed by coma comes on, the eyelids become glued together with thick semi-purulent secretion, sordes appear on the mouth, the tongue is brown and dry, and unless improvement takes place the child sinks.

**Catarrhal or membranous Laryngitis** is not uncommon in the pre-eruptive stage, or as the eruption is receding. Tracheotomy may be required if the obstruction to respiration becomes sufficient to threaten life, but it must be borne in mind that an amelioration of symptoms generally takes place when the rash appears. In those cases attended with membranous

exudation the laryngitis generally follows rather than precedes the eruption. **Ophthalmia** frequently occurs in anæmic and unhealthy children, corneitis and corneal ulcers may also be met with. **Glandular enlargements** may take place, the deep cervical gland being especially involved, as in scarlet fever; abscesses are not common. **Otitis** is very common during convalescence, suppuration taking place in the middle ear, and the membrane becoming perforated. **Diarrhœa** is not an uncommon complication or sequela, especially during the hot weather, though by no means exclusively so; it is apt to become dysenteric in character, mucus, blood and hard lumpy fæces being passed, with prolapse of the bowel.

The health often remains impaired for a considerable time after an attack of measles; it is during this stage that **Acute Tuberculosis** and **Cancerum oris** may arise. The tuberculosis very frequently appears to take its rise from enlarged and cheesy bronchial glands.

*Diagnosis.*—The disease most likely to be mistaken for measles is rubella, the latter disease closely resembling mild measles.

It is possible to confound measles with small-pox, though this difficulty is more likely to arise in the case of adults than children. According to Collie there are two kinds of small-pox which it is possible to confound with measles, the commencement of a confluent case and the commencement of a hæmorrhagic case. The papules in small-pox are much harder and more shotty, and moreover in a confluent case, the headache, lumbar pain and general symptoms would be more severe. Hæmorrhagic measles is very rare, and according to the same author would be difficult to diagnose from 'black smallpox'; the quantity and quality of the vaccination marks should be taken into account.

*Morbid anatomy.*—There is not much to be said under this head, inasmuch as there are no post-mortem appearances characteristic of measles, the principal lesion found being catarrhal pneumonia; the whole of the internal organs are gorged with blood and minute hæmorrhages are present on their surfaces. The mucous membrane of the bronchi is intensely congested, the surface of the pleura roughened and perhaps covered with lymph, one or both bases being solid from catarrhal pneumonia; in such case the pneumonia resembles that found in septicæmia. In some instances croupous pneumonia involving a lobe or portion of a lobe may be present, or there may be patches of croupous pneumonia. At other times there is intense bronchitis, with patches of catarrhal pneumonia and emphysema. In all cases of pneumonia following measles which we have examined microscopically we have found fibrinous exudation in the air vesicles in spite of their being apparently of the catarrhal variety.

The following post-mortem record taken from one of our note-books illustrates a malignant case. 'Child of 11 months; death on 4th day. On removing lungs it is noted that the upper lobes are emphysematous on their surfaces; in the lower lobes emphysema alternates with collapse; on section there is intense injection of the trachea and bronchi, yellow mucus exudes from the minute bronchi; the lungs are intensely congested, there are patches of broncho-pneumonia in the lower lobes.'

*Treatment.*—No very active treatment is needed during an attack of ordinary severity, but much may be done to promote the patient's comfort and

to prevent any complications. He should of course be confined to bed as soon as measles is suspected, the temperature of the room being maintained at 65° F., and if the cough is hard and irritating a steam kettle should be called into requisition to keep the atmosphere moist. The diet should consist of milk diluted with barley water or seltzer; in mild cases sops or light puddings may be allowed. Demulcent drinks, such as barley water, lemonade, black currant, or tamarind drinks or jellies, are useful in allaying the irritating cough. Frequently spongings with warm water containing a weak solution of tar or 'sanitas' relieve the itching and help to bring out the rash. During the pre-eruptive stage, when there is high fever, restlessness, cough, and frequent pulse, small doses of tr. aconiti, one or two drops every two hours, carefully watching the effect, especially after five or six doses have been given, will be usually attended with relief. Jelly containing codeia or small doses of Dover's powder may be given to relieve the cough. Great care should be exercised during convalescence to prevent catching cold, especially in those who are liable to bronchial catarrh, as the bronchial mucous membrane remains for some time in an irritable condition, and exposure to cold is exceedingly likely to give rise to bronchitis or diarrhœa.

In cases of greater severity, especially those in small children which are accompanied by a scanty rash, congestion of the internal organs, high temperature and broncho-pneumonia, active treatment is required. It is necessary to get the skin to act efficiently and thus relieve the congested internal organs; to this end tepid sponging, hot packs, or mustard baths may be employed. For children under two years of age the mustard bath is the most suitable; the child being placed for three minutes in a bath of 100° F., one table-spoonful of mustard to the gallon of water being about the proper strength. The child must be quickly dried and put between blankets; the bath may be repeated in a couple of hours if necessary. The stimulating effect of the bath upon the skin is often of great service. Linseed poultices to the chest are to be avoided in the case of young children, unless the attendants are trained nurses; hot fomentations or bran poultices are preferable in dispensary practice and in the hands of the unskilled, as being less heavy.

In older children the hot pack is to be preferred to baths. In the early stages small doses of antimony, pot. ant. tart.  $\frac{1}{100}$ - $\frac{1}{40}$  of a grain, with some tartarated soda or citrate of ammonia, should be given every three or four hours, but omitted if there is nausea. Aconite may be useful, but it must be carefully watched, on account of the depression it is apt to produce if pushed too far. Alcohol in the form of whisky or brandy should be given if the pulse is small and rapid and the tongue dry and brown. If the cough becomes loose and there is excessive secretion from the bronchi, ammonia, digitalis and alcohol in combination should be given. The eyes, nose and mouth in severe cases require attention; they should be bathed or mopped out with warm water; if there are any aphthous patches in the mouth, some borax in dilute glycerine should be applied. Otitis and glandular inflammation may require attention. During convalescence no medicine answers better than nitric acid and bark.

*Quarantine.*—How long should quarantine be maintained in a case of measles? This is not an easy question to answer, though it is certain that

the infection is not given off from the patient for so long a period as is the case in scarlet fever. In uncomplicated cases hot baths may be given as the rash begins to disappear, they are useful to cleanse the skin and render the patient more comfortable. It is well for the patient to keep his bed for ten days and his room for three weeks; then, if he is quite well in every respect, there can be little danger in his mixing with his fellows. When a case of measles occurs in a house, it is necessary for the other children who have not had it to stop going to school or mixing with other children, as it is probable they will have contracted the disease; and as measles is infectious in its early stages—if not during the incubation period—they may readily be the means of giving it to others. For the same reason it is unwise to send them away from home, though care should be taken that they do not come in contact with the patient at home. The bedding should be stoved and the room occupied by the patient disinfected at the conclusion of the illness.

**Rotheln or Rubella.**—Rubella is an infectious fever closely resembling but distinct from measles; it is for the most part a milder disorder and does not protect from it.

**Etiology.**—The resemblance between these two diseases is unquestionably a close one, and there is little doubt that not infrequently epidemics of rubella, or at any rate sporadic cases, are mistaken for measles. It has however been clearly shown by those who have had the opportunity of watching successive epidemics of infectious diseases in schools and asylums, where the same individuals have been attacked, that rubella does not protect from either measles or scarlet fever, nor do attacks of the two latter afford any immunity from attacks of rubella. The resemblance, and yet the difference, between the two diseases is well put by Dr. West when he says 'they resemble each other somewhat as varicella and variola—alike, but not the same—not twin sisters indeed, but half sisters at any rate.' That they should be confounded in practice is not surprising, especially when we remember that measles is sometimes an extremely light disease and the rash by no means characteristic. In mild attacks of measles the coryza is usually slight or absent and the rash little else than an ill-defined mottling.

Rubella occurs in epidemics, sometimes being prevalent and widespread, as it was in this country during 1880; at other times sporadic cases crop up and there appears but little tendency for the disease to spread. As a result, rubella has earned a different character as regards contagiousness from different writers who have observed it, some maintaining that its contagiousness is almost *nil* and others that it is extremely contagious. The truth is that susceptibility to its influence seems to vary strangely at different times and in different places in a way which it is difficult to account for. Thus in one locality there may be an epidemic prevalent; an individual goes to another while incubating, he suffers from an ordinary attack and the disease does not spread, though he comes in contact with many individuals. Age does not seem greatly to influence predisposition; infants, children and adults suffering alike; indeed in some epidemics adults suffer more in proportion to their numbers. Thus in an epidemic in the Children's Hospital observed by Dr. Hutton and ourselves, out of twenty-seven cases, eight were those of lady-probationers or 'sisters,' and nineteen of children; so that the adults suffered

far more largely in proportion to their numbers, though there can be no doubt that the nurses came in contact with those suffering from the disease much more than the children. Considering how much rarer a disease rubella is than measles, it would appear that a smaller number of individuals are susceptible to its influence who are unprotected by a previous attack.

The relationship of rubella to measles and scarlet fever is an interesting question, and while very few believe it to be a hybrid disease, the attack resulting from the reception by the patient of both scarlatinal and measles poisons, yet, considering the close resemblance which it bears to measles, there is nothing inherently improbable in the idea that the resemblance is something more than coincidental, that the poisons may have been derived from one another or from the same stock at some distant epoch, and have become modified by being cultivated under different conditions. It is interesting to note that some observers assert that the character of an epidemic becomes modified in the direction of either measles or scarlet fever if either of these is prevailing at the same time.

Another question is well worthy of investigation, and that is, Are there not really two varieties of rubella, one the common one which mimics measles, 'Rubella morbillosa,' and another form which mimics scarlet fever, 'Rubella scarlatina,' and which is less prevalent than the other?

*Incubation.*—There has been some uncertainty about the length of the incubation period. The common period is from two to three weeks, as observed both by W. Squire and Lewis Smith. In three cases coming under our own observation the time appeared to be sixteen, seventeen, and eighteen days respectively.

*Premonitory stage.*—In children as a rule no prodromal symptoms are observed, the rash being the first thing to be noticed. In adults who are able to describe their feelings, complaint is made of weariness, headache and backache for twenty-four hours before the appearance of the rash. There may be vomiting, coryza, slight sore throat, or a tingling sensation of the skin of the face. Another noteworthy symptom sometimes present is the enlargement of the superficial lymphatic glands situated along the posterior edge of the sterno-mastoid, or the submaxillary and occipital being tender as well as slightly enlarged, and giving rise to a certain amount of stiffness of the neck. On the other hand, it is by no means uncommon even in adults that the discovery of a rash is the first thing to call attention to the attack. The rash usually appears first on the face and consists of indistinct ill-defined papules, which form irregular patches of a rose-red colour, which shade away into the colour of the skin; there may be simply erythematous blotches. The patches of confluent papules vary much in size and shape, many perhaps consisting only of a few papules grouped together; sometimes, on the contrary, the whole face is of a red colour. The rash is usually also abundant on the neck, chest, back, buttocks, and flexor surfaces of the arms and thighs; in these situations it is usually less confluent and patchy than on the face, the rash consisting of groups of papules or of single papules. Occasionally the confluence of the papules and the erythema which surrounds them gives rise to the suspicion of scarlet fever, especially to that form in which the rash is patchy on the limbs, but the rash of rubella always consists of papules, is not diffuse or punctated as is the rash of scarlet fever. Rubella

rashes undoubtedly vary considerably, especially in the confluence of the papules ; as a rule, the colour is of a rose-red when it first comes out, being of a brighter colour than measles ; the papules do not so constantly arrange themselves in crescents, and they are less distinct than the measles papules. The rash is usually most intense on the second day, but remaining visible for three or four days ; by the end of this time it has mostly faded, often leaving more or less staining of the skin, and a light branny desquamation. The rash frequently gives rise to much itching.

The course of the attack may be feverless, though usually there is a slight rise of temperature, the highest usually being on the second day,  $99^{\circ}$  to  $100^{\circ}$  ; in rare cases it reaches  $102^{\circ}$  or  $103^{\circ}$ . The temperature becomes normal as the rash disappears.

Hyperæmia of the conjunctiva and fauces exists in many cases, but it is rarely as marked a feature of the attack as it is in measles. Sometimes a dryness and soreness of the throat in swallowing is complained of, with more or less catarrhal tonsillitis.

While such may be taken as a typical attack, it must be acknowledged that the attacks of this exanthem vary greatly in intensity, and the rash may be too ill defined to admit of a positive diagnosis. In some rare cases, such as those described by Dr. Cheadle, the course of the disease is that of a serious illness, with marked implication of the larynx and bronchi, the cough being incessant and crouplike. In two of these broncho-pneumonia supervened, in several others earache was a prominent symptom. On the other hand, cases may occur of the mildest form, so wanting in character both as regards rash and coryza, that they may be looked upon as of a doubtful nature and perhaps forgotten, and only when they are succeeded by more typical cases does their character become clear.

*Complications and sequelæ.*—There are usually none ; in the more severe cases catarrhal disorders such as coryza, tonsillitis, and broncho-pneumonia may complicate and succeed the attack. The prognosis is favourable ; it is probably never fatal in healthy children ; in epidemics in hospitals, where it attacks children already suffering from and much reduced by pulmonary affections, it has appeared to be the immediate cause of a fatal result. Even in healthy children the health may remain below par for some time afterwards.

*Diagnosis.*—Rubella may at times be mistaken for some of the anomalous erythematous or roseolous rashes from which children suffer from various causes. In single cases diagnosis may be difficult, but the fact that rubella prevails in epidemics often assists in making a diagnosis. The diagnosis between measles and rubella in an individual case is at times impossible ; often it is difficult, inasmuch as it must be admitted that there is no one characteristic symptom of rubella, and moreover the rash differs in different cases. The differences between typical cases of rubella, measles and scarlet fever are shown in the table on the following page.

Rubella is much more frequently mistaken for mild measles than for any other disease, and this on account of the papular character of the rash and slight coryza ; that it is also not infrequently mistaken for scarlet fever, all those who have experience of a scarlet fever ward can testify. That attacks of rubella do in some instances resemble those of scarlet fever more than measles we feel certain ; there is a diffuse red rash and slight tonsillitis which

at first sight looks like mild scarlet fever. The distinction principally rests in the character of the rash—in rubella it is not *punctiform* as in scarlet fever, but more erythematous in character, and in places, more especially the neck, the backs of the hands, and dorsum of the feet, it is papular or at least raised. The difficulty in distinguishing between the two may be very great when the rash is fading.

—	RUBELLA	MEASLES	SCARLET FEVER
Incubation. Premonitory fev. Prodromal symptoms.	14 to 21 days. 1 day. Often none. Sometimes enlarged glands, weariness and slight coryza.	8 to 12 days. 3 to 4 days. Sneezing, coryza, headache, cough.	2 to 5 days. 1 day. Vomiting, headache, sore throat.
Rash.	Appears on the first or second day. Consists of confluent indistinct papules of a rose-red colour on the face, usually discrete on the limbs, buttocks, and thighs. Often fades from the face before it is fully developed elsewhere. Often much itching. Desquamation absent or only very fine branny scales.	Appears on the fourth or fifth day. Consists of confluent papules of a dusky red colour on the face, and groups of papules often in a crescentic form on the trunk and limbs. Desquamation absent or only in fine scales.	A diffuse punctiform red rash comes over neck, trunk, and limbs—may be patchy on the extremities—usually followed by free desquamation.
Temperature.	Often normal throughout, rarely above 100° F.	Fever always present, sometimes high, reaches its maximum when the rash is fully out, then falls.	Fever always present, mostly high, disappears as the rash fades.

*Treatment.*—Every case of rubella or every suspicious case should be carefully isolated, being confined to one room, if not to bed. The diet should consist largely of fluids and slops. A simple saline such as citrate of potash may be given and other symptoms be treated as they arise.

*Quarantine.*—The patient should be isolated for at least three weeks; better if four weeks elapse before he is allowed to rejoin his companions.

## CHAPTER XV.

THE SPECIFIC FEVERS—*continued.*

**Diphtheria** is an infectious disorder, which is especially characterised by the formation of a tough fibrinous exudation on mucous surfaces: it is usually accompanied by anæmia and albuminuria, and is frequently followed by a peculiar form of paralysis. At the very threshold of the subject it may be as well to attempt to clear the ground by asking Are we to consider all fibrinous exudations which have the characters of a 'false membrane' as evidence of the presence of diphtheria? Are all fibrinous exudations specific and diagnostic of diphtheria? Unfortunately it is impossible to definitely answer this question, and until the discovery and isolation of a specific bacillus it will probably remain unanswered; there is however good reason for believing that inflammation of a mucous surface, accompanied by the exudation of fibrin, may take place, as for instance after the entrance of scalding water into the larynx, without the existence of diphtheria. In the present state of our knowledge we are justified in saying:—A strong probability exists that there is a non-specific as well as a specific fibrinous exudation, though in any given case it may be impossible at present to make a diagnosis.

That diphtheria is a contagious disease is made clear by very definite evidence; as the disease passes from patient to nurse, from one patient to another in the wards of a hospital, or from a sick child to its playmates or parents in private houses. Direct inoculation has taken place accidentally by means of membrane, as in sucking a tracheotomy wound; it has formed within twenty-four hours of an operation at the seat of the wound; and inoculation has also been successful in transferring the disease from man to some of the domestic animals.<sup>1</sup> The poison, there is reason to believe, may remain with unimpaired vitality for an indefinite time in bed-linen, clothes, carpets, and surgical instruments, as scalpels and tracheotomy tubes: and it may be carried any distance by such means. There is also evidence to show that diphtheria may be contracted by the inhalation of sewer gas or the emanations from putrefying organic matters; if this be true, it would seem probable that the diphtheritic bacillus, like typhoid, multiplies and develops in decomposing organic matters, and is given out in the emanations arising therefrom.

Diphtheria occurs in epidemics, but is also endemic in some cities and country districts. It is constantly present in such cities as Berlin, Paris and New York, and in many rural districts. In its distribution and in the character of its epidemics it is one of the most mysterious diseases with which we are acquainted, and there is much about it which requires continued

<sup>1</sup> C. J. Renshaw.

investigation. Thus it is a very common disease in the continental cities, whilst in this country it is commoner in rural than in urban districts. At first sight it would appear that it would be commoner where the population is densest, as in large cities; but, as a matter of fact, the returns of the Registrar-General show it to be more prevalent and fatal in the south-eastern and eastern rural districts than in London or Manchester. This is not explained by the nature of the soil, as it occurs on chalk, sandstone and slate, though it occurs most commonly on cold wet clay soils (Airy). Some country districts appear to be especially prone to its visitations. It makes its appearance at times in isolated farmhouses or villages remote from other habitations, under circumstances which have led many to suppose that the disease may arise *de novo*; by others, especially as in many cases the spots attacked have been 'bleak and exposed situations,' that the contagion has been conveyed thither from a distance of perhaps many miles by means of the wind (Airy.) The disease is undoubtedly more common in the autumn than at other periods of the year, and this would suggest that cold and damp acted in some way as a predisposing cause. No age is exempt, but children between the ages of two and eight years are most often attacked. Diphtheria, unlike most other infectious disorders, does not protect, but appears to create a disposition for another attack. The disposition to diphtheria seems to run in families, members of the same family being attacked in quick succession or at variable intervals. The parts which are most often attacked are the fauces, nasal mucous membrane, larynx and trachea, glans penis and vulva; less often some wound or denuded surface of skin. It is most likely that the poison is inhaled, finds a resting place in the fauces or larynx, and enters the system from these points. The incubation is mostly two or three days, rarely more than a week, though it cannot be stated with certainty that the incubation cannot be longer. In diphtheria following an operation, the membrane appears on the wound in some cases within twenty-four hours. The fatality of various epidemics varies strangely; sometimes whole families are swept away, as in the epidemic described by Trousseau in Sologne, where on one farm, where the residents numbered eighteen, only two, the father and a servant girl, escaped.

**Pharyngeal Diphtheria.**—The local affection in diphtheria has a marked preference for the tonsils and soft palate, and by far the larger number of cases occurring in practice are those of pharyngeal diphtheria. The attack, unlike scarlet fever, begins insidiously. The friends notice that the child is ill, does not care for its toys, is peevish and probably feverish at night. The glandular enlargement and swelling at the angles of the jaw or the discharge from the nose excites their apprehension and medical aid is summoned. In older children there is complaint of sore throat and difficulty in swallowing, which may exist for some days before any membranous exudation is seen. The first examination may decide the diagnosis, but not unfrequently, if the examination is made in the early stages, there will be simply redness and swelling, with perhaps some yellowish exudation in points or patches, and it may be quite impossible to decide whether the case is one of catarrhal tonsillitis, scarlet fever, or diphtheria. The swelling of the glands is generally an early symptom; the deep glands at the angles of the jaw are swollen and hard, as are too the glands beneath and upon the

sterno-mastoid with the cellular tissue around, so that there may be a considerable swelling on both sides, which strikes the observer at once. Usually within forty-eight hours of the commencement of the illness the membrane characteristic of the disease is seen. The tonsils are swollen and congested, and on their inner surfaces patches of greyish-white membrane, which adheres firmly to the surface, are visible. The patches cannot be removed by brushing, and if forcibly torn off by the forceps leave a raw bleeding surface. Membranous patches are common also on the uvula, soft palate, and posterior wall of the pharynx. The nasal mucous membrane joins in the inflammation, and a semi-purulent, often bloody, discharge makes its appearance at the anterior nares. The fauces and nasal passages become obstructed by the swelling and excessive secretion, so that there is snoring during sleep, and perhaps fits of choking from the entrance of the secretion into the larynx. The temperature is rarely high, being mostly  $101^{\circ}$  to  $102^{\circ}$ , the evening temperature being as a rule higher by a degree or two than the morning. The urine from the first frequently contains albumen, varying from a trace to one half; there are usually no casts of blood; very rarely, and that only in severe cases, the urine is dark and contains many fibrinous and blood casts. In other cases the albumen may be late in appearing. For the next few days fresh patches make their appearance, the older ones becoming detached by a process of sloughing or disintegration. In the meantime the patient becomes weak and anæmic and easily exhausted; the tongue is coated and the breath foul. In favourable cases the swelling of the glands becomes less, no fresh membrane appears, and the old patches become detached and the fauces less swollen, so that by the end of a week or ten days the throat has regained its normal appearance.

Mild cases occasionally occur in which the local lesions and general depression are slight. Membranous patches appear on the tonsils, but the nasal mucous membrane remains free, and there is no glandular swelling or albuminuria. Such patients are often running about with but little appearance of being ill, and the throat lesion may disappear in a few days: it is important to remember that in such cases paralysis may follow, or even a fatal result from cardiac failure.

Of severe and fatal diphtheria there are several types. In the malignant or septic form the attack is sudden and ominous in character from the first; within a few hours of the onset there is extensive swelling about the angles of the jaws, which has a stony hardness, a foetid sanguineous discharge issues from the nostrils, it is difficult to get a view of the throat on account of the cervical swelling. The tonsils are swollen and meeting, the uvula and soft palate œdematous and covered with more or less sloughy-looking membrane. The temperature is usually high,  $103^{\circ}$  or  $104^{\circ}$ , and the pulse quick and exceedingly feeble. In the course of a day or two, sometimes less, the cellulitis extends, the cheeks and face become œdematous, and the skin pits as low as the clavicle, or even over the sternum and chest walls; the patient becomes drowsy and cyanotic, there may be an erythematous rash, especially about the neck and chest. Death occurs within a few days. Such cases resemble malignant scarlet fever, and it may be very difficult or impossible to distinguish between the two in the absence of a characteristic rash.

In other cases the throat complications are less severe, but the symptoms

of depression and cardiac weakness supervene after a few days. This insidious commencement of severe cases must never be forgotten ; there may be several days of slight illness, with symptoms resembling a feverish sore throat, and then a sudden manifestation of an alarming character.

Various local manifestations of diphtheria may occur. In the majority of cases the tonsils and soft palate are the parts primarily attacked, and in mild cases the membranous exudation remains localised to the fauces. In the severer forms it extends to the posterior wall of the pharynx and the Eustachian tube ; it very frequently involves the nasal membrane, as evidenced by the foetid secretion from the nares, and may often be readily seen on the inferior turbinated bone. But the most formidable extension that can possibly occur is its spread to the epiglottis and larynx, for here the swelling of the mucous membrane and the exudation of fibrin necessarily interfere with the supply of air to the lungs. Whilst both nasal and laryngeal diphtheria are often secondary to pharyngeal diphtheria, yet both may be, and laryngeal often is, the first and only part to be attacked. In a similar manner any other mucous or cutaneous surface may be attacked. The glans penis or vulva may be the primary seat of diphtheritic membrane, or they may be affected by the transference of the virus from the throat by means of the patient's fingers. Diphtheritic membrane may make its appearance on the lips, anus, or any part of the skin, though in the latter case mostly where abraded, as after the application of a blister, a surgical operation, and in eczema. It has appeared on the breast from suckling an infant affected with pharyngeal diphtheria. Diphtheria of the palpebral conjunctiva sometimes occurs in infants, giving rise to perforation of the cornea and irretrievable damage to the sight. Diphtheria in these various situations may remain from first to last a local affection ; there may be no symptoms of the general affection, or, on the other hand, the constitutional symptoms described under Pharyngeal Diphtheria may all be present.

**Laryngeal Diphtheria. Diphtheritic Croup.**—It is not necessary to enter here into the disputed question as to whether membranous croup is identical with diphtheria of the air passages, inasmuch as the evidence is far too strong to be gainsaid that the same diphtheritic process which attacks the pharynx may spread also to the larynx. It must have happened again and again to most of us to have seen some member of a household suffering from pharyngeal and another member from laryngeal diphtheria ; moreover, it is common to find membranous exudation first on the fauces and later in the larynx. It has been argued, in opposition to this view, that in membranous croup there is mostly no evidence of the general affection and the sequelæ so often witnessed in pharyngeal diphtheria. But it must be evident that there is a far greater probability of a general affection of the system, and consequently the symptoms of anæmia and depression, in the pharyngeal form, inasmuch as the tonsillar mucous membrane is in far more perfect relation with the lymphatic system than any other locality likely to be attacked, and a position in which micro-organisms are more likely to flourish. It accords with experience that a diphtheritic lesion is more likely to remain local and unaccompanied by any general symptoms when situated in the larynx, genital organs, or cutaneous surface, than on the tonsils. The symptoms and course of membranous croup are described at p. 153.

*Complications and Sequelæ.*—These, though less numerous than those occurring in scarlet fever, are hardly less important. There is the extension of the inflammation from the pharynx to neighbouring parts already referred to—viz. to the larynx, nose, middle ear and lymphatic glands; the latter may suppurate. **Synovitis**; **Endocarditis** and **Pneumonia** occasionally occur. The most noteworthy are the following: 1st, albuminuria; 2nd, disturbed innervation of the heart; 3rd, paralysis.

1. **Albuminuria** may be present during the first week, mostly from the fifth to the eighth day, though it may occur later. In some epidemics it is much commoner than in others; thus, in ninety-one cases observed by Dr. J. Abercrombie, albuminuria existed in twenty-four—that is, in less than a quarter; whilst in eighty-five cases observed by Cadet in Paris, sixty-three, or three-quarters of the total number, had albumen. It is commoner in pharyngeal than in laryngeal diphtheria, and is of little significance in the latter case, as the danger threatens rather from interference with the respiratory organs than from toxæmia. Has albuminuria any prognostic significance in pharyngeal diphtheria? Not much perhaps, for in some fatal cases, especially those dying during the first few days, there is no albuminuria, whilst some cases in which the urine is loaded with albumen recover. There is however no doubt that, while traces of albumen are of no importance, a large amount of albumen, especially if it is present day after day, indicates a severe attack and calls for a grave prognosis. The urine is usually normal in colour and in quantity, but blood corpuscles and a few casts may be found microscopically. There is no œdema and rarely uræmic symptoms, and there is no reason to suppose that chronic renal disease is set up, inasmuch as the albumen disappears during convalescence. In one fatal case of diphtheria of the glans penis under our care, hæmaturia supervened within a few days of the onset. At the post-mortem, acute hæmorrhagic nephritis was found; the kidneys were of a chocolate colour, the tubules being choked with blood casts. Such cases are rare.

2. In all severe cases at the height of the attack the pulse is feeble and for the most part rapid. It sometimes happens at this time that the heart's action becomes irregular, intermittent, or abnormally slow. This condition is however more common during convalescence, or at least when the membrane is disappearing and the patient apparently improving. There is often dyspnœa on the slightest exertion, an intermittent cantering action of the heart, and frequently vomiting. **Sudden cardiac syncope** is apt to take place. This may occur from any unwonted mental disturbance, or from some slight exertion, such as getting out of bed or sitting up to use the chamber vessel. With an irregular action of the heart there is often dyspnœa; frequent vomiting and slow pulse during convalescence from diphtheria are symptoms of great gravity.

3. A peculiar form of **paralysis** is apt to follow not only diphtheria, but also other febrile disorders, as typhoid fever, measles, and erysipelas; it is however very much more common after diphtheria. The paralysis comes on in the majority of cases during convalescence, mostly between the third and fifth weeks; it appears to follow mild cases as often as it does severe ones. Its usual course is to attack the soft palate, the first symptoms being a return of fluids through the nose, perhaps only a few drops, and a nasal twang in

speaking ; an examination of the soft palate shows that its movements are less free than usual. In many cases a slight paresis of the soft palate which may pass off in the course of a week or two is the only evidence of post-diphtheritic paralysis. In other cases the paresis is much more decided ; when the patient attempts to swallow any fluid, much of it returns through the anterior nares, and some may perhaps enter the glottis, giving rise to a fit of choking. Other parts may become affected—the pharyngeal muscles and œsophagus, so that deglutition is performed with difficulty and the patient has to be fed through a soft catheter. The pupils may become dilated and irregular from paresis of the circular fibres of the iris, there is impairment of vision, and squint from the ciliaris muscle being affected. The paresis may extend to any or all of the voluntary muscles, so that the patient is unable to stand or sit up in bed or even raise his head. Further, the respiratory muscles, the intercostals, and diaphragm may be affected, in most instances speedily producing a fatal result. It must be borne in mind that in post-diphtheritic paralysis there is rarely complete paralysis, but rather a partial loss of power, combined with numbness and sensations as of prickings with ‘pins and needles.’ Both rectum and bladder may also become paralysed. It is important to bear in mind that paresis may follow very mild cases, so that the patient may be seen for the first time when suffering from the paresis and make no mention of sore throat. Such cases, especially if there be no paresis of the soft palate, may be very puzzling, and, if there be weakness of the legs and staggering gait, may be mistaken for tumour of the cerebellum or ataxy. The knee reflex may be absent in such patients, and be many months before it makes its reappearance.

*Pathology.*—Is the fibrinous membrane in diphtheria to be looked upon as corresponding to the rash in other of the fevers, or is it in reality the result of the local working of the diphtheritic bacillus or micro-organism? There is much in favour of the latter view. Though no specific organism has been satisfactorily demonstrated, there is much reason to believe that such exist, that they are inhaled by the breath, adhere to the mucous membrane of the pharynx or larynx, and, finding conditions suitable to their development, grow and multiply locally, giving rise to an acute inflammatory exudation, and, entering the system through the lymphatics, they give rise to various constitutional symptoms. Whether the latter are brought about directly by the organism itself or by some chemical poison generated by the organism may be open to doubt. If this is true, diphtheria would resemble such diseases as malignant pustule, or septicæmia from a post-mortem wound, where the lesion is at first local ; but the system becomes affected by the entrance of micro-organisms or septic matters from the cultivation or multiplication process going on there.

The membrane, which forms locally, is of a whitish-grey colour, tough, and at first firmly adherent to the tissues beneath. It is formed by the effusion of fibrin from the vessels of the mucous membrane, beneath or rather into the epithelial layer. If a section be examined in an early stage, the membrane will be seen to consist of a fine network with epithelial cells and leucocytes in the meshes. Later, the epithelium disappears, leaving a finely reticular network of fibrin, with leucocytes and blood corpuscles ; usually there are also numerous micrococci and other micro-organisms to be seen.

In the course of a few days the membrane becomes first loosened and then detached. The kidneys are usually pale, with minute hæmorrhages on their surfaces; the pallor is due partly to anæmia, partly also to fatty changes in the epithelium; only in rare instances is there any intertubular nephritis. The changes found in those dying with paralytic symptoms have been in dispute. The essential changes consist in a peripheral neuritis, as pointed out by Buzzard. In a case described by Mendel there were minute hæmorrhages in the medulla and pons and along the course of the cranial nerves, especially the vagus, due to inflammation of the sheath and roots of the nerves.

*Diagnosis.*—The diagnosis of diphtheria is often attended with difficulty, inasmuch as in its milder forms it may easily be confounded with **catarrhal tonsillitis** or **pseudo-diphtheria**, and in its severer forms with **scarlatina sine eruptione** or **anginosa**. It must be candidly admitted that diagnosis is often impossible, inasmuch as diphtheria may exist, as is proven by the occurrence of sequelæ, such as paralysis, without any distinct membrane being present on the fauces, the sore throat being indistinguishable from a catarrhal tonsillitis. Difficulty principally occurs in those cases in which there is an exudation present on the tonsils, mostly of a yellowish colour and of a distinctly membranous character, such being apt to occur in epidemics, and to which the name of pseudo-diphtheria has been given. It is uncertain whether this is a distinct affection or is due to the diphtheritic virus modified in some way. Such cases differ from typical diphtheria in the more sudden onset, in the less distinctly membranous character of the exudation, and the small tendency there is to involve the nasal mucous membrane and cervical glands. In **malignant scarlet fever** there may be no rash, much cervical swelling, and a gangrenous condition of throat resembling diphtheria. The tonsils are mostly deeply excavated and of a greyish-white colour, the soft palate may have a pale greyish colour and become perforated and ragged, while there is a large excess of purulent mucus present. There are not however, except in rare cases, raised patches of white adherent membrane, which, if forcibly detached, leave a raw surface. There is no punctiform rash present in diphtheria; in rare cases there is an erythema which spreads from the neck. Desquamation may take place after diphtheria, as it does after pneumonia or typhoid, but is not often so free as it is after a typical attack of scarlet fever.

*Treatment.*—When a case of diphtheria occurs in a house it should at once be isolated as far as it is possible, and if practicable all other children in the house should be sent away, bearing in mind however that they may be incubating the disease, and they should not therefore be sent where there are children, nor to any not readily accessible place. If they remain at home, they should keep away from the sick-room and not be allowed to attend at school. The sanitary arrangements of the house in which diphtheria occurs should be examined and the drains thoroughly flushed and cleansed. The indications for treatment consist: 1st. In supplying the patient with large quantities of fresh warm air, so that the poisonous matter given out by his breath may be well diluted; for this purpose the patient should, if possible, be provided with two large airy rooms on the same landing, so that he can be removed from one to the other, and thus one can be constantly ventilated. 2nd. To repeatedly cleanse the throat of accumulated mucus and remains of food, and any sloughing or disintegrating membrane.

3rd. To support the strength of the patient with reasonable quantities of liquid food and stimulants. The local treatment in diphtheria is probably the most important part of the treatment, and certainly it is the most difficult to carry out. There is an inflammatory condition of the tonsils, soft palate, pharynx, and nasal mucous membrane, large quantities of mucus and perhaps blood are secreted, which with flocculi of milk and beef-tea adhere to the mucous membrane, forming a foul decomposing mass which cannot fail to act injuriously on the patient. The capacity of the patient to take food, and probably also the course of the disease itself, depends upon the constant cleaning of the fauces. The multiplication of the bacteria or micro-organisms in all probability takes place locally, and it is consequently to these parts that treatment must be directed. It must however be conceded that the effects of local treatment are not always as evident as could be wished, especially in malignant cases, but it must be borne in mind how difficult it is to apply antiseptics and thoroughly cleanse the fauces of a struggling child, and how favourable are the circumstances to the cultivation of micro-organisms in the mouth or in the recesses of the tonsils. It need hardly be said that for the local treatment to be of the least use it must be effectual and thorough, and to carry it out systematically trained nurses are required, as it is utterly impossible for those unskilled in nursing and weary with watching day and night to carry out the details of the treatment required. The applications may be applied in various ways; the throat and nose may be syringed by means of an irrigator or ball syringe capable of holding five or six ounces, the child's head being held forward so that the fluid may return, washing out the mucus and decomposing matters, thus preparing the way for the application of some antiseptic or fibrin solvent by means of a brush or mop, or the insufflation of powders. Instead of syringing and mopping, the fauces may be sprayed, but this is only possible in older children and is unsuitable for fractious patients. Very few children are able to gargle. In addition to any of these measures, the air which the child breathes may be kept impregnated with some antiseptic by means of a Siegel's steam spray-producer or bronchitis kettle. Operations should commence by syringing the mouth and throat with some weak antiseptic solution of a non-poisonous nature, inasmuch as it is probable that some may be swallowed. The syringing will probably produce more or less coughing, and consequently clearing away of mucus and other accumulated materials. Of the antiseptics to be selected there are many, but perhaps primarily come some of the older ones, such as iodine, chlorine, Condyl's fluid, sulphurous acid, or the newer 'Sanitas.' The solutions may be of the strengths of tr. iodi 1 to 40; liq. sodæ chlorinatæ 1 to 20; sulphurous acid 1 to 10; Sanitas and Condyl's fluid 1 to 40. The sulphurous acid should not contain any free sulphuric acid. The same solution may be employed to syringe the nose or used in a spray to the throat. The fauces having been cleansed either by syringing or mopping, all loose membrane and detritus cleared away by the brush or forceps (all forcible tearing away being avoided), a stronger antiseptic solution may be applied. This may consist of glycerinum acidi carbolicum and iodine,<sup>1</sup> saturated solution of sulphate of copper, camphor

<sup>1</sup> Glycerini acidi Carbolicum 1 part;

Tr. Iodi, 2 parts.

and carbolic acid, or 'boroglyceride.' Among the milder antiseptics we prefer a saturated solution of 'Barff's boroglyceride,' in glycerine, applied frequently with a brush. We have also used with advantage equal parts of iodoform and boracic acid applied to the fauces with a wetted brush, or blown in by means of an insufflator. Papaine we have also used; it undoubtedly possesses solvent powers over the membrane, in some cases we have seen good results from its use. It may be applied as a powder with a wetted brush or a saturated solution may be used. A 5 per cent. solution of chinolin in alcohol has been recommended; it is certainly efficacious as an antiseptic, but it is hot and unpleasant, and children usually strongly resist its use after having had one or two applications. It is better to thoroughly use one of the milder applications than have a prolonged struggle, and perhaps in the end only partially succeed in applying the 'more caustic remedy. Ice, if the patient will suck it, is of the greatest use. Unfortunately there is no internal remedy which can be accounted a specific; it is indeed doubtful if any drug modifies the course of the disease. We generally prefer to use tr. ferri perchlor. in three to five drop doses every four hours or more, given in lemonade, soda water, or any way in which the little patient can be induced to take it. Digitalis, caffeine, coca wine, alcohol, should be given from the first if there is much depression of the system, and in the worse cases alcohol in the form of brandy or port wine must be given with a free hand. The diet supplied to the patient must consist of the most concentrated form of nourishment possible, as in most cases there is great difficulty in getting him to take food on account of the difficulty and pain in swallowing; beef juice, peptonised meat preparations, milk, and nutrient suppositories may be needed. If there is swelling or cellulitis, the neck should be painted with glycerine and belladonna and covered with cotton-wool. If the glands suppurate, incision and proper drainage must be resorted to. The greatest care must be exercised during convalescence to supply the patient with suitable food and fresh air, and to prevent any exertion on his part. Paresis of the soft palate, general paralysis, and failure of the heart may come on at any time within a month or five weeks of the commencement, even in mild cases, and the practitioner should constantly be on his guard, and warn the friends against allowing any excitement or unwonted exertion. During convalescence quinine, strychnine, and iron should be given. The continuous current and massage is of use in the paralysis which follows. Change to the seaside after five or six weeks reckoned from the commencement of the attack will prove of great benefit.

*Quarantine.*—This should be maintained for three weeks in mild cases, and a month or more in the more severe attacks.

**Enteric Fever.**—As a general rule it may be said that children and young people are more susceptible to enteric fever than are adults, and they usually suffer from it in a milder and less complicated form. It is not common in children under three years of age, though it undoubtedly does occur at this time and may be fatal; it is not easy to say at what period of life it is most common, as statistics of fever hospitals are apt to be fallacious, since the milder cases are certain to be nursed at home, and children suffering from the disease in a mild form will in a great many cases never enter a hospital at all. According to Collie, ten years to twenty years of age is the com-

monest time for an attack ; five years to ten years of age ranking next. The mortality at all ages from enteric fever, according to Murchison, is fifteen to twenty per cent. In children, according to Barthez and Rilliet and Gerhardt, ten per cent. In our own hospital 474 cases have been treated, with 37 deaths, giving a mortality of 7·8 per cent. It is obvious that too much reliance must not be placed upon these figures, as in the different hospitals a different proportion of severe cases may be admitted, or the mild and abortive cases may or may not be reckoned as attacks.

Enteric fever spreads by direct contagion, by means of emanations from both fresh and stale fæces, possibly also by the breath, certainly by inhalations of sewer gas given off from drains into which the excretions of enteric patients have been thrown, and by the taking of drink or food which has become contaminated by the poison. There is reason to believe that infection may be carried from the sick to the healthy on the fingers or clothes of a third person. The evidence that enteric fever is directly contagious, the disease being contracted by coming in contact with a patient, is too strong to be explained away, notably the evidence produced by Collie at the Homerton Fever Hospital ; and in our own hospital hardly a year passes without one or more probationer-nurses contracting the fever from patients they are nursing ; and we have known it to happen that patients in the same ward with cases of enteric fever, who have never been out of bed, have contracted the fever, doubtless by the contagion having been brought to them by one of the attendants. It appears to spread in this way in the crowded homes of the poor, where one member, mostly one of the children, contracts the disease, and remains at home, being nursed in a room where others sleep ; then in the course of two or three weeks other members are attacked. Indeed no disease is more certain to spread in the houses of the poor than enteric fever.

*Incubation.*—Usually fourteen to twenty-one days.

*Symptoms and course.*—In every epidemic cases may be met with which are so mild that they can only be recognised as enteric inasmuch as they occur in the same house with other undoubted cases. In such cases the temperature may be from first to last intermittent, being perhaps  $102^{\circ}$  or  $103^{\circ}$  in the evening, and falling nearly to normal the following morning ; it was evidently these cases which were classed by the older writers as ‘infantile remittent fever.’ Other cases, which begin like an ordinary attack, abort by the end of the second week, and are at once convalescent without going through the ordinary three weeks’ course. In other cases the morning remission is much more marked, being perhaps three or four degrees lower than the evening, and this tendency is especially shown after the middle of the second week. In these mild cases the patient does not appear ill ; in the morning the child will be seen sitting up in bed playing with his toys, and but for a heavy look about the eyes and a glance at the temperature chart over the bed, it would be difficult to persuade oneself that he was suffering from any febrile disease. Such patients are often brought to the out-patient rooms of dispensaries, and are not considered by their parents as anything but ‘out of sorts.’ There is rarely diarrhoea in the milder cases. On the other hand, cases of great severity may be met with in children, the fever may run high and last for many weeks, or fatal complications may super-

vene, or death may take place early in the disease from the intensity of the poison, as in the case of a child of three years coming under our notice who died as early as the 8th day.

*Initial symptoms.*—These mostly come on gradually, though exceptionally there is a somewhat sudden onset; the fact that the onset in any case has been abrupt does not certainly negative the diagnosis of typhoid fever. Frontal headache is nearly always complained of, with a feeling of chilliness, which induces the patient to sit over the fire; there is usually 'rambling' at night, less often abdominal pain, diarrhoea, and epistaxis.

*Temperature.*—In an attack of ordinary severity the evening temperature reaches  $104^{\circ}$  by the fourth evening, continuing to reach this point or thereabouts once daily for about ten days, the diurnal remissions usually being  $1^{\circ}$  to

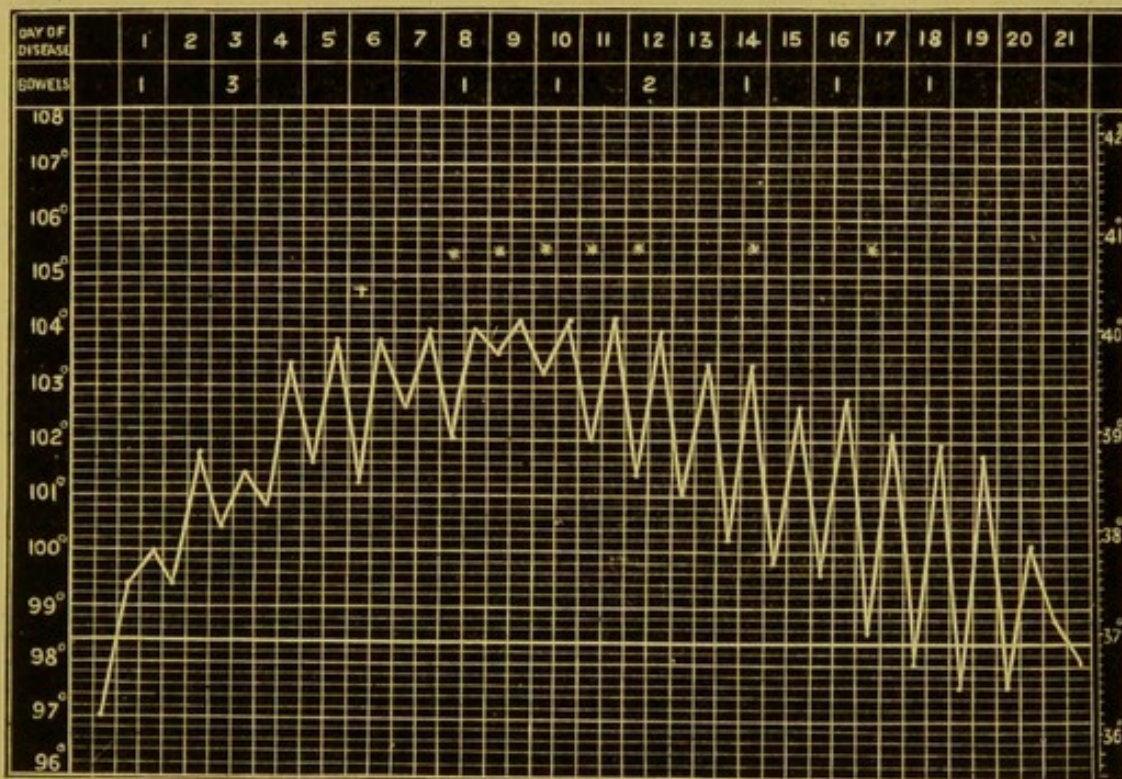


Fig. 32.—Temperature Chart of Mild Typhoid in a girl aged 9 years. \* rose spots; † spleen felt.

$2^{\circ}$ ; the remissions then become more marked, amounting to  $2^{\circ}$  or  $3^{\circ}$ , the fever gradually subsiding by lysis, and in an intermittent type, remaining normal after the 21st day (see fig. 32), though perhaps touching normal a day or two before. The highest temperature of the twenty-four hours is usually late in the afternoon at 4 or 5 P.M.; later in the attack it is postponed and reaches its highest point at 8 P.M. or midnight. In mild attacks there is a marked tendency to remit  $2^{\circ}$  or  $3^{\circ}$  or more early in the attack, and to abort at the end of the second week, in a way which is rare in adults.

Hyperpyrexia is the exception in children; in a few cases a temperature of  $105^{\circ}$  or even  $106^{\circ}$  may be reached, but the usual maximum during twenty-four hours in the first ten days is  $103^{\circ}$  to  $104^{\circ}$ .

The temperature curve of a relapse differs very much in different cases;

it is usually of a remittent type. It is hardly necessary to insist that the temperature should be always carefully taken during enteric fever, as it affords the best index we possess of the severity of the disease or the patient's progress to recovery.

*Tongue and mouth.*—During the first week there is usually nothing characteristic about the tongue; it is coated with a thin white fur, but clean and moist at the edges; there is often a glazed clean strip down the centre. It may remain moist and furred throughout, while later, especially in cases of moderate severity, the tongue is covered with a brown fur, dry, with a brownish glazed central strip. Later the tongue becomes clean, red and glazed; sometimes there are superficial ulcerations on the surface. Sordes very readily collect on the teeth, and the mouth becomes foetid if not cleansed.

*Abdomen.*—The abdomen does not become distended till the end of the first week; it is now that gas begins to accumulate and distend the small intestines, giving a rounded appearance to the abdomen; at the same time a certain amount of pain on deep pressure may be elicited and gurgling detected in the iliac fossæ. In mild cases the abdomen may be normal from first to last.

*Spleen.*—The spleen usually enlarges during the first week, the earliest day on which we have felt it to be enlarged was in one case on the 6th day. It continues enlarged and somewhat soft during the pyrexia; according to Jacobi, if the spleen remains enlarged after the temperature has fallen, a relapse is to be feared. In some cases there is no enlargement to be felt during life and the post mortem has revealed a spleen of normal size.

*Bowels.*—Typical 'pea-soup' stools are the exception in children, certainly diarrhoea is not usually a prominent symptom. The bowels may be constipated or normal, they may be simply loose, or there may be the watery pea-soup stools characteristic of the disease. As a rule it is the severe cases which have troublesome diarrhoea, but cases may be severe with high temperature and prolonged course without diarrhoea being present. During convalescence constipation is apt to be troublesome, on account of the atony of the bowel left by the disease.

*Cerebral symptoms.*—Slight delirium at night with a tendency to talk and chatter nonsense is common; acute delirium like that present in typhus or acute pneumonia is rare. After a severe attack the mind sometimes remains weak, a condition of dementia existing for some weeks; sometimes aphasia is left; more often the loss of speech is due to mental weakness. The prognosis is good, the mind recovering as the system gathers strength.

*Eruption.*—The characteristic rose spots are present in about 75 per cent. of the cases. The spots may be detected by the end of the first week, rarely earlier; fresh spots appear daily till towards the middle of the third week; they may go on longer, into the fourth or even fifth week. They often reappear during a relapse. Their numbers vary from two or three to many hundreds, so that the child has a freckled appearance.

*Urine.*—If the temperature is high and continuous, albumen in slight quantity is mostly present. Indican is often present. The urine is high-coloured and concentrated.

*Complications.*—The same complications that occur in adults are found also in children. There is the same tendency to **relapse**, there may even

be more than one. Not infrequently the relapse is more severe than the primary attack; death from perforative peritonitis may take place in a relapse. The interpyrexial period is very variable. Thus in a severe case the temperature touched normal on the 21st day, was then intermittent till the 30th, then normal till the 34th, then a relapse occurred, the temperature varying from  $102^{\circ}$  to  $104^{\circ}$ , till it reached normal again on the 53rd day; recovery followed. In another case the primary fever ended on the 19th day, a relapse occurred on the 30th, lasting till the 50th. In another the primary fever ended on the 20th, the relapse occurred on the 28th, and lasted till the 42nd. In another the primary fever ceased on the 25th, and a relapse occurred lasting from the 27th to the 46th.

**Epistaxis** is not uncommon as an early symptom and is of no importance. Small quantities of blood in the stools are common during the 2nd and 3rd week, and if small in quantity need not be a cause of alarm. Smart **hæmorrhage from the bowels** is rare; though serious when large in amount, yet we have not seen a fatal case result from it. We have seen severe hæmorrhage in three cases, all however ending in recovery. In one case, a girl of eleven years, there was a fall of temperature on the 27th day, from  $103.2^{\circ}$  to  $98.8^{\circ}$ , followed by a hæmorrhage of ten ozs. of blood per rectum; another hæmorrhage occurred on the 31st day, and again on the 32nd day some twelve ozs. were passed; she eventually recovered. In another case in a boy of twelve years, who was admitted after having been ill a month, the same evening there was a large hæmorrhage per rectum, sufficient to blanch his lips and for the time he was nearly pulseless; he finally recovered.

**Bronchitis and pneumonia** come on in many of the severe cases; they occur quite independently of a chill or from taking cold, they are due rather to stasis of blood in the lungs, mostly at the bases. Diminished resonance with rales and rhonchi are detected at one or both bases if pneumonia is present. The temperature is usually high and the pulse and respiration are increased. We have seen death take place from this cause on the 19th, 20th, 21st, 23rd, and 35th days. The pneumonic lung is of a purplish colour, has a solid airless feel, and is often more or less collapsed on section; the cut surface is not granular like croupous pneumonia, but smooth and dark red. The lung is airless, and sinks in water.

**Pyæmia**, with secondary abscesses in the lungs and elsewhere, the result of septic embolism from the ulcers in the intestines, occasionally occurs. In four of such cases dying in the Children's Hospital, the course of the disease was acute, with hyperpyrexia and an intermittent temperature towards the close; one died on the 19th day with suppuration in the parotid, the others on the 25th, 29th, and 37th day respectively. At the post mortem pyæmic abscesses due to infarcts, and pneumonia were found.

The most dreaded complication in enteric fever is **perforation of the intestine** followed by **peritonitis** in consequence of an ulcer penetrating through the wall of the intestine. This complication is fatal with very few exceptions, though it is difficult to say if it always is, as cases with symptoms of peritonitis sometimes recover, and it is not unreasonable to suppose that at times no extravasation may take place, the affected portion having become glued by means of lymph to another piece of intestine. In four of our cases death occurred on the 16th, 22nd, 30th and 48th days respectively.

In the case in which death occurred on the 16th day, it was not certain if it was the 16th day of the primary fever or of a relapse, as there was a history of indefinite illness before admission. The temperature on admission was normal, though there was some rhonchus and rales were heard in the chest; the disease ran an acute course (see fig. 33) for fifteen days, when suddenly there was collapse, the temperature falling abruptly, with vomiting and abdominal pain; the temperature rose again to  $104^{\circ}$ , death occurring next day. A perforation in the ileum, three inches from the cæcum, was found, with extravasated fæces and general peritonitis. In all the cases there was

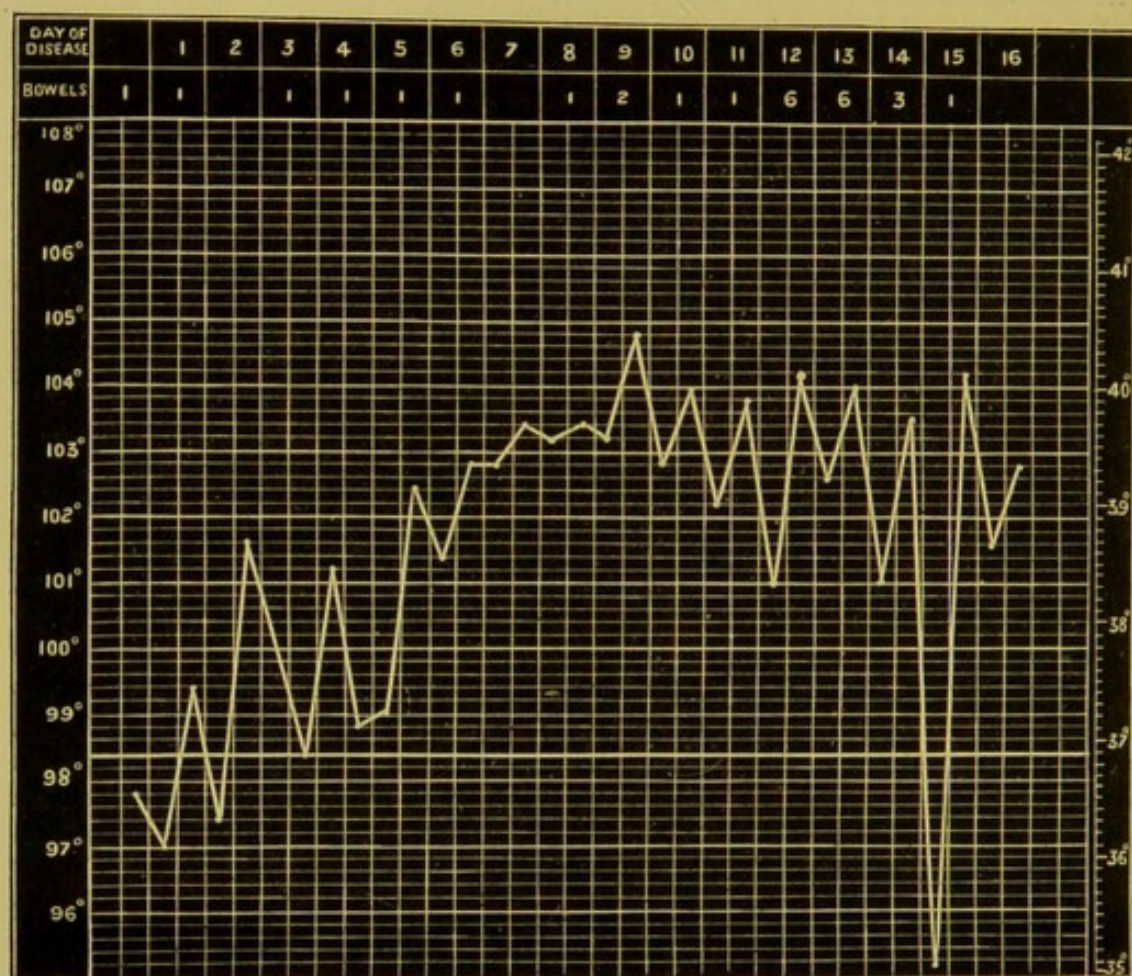


Fig. 33.—Temperature Chart of Enteric Fever; Peritonitis; death 16th day; in a girl of 9 years.

abdominal pain and collapse a day or two before death. In the case in which death occurred on the 48th day, the girl had been ill three weeks before admission, and the attack treated in the hospital may have been a relapse. There was hyperpyrexia and intermittent fever.

Some cases of enteric begin with tonsillitis and **membranous exudation** on the tonsils; occasionally sloughing tonsillitis supervenes in the course of the attack; this was so in one fatal case, in another a membranous laryngitis occurred, causing death on the 21st day. **Otitis** may occur, and occasionally a fatal result follows from thrombosis of the lateral sinus and pyæmia.

**Tuberculosis** may complicate the course of enteric fever, or it may follow as a sequela. In one case a child died of pneumonia on the 21st day; tubercles were present on the pleura and in the lung. In another case a girl recovered from enteric, the temperature becoming normal on the 26th day; it remained normal for a few days; she continued to improve for a month, though the temperature went up occasionally at night. Then hectic fever came on, with vomiting, and she died comatose three weeks after; the post-mortem showed tubercular meningitis and a few tubercles in the lungs.

*Diagnosis.*—During the first few days the diagnosis of enteric is difficult, often impossible, and especially in children typhoid may be confounded with the feverishness which so often accompanies dyspepsia and intestinal catarrh. Children are frequently brought to the out-patients' room of children's hospitals with indefinite symptoms and feverishness; a tentative diagnosis of enteric is made, but in a few days the symptoms disappear and the child is practically well again. Such attacks may be more severe, and it may be impossible to say whether the patient has had an abortive enteric attack or not, unless there are undoubted enteric cases in the household. In all doubtful cases, in the early stages, the temperature should be carefully taken every four hours and a careful examination made for rose spots and enlargement of the spleen. The diagnosis in small children and infants is extremely difficult, on account of the many causes, such as patchy catarrhal pneumonia, intestinal catarrh, dentition, and tuberculosis, which may give rise to an intermittent or remittent fever; but, as enteric rarely attacks an infant first in a household, we are often able to practically exclude it, even when the symptoms are suspicious.

**Acute Miliary Tuberculosis** and enteric may be very similar, and for a week or two the diagnosis may have to be held in abeyance. Careful temperature-taking every four hours will often greatly aid the diagnosis. In acute tuberculosis, the fever is mostly intermittent, the diurnal ranges being perhaps  $3^{\circ}$  to  $5^{\circ}$ ; there are no true spots, rarely diarrhoea; miliary tubercles may occasionally be detected in the choroid, crepitation may be heard in the lungs, or there may be some want of resonance at one apex; the abdomen is not usually rounded. **Tubercular Meningitis** in the early stages may simulate enteric.

A child who is seen for the first time, recovering from typhoid fever, being anæmic, wasted, and having perhaps some cough with rhonchi heard on examining the chest and possibly bedsores, might readily be thought to be suffering from **Chronic Tuberculosis**. If there is diarrhoea and abdominal tenderness, the two diseases at this stage may be still more alike. A careful examination of the lungs would generally distinguish between the two, as in chronic tuberculosis some consolidation at the apices or elsewhere would usually be found.

**Pyæmia** may resemble enteric fever, especially in those cases where the pyæmia is secondary to some bone disease without any external wound. A case of pyæmia secondary to Pott's disease of the spine, with abscesses in the lungs, which came under our care, was thought for a few days to be enteric fever; but the daily ranges of temperature are more extreme, the type more markedly intermittent, in pyæmia than typhoid. A rounded dis-

tended abdomen, with a pimply rash, may certainly occur in other diseases than enteric, though when true rose spots are present they are characteristic.

*Treatment.*—The management rather than the medicinal treatment of typhoid fever is of the greatest importance. The patient must of course be put to bed in a cool room and arrangements made for both night and day nursing; it is needless to emphasise the importance of a trustworthy nurse at night to feed and attend to the patient's wants and soothe him to sleep. Sponging with warm water to which some Condyl's fluid or Sanitas has been added should be performed every evening before settling the patient for the night, great care being taken to cleanse the buttocks and anal region, especially if the patient is suffering from diarrhoea, as the stools are apt to be smeared about. To keep the patient's back scrupulously clean is a matter of importance in the prevention of bed-sores. The patient's mouth must be carefully attended to, being cleansed, by means of a paint-brush or rag, of decomposing food and foul secretions; the more ill and insensible the patient is, the more important does this become. Condyl's fluid or dilute solution of boro-glyceride may be used for the purpose. The diet should consist of milk diluted with barley water or soda water and in amount should be suited to the age. During the pyrexial period milk is better taken than beef-tea or other savoury foods, which as a matter of fact are quite unnecessary. The more thirsty the patient is, the more must his milk be diluted, lest too much curd remain undigested in the stomach and intestines and give rise to flatulence and discomfort; a pint and a half to a quart of milk will be sufficient. An excess may give rise to diarrhoea or accumulate in the large intestine as hardened faeces. In the later stages, when the tongue is cleaning, beef-tea is usually taken well and forms a pleasant change of diet. Where milk does not agree, or when the diarrhoea is troublesome, peptonised milk or Benger's food should be given. It is well to continue the fluid diet till a full week after the temperature has become normal. Our usual practice is to allow sops in the milk or beef-tea on the 30th day, at once discontinuing it if the temperature rises. In mild or medium cases alcohol is unnecessary. No medicine is required; a simple saline may be given. The treatment of hyperpyrexia must depend upon the effect which it has upon the patient, though in any case, if the temperature rises to  $104^{\circ}$ , sponging the head, trunk, and limbs with water at  $60^{\circ}$  should be resorted to, or the cold pack may be given, provided there is no immediate risk of peritonitis. If the temperature is not kept in check by these means, but the fever is not making the patient drowsy or delirious, no other means need be taken, except perhaps applying an ice-bag to the head. Other means are however available, such as the administration of antifebrin or quinine, and the graduated bath. Antifebrin may be given in a large dose or in small doses of two or three grains, frequently repeated, so as to keep the hyperpyrexia in check, rather than to reduce it suddenly, as the latter is mostly attended by more or less collapse; in any case both antipyrin and antifebrin are apt to be depressing, and can only be safely used in the early stages, and not for too long a time together. In the early stages, with due care, the graduated bath is useful in reducing temperature; in the later stages it is contra-indicated, on account of the disturbance to the patient which it entails. The patient may be placed in it at a temperature of  $100^{\circ}$ , and cold water added so as to reduce it to  $70^{\circ}$  or  $80^{\circ}$ ,

though it is rarely wise to allow the child to remain in longer than five minutes. Excessive diarrhoea should be checked by starch and opium enemata, or Dover's powder by the mouth; sleeplessness and delirium by a wet pack or small doses of nepenthe, the latter being more useful than bromides, chloral, or urethan; abdominal pain or tenderness is best treated by nepenthe in free doses by the mouth, and opium fomentations, while the food and liquids taken are reduced to a minimum compatible with safety; pneumonia by stimulating applications, such as mustard poultices or turpentine stupe, the latter being used with great care on account of the sores apt to be produced. Any signs of cardiac depression must be combated by alcohol in the form of mist. vini gallici, champagne, caffeine, ammonia, ether, or digitalis.

It is often an anxious question to decide as to whether a laxative should be given when the bowels are constipated, inasmuch as a patient is rendered more comfortable by a free action of the bowels and the distention and discomfort are lessened. On the other hand, one fears that the peristalsis set up by a purgative or even an enema may do irretrievable damage by converting an ulcer into a perforation or tearing down adhesions of lymph which have formed. At the same time it must be remembered that hard lumps of faeces irritate the bowel and fret and rub the ulcers, and in some of the worst instances of extensive ulcers in fatal cases we have found numerous hard lumps of faeces in the lower part of the ileum and large bowel. Some doses of castor oil during the first ten days are often beneficial if the bowels are confined; after this time enemata are safer, though they are not free from risk, and should certainly be avoided if there are signs of peritonitis. If severe hæmorrhage from the bowel occur, the greatest care must be taken to give the child only the smallest quantities of food by the mouth and to keep him as quiet as possible. An ice-bag should be placed on the abdomen and a grain of ergotin given subcutaneously and repeated every two or three hours. Opium should be given in small doses if there is much restlessness. Turpentine or terebene in two or three drop doses in mucilage is useful as a stimulant and hæmostatic. During convalescence dyspepsia and constipation are frequently troublesome; flatulence and a rise of temperature is very apt to follow any excess of starchy or any indigestible food, especially in early convalescence. The food should consist of meat essences, of broths, jellies, pounded meat, chicken, and fish, with small quantities of toast or stale bread. Good sherry with a grain or two of pepsine and some liquid malt extract, such as that of Allen and Hanbury's or Hoff's, are often very useful. The constipation is usually slow in disappearing; purgatives should be avoided, as the constipation is simply due to wasting of the muscular fibre of the bowel and weakened secretions. In this condition the mineral acids, strychnine, cascara sagrada and bitters, are of most use.

**Typhus.**—During an epidemic of typhus children suffer equally with adults, though the mortality is exceedingly small. It is probable that the fact that children usually suffer from the disease in a mild form, and but few die, has given rise to the general belief that children are less susceptible to the typhus poison than are adults. That this is not the case has been shown conclusively by Dr. Buchanan, who, after referring to the slightness of the fever in children, says, 'When inquiry as to age is made to include every case of attack, children and adults are found to be equally

susceptible ; the actual incidence may even be observed to be strongly upon the young, partly because of their greater numbers and partly because adults are frequently protected by previous attacks.' That many children are attacked with typhus is shown by the statistics of Homerton Fever Hospital (given by Collie), for out of 711 admissions of typhus to the hospital during the period 1871-1880, 24 were under 5 years of age, 54 from 5-9 years, 113 were from 10-14 years of age ; it is more than probable that the proportion really attacked as compared with adults was much greater, but on account of the mildness of the fever they were nursed at home and not sent to hospital. Only two deaths took place among the 191 children under 14 years of age admitted, while the total mortality was ten times greater, being nearly 20 per cent.

*Symptoms and course.*—The symptoms and course do not differ from those seen in adults, with the exception of their usually greater mildness. The attack commences with headache, pains in the limbs, drowsiness, more or less shivering, sometimes vomiting, rarely diarrhoea. This history closely resembles that often obtained in scarlet fever, and this should be borne in mind, as a hasty conclusion as to the nature of an attack may be a wrong one. If seen for the first time at the end of three or four days, there is a listless expression on the face, it is flushed, the eyes suffused, the conjunctivæ injected ; the child may answer questions if spoken to sharply, but is drowsy, semi-delirious and irritable if interfered with. The tongue is dry, coated with a brown fur and protruded with difficulty, the lips are black, there are sordes on the teeth, while the gums easily bleed. An examination of the lungs reveals the presence of rhonchi, perhaps rales, and some loss of resonance at one or both bases. On the 4th or 5th day the rash usually appears, the skin has a dusky congested appearance, with an indistinct mottling, in addition perhaps to petechial points, due to flea-bites ; for our patients with typhus usually come from the dirtiest and most squalid quarters. Perhaps a dusky mottling is all that can be seen, but in more typical cases the rash is more definite, consisting of rose-coloured spots or maculæ larger than typhoid spots, and with more ill-defined margins, scattered over the body. According to Collie they are first seen on the sub-clavicular regions, along the lower border of the pectoralis major, on the wrists, back of the hands, and epigastrium. We have sometimes noted the rash especially well marked on the dependent parts of the body, sides of the thighs, and arms, and back, extending along the neck on to the cheeks, and present also on the dorsum of the feet. The temperature is usually continuously high,  $103^{\circ}$  to  $104^{\circ}$ , the pulse small and weak, perhaps 120 to 130, and there is some cough, and frequently much delirium or wandering at night. The fever may last for the whole two weeks ; more frequently the symptoms undergo marked amelioration after the first week, and possibly the temperature declines to normal by the 8th or 10th day, all the symptoms becoming milder and the rash disappearing without becoming petechial, as it often does in adults. The rash may be only visible for a few days or may fade as the fever becomes less. While the above description applies to a typical case in a child, very severe ones may sometimes be met with, though far oftener the symptoms are decidedly milder. The tongue may never be brown, only coated with a white fur ; the rash may consist of a dusky mottling only ; there may be drowsiness without active delirium. Dr. Tomkins observed in some of his cases at

Monsall Fever Hospital that there was marked torpor and lethargy during the first few days, so that the child was with difficulty aroused to take food.

It is obviously important to recognise typhus, though the attack may be mild, as such cases are of course infectious and may spread the disease. Dr. Tomkins records the case of a woman who contracted a fatal attack by sleeping with a child suffering from mild typhus, the cause of the child's illness not having been recognised.

*Diagnosis.*—The fact that typhus occurs in epidemics and is apt to prevail in the overcrowded and poverty-stricken quarters of a large city often helps

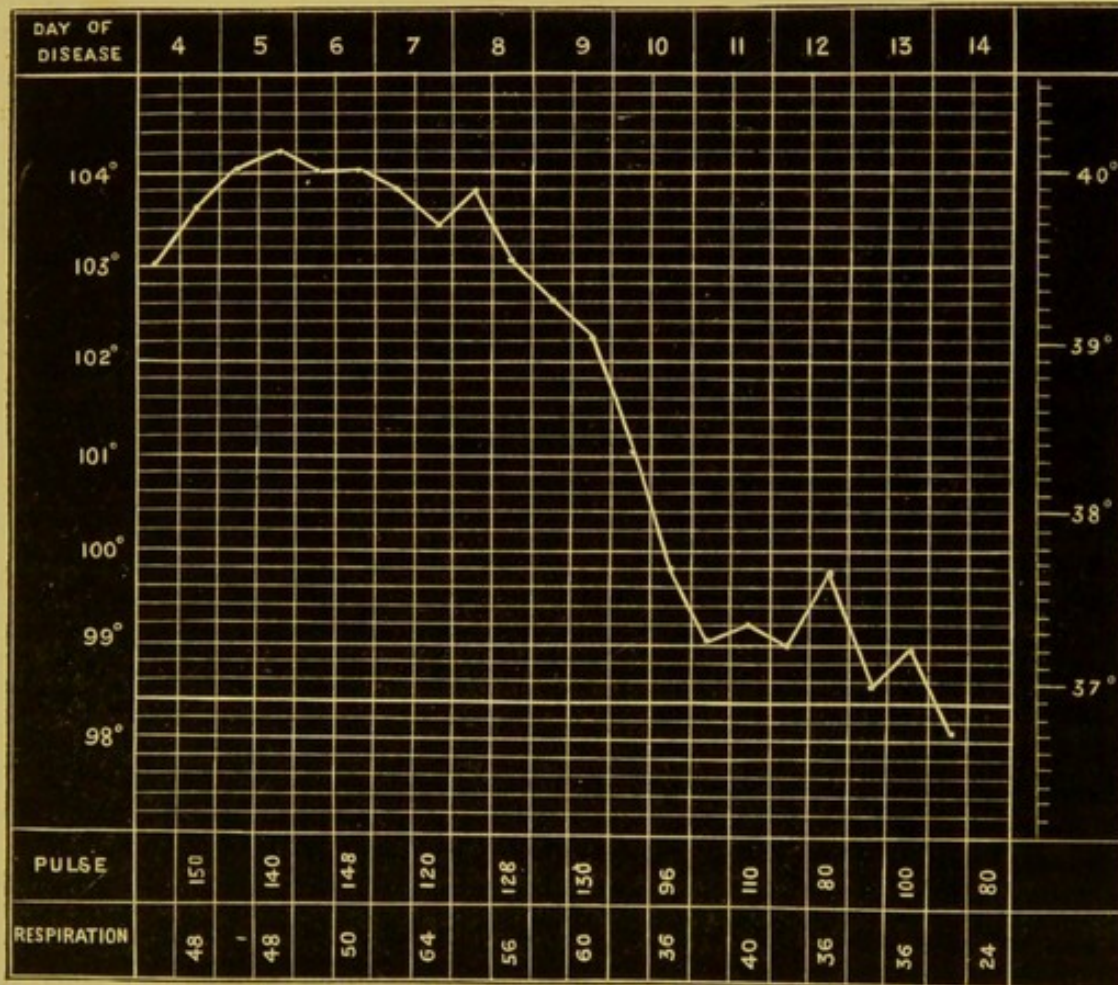


Fig. 34.—Temperature Chart of Typhus Fever, ending in recovery. Eliz. G., aged 7 years.

the diagnosis ; but occasionally an epidemic breaks out in a school or in the homes of the well-to-do. The onset of the attack may suggest scarlet fever ; the high fever, drowsiness, and dusky condition of skin present in a malignant case of the latter disease might render the diagnosis doubtful at first ; but the condition of the tonsils would usually clear up a doubt if the characteristic rash of scarlet fever was not present. Nevertheless we have seen a case fatal in two or three days that gave rise to some doubt, and in the absence of a post mortem was never cleared up. The disease most likely to be mistaken for typhus is **acute pneumonia** (Collie) ; this is in accord with

our own experience, as we have seen cases of acute 'cerebral pneumonia with physical signs delayed, sent into hospital as typhus; the mistake is likely to occur, as in most cases of typhus some rales or rhonchi are to be heard.

In 'cerebral pneumonia' the lesion is often at the apex of the lung; if seen on or after the fourth day of illness, and there is bronchial breathing or dulness, or some high-pitched resonance over a portion of lung and no rash, the disease is almost certainly acute pneumonia. A dusky or mottled skin, brown dry tongue, rales or rhonchi scattered over the whole lungs or bases, would indicate typhus. **Enteric fever** may be mistaken for typhus, especially when acute, but the insidious nature of the onset, the absence of marked delirium or torpor, the tenderness on pressure over the abdomen, and the rose spots usually suffice to make a diagnosis. We have seen some cases of typhus where there was a good deal of general hyperæsthesia and muscular tenderness, where pressure on the abdomen evoked expressions of pain.

*Prognosis.*—This is mostly good, but fatal cases sometimes occur, the children succumbing in the first few days of the fever from the intensity of the poison.

*Treatment.*—That of fever generally. Sponging with Condyl's fluid should be resorted to daily; the apartment should be large, airy and warm; stimulants are required in all but the mild cases; milk and other liquid nourishment must be given in suitable quantities. Directly convalescence has set in a more liberal diet may be allowed.

**Varicella.**—Varicella is a specific infectious disease closely resembling modified small-pox, though perfectly distinct from it. There are still a few who believe varicella to be a variety of small-pox, notwithstanding the many facts which point in a contrary direction, which may be summed up as follows: they are not mutually protective, children who have recently had small-pox may contract varicella; during epidemics of one disease the other is not unusually prevalent; small-pox affects all ages, varicella affects children almost entirely; inoculation with the virus of small-pox produces small-pox, inoculation with the contents of the vesicles of varicella, when successful, produces only chicken-pox.

Varicella occurs in epidemics in schools, workhouses, children's hospitals, and among the poorer classes of society where there are many children in constant contact with one another; its epidemics however are not so widespread as those of measles or hooping-cough, nor does it affect so large a proportion of the unprotected. It affects children almost entirely; thus in 584 cases observed by Baader in Bâle, 98 per cent. were under the age of ten years, and 65 per cent. below five years of age. Adults do however occasionally take it. We have several times seen nurses contract the disease from children suffering from it.

Varicella can be communicated from the sick to the healthy by inoculation, by simple contact, or by infection being carried by a third person. Trousseau failed in his attempt to inoculate; Steiner seems to have been more successful, succeeding in eight cases out of ten. The disease is most usually communicated directly from children suffering from or convalescent from an attack; it is also certain that the infection can be carried by means

of a third person, or remain in an active condition in clothes for many weeks, inasmuch as sporadic cases of the disease will occur in hospital wards in patients who have been in for months, and where no cases had occurred previously in the ward for a long interval.

*Symptoms.*—The *incubation* period in the inoculated cases reported by Steiner was eight days ; when contracted in the ordinary way it is usually about fourteen days, sometimes a day or two more. We have on several occasions had an opportunity of verifying this. There are usually no *premonitory symptoms*, the discovery of papules and vesicles on the body is usually the first thing noted by the friends. In a few cases there is a diffuse redness of the body resembling the roseolous rash which sometimes precedes small-pox, and which has given rise to the suspicion that the case is one of scarlet fever ; in one case a measly rash, preceding the vesicular eruption,

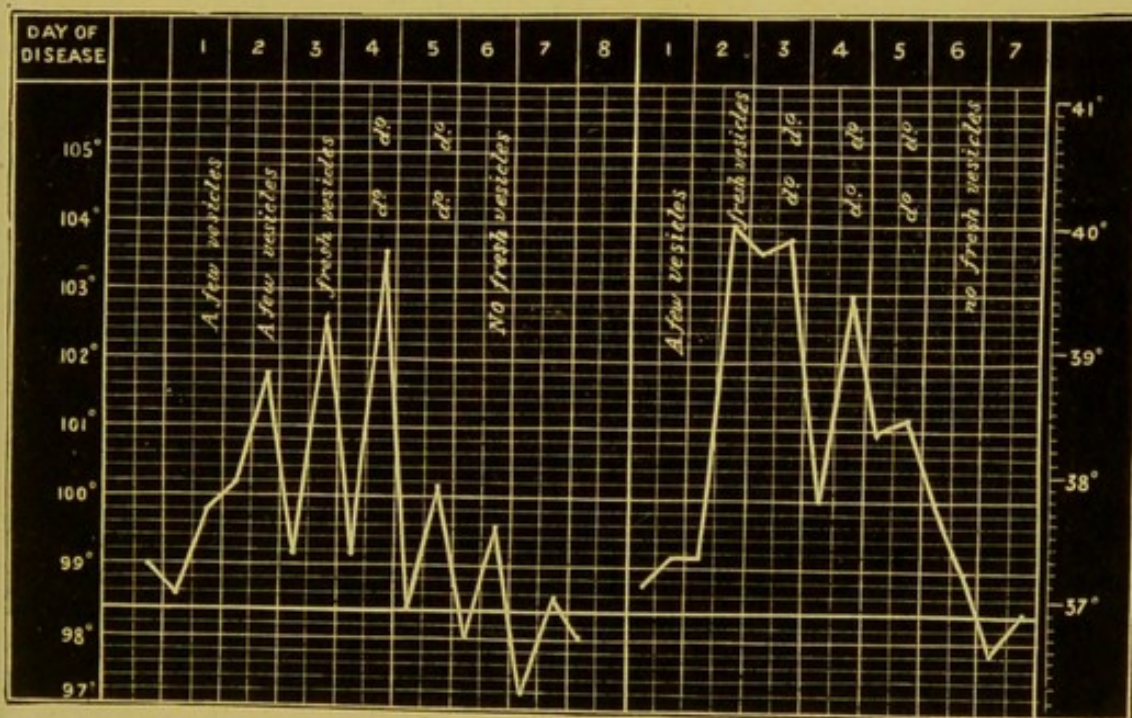


Fig. 35.—Temperature Charts of two cases of Chicken-pox in children of 3½ years and 18 months.

made it look as if the child was suffering from both measles and varicella, but of this there was no confirmatory evidence. Frequent micturition was observed in one of our cases before the rash appeared. The premonitory fever if present is of short duration, varying from a few hours to twenty-four hours, and in this respect varicella presents a marked contrast to variola. The temperature is not as a rule characteristic, and varies with the acuteness of the attack, mild cases with only a few vesicles being feverless, severe cases with a great number of vesicles being accompanied by a temperature of 104° or more. The most frequent type is the intermittent (fig. 35).

The rise of temperature is accompanied by an accelerated pulse, coated tongue, and restlessness, though in mild cases these may be absent, and in a few hours by rose spots, resembling the rash of typhoid, which quickly become vesicular. Probably at the time the first examination is made there

will be both rose papules and minute blebs or vesicles containing clear fluid and surrounded by a zone of redness. By the next day a fresh crop of papules and vesicles will have appeared, the vesicles of the previous day are larger, perhaps some of them have aborted and commenced to dry up. Fresh crops appear on the third, fourth, fifth days, and perhaps later still, so that when the attack is at its height, as it usually is on the third or fourth day, the trunk and extremities are thickly covered with vesicles and scabs, probably also a few pustules where there has been some scratching and the vesicles have burst. The contents of the vesicles are at first quite clear, as they enlarge their contents become more cloudy, but not purulent unless the vesicle has been injured and part of its contents has escaped. The vesicles are mostly unilocular, their upper surface is convex and collapses as soon as it is pricked, though in some cases a few vesicles may be seen more or less flattened, umbilicated, and multilocular, closely resembling small-pox or vaccination vesicles. The number of vesicles varies greatly, in some cases only a few being present, in others there may be many hundreds. They are never confluent. In the majority of cases the vesicles dry up and scabs are formed at their site; these fall off in the course of a few days, leaving clear and healthy skin beneath. In some of the worse cases this is not so; an ulcer, which may be some weeks in healing, forms beneath the scab, and thus a scar is left not unlike those following severe small-pox. The vesicles make their appearance on the trunk, limbs, and scalp; they are generally more sparsely present on the face, tongue, and soft palate.

The prognosis in varicella is uniformly good, as it is apparently never fatal in a previously healthy child. In weakly and tubercular children the varicella vesicles are apt to be followed by spreading ulcers, which, joining one another and taking on an unhealthy action, sometimes assist in bringing about a fatal result. Such cases have been described by Mr. Hutchinson under the name of **varicella gangrenosa**; they are by no means uncommon in the out-patient room. The gangrenous action is usually associated with tuberculosis, and it is curious that in all fatal cases of this affection—as has been remarked by Dr. J. F. Payne—tubercle has been found post mortem. Eustace Smith has known acute tuberculosis to follow varicella, and we have also seen several such cases. Nephritis is an occasional sequela, as first noted by Henoch.

*Diagnosis.*—The disease with which chicken-pox is most likely to be confounded is mild or modified small-pox, but as a rule no difficulty is experienced. The point of most importance in making a diagnosis is the absence of premonitory symptoms and the character of the rash; the following table shows these:—

VARICELLA.	VARIOLOID, or modified Small-pox.
<i>Incubation.</i> —13 to 16 days.	12 days.
<i>Premonitory fever.</i> —A few hours.	2 or 3 days.
<i>Premonitory symptoms.</i> —Mostly <i>nil</i> .	May include headache, backache, drowsiness, vomiting, delirium, convulsions.

*Rash.*—Red spots becoming vesicular in a few hours and drying up in three or four days leaving crusts ; coming out in crops on four or five successive days on the scalp, trunk, limbs, face, and mucous membranes. The vesicles are mostly unilocular.

*Temperature.*—Intermittent in character.

Red shot-like papules appearing on face, wrists, body, limbs, and soft palate ; in the course of a day or two the papules becoming vesicles, and developing into pustules by the eighth day, or they may dry up leaving only scabs.

Sudden rise, reaches its height when the papules are fully out, then comes a speedy fall. The secondary fever is slight or absent in modified cases.

Occasionally a vesicular syphilitic eruption may simulate varicella, though such eruptions are rare in congenital syphilis and when present take the form of bullæ of various sizes rather than vesicles. In one case which came under our notice, a vesicular syphilide closely resembled varicella, but there was no fever, and some brown staining followed the rash.

*Quarantine.*—How long does the infection last in varicella? No case should be considered past the infection stage until all the scabs have cleared away and the skin is quite smooth and normal. This is usually accomplished in three or four weeks. In one case which was admitted to hospital, suffering from psoriasis, which had succeeded the eruption of chicken-pox, and where some unhealed ulcers were present, the admission into the ward was followed by an outbreak of the disease some fortnight afterwards. The child admitted had had chicken-pox five weeks before.

*Treatment.*—Not much treatment is necessary. The child should be isolated, and preferably be kept in bed if there is a copious eruption. A light diet, salines, and ointment containing some tarry or carbolic compound, will be useful to apply to the scabbing vesicles.

**Vaccinia.** *Performance of Vaccination.*—The safest age for vaccinating infants has been in dispute, some preferring to vaccinate within a few weeks of birth and before the monthly nurse leaves, while others much prefer postponing the operation till three or even six months. Inasmuch as unvaccinated children under one year if they contract small-pox almost certainly die, no time should be lost in vaccinating infants, if there is any chance of their being exposed to contagion, if small-pox exists in the house or is present in the neighbourhood in epidemic form. On the other hand, if the risk of their being exposed to contagion is small, it is unwise to vaccinate during the first few weeks of life, on account of the disturbance of the general health liable to follow ; infants of three months or six months old bear the operation better than infants a few days or weeks old. It is of importance to postpone vaccination beyond the end of the third month if the infant is not robust, or suffers from diarrhoea, malnutrition, eczema, intertrigo, or if erysipelas is prevailing in the neighbourhood. Revaccination should be performed at or before puberty. If human lymph cannot be obtained from an infant of an undoubtedly healthy family, fresh calf lymph should be obtained, and if the latter is used, any objection to the performance of vaccination on the ground of transmitting syphilis

and other diseases is obviated. Calf lymph answers usually very well ; it is more viscid than humanised lymph and consequently may fail to take unless care is taken to work it well in. The cuticle should be raised by a few scratches of a needle or lancet at the spot where a drop of lymph has been applied. After vaccination nothing is usually to be seen till about the third day, when there is some itching and a slight redness surrounding the spot, or there may be a tiny papule. By the seventh or eighth day there is a flattened vesicle at the seat of puncture, containing clear fluid in various loculi. During the next few days a red areola forms round the vesicle and its contents become cloudy ; by the tenth or eleventh day the fluid oozes out and forms a scab on the surface, which, becoming detached, leaves a superficial ulcer, which takes a variable time to heal ; a permanent cicatrix, which is circular, depressed, pale and pitted, is left. The size and distinctness of the scar will depend upon the ulceration which has followed the pustule ; if the latter dries up without an ulcer forming, there will be hardly any scar left. There is often some febrile disturbance from the fifth to tenth day.

What are we to regard as the finest vesicles for obtaining lymph from ? According to Dr. Hugh Thompson,<sup>1</sup> 'they are such as, at the beginning of the eighth day (the day usually chosen for taking lymph, although not always the best), show the punctures made in vaccinating well-healed with no scabbing, the vesicles depressed in the centre and elevated at the margin, containing a moderate amount of lymph, not acuminate ; that is, flat in proportion to breadth, and not having lost the inequalities—bosses and foveæ—resulting from some of the connections between the epidermis and corium still remaining intact, the areola incipient or only slightly developed. The lymph which exudes from them, on being pricked, is nearly if not quite limpid, somewhat viscid, moderate in quantity, and does not tend to run down the arm.

'As a general rule it is the finest children—those, at least, who are such in the eyes of the vaccinator : "children of dark complexion, with a thick, clear, smooth skin," as Seaton remarks—indications of a strong vigorous constitution—who furnish the finest vesicles. At the same time care must be taken to see that the child is in perfect health, and especially, by a thorough examination, that it is free of all skin diseases, and more particularly all indications of syphilis, among the most persistent and obvious of which (excepting, of course, manifest syphilides) are chronic coryza, generally from birth ; a depressed nose, open fontanelles, hydrocephalic head, turgid veins of scalp, tumid lymphatic glands. Many of the manifestations of syphilis disappear under treatment, and it is possible they may have thus disappeared without the disease being thoroughly eradicated ; but it is rare that one or more of the above may not be found if searched for. It is superfluous to caution against the smallest admixture of blood.'

*Complications and sequelæ.*—These are fortunately few, though numerous and important in the eyes of prejudiced persons, and a lengthy list could be easily compiled if all the evidence collected by such were to hold good. The most important are the following : (1) **Syphilis** (see p. 349) ; (2) **Erythema**

<sup>1</sup> 'Inoculation for Small-Pox,' by Hugh Thompson, M.D. ; *Glasgow Medical Journal*, vol. xxvii.

and **Erysipelas**. There may be an unusual amount of redness and hardness surrounding the pustules; this may spread down the arm and on to the chest, while there may be more or less constitutional disturbance. True erysipelas may follow from the direct inoculation of the poison, in which case the redness and fever makes its appearance as early as the second or third day, or the virus may accidentally gain entrance after the pustule has matured, in this case appearing from the seventh to the tenth day (Bohn). The prognosis in vaccino-erysipelas is very grave, the mortality being very high, especially when the rash appears two or three days after the vaccination. (3) **Glandular enlargement**.—The axillary and cervical glands may enlarge and suppurate during the maturation of the pustules or more commonly in the second week. We have seen several cases in infants with chronically enlarged and caseating superficial cervical glands of the left side, which had commenced to enlarge shortly after vaccination, and it appears likely that in infants of a tubercular or 'strumous tendency' vaccination may be the exciting cause. The lymphatics passing over the shoulder connect the lymphatics of the arm with the supra-clavicular and cervical glands. (4) **Cold abscesses** and boils may form in various parts of the body, as they will at times after all suppurations, especially in tubercular or 'strumous' children. (5) Various rashes occasionally make their appearance, mostly towards the end of the week, when the vesicle is maturing. A **roseolous** rash over the body and arms, which is fugitive, disappearing mostly in twenty-four hours; a **vesicular** rash, consisting of a few pimples becoming vesicular; a **lichenous** rash; and patches of **erythema** may be sometimes present. We know of no evidence which directly connects eczema with vaccination; it is very common during infancy in one form or another, and it is not surprising that vaccination often gets the credit of producing it.

**Varioloid or post-vaccinal Small-Pox**.—Unvaccinated children suffer from small-pox in as violent a form as do unprotected adults; indeed, according to Collie, 'small-pox is very fatal in unvaccinated children under five years of age, more than half dying and nearly all infants under one year.'

Children who have been vaccinated in infancy and take small-pox usually suffer from it in a modified form; there may be no rash at all, or more often the attack aborts and the vesicles dry up without passing through the pustular stage, the secondary fever being absent or only slight. Sometimes the attacks, according to Collie, are so slight that diagnosis is impossible, except from the fact that they occur after exposure to infection or in association with cases of undoubted small-pox. The premonitory symptoms may be present, headache, feverishness, backache, which disappear before the rash appears, the attack coming to an end without any papular eruption. It is much more common for the attack to abort immediately after the rash appears, secondary fever of pustulation being absent. The premonitory symptoms may be severe, headache, backache, the temperature rising to  $103^{\circ}$  or  $104^{\circ}$  on the third or fourth day, a copious eruption of papules appearing, perhaps being confluent on the face, to be followed by a sharp fall in the temperature of perhaps  $4^{\circ}$  or  $5^{\circ}$ . The papules become vesicular and dry up with but slight if any pustulation, and the child is convalescent at once.

The temperature chart (fig. 36) was that of a child aged ten years who was convalescent from scarlet fever, and who contracted small-pox while in the scarlet-fever ward; the only source of infection which could be traced was a visit of her mother twelve days before, the latter coming four miles from a district where small-pox was prevailing. There was marked headache but no pain in the back; on the third day an erythematous rash was seen on the body, which suggested that her illness might be scarlet fever, though she had passed through a typical attack some weeks before: on the afternoon of the same day a few tiny papules like the rose-spots of typhoid were seen on the abdomen and arms, the headache was severe and the eyes suffused. The spleen was enlarged, being felt  $1\frac{1}{2}$  inch below the ribs. On the fourth day the face, neck, trunk and limbs were covered with well-

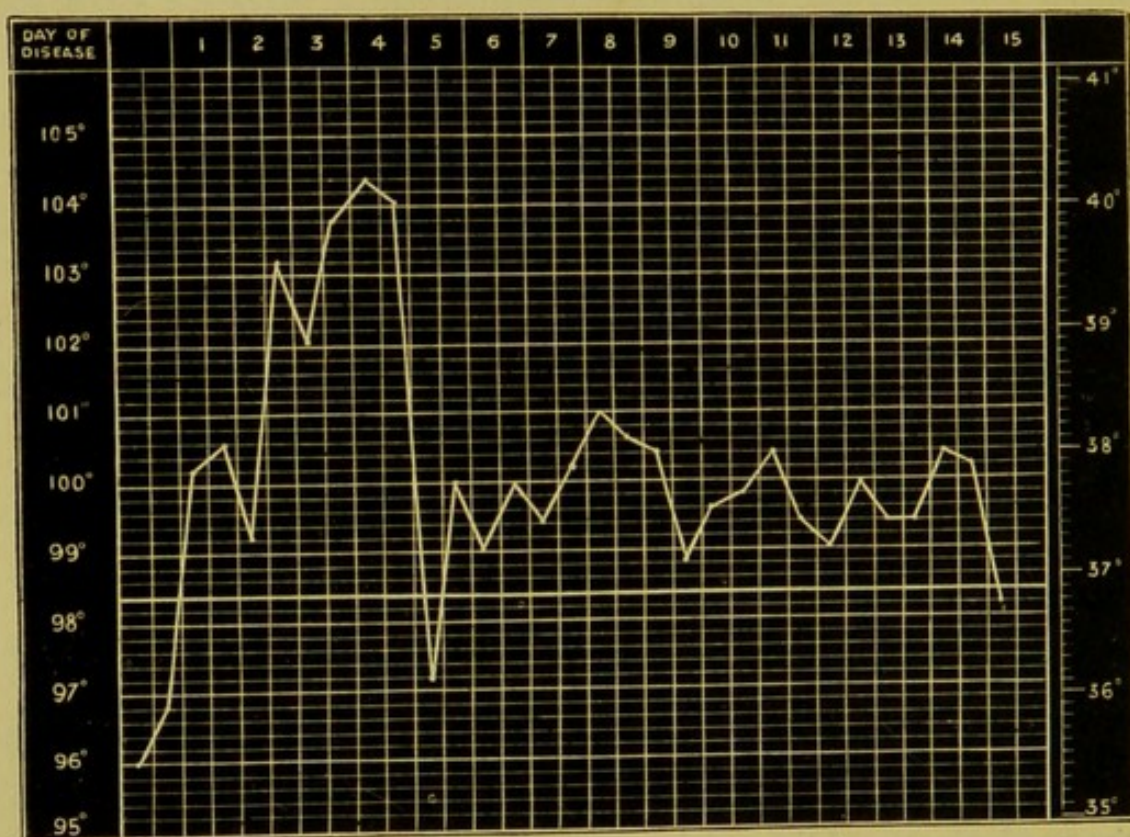


Fig. 36.—Temperature Chart of a case of modified Small-pox in a girl aged 10 years. Papular rash on the 3rd day, becoming vesicular on the 5th.

defined papules, many confluent. The same evening the temperature fell from  $104^{\circ}$  to  $97^{\circ}$ . On the fifth day the eruption was copious, some of the papules were beginning to be vesicular; the vesicles quickly began to dry up and scab, no true pustules appearing. The girl made a good recovery and was not permanently pitted.

*Diagnosis.*—The fact that small-pox is at times a very mild disorder makes it important that it should not be overlooked, inasmuch as a mild case as well as a more severe one may be the means of spreading the disease. Diagnosis is hardly possible in the absence of a papular eruption, or the purpuric spots of the malignant form.

*Treatment.*—The treatment is that of fevers generally.

**Hooping Cough.** *Etiology, &c.*—Hooping cough is an infectious disease which is characterised by a catarrh of the air-passages and a peculiar spasmodic cough. It prevails in epidemics which are both widely extended and prolonged, though sporadic cases are mostly present in large centres of population. There is no disease which is more certainly infectious than hooping cough, in the sense that if those who are unprotected by a previous attack come in contact with those suffering from it, they are almost certain to take it. If one member of a household is attacked, all the other members, both children and adults, who are unprotected, take the disease. If it enter a court or alley, it is tolerably certain that the unprotected inhabitants will suffer. It is almost certain to spread in a similar way in a school or convalescent home. It is however a curious fact which we have often noticed that hooping cough does not appear to spread to any great extent in hospital wards in which the children are in bed and the cubic space large (the same fact has been noticed by Dr. Sturges and Dr. Goodhart), and it would almost appear that close contact with the infected individual so as to inhale his breath was necessary to take the disease. It is impossible dogmatically to deny that the poison of hooping cough cannot be conveyed on the person or by clothes to a distance and so infect the healthy; but it is certainly exceptional; the common way in which it spreads is by direct contact with the sick. A very short contact is all that appears to be necessary, such for instance as a child meeting another for a moment in the street or in a shop; several instances of attacks contracted in this way have come under our notice. The epidemics like those of measles appear to occur in large cities, every eighteen months or two years. It has been asserted that there is some definite relation between these two zymotics, as they frequently prevail epidemically together or one immediately preceding or following the other; it is very doubtful if this association is anything more than accidental, as they both are apt to recur every eighteen months or two years. The hooping cough epidemic lasts longer and more slowly reaches its height than the measles epidemic. Like measles, hooping cough seems to prevail at all seasons of the year; but, as one would naturally expect, it is more fatal in the colder months of the year than in the warmer months, in consequence of the broncho-pneumonia which is so apt to supervene if the child takes cold. The mortality is very high among the very young and weakly children, while in older children it is rarely fatal. During the decade 1878-1887, 3669 cases of hooping cough were treated in connection with the children's dispensary, with 281 deaths or a mortality of 7·6 per cent. Of these, 217 or 77 per cent. were under two years of age, 63 or 13 per cent. were from two to five years of age, and only one fatal case occurred in a child over five years of age. It is certain these figures do not represent the total mortality, as they do not necessarily include those who die some months later of tuberculosis and gastro-intestinal atrophy.

*Incubation.*—It is difficult to fix the latent period with precision, as the onset is gradual and the symptoms so often indefinite. It is usually seven to fourteen days before the child begins to cough and another week or ten days before the characteristic 'hoop' is heard. This makes an interval of two to three weeks between being infected and commencing to 'hoop.'

*Symptoms and course.*—The course of the disease is marked by three

stages :—(1) The catarrhal or premonitory stage ; (2) The *convulsive* or *spasmodic* stage ; (3) The stage of decline or *convalescence*. These stages, it is needless to say, are not well marked, but one gradually succeeds the other, and this is especially true with regard to the third.

The catarrhal stage begins with the symptoms of a feverish cold and tickling dry cough, which is not readily relieved by ordinary remedies. The cough is especially apt to recur at night, and it is remarked on by the friends as being more than usually troublesome, the child coughing and straining as if to relieve a persistent irritation in the throat. The cough keeps it awake at night, or it wakes up coughing and fails to get to sleep for some hours. During the day the child may appear well, or on the other hand the appetite fails and he looks pale and poorly. The cough, if not paroxysmal from the first, becomes so in the course of a few days before the actual hoop is heard. There is usually some degree of fever at night and dry rhonchus may often be heard on listening to the chest. The first stage may be complicated with bronchitis or pneumonia.

The *convulsive* stage.—The cough now comes not only in paroxysms, but there is a distinct hoop ; there are a number of short forcible expiratory efforts, as if an effort was being made to expel some irritating matters, to be followed by a long-drawn shrill inspiration which is so characteristic and which is technically called a 'hoop' or 'whoop,' or in some parts of the country a 'chink.' It is perhaps hardly right, at any rate when the second stage is well established, to speak of the expiratory coughs as 'efforts ;' the child, prompted by a peculiar tickling sensation in the throat, attempts to relieve it by coughing, but in a moment the coughing goes on in spite of any voluntary effort to repress it, so that the child's face becomes congested and the facial veins distended before the inspiratory act takes place, and the air rushes into the air-passages and lungs through the narrowed glottis. Fit after fit of coughing will often follow one another, till the child vomits or a rush of stringy mucus pours out of the child's mouth and nose, perhaps streaked with blood. In the worst cases the distress occasioned by these fits of cough is extreme, and the child dreads their recurrence, not only on account of their discomfort, but from the aches and pains it suffers from the over-strained and weary respiratory muscles. To a weakly child the disease is necessarily a formidable one ; the exhaustion produced by the constant muscular efforts, the frequent vomiting which prevents a proper amount of food from being assimilated, together with the intestinal catarrh which in a greater or less degree accompanies it, often reduce the child to a feeble and weakly state. It can easily be imagined that forty or fifty attacks of coughing every twenty-four hours entail great muscular exhaustion and affect the child's vital powers. In milder cases where the fits of coughing do not exceed twelve the child may appear quite well between the paroxysms, and, though perhaps vomiting after the cough, it is quickly ready for another meal, with sharpened appetite. Fever is mostly present in the second stage in variable degree, especially at night. An examination of the chest will generally discover bubbling rales in the larger tubes, the secretion being freer than in the first stage.

The stage of decline.—After a variable period of four to six weeks, during the latter period of which the attacks of coughing have been diminishing, the characteristic hoop disappears and convalescence may be said to be estab-

lished. Mostly the paroxysmal character of the cough remains and often the vomiting; gradually the bronchial catarrh disappears and the cough ceases, though it is very likely to return and the hoop along with it whenever fresh cold is taken.

*Complications.*—By far the commonest is some form of **broncho-pneumonia**; **pleurisy** and **empyema** are not uncommon. There is nothing specially characteristic about the broncho-pneumonia of hooping cough; it is usually double, is very apt to be generalised rather than 'patchy,' and tends to resolve, slowly passing into a subacute or chronic state. **Croupous pneumonia** is not uncommon in older children who take a chill during convalescence, it may be followed by empyema. **Empyema** and **atelectasis** are very apt to occur in connection with the bronchitis in small and rickety children. Young children are sometimes convulsed, the convulsions perhaps being due to exhaustion, or to asphyxia, the result of atelectasis and emphysema; drowsiness and coma are usually due to the same causes. Cerebral symptoms, whether **convulsions** or drowsiness, are of grave import. **Intestinal catarrh** and diarrhoea of a mucous character are also common; the catarrhal condition of the air passages extends to the intestines, and large quantities of mucus are secreted, which prevent the digestion and assimilation of food and cause a rapid passage of the food through the intestines. The child passes small mucoid stools many times a day, is feverish and rapidly wastes. Sometimes the diarrhoea is of a dysenteric character. **Tuberculosis**, especially of the bronchial and intestinal glands, is a sequela rather than a complication, and usually follows some months after. A wasting during the third stage is oftener due to intestinal catarrh or chronic broncho-pneumonia than to tuberculosis. Among the lesser complications are ulceration of the frænum linguæ, stomatitis, and sores about the nose and lips. Small conjunctival hæmorrhages are very common. The child often remains for a long time in a weakly state of health, and may take long to regain its former strength. Permanent deformity of the chest may remain as a legacy left by an attack of hooping cough.

*Diagnosis.*—Often no diagnosis can be made in the early stages, and this is the more unfortunate as there can be no doubt the disease is infectious during this stage. The fact that hooping cough occurs in epidemics will often aid in coming to a conclusion. Difficulty may often arise in more chronic cases in which there is a paroxysmal cough followed by more or less of a stridulous sound, as to whether such are specific and are to go into quarantine. The diagnosis will turn largely on whether any cause for the spasmodic cough can be discovered as well as the history; if there has been previous wasting, and there is some evidence of tuberculosis of the lungs, enlarged mediastinal glands would be suspected as the cause of the spasmodic cough. Diagnosis is often difficult in infants, as also it sometimes is in older children, who may have hooping cough without any characteristic 'hoop;' the 'hoop' may also cease when pneumonia supervenes.

*Prognosis.*—The fact that the mortality is vastly greater in children under two or three years of age than it is in older children must be borne in mind in forming a forecast of results. The prognosis in the case of an infant or a weakly child of eighteen months or two years of age is very uncertain, and death may suddenly occur during a fit of coughing from convulsions

or spasm of the glottis. The prognosis is always rendered grave by the presence of broncho-pneumonia; the latter when it follows whooping cough is more fatal than when non-specific. Whooping cough during the winter months is always more likely to be complicated with chest disease than in the summer, and while this is especially true of the poorer classes, it holds good also to a lesser extent in the better housed classes of the population. The presence of rickets unfavourably affects the prognosis. The diagnosis between chronic broncho-pneumonia and tuberculosis and between chronic intestinal catarrh and mesenteric disease is very difficult, but the tubercular diseases are much more likely to follow at a distance with a period of comparative health intervening, while the simpler forms are more likely to complicate or immediately follow. A chronic pneumonia often clears up, and the child recovers, and a subacute intestinal catarrh may not improbably do the same.

*Quarantine.*—Six weeks is usually stated as the time the infection lasts, dating from the commencement of the hoop; but in all cases it is wise to keep up the quarantine till all cough has ceased and the child is quite well. If the cough or even hoop recur after a period of undoubted health, there is no fear of infection.

*Pathology and morbid anatomy.*—The epidemic prevalence of whooping cough and its infectious character would suggest its cause being due to some micro-organism. Letzerich and others have described such micro-organisms in the sputum of patients suffering from whooping cough; but it is doubtful if the actual specific bacillus has been isolated from the numerous micro-organisms found in the secretions of the mouth and fauces. From the observations of Von Herff and others who have watched the larynx with a laryngoscope during a paroxysm of coughing, it would appear that a small flake of mucus secreted from the posterior wall of the larynx was the excitant of the spasm. The entire larynx and trachea was in a condition of catarrh, the greatest irritability being in the inter-arytenoid region and the under part of the glottis. Some believe that the nasal mucous membrane rather than the lower respiratory tract is the seat of irritation, and that it is here that local remedies should be applied.

No characteristic appearances are found on the post-mortem table; the lesions found will vary according to the mode of death. The brain is usually congested, especially the veins; there is often some subarachnoid fluid on the convexity and much fluid in the lateral ventricles. Various lesions may be found in the lungs, such as injection of the mucous membrane of the larynx and bronchi, with excessive secretion, emphysema, collapse, and various stages of broncho-pneumonia.

*Treatment.*—The most important part of treatment consists in confining the patients to well-aired rooms which are free from draughts and maintained at an equable temperature. Two large rooms should, if possible, be set apart for the treatment, the one occupied being maintained at a temperature of 60°, while the other is being thoroughly aired or disinfected, the latter being again warmed before the patients are removed. There can be no doubt that the attack is rendered more intense and protracted by rebreathing the infection as well as by a fresh catarrh being set up. Except in the warmest weather, the patient should be confined to his rooms in the house the whole

time the disease lasts, as long as any 'hooping' is present, and as long as any rales or rhonchi are heard in the chest. Too great care cannot be exercised here; the bronchial tubes and lungs remain exceedingly sensitive to cold, and many severe attacks of pleuro-pneumonia have resulted both in old and young from a chill caught at outdoor games or from having gone to the seaside for change of air. Children are much better at home until well over the attack, not only for the sake of others but for themselves; and the pleadings of the friends for change of air must be sternly resisted until six weeks at least from the commencement of hooping. With regard to medicinal treatment, there are no lack of remedies which have been tried, and no disease has been more ineffectually though diligently drugged. It is quite safe to say that no specific has as yet been discovered. During the catarrhal stage, when the cough is hard, the expectoration scanty, and there is fever, the best remedies include small doses of antimony, ipecacuanha, liq. ammon. acetatis, or nitrate of potash. At night, when the cough is especially troublesome, hot mustard poultices should be applied to the chest, and hot demulcent drinks, such as black-currant tea, or barley water, or lemonade, may be taken. Beef-tea is often of service for the night and a dose of hot brandy-and-water will sometimes lull off to sleep. The room should be kept moist with hot steam, if there is much bronchial catarrh or laryngitis. In the spasmodic stage, when the secretion is free, the expectorants should be stopped and sedatives and small doses of narcotics substituted. At this stage the diffusion of carbolic acid vapour through the apartment is frequently of great service; this may be done by vaporising strong carbolic powder in one of Calvert's carbolic vaporisers; it is not certain how this acts; no doubt to some extent it soothes by acting as an anæsthetic to the fauces. In a similar way cocaine or resorcin may be used in the form of a spray or mopped on to the fauces with a brush, but the effect is usually only temporary, as the anæsthesia produced by cocaine is too short to be of much service. Of the drugs at this period, belladonna, chloral, bromides, opium, cannabis indica, quinine, take the first place, but all at times fail to give any appreciable relief. It is best to begin with small doses, given every four or six hours, increasing the frequency rather than the size of the dose. The combination of belladonna and cannabis indica is a favourite one; they may be combined as in the following formula:—

( 28 )	
Tincture of belladonna . . . . .	℥v-xv
Extr. of cannabis indica . . . . .	gr. $\frac{1}{4}$ — $\frac{1}{2}$
Glycerine . . . . .	ʒss
Tincture of orange peel . . . . .	℥ x
Water . . . . .	ad ʒij

*Two tea-spoonfuls every four hours for children of three to seven years.*

The bromides and quinine dissolved in syrup of lemons with syrup of Sanfa Yerba is also a good combination. Croton chloral is highly praised by Dr. Webb; he orders a drachm of this drug to be dissolved in two ounces each of tr. cardamoms and glycerine, giving half a tea-spoonful to two tea-spoonfuls every four hours to children of one to ten years. Dr. Ringer advises tr. lobelia, and gives doses of five to ten minims every hour even to

young children. Opium is of all drugs the most certain to relieve ; but it is perhaps best reserved to be given in one dose at night ; one to five drops of nepenthe or half to two grains of Dover's powder will often secure a fairly good night. The bowels should be carefully attended to, and a laxative will frequently be required. Unless the secretion is very copious, poultices or fomentations in this stage give more relief than do liniments.

In the later stages, when the secretion is copious and the cough less and less spasmodic in character, nitric acid, alum, quinine, are most likely to be of service. Alum may be given with some sedative as conium or hyoscyamus, the old formula of Golding Bird's being a good one :—Alum gr. j, succus conii ℥v, syrup. rhæados ℥x, aq. anethi ad ʒj ; ʒj-ʒiij every four hours. Of external applications there are a goodly number which have been employed with varying success. Equal parts of lin. camph. co., lin. saponis and lin. belladonnæ, used cautiously to tender skins, make a good stimulating liniment. Some have great faith in oil of amber, as in the following : Ol. succini ʒij, tr. opii ʒij, sp. camph. ʒss, ol. amygdalæ ʒss. The liniment of iodide of potassium and soap is useful. The diet both in the spasmodic and catarrhal stage should be carefully arranged, and is difficult on account of the vomiting so frequently present. It will often be necessary to feed little and often to make up for food vomited. The complications such as bronchopneumonia and intestinal catarrh must be treated on the general principles given elsewhere.

**Mumps, Parotitis.**—Mumps is an infectious disease which is apt to prevail in epidemics ; sometimes these extend over wide areas, though at other times cases occur and there is little tendency to spread. We have never noticed an extensive epidemic in hospital, but the nurses are apt to catch the disease from children who have been admitted incubating mumps, and it would seem that close contact, perhaps inhaling the affected person's breath, was the commonest way in which an attack was contracted. It sometimes happens there is no spread of the disease in the ward where the affected child was, but cases have occurred in other wards, the infection being carried by a nurse, or perhaps by a nurse who has herself had a slight attack.

*Incubation.*—According to Dr. Dukes, 14-25 days. In some cases observed by us, it was 14, 17, and 21 days respectively.

*Symptoms and course.*—Mumps is usually a mild disease attended by discomfort rather than serious illness. The attack usually begins with chilliness, stiffness about the jaws, local tenderness, often neuralgic pains ; there is often no fever, sometimes the temperature goes up suddenly to 102° or 103°. The swelling is at first one-sided, involving the region of the parotid, which is prominent and tender ; deglutition is difficult and painful. Both sides are usually swollen in a day or two and the patient presents a characteristic appearance. The fauces and tonsils are normal. While the parotids are usually affected, in some cases the swelling is entirely confined to the sub-maxillary salivary glands on one or both sides ; it is in these cases that the nature of the attack is likely to be overlooked. The attack lasts, as a rule, from a few days to a week. **Orchitis** occasionally occurs in boys about puberty. **Hemiplegia** has been known to follow (Gowers).

*Diagnosis.*—We have known cases of mumps sent into a scarlet fever

ward as cases of scarlet fever, and we have also seen a case of tonsillitis with enlarged cervical glands, probably scarlatinal, which was diagnosed as mumps. In all cases of doubt as to the nature of the external swelling, the appearances presented by the tonsils should be decisive. The swelling due to mumps in the majority of cases corresponds to the parotid region, the swelling of cervical glands secondary to tonsillar affections is at the angle of the jaw or just behind it. There is rarely much fever or illness with mumps; in diphtheria or scarlet fever, where there is much external swelling or cellulitis, the child is evidently gravely ill, and if a satisfactory view of the fauces can be obtained, they will be seen to be swollen, œdematous and perhaps covered with exudation. In adenitis, attended by fever, it is the lymphatic glands rather than the parotid which are affected. In spite however of these distinctions, difficult and doubtful cases may occur.<sup>1</sup>

*Treatment.*—Not much is required except hot fomentations or belladonna liniment to the parotid regions and a saline followed by a tonic. Three or four weeks, according to the severity of the case, should elapse before the patient returns to school or mixes with his fellows.

**Malarial Fever.**—Children who live in malarial districts suffer from malarial attacks as frequently as do adults; indeed, according to Holt, they are peculiarly susceptible. In this country many opportunities do not occur of seeing the disease in its early stages; the cases which mostly come under observation are those which are chronic; having acquired the disease abroad and having been invalided home. In these cases marked anæmia with enlarged spleen, and perhaps intermittent fever, form the commonest symptoms. The anæmia is frequently profound and the spleen attains to an enormous size. Nephritis as a sequela of aguish attacks is sometimes seen in this country. Such a case we saw with Dr. Massiah, the attack having been contracted in Brazil; there was marked anæmia, enlarged spleen, the urine was highly albuminous, and contained fatty and fibrinous casts. According to Lewis Smith, intermittent fever when it affects those over 3½ years differs little from the adult form, while below that age it presents some peculiarities. Malarial fever may be hereditary, being derived from the mother. In one case, recorded by Lewis Smith, an infant showed distinct symptoms a week after birth; the mother had suffered from tertian ague at intervals during the two years prior to her confinement. In the infant the type is quotidian, rarely tertian; there are three stages presented by an attack; the second or febrile is well marked, the temperature rising to 104° to 106°; the first and third less so. The spleen soon enlarges, and after a week or two, if the attack continues, there is marked anæmia. The enlargement of the spleen fails to take place in some of the cases. Dr. Emmett Holt, of New York, in making an analysis of the symptoms of 184 cases of malaria in children, has pointed out how much more insidious the invasion of the disease is in children than in adults, and consequently there is more liability to overlook it and attribute the symptoms to other causes. Even the periodicity of the recurrence may not be regular, which would still more throw the physician off his guard. In his cases with a gradual invasion he noted anæmia, frontal headache, constipated bowels, muscular

<sup>1</sup> Suppuration in a parotid gland may take place in enteric or pyæmia, but this can hardly be mistaken for mumps.

weakness, vomiting, furred tongue, drowsiness and epigastric pains ; these symptoms usually recurring in the afternoon. The spleen was enlarged, but there were exceptions to this. The fever noticed by this author assumed three types : the first in which the fever remained high for 24-72 hours, when a marked remission took place, the temperature then assuming a remittent type ; secondly, the fever is at first slight and only present at one period of the twenty-four hours, but gradually increases in intensity and assumes a remittent type ; thirdly, assuming a distinctly remittent or intermittent type from the outset. Cerebral symptoms are common ; there are frontal headache, drowsiness, and apathy, occasionally convulsions ; pains in various parts of the body ; various spasmodic disorders, as torticollis and motor paralysis, are less common, but sometimes take the form of paraplegia. Dr. Holt has also pointed out that the malarial poison may complicate and modify other diseases ; of these bronchitis and pulmonary congestion are common, the latter closely resembling pneumonia in the onset, but subsiding in a few hours, to come on again in the course of twenty-four hours. Spasmodic asthma of malarial origin may occur. Various gastro-intestinal disorders, as vomiting and diarrhœa, occur periodically at a certain time daily. The diagnosis in these cases depends upon (1) Periodicity of the symptoms, (2) The co-existence of splenic enlargement, (3) Failure of the usual remedies to relieve, (4) Their prompt disappearance under the use of antiperiodics.

*Treatment.*—The treatment consists as in adults in the administration of antiperiodics, such as quinine, cinchonine, and arsenic.

## CHAPTER XVI.

## DISEASES OF THE CIRCULATORY SYSTEM.

**Diseases of the Heart.**—The most interesting point to clinicians in connection with the topographical anatomy of the heart in infancy and childhood relates to the position of the cardiac impulse, inasmuch as in several morbid conditions the position of the heart is likely to be altered, and this altered position of the impulse is often of the greatest importance in making a diagnosis. The most recent and complete observations of the normal position of the heart in infancy and childhood have been made by Symington, who has examined a large number of frozen sections of the thorax at various ages, and thus was enabled to state more positively the actual position than it is possible to do by observations made upon the living subject by palpation and percussion. He comes to the conclusion that the cardiac impulse in infants and children usually takes a more external position than in adults; for while in the latter the impulse is usually about an inch internal to the nipple line, in children it is usually either in the nipple line or it may be  $\frac{1}{4}$  in. external to it. This is attributed by Symington to the greater relative narrowness of the infant's chest in the transverse diameter, while, at birth at least, the heart is relatively larger than in the adult. It has been asserted that in children the impulse is usually raised and visible in the fourth space instead of the fifth space, as it usually is in adults. No doubt this is true, but it is due to the frequency with which the stomach and bowels are distended with gas during childhood, the diaphragm, and therefore the heart, being pushed up. According to Symington's observations, the position of the heart and great vessels is normally practically the same as far as the vertical position is concerned.

**Diseases of the Pericardium.**—In a few cases a congenital absence of the pericardium or some defect in the pericardium has been recorded. In some cases a hernia or diverticulum has been present; these congenital defects are of little practical interest.

**Pericarditis. Etiology.**—In children as in adults the most important association of pericarditis is with rheumatism, acute or subacute, as it arises more often during a rheumatic attack than under any other condition. An exception to this dictum must however be stated; for in children under two years of age rheumatism is an uncommon ailment, and pericarditis when it occurs is most frequently the result of an extension of the inflammation from a pleuro-pneumonia or pleurisy, or arises in association with such an attack. It is by no means uncommon to hear a pericardial friction sound during an attack of pneumonia in young children, or perhaps to discover post mortem that a pericarditis has taken place in a case which was looked upon during

life as one of simple broncho- or pleuro-pneumonia. In such cases, if they recover, a chronic pericardial effusion may remain after the pulmonary lesion has been recovered from.

Pericarditis occasionally occurs during an attack of scarlet fever, either being associated with synovitis, especially affecting the fingers, or in the absence of any joint complications. It occurs also during the course of post-scarlatinal nephritis, as a result of a uræmic condition, and under such circumstances must be looked upon as of extremely evil augury. It may occur during septicæmia, to whatever cause this may be attributed, periostitis and ostitis, puerperal pyæmia, or some zymotic disease. But, with the exception referred to in children under two years of age, pericarditis is more frequently than not associated with the rheumatic state. Not that it only occurs during an attack of acute rheumatism, for it may supervene when there is no joint pain whatever, or when the joint pain is slight; but it occurs in a rheumatic individual, one who has already suffered from an attack or in whom has been developed some of the associations of rheumatism, such as chorea, erythema nodosum, or endocarditis. Pericarditis is apt to crop up in an unexpected and unexplained manner, and it should be carefully looked for whenever indefinite precordial or epigastric pain is complained of. It must be borne in mind that, like pleurisy, it occurs in an extremely mild form; a pericardial rub may be heard unexpectedly in the absence of any definite symptoms in children who are going about and make no complaint of pain or dyspnœa. These attacks pass away, and presumably leave more or less of adhesions between the visceral and parietal layers of the pericardium.

Cases of pericarditis occurring during foetal life have been recorded by Billard, Bednar, and others. It also occurs in the septicæmia of the newly-born.

*Symptoms.*—The subjective symptoms are usually ill defined, especially in young children, and are of comparatively little importance as helps to diagnosis; pain referred to the precordial or epigastric region is usually complained of. The type of respiration is thoracic, the diaphragm being used as little as possible, excessive movement of the diaphragm giving pain. The fever is only moderate, dyspnœa is only present where there is much effusion, or where advanced heart disease is present. The symptoms mostly to be relied upon are (1) The presence of a pericardial friction sound, (2) An increased area of cardiac dulness proportionate to the effusion present, (3) The disappearance of the apex-beat, or it is raised and its area extended. (1) A pericardial friction sound can hardly be overlooked, if carefully listened for, and is not likely to be mistaken for valvular murmurs, except perhaps in the case of infants the subject of congenital heart disease, the murmur in such cases being often harsh and superficial. It must not be forgotten that the presence of a friction sound is not incompatible with a moderate amount of effusion into the pericardial sac. It mostly however disappears as effusion takes place and reappears as the liquid becomes absorbed. (2) As effusion takes place into the sac, the area of cardiac dulness is necessarily increased in proportion to the amount of fluid present. A child's pericardium (age 6-9 years) when fully distended contains about 6 oz. (Sibson); the effect being to increase the cardiac dulness laterally the

lungs, especially the left, being pushed on one side and in an upward direction, so that the dulness extends to the second left costal cartilage, or even higher, and over a corresponding portion of the sternum. In lesser effusions the fluid tends to accumulate in the lowest part, and so modifies the dulness in a lateral direction. (3) The cardiac impulse disappears and the sounds become faint if the effusion is large, as a layer of fluid is interposed between the heart and the chest-walls. Instead of the apex beat disappearing, it may be diffused and raised so as to be palpable or visible in the 3rd and 4th spaces as pointed out by Sibson. While the above are the usual symptoms in a hitherto healthy subject, it must not be forgotten that many of the cases of pericarditis with which we have to do occur in children who are the subjects of long-standing heart disease, and whose hearts are hypertrophied and dilated. It is evident that in such cases pericarditis becomes an extremely grave and dangerous complication, and a small amount of effusion may seriously affect a heart which is already labouring under severe difficulties. Moreover the physical signs, especially the cardiac dulness, will be modified, and a question will arise, if the case is seen for the first time, as to how much of the dulness is due to hypertrophied heart and how much to effused fluid. In such cases the cardiac impulse will remain unaltered and will be palpable in its old position—namely, outside the nipple line in the 5th or 6th space. In old-standing cases there may be bulging forward of the chest-walls in consequence of the hypertrophy of the left ventricle; this can hardly be present, or not to the same extent, in simple effusion. The existence of a bruit and the history of the case would help in the diagnosis. The diagnosis is of importance in cases where there is much dyspnoea and distress, and the question of paracentesis has to be considered.

*Course.*—The discovery of a friction sound is usually the first thing to call attention to the attack. There may be only a slight rub or a loud grating sound heard all over the chest. At this stage, where there is no fluid present, presuming there is no valvular disease or dilatation, there is no dyspnoea, probably more or less pain in the chest, quickened pulse and moderate fever. The rub may disappear in a few days in consequence of adhesions being formed. On the other hand, the friction sounds may disappear in consequence of effusion taking place; as the effusion increases dyspnoea is occasioned; at first it is slight, but if the effusion becomes large the dyspnoea increases, coming on in paroxysms accompanied by cyanosis, and a small irregular pulse. Death may be sudden at this stage, especially in those cases where pericarditis supervenes on old heart mischief and the cardiac walls have become degenerated. In other cases the fluid is gradually absorbed, the friction is again heard more or less intensely, and finally disappears as adhesion takes place.

**Chronic Pericarditis.**—In many cases of old heart disease the pericardium is more or less adherent and much thickened, sometimes to as much as a quarter of an inch, or even more. This appears to be due, in some cases at least, to repeated attacks of a slight character. This thickening of the pericardium clogs and impedes the action of the ventricles. An effusion into the pericardium, like an effusion into the pleural cavity, may be chronic. It sometimes happens, especially in young children, that a pericardial and pleural effusion takes place, the latter becomes absorbed, and adhesions form,

while the pericardium remains distended with fluid. If the child is seen for the first time when this has occurred an error in diagnosis is very easy, as the dulness caused by a distended pericardium shades away into the impaired resonance given by a compressed and adherent left lung. We have several times seen in young children fluid aspirated from the pericardium by a needle passed into the axilla, when it was believed the fluid was being drawn from the left pleural cavity. In these cases the needle had passed through the compressed left lung and entered the distended pericardium. A chronic pericardial effusion is sometimes present in tubercular subjects, after the manner of a peritoneal effusion; this may be of long standing, and the diagnosis may be difficult, as the effusion may be associated with a mediastinitis and may suggest the presence of mediastinal tumour.

Chronic pericardial effusions are apt to become purulent, and in rare cases the pus may find its way to the surface after the fashion of an empyema; this happened in one of our own cases, a child of eighteen months, the abscess pointing near the tip of the sternum; after the abscess was opened, the child died of exhaustion and the diagnosis was verified post mortem. In such cases there is much difficulty in deciding as to the origin of the pus; as to whether the abscess pointing is a collection of pus finding its way out from the mediastinum or from the pericardium. It may also be a local empyema or periosteal abscess.

*Results of the Pericarditis.*—When acute pericarditis supervenes in a case of old cardiac disease, such as mitral regurgitation with dilatation of the left ventricle, it generally marks the beginning of the end. The pericarditis not only imposes greater work on already overworked ventricles, by the friction which it causes, but also it is apt to damage the cardiac walls themselves by the inflammation, giving rise to acute dilatation and a condition of asystole. In such cases death is often sudden, or perhaps the patient lingers for a few weeks in a state of great discomfort, with all the symptoms of a dilated and weakened heart. The results of an adherent pericardium are necessarily also prejudicial to the work of the heart, presuming the adhesions to be strong and complete. Its effects are slowly but surely to give rise to dilatation and inefficient contractions of the cardiac walls, a result in which it is often aided by mitral regurgitation, and it may be difficult to apportion the divided responsibility. But sometimes cases occur in which there is marked dilatation of the ventricles, a closely adherent pericardium, and mitral valves with no trace of old endocarditis, but which acted inefficiently in consequence of a primary dilatation of the ventricle; in such cases the aorta and its branches are often remarkably undersized, as compared with the heart—a result doubtless due to their being inefficiently supplied with blood and their growth thus checked. A chronic effusion may become purulent, as already stated.

*Complications.*—In rheumatic pericarditis, endocarditis is exceedingly likely to occur during the attack. Pleurisy or pleuro-pneumonia may be present; more rarely peritonitis and meningitis.

*Diagnosis.*—A pericardial friction sound is not likely to be confounded with anything else, unless perhaps it is an exo-cardiac sound, such as is produced by the external surface of the pericardium rubbing against a roughened pleura; but this latter is heard only, or at any rate more loudly, during inspiration. The difficulty most likely to occur is, in a case in which there is admittedly old cardiac mischief, to distinguish between dulness due to the

presence of fluid and that due to a dilated heart. To anyone who has carefully watched a case from the commencement of the heart disease this difficulty may be small; but in cases which are suffering from great dyspnœa and distress, in which pericarditis and dilated ventricles exist together, it is often difficult to decide when seen for the first time what amount of fluid is present and what share it takes in the production of the cardiac distress.

**Mediastino-pericarditis, Pleuro-pericarditis.**—An inflammation of the serous membrane which is reflected over the anterior edges of the lungs and surrounds the pericardium sometimes takes place, mostly in association with a more general pleurisy or with pericarditis. At times the pleurisy appears to be local, being confined to the serous membrane covering the pericardium and lung adjoining it. The symptoms of such an inflammation are necessarily indefinite, almost the only definite sign being a pleuro-pericardial friction sound—that is, a rubbing sound which is synchronous with the cardiac beats, and which is more intense during inspiration as the lung expands and its edge passes in front of the heart. The rub may disappear entirely during expiration. The deeper the inspiration the more intense the friction sound becomes. As a result the edge of the lung becomes adherent to the pericardium, the space between the two becoming obliterated. In some cases a subacute or chronic inflammatory process goes on in the mediastinum, involving the serous membranes, connective tissue, and perhaps the mediastinal glands, so that a matting of all the parts takes place, the edges of the lungs, pericardium and great vessels being firmly bound together. The pericardium may be adherent to the walls of the heart, there may be extensive pleuritic adhesions of one or both lungs, and the adhesions in some cases are tough and firm and of almost cartilaginous hardness.

The etiology of these cases is uncertain. In some cases they are associated with chronic tuberculosis of the lung or with caseous mediastinal glands; in others no evidence of tubercle can be found, a simple chronic inflammation of the connective tissue going on, ending in cicatrization. The immediate result of this process is to hamper the action of the heart, preventing its complete systole, to interfere with the filling of the lungs during inspiration, and to compress the large veins entering the chest. The liver becomes constantly engorged, the hepatic system of veins dilated, and a secondary cirrhosis results.

*Symptoms.*—The course of this curious affection is very chronic. In well-marked cases the symptoms are those which are likely to be caused by an obstruction to the flow of blood into the chest. Dyspnœa on exertion, cyanosis of the face, clubbing of the fingers, distention of the veins of the neck, chest, and abdomen during inspiration, and, later, œdema of the face, arms, feet, and abdomen. There may be signs of pulmonary tuberculosis. The 'pulsus paradoxus'—i.e. an exaggeration of the normal diastolic pulse during inspiration—may be present; or the pulse may intermit or disappear if a deep inspiration be taken. In some other cases the most marked symptom is ascites, with an enlarged liver; such cases are exceedingly chronic, and they improve if the fluid in the abdomen is removed by tapping, and will go on for months or even years; gradually the portal obstruction becomes greater and the patient dies of exhaustion.<sup>1</sup>

<sup>1</sup> See 'Mediastino-Pericarditis in Children,' by H. R. Hutton, *St. Thomas's Hospital Reports*, vol. xiii.

**Congenital Heart Disease.**—The different forms of malformed hearts are exceedingly numerous and defy any attempt at classification, but as many of these, though of great interest to the anatomist as illustrating the various stages of development, are of little practical importance to the clinician, no detailed description is needed here. The principal causes at work in producing these malformations may be classified as follows: (1) Persistence of foetal openings, more particularly the foramen ovale, in consequence of the lungs remaining in part in the foetal state after birth; there is obstruction through the lungs and overfilling of the right heart. (2) Endocarditis, occurring during foetal life, affecting the pulmonary, the tricuspid, and less often the aortic or mitral valves, producing stenosis at the valvular orifice, and as a secondary effect the persistence of the foramen ovale, or ductus arteriosus; or the septum ventriculorum may remain incomplete. (3) An arrest of development at some period of foetal life or the results of a false step as it were, as when a transposition of the aorta and pulmonary artery occurs.

**Symptoms.**—Cyanosis and the presence of a bruit are the only reliable signs of congenital heart disease. Cyanosis is mostly, but not universally, present and it varies considerably in intensity. It is most marked and is sometimes only present when the infant cries, the face being dusky, the lips and tongue and extremities becoming of a bluish tinge. We must however bear in mind that some cyanosis may be present in prematurely born infants when the lungs are but partially inflated, and remain in the foetal state. If however the cyanosis persists for many weeks, it is probably due to malformation of the heart. In a certain proportion of cases murmurs are heard. These are apt to be of a rough, rasping, superficial character, and the rhythm is often exceedingly difficult to determine, on account of the rapid action of the infant's heart. The differential diagnosis is very frequently impossible and only a sort of guess can be made. The position of greatest intensity should be determined, but this is not always easy, as many of the murmurs are so loud that they are heard all over the chest. Note should be taken as to whether the bruit replaces or is only heard through, as it were, the heart sounds. A thorough examination cannot perhaps be made at first, as it is unwise to expose a weakly infant too much, and, moreover, the possibility of a pericardial friction sound in newly-born infants must not be forgotten.

The *prognosis* is bad and much uncertainty must necessarily exist, as the diagnosis of the exact form of lesion present often cannot be made. The more cyanosis present the worse is the prognosis, as, in infants at least, there is a great liability to meningeal hæmorrhage taking place either slowly or during a fit of crying, vomiting, or coughing. Convulsions may at any time supervene and quickly prove fatal. The venous state of the blood interferes with the secretion of the digestive juices, and the whole system is worked at a disadvantage. In older children the amount of hypertrophy and dilatation must be taken into account in making a prognosis; the larger the heart, the nearer is it to the end of its tether. The extent to which clubbing of the fingers is present must also be considered.

**Patent Foramen Ovale.**—The foramen ovale allows of the passage of blood from the right to the left auricle during foetal life (see fig. 37), but closes up shortly after birth, if there is no obstruction to the circulation of blood in

the pulmonary system, and consequent increased blood pressure on the right side of the heart. If, on the other hand, the lungs are only partially ex-

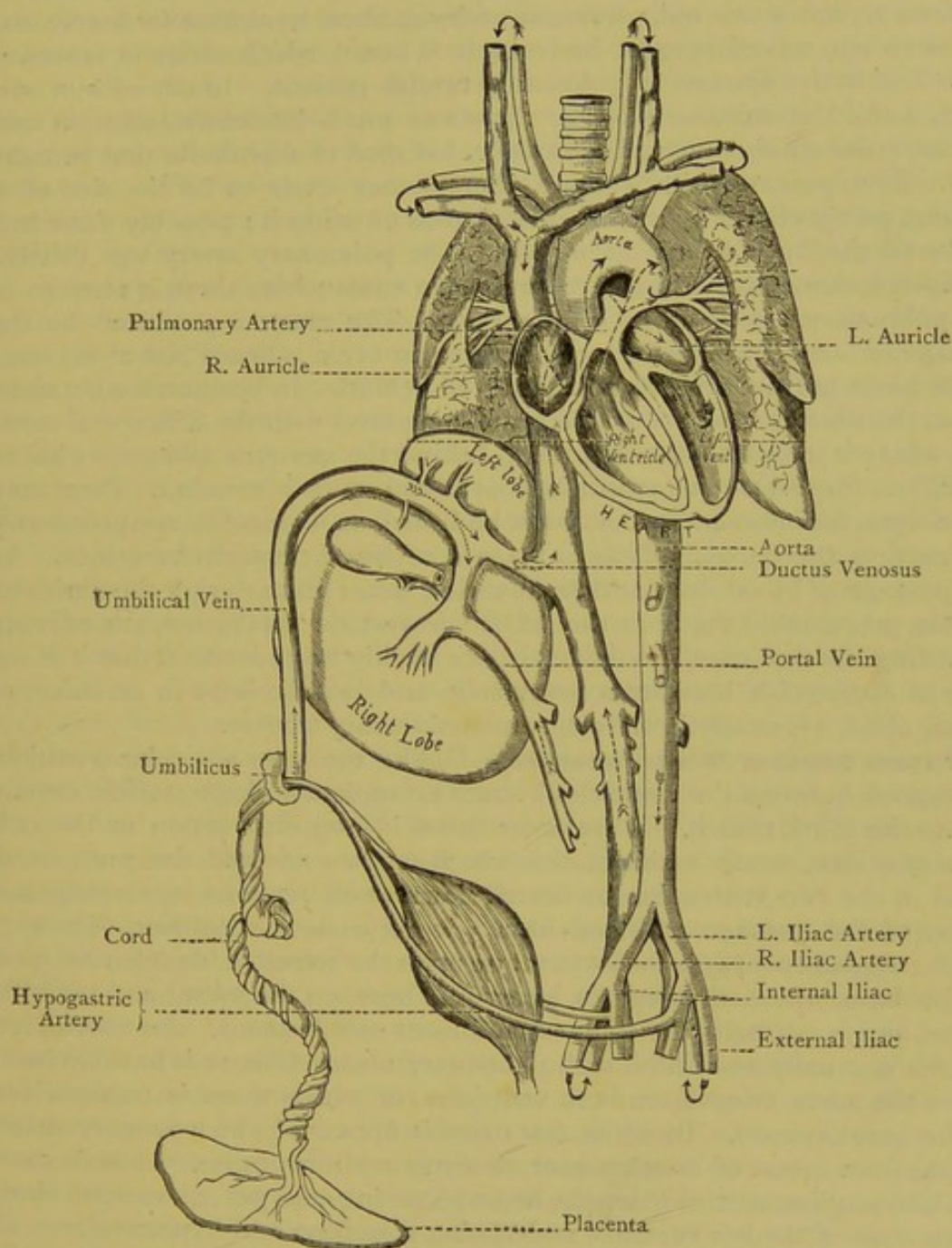


Fig. 37.—Plan of Fœtal Circulation (Gray's 'Anatomy').

panded, remaining in part in the foetal condition, a portion of the blood which under normal conditions would enter the pulmonary circulation escapes it by passing directly from the right heart to the left through the foramen ovale. Repeated attacks of bronchitis after birth may have a similar effect in preventing the closure of the foramen ovale. The further history of such cases is uncertain, but there is reason to suppose that, if the child remains free

from the pulmonary trouble, the foramen ovale may close, or at least allow of little mixture of the blood of the auricles, and be therefore of but slight detriment to the patient. It is not uncommon to meet with such cases in children a year or two old, who come under medical treatment for bronchitis, and in whom a loud systolic basic bruit is heard, which varies in intensity according to the amount of pulmonary trouble present. In one of our own cases, a child of thirteen months, there was much bronchitis, anæmia and œdema; the child recovered for awhile, but died of diphtheria nine months later. The post mortem showed the foramen ovale to be the size of a shilling, partly closed by membranous bands crossing it; possibly these had produced the bruit heard during life. The pulmonary artery was dilated. An open foramen ovale is usually present in cases where there is stenosis of the pulmonary artery or tricuspid orifice. The murmur produced by the passage of blood through an unclosed foramen ovale is heard best at the base of the heart in front and is also heard well behind. In position the foramen lies at the posterior aspect of the heart, on a level with the fifth costal cartilage where it joins the sternum, being behind the sternum and somewhat to the right. Posteriorly it lies just in front of the seventh vertebra. There may be an open foramen and yet no bruit be heard, as, if there is no pulmonary obstruction, there may be little or no rush of blood through the orifice. As the passage of blood from auricle to auricle takes place during the auricular systole, presumably the bruit should be 'presystolic' in rhythm, immediately preceding the first cardiac sound. It can readily be understood that it is not easy to distinguish between a presystolic and systolic bruit in an infant or young child, especially if there is some pulmonary trouble.

**Patent Septum Ventriculorum.**—Unlike the inter-auricular partition, the septum between the ventricles becomes complete during foetal life, usually during the third month. If however there is any obstruction at the pulmonary orifice, or any malformation which renders unequal the pressure of blood in the two ventricles, the ventricular septum remains incomplete and allows of the passage of blood from one ventricle to the other. The spot which remains open, or is the last to close up, is the so-called 'undefended spot' at the base, where the septum intervenes between the mitral and tricuspid valves, and is normally the thinnest and most membranous. An incomplete septum is usually associated with pulmonary obstruction, or is found in cases where the aorta arises from both ventricles, or where there is transposition of the great vessels. In some few cases it appears to be a primary defect arising from arrest of development or some unknown cause. In such cases the child may live several years, the heart becoming enlarged, more particularly on account of the left ventricle undergoing dilatation and hypertrophy in its efforts to maintain sufficient tension in the arteries during the systole, while under the disadvantage of its contents being in part forced into the more feebly acting right ventricle. The murmur produced is loud and rough, replacing the first sound; it is heard loudest over the lower part of the sternum, but is well conducted to the seat of cardiac impulse. It is also, if loud, heard both in the axilla and posteriorly.<sup>1</sup>

**Stenosis of the Pulmonary and Tricuspid Orifices.**—If an endocarditis

<sup>1</sup> See case reported by Hutton in the *Abstracts*, 1883, p. 45; and Keating and Edwards, *Arch. of Pædiatrics*, p. 134, 1887.

occur during foetal life, especially during the early period, it is apt to affect the pulmonary and tricuspid valves, the liability of the valves on the left side being greater towards the end of foetal life, as more and more work is imposed upon the left heart. In some cases a complete stenosis of the pulmonary and tricuspid orifices takes place, the heart becoming trilocular. Thus in the case of an infant, markedly cyanotic during life, but who lived for four months, it was found that the pulmonary orifice was completely closed, the tricuspid only admitted a crowquill, and the right ventricle was contracted and diminutive. There was an open foramen ovale and the pulmonary circulation had been maintained by an open ductus arteriosus, the lungs being thus supplied by the aorta. In other cases where the stenosis of the pulmonary artery is only partial, the patient may live for years or even reach adult life; there is usually an open foramen ovale, or ductus arteriosus, or defective interventricular septum; cyanosis is mostly present, of a more or less high grade; the child easily gets out of breath, is backward in talking and getting on its feet, and is incapable of any great amount of exertion. The murmur present is usually loud, superficial, and rasping, being best heard over the pulmonary valves, over the second left costal cartilage near the sternum. There may be signs of dilatation of the right ventricle, such as epigastric pulsation.

This is perhaps the commonest form of congenital heart disease found in children who have survived infancy and early childhood. Such children may live to grow up, but are apt to suffer from tuberculosis or to be carried off by bronchitis or pneumonia. Post-natal endocarditis is sometimes superadded. The diagnosis is not always easy, between pulmonary stenosis and open foramen ovale without other lesion, especially as the bruit heard may result from the presence of both lesions. In pulmonary stenosis there is more likely to be cyanosis and a dilated right ventricle, and the murmur is more likely to be confined to and heard loudest in the pulmonary area. Cadet de Gassicourt has reported a case where a bruit was produced through enlarged glands pressing on the pulmonary artery.

**Stenosis of the Aorta or Mitral Valves.**—In some cases there appears to be a congenital smallness of the aorta and arterial system, though it most probably is the result of undergrowth, being secondary to some other cardiac lesion by reason of which the arterial system is imperfectly supplied with blood. An endocarditis occurring late in foetal life sometimes affects the aortic valves, and an endocarditis may also occur after birth, and still further deform or pucker the valves. In such cases, if there is marked obstruction at the aortic valves, the ductus arteriosus may remain open, and some of the blood may pass, as it does during foetal life, from the pulmonary artery into the aorta, without passing through the lungs. The left ventricle will become hypertrophied. When the stenosis is only moderate life may be prolonged for many years. Stenosis of the mitral valves may also occur.

**Transposition of the Aorta and Pulmonary Artery.**—This curious mal-formation is not uncommon; the foramen ovale and ventricular septum remain open. Life is rarely prolonged for more than a few months; there is much cyanosis, but no bruit is present. A diagnosis during life is hardly possible. Of the many other malformations or arrests of development, such as a heart consisting of single auricle and ventricle, or a three-chambered heart, it is unnecessary to speak.

**Endocarditis.**—Inflammation of the membrane lining the heart, more especially that part which covers the valves, occurs at all periods of life. It may attack the foetus, and then usually it is right-sided; but if it occur in the last few weeks of foetal life it may affect the mitral and aortic valves. It may also occur during the two or three years succeeding birth; it is however less common at this period than in later life, though it is probably often overlooked. It is common during the later periods of childhood and youth. Like pericarditis, its usual association is with the rheumatic state, not that there is necessarily marked joint-tenderness and high fever, but the patient exhibits some of the symptoms or associations of rheumatism, such as chorea, or erythema nodosum, or he has suffered from undoubted joint troubles in the past. During an attack of rheumatism, children are especially prone to suffer from endocarditis, and the proportion of those who do suffer is greater than in the case of adults, being in the case of children perhaps 75-80 per cent.; in adults the proportion must be far less than this. Endocarditis also occurs in scarlatinal synovitis; the heart does not so often suffer here as in simple rheumatism. In nephritis, in pyæmia, and during attacks of any of the zymotic fevers, especially diphtheria, endocarditis may occur. In all febrile conditions a difficulty may arise in the diagnosis, in distinguishing murmurs due to organic disease from hæmic murmurs. During fever the circulation is disturbed and the cardiac beats increased in number, the first cardiac sound being wanting in sharpness, or there may be a 'murmurish' sound heard; if this disappears during convalescence we are hardly justified in saying that an endocarditis has existed.

That endocarditis does occur at times during an attack of scarlet fever or during convalescence is certain; it is however rare to find the valves affected in a fatal case of scarlet fever. The etiology of malignant or ulcerative endocarditis is very obscure; it arises in some instances in connection with the rheumatic state, being engrafted on to an ordinary rheumatic endocarditis; it occurs in connection with acute nephritis, and suppurative periostitis and osteomyelitis. It appears sometimes to follow scarlet fever.

The symptoms of simple endocarditis, such as occurs during rheumatism, are not distinctive. There is often precordial pain, perhaps some dyspnœa, usually some fever of an intermittent type (see fig. 38), though this may be due to the rheumatism present; indeed the only symptom upon which any reliance can be placed is the presence of a bruit; it is certain however that endocarditis may exist without a bruit being present. In the vast majority of cases it is the mitral orifice which is affected, a murmur being heard which replaces the first sound at the apex. The constitutional disturbance is but slight, or at least it is impossible to separate the symptoms produced by the endocarditis from those produced by the rheumatism. When an attack of endocarditis takes place in a case of old heart disease where there is mitral regurgitation and a bruit present, it is rarely possible to make a definite diagnosis. When the endocarditis is of the malignant or 'ulcerative' variety, the constitutional symptoms are usually much more marked and are those of septicæmia engrafted on to heart disease. It may supervene in a subject already suffering from rheumatic heart disease, post-scarlatinal nephritis, or periostitis. In some cases the symptoms are very like those of acute tuberculosis, and in one case which came under our notice

a death certificate to that effect was given, a subsequent post mortem showing the real nature of the disease to be acute endocarditis. In such cases the bruit may be of a musical character and accompanied by a thrill; the aortic valves may also be affected and be the seat of a bruit. There is usually precordial pain, often pain in the left shoulder; a hectic temperature rising to  $103^{\circ}$  or  $104^{\circ}$  in the evening and falling in the morning, and enlargement and often tenderness of the spleen. The urine is usually albuminous, often highly so. There may be joint pain and some of the phenomena of embolism. In one of our own cases there was aneurism due to embolism of the middle cerebral artery.

In any case of undoubted heart disease with intermittent pyrexia, malignant endocarditis should be suspected, especially if there is enlargement of the spleen. The aortic, tricuspid and pulmonary valves are often affected in malignant endocarditis; the fact that an aortic bruit is heard in a case of acute cardiac disease may help us to decide in favour of malignant endocarditis.

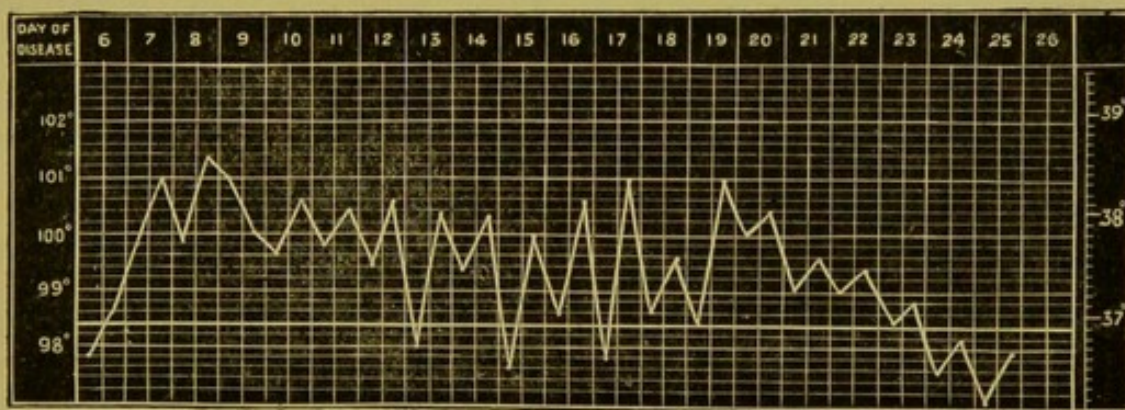


Fig. 38.—Temperature Chart of a case of Endocarditis supervening on the sixth day of a mild Scarlet Fever; there were no joint lesions, the bruit persisted, and dilatation of the left ventricle followed.

**Chronic Heart Disease.**—The immediate result of endocarditis is to cause a swelling and roughness of the endocardium which prevents the complete closure of the valves and thus allows of regurgitation; puckering and thickening of the valves takes place as time goes on, especially if there are recurrent attacks, and the valves become permanently damaged. In children it is the mitral which almost constantly suffers. In some cases the valves become adherent at their edges, and thus stenosis is produced. Gradually other and compensatory changes take place; if the regurgitation occurs at the mitral orifice, the left ventricle gradually dilates and becomes hypertrophied. At first the compensatory changes which take place are sufficient to prevent the patient from feeling any inconvenience, and both he and his friends may be ignorant of the existence of valvular disease; but sooner or later dyspnoea on exertion and precordial pain are complained of, which direct attention to the heart. Such patients often suffer from bronchitis—a result of the constant congestion of the lungs which is present in mitral regurgitation. If a physical examination of the heart is made at this period, a bruit is detected, heard loudest at the apex, but well conducted into the axilla and to the angle of the scapula; the click of the pulmonary valves is accentuated, while

the aortic sounds are weak. The apex beat is diffused and situated outside the nipple line, the cardiac dulness is increased to the left and frequently also to the right, as the right ventricle is apt to be dilated on account of the congested state of the lungs. In some cases the heart becomes enormously enlarged, so that the area of cardiac dulness extends from nipple to nipple, and the apex beat occupies perhaps the 5th, 6th, and 7th spaces outside the nipple line, while the whole of the precordial region is bulged forward by the hypertrophied heart. Often the left bronchus is pressed upon and the lower lobe becomes collapsed. During the last stages, which may be short or prolonged for many months or even years, the liver becomes congested and enlarged, there is albuminuria from congested kidneys, while the belly, scrotum, and legs become dropsical. Attacks of dyspnoea with pain resembling angina pectoris are not uncommon. Such cases may be very chronic, and even repeated attacks accompanied by much orthopnoea, cardiac distress, bronchitis, and dropsy may be recovered from and the patient once more be patched up. In such cases however probably no fresh endocarditis occurs, and the attack is due more to the engorged state of the lungs and a temporarily overworked heart, the latter recovering by rest in bed, and the symptoms disappearing as the bronchitis passes off. Should however pericarditis occur in a case of old-standing heart disease, the end is not far off, as the muscle becomes damaged and further work is imposed on an already burdened heart. In these large hypertrophied hearts the systolic bruit present is apt to be accompanied by an ill-defined pre-systolic or post-systolic bruit of uncertain origin, but it may in some cases be endocardial or due to muscular sounds.

The aortic valves are far less commonly affected than the mitral, but both aortic and tricuspid valves may be affected secondarily, especially in malignant endocarditis. In the former case a bruit, either systolic or double, is heard to the right of the sternum in the 3rd interspace; but in some cases where the aortic valves are affected, the bruit is heard best to the left edge of or behind the sternum, and closely simulates a murmur produced in the pulmonary artery. If this is not borne in mind, a diagnosis of disease of the pulmonary valves is made when in reality the aortic valves alone are affected. A water-hammer pulse may be present, but it is usually less marked in children than adults. Capillary pulsation may be present, and pulsation may be readily observed in the retinal arteries.

Endocarditis of the tricuspid valves, less often of the pulmonary, may be observed secondarily to endocarditis of the mitral.

Dilatation of the cavities of the heart takes place in children apart from valvular disease, under two circumstances—an excess of blood pressure, as in acute nephritis, the force acting from within and bulging the heart walls as it were; and a chronic pericarditis, with adherent pericardium interfering with the systole, and so tending to dilatation; perhaps this may be aided by a degeneration of the cardiac walls. Acute dilatation rapidly takes place in some cases of acute nephritis following scarlet fever; the apex beat becomes diffused, and is seen outside the nipple line; there may be a bruit, due to the imperfect closure of the mitral valves, and symptoms of cardiac failure and perhaps sudden death. Dilatation due to chronic pericarditis is a cause of chronic rather than acute heart disease; a pure case of this is rare, as endocarditis mostly occurs also; but sometimes cases may be found in

which the heart is enlarged and the cavities dilated, with a thick pericardial attachment outside; the valves are normal or perhaps more or less thickened, and have evidently been incompetent during life.

**Acute Myocarditis.**—Acute myocarditis is not a common affection at any time of life, and much difficulty exists in stating what it consists in, as any general acute process affecting the heart must quickly bring a fatal issue. Changes in the cardiac muscles of a coarse description do occasionally occur. In rare cases children have been attacked with an acute illness with fever and delirium, and at the post mortem an unsuspected abscess has been found in the muscle of the heart; such cases are probably septicæmic, as also are those where minute abscesses are found. Acute myocarditis appears also to occur in diphtheria; there is a general dilatation of the heart, more or less local pain, and dyspnoea followed by a fatal issue, changes being found in the muscular fibre of the heart, the muscular fibres being distended with fine granules of fat obscuring the striæ. It is well known however that sudden death may occur in diphtheria from paresis of the respiratory muscles as well as from disturbed innervation of the heart, so caution is required in coming to a conclusion that a myocarditis exists. Steffen has described a form of local myocarditis occurring in the course of typhoid, accompanied by symptoms of cardiac failure during life. Such cases must be rare. Myocarditis or a degeneration of the cardiac muscle may accompany both pericarditis and endocarditis.

**Prognosis.**—The prognosis is usually favourable in pericarditis if it occur in a hitherto healthy heart; the rub gradually disappears from adhesion taking place. There is of course the danger of an endocarditis occurring at a future time, and also the danger of the injurious effects of an adherent pericardium. Pericarditis occurring in a heart which is hypertrophied from old-standing valvular disease is an exceedingly dangerous and fatal affection, and generally marks the beginning of the end. Death may be sudden at the last. In endocarditis occurring in the course of rheumatism there is of course great danger that permanent damage may be inflicted on the valves and the patient be handicapped for life. On the other hand, there is abundant evidence to show that bruits due to endocarditis may disappear, and there is no reason why the endocardium may not return to its normal condition without crippling the valves; there is, however, the constant fear of a fresh attack at the old spot. The prognosis in malignant endocarditis is eminently unfavourable, though cases which apparently belong to this category occasionally recover. In chronic heart disease the amount of hypertrophy and dilatation present may be taken as an index of the damage the heart has suffered. The prognosis in dilated hearts secondary to nephritis is favourable if the nephritis subsides and no valvular disease remains.

**Treatment.**—The treatment of pericarditis and that of endocarditis have so much in common that they may be taken together. It is needless to insist that the child should be put to bed and religiously kept quiet, all exertion and excitement being zealously guarded against. Too much stress cannot be laid upon the importance of this, and of maintaining rest in bed long after the acute symptoms have passed away. To keep the heart as quiet as possible, and to impose the lightest work on it, during and after the attack, are points of the highest moment. The diet given must be suited to the rheumatic state, if

peri-endocarditis is associated with it, milk and fluids will form the principal part. Of the local treatment during the acute stage, applications which soothe are better than counter-irritants. Ext. of belladonna moistened with glycerine may be spread on lint or flannel, and applied to the precordial region, and covered with a layer of cotton wool, or spongio-piline wrung out of hot water and sprinkled with laudanum may be applied. If there is much pain, a light mustard poultice (one in four or six) kept on for some hours so as to redden the skin will usually relieve. Local blood-letting by applying one or two leeches over the sternum is often useful in appropriate cases. Of medicines, salicylate of soda, with liq. ammon. acet. if the inflammatory lesion is dependent on the rheumatic state, may be prescribed, tinct. digitalis being substituted and given in 3 to 5 minim doses every four hours if there is much dyspnœa or sign of cardiac failure.

Small doses of opium are usually required, and are often of the greatest use in relieving pain and quieting the heart's action. Half to two grains of Dover's powder may be given at night, and repeated once or twice in the twenty-four hours, according to circumstances.

In pericardial effusion, if extensive, tapping of the pericardium may have to be resorted to, to relieve the pressure on the heart. Before this is done as accurate a diagnosis as possible must be made, to ascertain how much the symptoms present, dyspnœa, orthopnœa, and cyanosis, are due to pressure of fluid, and how much to a dilated or hypertrophied heart; as many, perhaps most, of the cases of children with which we have to deal are in reality cases of pericarditis supervening on chronic heart disease. In the latter case, if there is much cardiac dilatation and comparatively little fluid, paracentesis cannot relieve to any extent, and the cardiac walls may be wounded, though, if a fine exploring needle be used, no great damage can be done. The spot selected for paracentesis is usually the 4th or 5th interspace, half-way between the left nipple line and the left edge of the sternum, the finest or second aspirating needle being used. It is preferable to use one in which the trocar can be withdrawn when the pericardial sac is entered; the needle should be directed upwards. Care should be used to ascertain the position of the apex beat as nearly as possible. In chronic pericardial effusion the inunction of blue ointment or counter-irritation by flying blisters may be tried. In chronic purulent effusion, aspiration should be first tried; if this fails to prevent reaccumulation, incision and drainage by an india-rubber tube should be resorted to; this is occasionally successful, as in the case recorded by Dr. S. West. Symptoms of cardiac failure should be treated by digitalis, ammonia, ether, or alcohol. Ether may be injected subcutaneously or a few drops may be inhaled. The treatment of malignant or ulcerative endocarditis is unsatisfactory, and no drugs appear to influence its course. The most likely to be useful are quinine, digitalis, and the sulphocarbolates. The treatment of congenital or acquired heart disease must be directed to saving the heart all unnecessary work and to strengthening it as much as possible. Such children need to be guarded most carefully against the effects of cold, as bronchitis is easily contracted in such, and a little bronchitis adds materially to the work of the heart, which is perhaps at best labouring under great mechanical disadvantages. The parents and friends of a child with chronic heart disease must be cautioned against

allowing the child to overtire itself; it is no uncommon thing for such a child to go for awhile to the sea-side or convalescent home and come back worse, for the simple reason that it has been on its legs all day, enjoying the novelty of its newly found pleasures; whereas a moderate amount only of exercise, insufficient to overwork the heart, would have secured an improvement. All active exercise should be forbidden, rough games, riding 'cycles,' and gymnastics. The medicines of most use to control and regulate the cardiac contractions are digitalis, belladonna, iron, and strychnine. Digitalis is of the greatest value, but must not be too continuously given, any intermittency in the beat should be the signal for its omission. When dropsy sets in, digitalis with diuretics like iodide of potassium, acetate of potash, and squills will be required. In excessive dropsy Southey's cannulæ may be used with advantage.

## CHAPTER XVII.

DISEASES OF THE CIRCULATORY SYSTEM—*continued.*

**Nævus.**—Nævus is perhaps the commonest congenital disfigurement met with in children ;<sup>1</sup> usually it is nothing more than a blemish, though occasionally it becomes more serious, either from danger to life or serious interference with its subject's welfare. Nævi are probably always congenital, though not always noticed at birth, since they may not be large enough to be conspicuous until some time later.

Nævi belong to the class of angiomata, and are defined as 'tumours consisting of newly-formed blood-vessels,' though it is obvious that they are not always tumours in the sense of there being any definite mass of tissue, e.g. 'port-wine stains'; still this is merely a question of a diffuse as contrasted with a circumscribed growth.

These growths may be classified as :—

I. (a) *Simple angioma*, telangiectasis, congenital nævus, mother's mark or port-wine stain. The vessels composing the new formation are identical in structure with normal arteries, veins and capillaries. (b) *Cavernous angioma*, lacunar or erectile angioma. The blood circulates in a lacunar system as in normal erectile tissue. (Cornil and Ranvier.)

II. Nævi may be considered as (1) arterial, (2) venous, (3) capillary, (4) lacunar, blood vascular growths.

III. Or, considered from their locality, the nævi may be divided into (1) cutaneous : (a) a mere staining or port-wine mark, (b) a distinct mass with larger vessels. (2) Subcutaneous. (3) Mixed, i.e. both cutaneous and subcutaneous. The different forms of nævi are readily distinguishable.

**Stellate Nævus.**—The so-called 'stellate' nævus, which is doubtfully a new formation, and very probably only a dilatation of pre-existing vessels, resembles in appearance the *venæ stellatæ* on the surface of the kidney of a carnivore. It is most common in the face, disappears on pressure, and is closely allied to the mere weather marks of those exposed to wind and cold ; it is sometimes seen about the face of children.

**Port-wine mark** consists of a diffuse stain varying much in size, form,

<sup>1</sup> Depaul is quoted by Cornil and Ranvier as saying that one-third of the children born at the Clinic of the Faculty of Medicine in Paris have nævi, and these mostly disappear spontaneously during the first few months of life.

position and colour ; usually there are no obvious dilated vessels, though these can be made out on more minute examination. These marks occur perhaps most commonly on the face, often on the hands, and occasionally elsewhere ; they may cover very large surfaces, such as the whole side of the face. There is no elevation of the growth above the level of the skin, only the superficial layers of which are involved, and pressure completely obliterates the stain for the time.

**Cutaneous Nævus.**—The common cutaneous nævus is usually small, not covering more than a square inch of surface at most ; it is somewhat raised above the level of the surrounding skin ; the individual vessels can often be distinctly made out, though not always ; the colour of the growth is usually vivid red, and on pressure the colour and much of the swelling disappears, but a slight thickening remains and the skin is 'granular.'<sup>1</sup> These growths lie in the corium, and are usually sharply defined, but not encapsuled.

**Subcutaneous Nævus.**—The growth lies entirely beneath the corium, and forms a distinct tumour ; the skin over it is natural in colour, or only shows a faint bluish tint ; the swelling does not entirely disappear on pressure, and is often encapsuled more or less perfectly.<sup>2</sup>

**Mixed Nævus.**—This is a commoner form than the last ; it has the characteristics of the cutaneous and subcutaneous varieties combined, i.e. there is a subcutaneous nævus with a cutaneous patch on its surface ; corium and subcutaneous tissue are both involved. It is seldom that the cutaneous part is as extensive as the subcutaneous, and in this and the last form there is often some cavernous formation.

After removal from the body and escape of its blood, a subcutaneous or mixed nævus consists of a tough, spongy, or stringy mass, often somewhat lobulated, and always much smaller than might be expected from its size before removal. If encapsuled, it will be found that only a small number of vessels, and those of considerable size, feed the growth, and enter it at various parts—a very important fact as regards the treatment of these cases.

**Simple Nævi** consist of newly-formed vessels having the structure of capillaries and presenting ampullar or cirroid dilatations ; the vessels are supported by a framework of connective tissue and often fat.

<sup>1</sup> Sir J. Paget.

<sup>2</sup> A good account of the structure of nævi will be found in Cornil and Ranvier's *Histology*, to which we are indebted for part of our description.



Fig. 39.—Extensive 'Mixed' Nævus of the Face, involving the lower lip and both cheeks up to the ears.

**Cavernous Nævi** consist of an irregular network of fibrous tissue, enclosing freely intercommunicating spaces like the channels in a sponge; there is occasionally unstriated muscular fibre developed in the septa as well as vessels and nerves. The endothelium lining a nævoid lacuna is exactly like that of a vein. These nævi are formed by dilatation of newly-developed capillaries and subsequent absorption of their barrier walls, so that free openings are made between adjacent vessels.

*Importance of Nævi.*—Usually nævi are simply disfigurements; sometimes however they may give rise to serious bleeding from rupture of vessels by injury or ulceration, as in a case of our own where the soft palate and uvula were the seat of a large nævoid growth and frequent bleeding occurred; similar trouble has been met with in the case of rectal nævi. Internal nævi may possibly be dangerous from hæmorrhage, or from extravasation of blood

setting up peritonitis, &c.; but this must be very rare. Some very extensive nævi are of importance from interference with the action of muscles or the growth of bones, or from producing unwieldy hypertrophy of skin. We have seen fracture of the thigh due to weakening of the femur from an extensive nævus growth in the limb.<sup>1</sup> Unwieldy overgrowth of limbs may occur also from the presence of nævi; and in the case figured (fig. 40) the man was unable to obtain work on account of his disfigurement. We have seen a case of pyæmia having its origin in a suppurating nævus, and another where pyæmia followed puncture and partial removal of a nævoid growth.

*Changes occurring in Nævi.*

Nævi sometimes grow rapidly

from the first and spread over considerable areas; in many cases however they grow very slowly, alternately grow and remain stationary, or disappear altogether, the last result being especially common in the cutaneous form. As Mr. Holmes and others have pointed out, and as we ourselves have seen, an illness, especially apparently hooping cough, often seems to bring about the cure of a nævus; possibly the straining in coughing may produce extravasation and thrombosis in the nævus and so obliteration.

Nævi undergo spontaneous cure by fibroid change, the vessels becoming obliterated and shrinking into fibrous cords. Such result may follow treatment, or accidental irritation by friction of the clothes, or pressure in lying, and so on. In other instances calcareous degeneration or thrombosis takes



Fig. 40.—Nævus of the Face in a man of 50. The growth was steadily but slowly increasing. The whole skin of that side of the face was deep crimson, the lip and tongue were involved, and the lower jaw distorted and everted by the weight of the enormous lower lip. The man died of aortic aneurism. The specimen is in the Owens Collège Museum.

<sup>1</sup> The patient was under the care of our colleague, Mr. T. Jones,

place. Cystic change in nævi is very common ; the cysts contain serum, more or less deeply coloured, and arise from the shutting off of a lacunar space or dilated vessel from the blood stream ; the cystic is often combined with the fibrous and fatty degeneration.

Suppuration and ulceration of a nævus is an important condition ; for, on the one hand, it may produce a cure by obliteration of the vessels, or, on the other hand, as already pointed out, septic absorption or bleeding may result ; happily obliteration is the common termination. Various combinations of these changes may be found going on in a nævus at the same time ; pigmentary changes are also found, and sometimes an overgrowth of hair, especially in the lipomatous form.<sup>1</sup>

*Sites of Nævi.*—Nævi may be found almost anywhere over the body, but there are certain markedly favourite positions. External nævi are most common on the head, and of all places we should say the most frequent is over the anterior fontanelle ; the lips, cheeks, eyelids, or any part of the face may be involved. The trunk and limbs are less commonly affected than the face, but perhaps this is partly to be accounted for by the mothers being less anxious about nævi on the body ; the labia are not uncommonly affected. Different forms of nævi often occur in the same patient, e.g. a port-wine mark on the face or hand and a mixed nævus on the scalp. Nævi occurring inside the mouth, in the cheeks, tongue, or inner surface of the lip, more rarely in the palate, are of course more serious than external ones ; they are also much less common.

Visceral nævi are often seen on the liver and less often on the kidneys, spleen and other organs ; the muscles and bones are also sometimes affected. It is common to see nævi on the skin of meningoceles—a fact noticed by Mr. Holmes, and one of some importance from a diagnostic point of view.

Several cases of rectal nævi are on record, among others one mentioned by Mr. Barker which caused death by hæmorrhage.<sup>2</sup> We have met with a case which exactly simulated piles and was cured by ligature. The extent of tissue involved is sometimes very great, as already stated ; thus we have seen the whole lower extremity nævoid, and Mr. Barker has recorded a case of the whole upper extremity being so affected<sup>3</sup> (vide also fig. 40).

*Treatment of Nævi.*—It should be a rule of practice not to interfere with nævi unless they are growing or have been stationary for some time, since, as already pointed out, very many disappear of themselves. The important points to consider for each nævus are whether it is cutaneous, sub-cutaneous, or mixed, and what is its relation to important adjacent structures which may be endangered by treatment or by the resulting scar. It is unnecessary to mention all the methods proposed for treating these growths ; only the most efficient will be described here. Stellate nævi may readily be cured by puncturing the centre of the star with a hot needle. Port-wine marks require careful consideration whether the resulting white scar will not be as disfiguring as the red mark, and it must be remembered that in cases where a large surface is involved a long course of treatment is required to remove the mark.

<sup>1</sup> Mere pigmentary maculæ are sometimes called nævi, but it is better to restrict the name to the vascular growth.

<sup>2</sup> *Brit. Med. Jour.* 1883.

<sup>3</sup> *Clin. Soc. Trans.* 1884.

Linear scarification, multiple puncture, the actual cautery or a caustic, such as fuming nitric acid and in some cases electrolysis,<sup>1</sup> will succeed. If large the patch should be treated in sections so as not to have too large a sore surface at once.

Cutaneous nævi are best treated with the actual cautery ; if small, a heated needle is sufficient ; in larger growths Paquelin's cautery is the most useful instrument. Narrow lines may be scored across and across the nævus, or multiple punctures employed ; after using the cautery once, as soon as the wound has healed, it will often be found that little patches remain unobliterated : these should be watched for some weeks before reapplying the cautery, as they often shrink subsequently without further operation. The cautery should be at a dull red heat, and should be applied deeply enough to reach through the nævus. Ethylate of sodium is fairly efficient, but usually requires several applications, and is not, we think, better than the cautery ; it has the advantage of not requiring the use of an anæsthetic, though it is followed by a good deal of temporary smarting. Vaccination on a nævus is not a good plan. For subcutaneous or mixed nævi we cannot recommend injections of any kind ; they are often efficient, but always dangerous, extensive thrombosis or embolism, causing immediate death, having followed their use ; if they are employed a temporary ligature should be put round the nævus and removed a few minutes after injection. Ligature of nævi is uncertain as well as tedious and troublesome. We think treatment by excision, by multiple puncture with the cautery, and in suitable cases by electrolysis, are the most generally useful plans.

Excision is applicable to well encapsuled growths of small or moderate size, not involving important structures. There are certain essential points in the operation : first the incisions must be carried well wide of the growth and not within its capsule, there will then be only a few well-defined vessels to secure, and not a freely bleeding cavernous tissue as is the case if the growth is cut into ; next, the skin in a mixed nævus, if the cutaneous part is very small, should be removed as far as it is involved, provided always the edges of the wound can afterwards be brought together easily so as to obtain primary union. If the skin is widely involved it should not be taken away, but, as suggested by Mr. Teale, dissected off the nævus and preserved : this necessitates opening up the nævoid tissue and complicates the operation, sometimes also the cutaneous nævus continues to grow afterwards.

A bloodless method of excising nævi is that of passing long needles or harelip pins beneath the base of the growth crosswise, then winding an elastic thread round the needles and excising the growth after dissecting back skin flaps ; the needles are then withdrawn and the vessels are secured. There is no bleeding until the elastic is removed.<sup>2</sup> Degenerated nævi should nearly always be excised if they are treated at all ; in some instances where there is cystic degeneration a seton passed through the cyst causes it to shrink, but there is a certain amount of danger in this plan if any part of the nævus remains undegenerated.

The little galvano-caustic apparatus devised by Mr. Golding Bird for enu-

<sup>1</sup> From 5 to 20 or more cells of a Stohrer's or Weiss' battery should be used.

<sup>2</sup> A plan devised, we believe, by Mr. Davies Colley.

cleating lymphatic glands we have used with good effect for large mixed nævi not removable by excision.

In using the actual cautery the fine or middle-sized point of the Paquelin's cautery is entered through the skin and made to traverse the nævus in several directions from one puncture ; if the nævus is large this is repeated at another spot, and so on ; a little vaseline is then applied to the cauterised surface and the effect is watched ; after all contraction has ceased another portion is, if necessary, attacked, until the whole mass has shrunk.

Pressure is occasionally successful as a means of treating nævi, but is chiefly applicable to cases where other treatment is impracticable, as in very extensive nævus of a limb<sup>1</sup> ; it may be employed successfully sometimes in nævus of the scalp, where the underlying skull forms a firm basis ; especially if combined with subcutaneous breaking up of the nævus with a tenotome.

*Importance of Nævi in special localities.*—Nævi occurring in certain localities have more than ordinary importance, either from the difficulty of their treatment or diagnosis or from the risk attaching to them. Nævus of the lip is often found involving the whole thickness of either lip and is usually either of the mixed or subcutaneous variety ; the surface is somewhat prone to ulceration in the mixed form from constant irritation, and the growth is often very unsightly. If degenerated and cystic, or if there are large cavernous spaces in the nævus, it may be mistaken for a labial mucous cyst or for lymphatic

macrocheilia. Puncture from the mucous aspect with the Paquelin's cautery is usually the best mode of treatment, but in some cases it is a good plan to excise a segment of the lip and bring the edges together as after a harelip operation. Orbital nævi are usually associated with similar growths upon the face : they may cause exophthalmos and ectropion ; the nævoid character of the growth is indicated by the spongy feeling and the possibility in some cases of pushing back the protruding eyeball and so emptying the growth of blood.<sup>2</sup> Treatment by electrolysis is the only serviceable method in these cases.



Fig. 41.—Orbital Nævus. The growth extended deeply, causing exophthalmos and ectropion, and spread upwards upon the forehead.

<sup>1</sup> A good case of the effects of pressure under such circumstances is recorded by Hardie, *Lancet*, May 1885.

<sup>2</sup> We have recorded a remarkable case of arterio venous varix of the face, orbit, and some of the intracranial vessels in the *Children's Hospital Abstracts*, 1883.

Nævus of the tongue may give rise to macroglossia and cause protrusion of the organ, or may be limited to a small part of its surface; it is liable to be mistaken for lymphatic macroglossia or for a mucous cyst. The colour will usually serve to distinguish it from the former, and the compressibility of a nævus will mark it off from the latter affection; in doubtful cases a grooved needle will clear up the difficulty. The actual cautery or in rare cases excision of a part of the tongue is the treatment required. A similar condition may be met with on the gums or inner surface of the cheeks. Sometimes large blood lacunæ are met with beneath the tongue, looking like ranula; the soft palate and uvula are also occasionally affected; in one instance where both conditions existed the sublingual nævus was cured by the actual cautery and the uvula removed by the galvanic *écraseur*; the patient was attacked by pyæmia, but ultimately recovered completely.

Nævus of the eyelids must be treated with great caution to prevent any subsequent distortion; it is best usually to attack small portions at a time with the actual cautery and wait until cicatrisation is complete before a second application. The same rule applies to nævus of the nose where too vigorous treatment may produce an unsightly, sharp-pointed, beak-like appearance if the skin is too much destroyed. In some instances excision is the better plan.

Nævi around the orbit are sometimes very difficult to diagnose, especially if they are degenerated and consequently have lost their colour; dermoid cysts, meningoceles, simple serous congenital cysts, and fatty growths should be borne in mind as sources of fallacy. In one instance (fig. 41) there was a cyst with none of the appearance of a nævus; on tapping it, altered blood escaped, and on incision it was found that the growth was loculated and in part solid (i.e. degenerated). A seton was passed through it at last after failure of incision and drainage, excision being out of the question, and the mass suppurated freely, but unfortunately erysipelas occurred and the child died. At the post-mortem the orbit and cavernous sinus were found full of more or less degenerated nævoid tissue, the nævus spaces were mostly full of blood, and minute abscesses were seen with the microscope in sections of the growth.

Speaking generally, most nævi can be recognised by the presence of the remains of some superficial nævoid tissue, by the possibility of reducing the size of the growth by pressure—this point must not, of course, be allowed to mislead in swellings about the head or spine—and by the peculiar spongy feeling. This sensation is sometimes to be felt in a growth where solid masses are also perceptible. The fact that the tumour is congenital or has been noticed in very early life, and occasionally the presence of extravasation of blood in the skin as well as, of course, the results of tapping will usually clear up a doubt.

Certain rare forms of vascular deformity are occasionally met with in children. In a case of our own the condition may be best described as arterio-venous varix, all the vessels being dilated and pulsatile; the facial, orbital, and intracranial vessels were involved as well as some of the cerebral sinuses, the straight sinus being converted into a pouch as large as a thrush's egg and its walls calcified.<sup>1</sup>

<sup>1</sup> A full report of the case here alluded to will be found in the Abstracts of the Children's Hospital for 1882-83. *Vide* also T. Smith, *Clin. Soc. Trans.*, 1882.

*Aneurism by anastomosis* is also occasionally met with in children, and sometimes ligature of a main vessel, such as the carotid, may be required, as also in some cases of arterial varix. St. Germain relates three cases of cirroid aneurism cured by the use of chloride of zinc arrows. (*Vide* 'Chirurgie des Enfants,' 1884)

*Nævus lipomatodes* is the term applied to a form of degenerated nævus in which there is much development of fatty tissue forming masses which often hang in pendulous folds; there is commonly pigmentation and hairy overgrowth. The condition is rare and appears to be associated with idiocy, as in the typical case under our care, from which fig. 42 was taken. No treatment is called for.<sup>1</sup>

**Lymphatic Nævi.**—Lymphatic nævi are much rarer than blood nævi, but many of the so-called congenital cystic growths should be classed

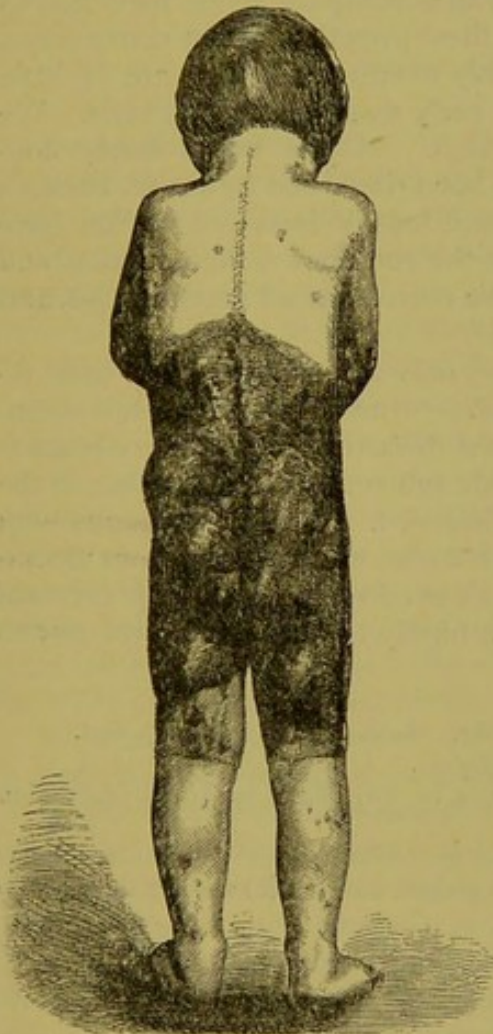


Fig. 42.—Nævus Lipomatodes. The darkly pigmented pendulous masses were composed of fat and degenerated nævus tissue, and the whole surface was thickly overgrown with hair. As usual in these cases, the child was idiotic.

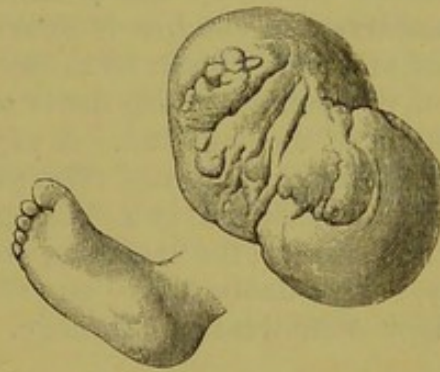


Fig. 43.—Lymphatic Nævus of the Foot. The soles of the two feet are seen, and in the affected one the extremities of the toes can just be made out, embedded in the mass of nævus tissue. Dilated and varicose lymphatics were visible in the skin.

as cystic lymphangiomata. Instances of this condition are seen, as shown by Virchow, in macroglossia, described at p. 135.

Hygroma and one form of so-called 'giant foot' are similar conditions, fig. 43. Sometimes in giant foot the cutaneous lymphatics are clearly visible as

transparent, dilated, tortuous canals running in the skin; the part is greatly enlarged and spongy on pressure. The disease is a rare one, and probably pressure or cautery puncture would be the most successful mode of treatment. Treves has recorded a case in which ulceration had occurred, and quotes Busey that congenital giant foot is commoner in females and most frequent in the right leg; the temperature of the part may or may not be raised. Ulcers, if they occur, readily heal.

<sup>1</sup> Hyde of Chicago has recorded a very similar case in the *Lancet*, August 1, 1885.

Occasionally in macroglossia, as in a case of ours, the superficial lymphatics form minute transparent cysts on the surface of the tongue; here removal of part of the tongue might possibly be required to prevent suffocation since these growths are liable to rapid increase in size. A large tumour of the thigh, of congenital origin, that we removed a short time ago from a child of  $2\frac{1}{2}$  years, was made up of spongy tissue exactly like a nævus, but the spaces were filled with lymph instead of blood; other similar cases have been recorded. (*Vide* also chap. on Tumours.) Hoggan has described multiple lymphatic nævi of the skin, a condition believed commonly to accompany blood nævi and to be much more frequent than is supposed; these growths are not conspicuous by their colour, and are therefore commonly overlooked; they are of little clinical importance, unless possibly as an early stage of elephantiasis. We have also met with instances of these nævi.<sup>1</sup> Cases of probably congenital lymphatic varices of the limbs have been described by R. W. Parker; he thinks they have a tendency to become locally inflamed.<sup>2</sup> We have recently met with a case of lymph nævus of the conjunctiva and supraorbital region, causing an unsightly deformity; the nævus varied much in size, and sometimes 'puffed up' and became painful.<sup>3 4</sup>

**Aneurism** in children is extremely rare, only a few cases have been recorded, and these appear all to have been either traumatic or the result of embolism, the embolus giving rise to softening of the arterial coat and consequent formation of the aneurism. A paper on this subject by R. W. Parker in the 'British Medical Journal,' 1884, may be consulted. We have only met with one case of aneurism, in a child aged 7 years who was suffering from ulcerative endocarditis; the aneurism, which was situated on the left middle cerebral artery, was no doubt due to an embolus; it finally ruptured and gave rise to extensive meningeal hæmorrhage.

<sup>1</sup> Hoggan, *Jour. of Anat. and Phys.*, April 1884. *Lancet*, 1882, vol. ii. p. 891.

<sup>2</sup> *Vide* also chap. on Tumour Growths in Childhood.

<sup>3</sup> The case, with a drawing, has been published by Dr. Mules in *Trans. Ophthalm. Cong.*, Heidelberg, 1888.

<sup>4</sup> For an account of various rare abnormalities of the blood and lymph vascular systems (also *nervæn nævus*, &c.) the reader is referred to Esmarch and Ku'enkampff's monograph on *Elephantiasis*.

## CHAPTER XVIII.

## GENERAL DISEASES.

**General Tuberculosis.**—In speaking of chronic tuberculosis of the lungs we have emphasised the fact that, far more commonly in children than in adults, the tubercular lesions affect not only the lungs, but are widely distributed through the body (see p. 206). It is this general distribution of tubercle which often renders the diagnosis difficult during life, as the physical signs of the disease in the lungs are less obvious than where, as in the adult, the tubercular deposits begin at the apex, and give rise to consolidation and cavitation. The classification is also rendered more difficult when a number of organs in the body are attacked, as we have to speak of a general tuberculosis rather than tuberculosis of the lungs, and some cases which are in reality a general tuberculosis may be referred to diseases of the respiratory system or diseases of the alimentary canal. In the majority of cases of general tuberculosis the principal stress falls upon the lungs, mediastinal glands, mesenteric glands, peritoneum, and intestines; in a lesser degree upon the liver, spleen, and kidneys; and in the last stage the membranes of the brain are frequently attacked.

We have already discussed the subject of chronic tuberculosis of the lungs (p. 205), we will now speak of the acuter forms of general tuberculosis.

**Acute Miliary Tuberculosis.**—Acute miliary tuberculosis is perhaps commoner in early life than it is in after years; it occurs at all ages during childhood, though it is rare before the end of the second year. Like tubercular meningitis, with which it is often associated, it usually supervenes in children already tubercular, and occurs but rarely in children who up to the time of falling ill have been in robust health. There is usually a history of more or less ill-health for some time previous to the attack; there is a history perhaps of hooping cough or measles some months before, which has left the child weak, and from which it has never really recovered. Sometimes the symptoms of a tuberculosis of the lungs or abdomen are unmistakably present, and then acuter symptoms supervene which mark the onset of the miliary form of the disease.

Acute miliary tuberculosis occurs usually in two forms: the 'typhoid form,' so called because it is apt to simulate enteric fever, and the broncho-pneumonic form, in which the symptoms present are those of acute pneumonia, the latter being set up by the presence of miliary tubercle.

**Symptoms.**—In the **typhoid form** the commencement is usually insidious and is usually preceded by a period of ill-health, during which time the child has been noticed to waste, to be feverish at night, to cough, and not infre-

quently to suffer from diarrhoea or pass slimy, unhealthy-looking stools. The child is languid, irritable; its appetite is very uncertain and it cares but little for its toys. Often there are decided signs of intestinal catarrh; the appetite is completely lost, the tongue is coated, and the abdomen distended. An examination of the chest may give no decided result, or only some rhonchi may be heard, and there may be no very decided cough. In this stage, if the symptoms are acute, the resemblance to an irregular attack of enteric fever is, very close, especially if rose spots resembling those of typhoid are present, as is sometimes the case. The diagnosis is especially difficult in young children of three or four years of age, who are perhaps very irritable and resist any examination of the chest or abdomen, the difficulty being to distinguish acute miliary tuberculosis from enteric or subacute intestinal catarrh with some patches of broncho-pneumonia. A careful and continuous record of the temperature is important; the temperature should be taken morning, afternoon, and evening; the variations are usually considerable, sometimes varying from  $99^{\circ}$  to  $104^{\circ}$  F., the highest being usually at 4 or 5 P.M. Too much stress, however, must not be laid on an intermittent temperature with considerable flights, as in some children a patch of broncho-pneumonia without marked physical signs will be accompanied by a striking, intermittent temperature, and moreover we have seen a case of miliary tuberculosis when the temperature only reached  $101.5^{\circ}$  or  $102^{\circ}$  in the afternoon or evening. Enlargement and tenderness of the spleen may be present in an early stage; in some cases there is a marked feeling of hardness about it. In one of our cases rigors, with enlargement of the spleen and an intermittent temperature, suggested malaria, but the case turned out to be acute tuberculosis.

Sooner or later, mostly in the course of a week or two, more characteristic

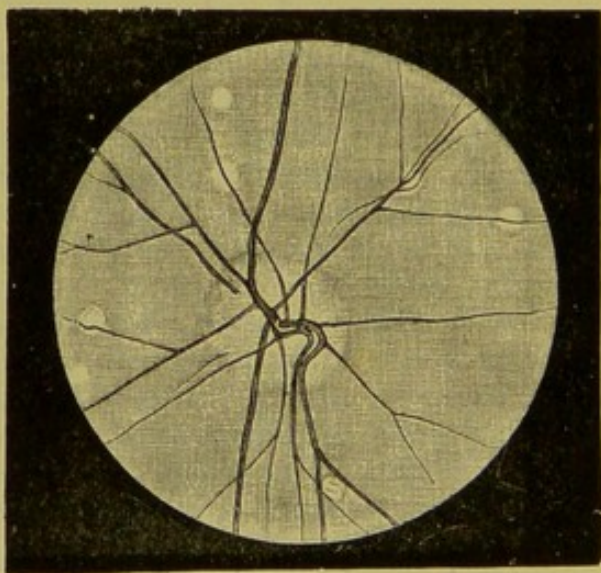


Fig. 44.—Miliary Tubercles of the Choroid; slight optic neuritis. (From a drawing by P. H. Mules.)

symptoms declare themselves. There is a dry hacking cough, especially troublesome at night; some crepitation or loose rales are heard at the apices, roots, or bases of the lungs, and not infrequently a sub-tympanic or high-pitched note may be elicited on percussion, or perhaps there may be signs of fluid at one or both bases, with a pleuritic rub. In some cases there is marked dyspnoea, out of proportion to the pulse-rate and fever; it is caused by the presence of miliary tubercles scattered through the lungs, with perhaps some disseminated emphysema or broncho-pneumonia.

The hectic continues, and probably sooner or later, in the majority of cases, cerebral symptoms, due to meningitis or the softening of the brain which accompanies it, supervene.

One of the most important physical signs which may be present is that of miliary tubercles in the choroid; the discovery of these may not infrequently clear up the diagnosis of a doubtful case. Unfortunately the restlessness and irritability of children suffering from tuberculosis often render it impossible to make a thorough ophthalmoscopic examination. The tubercles appear as small, rounded, yellowish bodies, scattered about the fundus; one or more may be seen near the disc, but usually they are eccentrically seated: five or six may often be counted. Often a branch of a retinal artery or a vein may be seen to cross in front of one. They appear very rapidly, being apparently formed in the course of a few days; if there is tubercular meningitis, the discs may be swollen and indistinct.

In a case recorded by Proebsting the detection of tubercular bacilli in the urine decided the diagnosis of a doubtful case in favour of miliary tuberculosis. In this instance the miliary tuberculosis was secondary to chronic tuberculosis of the kidney.

The duration of the disease varies, in some cases being short, often only three weeks; in others, perhaps the majority, it is longer, the patient lingering for six or seven weeks. The supervention of tubercular meningitis or broncho-pneumonia quickly brings the end.

**The broncho-pneumonic form** occurs most often in children from two to five years of age and in the vast majority of cases is mistaken for an attack of acute broncho-pneumonia. There is often a history of measles or whooping-cough shortly before the attack, and probably there has been a period of ill-health with wasting. The symptoms are precisely those of acute broncho-pneumonia; there is fever, dyspnoea; rales or crepitation are heard over an extended area of lung, with more or less impaired resonance over a corresponding area. The disease usually runs its course in about ten days to two weeks, death resulting from exhaustion and more or less asphyxia. The family history or previous health may suggest tuberculosis in any given case, but no definite diagnosis of tubercular broncho-pneumonia can be made unless tubercles are seen in the choroid. The supervention of meningitis suggests tubercle, but a simple meningitis may accompany or follow broncho-pneumonia, especially in infants and young children.

It must be borne in mind that acute or at least **subacute general tuberculosis** may occur, which is not of the miliary form, disseminated through all the organs. A tuberculosis may run a course of six weeks to two months, accompanied by hectic and wasting, and the principal lesions found *post mortem* are not miliary tubercles, though these may be present, but ragged cavities in the lungs, caseous bronchial and mesenteric glands, and caseous masses in the liver, spleen, and kidneys. In these cases the diagnosis may be difficult or impossible for the first few weeks, but careful examinations of the apices of the lungs will generally decide the question.

**Diagnosis.**—Acute miliary tuberculosis may be confounded with acute disseminated tuberculosis, in which the tubercular growth takes the form of caseous nodules or other forms rather than the typical purely miliary form. The diagnosis is of very little importance except as regards the acuteness of the case, the miliary form being necessarily the most rapidly fatal. Both miliary tubercles and caseous infiltrations may be found in the same organ. Acute miliary tuberculosis may be mistaken for typhoid fever,

sub-acute intestinal catarrh, acute broncho-pneumonia, acute endocarditis, and pyæmia.

In making a diagnosis the family and personal history are of great importance; if other children or older members of the family have died of tubercular disease, the probabilities in a doubtful case will naturally be in favour of tubercle, but it must not be forgotten that apparently healthy children with a good family history will sometimes die of acute tuberculosis. A history of a recent attack of measles or whooping cough would raise one's suspicion, but children with such a history may of course have typhoid or any other acute attack. There cannot be much difficulty in distinguishing a typical attack of typhoid fever from one of acute tuberculosis, but it may be quite impossible to make a diagnosis between an irregular and atypical attack of typhoid and tuberculosis. In both diseases there may be some looseness of the bowels, abdominal distention, and intermittent fever; in both the spleen may be enlarged. It is only by having the patient under observation for some days, and frequently examining the chest, that a diagnosis can be made. A short hacking cough, hectic fever, great variations of temperature, dyspnoea out of proportion to the temperature, and crepitation heard in the chest, would favour the diagnosis of acute tuberculosis. Any cerebral symptoms, such as convulsions, squinting, drowsiness, muscular rigidity, or paresis suggesting meningitis, favour the diagnosis of tubercle.

Some cases of broncho-pneumonia, where the distribution is patchy and the temperature markedly intermittent, closely simulate acute tuberculosis, and for a few days or a week a certain diagnosis cannot be arrived at. It is only perhaps when the pneumonia clears up, and the temperature tends to normal, that the suspicions of tuberculosis are relieved.

In acute endocarditis the temperature is apt to be hectic, and in the absence of a bruit the diagnosis may be difficult. The presence of a bruit would necessarily prove the case to be almost certainly acute endocarditis, in spite of it in other ways looking like tubercle.

*Prognosis.*—If the diagnosis of acute miliary tuberculosis can be definitely made, the prognosis cannot be otherwise than exceedingly grave. There can be little doubt that in a few cases, in an early stage, before the miliary tubercles are widely extended, recovery may ensue; but when the tuberculosis has become general very little hope indeed can be entertained.

*Morbid Anatomy.*—The amount of emaciation present depends upon the chronicity of the case; we have seen at the post-mortem cases in which there was a fair amount of sub-cutaneous fat in those who had died of acute miliary tuberculosis. On opening the chest, the lungs are found to be in a condition of deep inspiration, almost as if they had been injected with some fluid from the trachea, while miliary tubercles are seen on the surface or beneath the pleura. On section the lungs are found stuffed with miliary tubercles, of a grey colour and the size of millet seeds, usually so crowded that not a cubic inch in the whole lungs will be found free. They are mostly more crowded at the apex than at the base. Caseating or suppurating bronchial glands are almost certainly present. Frequently miliary tubercles are present in the glands. Miliary tubercles will be found crowded together in the liver, spleen, kidneys, and serous membranes—frequently also in the choroid, and on the vessels at the base of the brain.

In other less acute cases caseous masses and peri-bronchial tubercles may be found in the lungs, and may be associated with more or less miliary tuberculosis. It is curious to note that many observers have failed to find the tubercular bacilli in miliary tubercles, and others have found granular masses suggestive of spores (Biedert, Ribbert, Malassez and Vignal).

*Treatment.*—If the diagnosis of acute miliary tuberculosis can be made with certainty, little can be hoped for from the administration of drugs. The treatment must in such cases be a treatment of symptoms. If the temperature takes high excursions towards evening, quinine, antipyrin or antifebrin may be given to anticipate the rise, and the patient packed or sponged with cold water to reduce it. The troublesome cough may be relieved by codeia jelly or minute doses of opium. The strength should be maintained by a liberal diet of beef-tea, soups, port wine, Burgundy; extract of malt and cod-liver oil should also be given. Iodoform sometimes appears to be useful, though it can hardly be said to have any power in arresting the disease; it may be given in powder with sugar in half to two-grain doses. The combination of digitalis and bark has appeared to us to produce a temporary improvement, but any permanent change for the better cannot be looked for.

**Scrofula and Tuberculosis.**—In this work the word scrofulous or strumous will seldom be found, since we believe that all scrofulous or strumous lesions are identical with tuberculosis, or rather that they are mere varieties or forms of tuberculosis. Just as in the exanthems and in gout, taking these as types of *parasitic* and *non-parasitic* diseases respectively, many variations are found in the form and extent of the lesions, yet each presents some single feature or group of features characteristic of its species, so in the scrofulous or tuberculous affections there is much variation, as it were, in the habit of the disease, yet the naked-eye or microscopic appearances, or the clinical history, always reveals the unity of the affection.<sup>1</sup>

In certain children there is a characteristic tendency to inflammation from trivial causes; this inflammation is specially apt to occur in, or rather pick out the lymphatic tissues; once aroused, it tends to spread, attacking often distant parts of the body. If its course is slow the foci of disease tend to become caseous; once started, the process seldom stops, or rather, though it may be arrested for a time, it is apt to be set going again by slight causes, even after long intervals of time. This tendency is found to run in families, some members showing one form of lesion, some another. At times different forms occur at different periods or even simultaneously in the same child.

There is often, though by no means always, a characteristic appearance of the patient,<sup>2</sup> but it is quite common to find the disease under discussion in children not at all answering to either description.

The evidence of identity of scrofula and tubercle from the clinical history is best seen in two ways: first, that in a given number of cases where either

<sup>1</sup> *Vide* also Charvot, *Med. Chron.*, October 1884. König., *ibid.*, November 1884.

<sup>2</sup> The types usually described are: 1. Sanguine type—the child is tall, slight, graceful, with small fine limbs, clear skin, and fine silky hair; the intelligence is bright. 2. Phlegmatic type—the child is short and thick-set, with coarse skin and limbs, thick features, and a dull, flabby aspect. 3. 'Pretty strumous' type—which is intermediate between the two former. *Vide* Treves on Scrofula and Gland Diseases.

condition is present, enquiry will show a large proportion in which there is a history of lesions in other members of the family,<sup>1</sup> these lesions being often, as it were, crossed; thus the child with disease of its hip has a brother with chronically enlarged cervical glands, and the father died of acute phthisis. Why should we call the father tuberculous and the children 'scrofulous'? Or again, the child with a 'pulpy' knee may develop caries of the spine and then die with grey tubercles in its lungs and abdominal viscera, or suddenly be attacked with tubercular meningitis. Or again, a child with a 'scrofulous' joint disease, after some violent manipulation, perhaps forcible straightening of a flexed knee or imperfect removal of diseased tissue, rapidly develops tuberculosis, having had no sign of it before. There is strong reason to believe that in some of these cases there is direct tuberculous embolism or general rapid distribution of tuberculous infective material throughout the body. Take one more illustration: a child with 'strumous dactylitis' develops along the course of the lymphatics of its arm multiple 'strumous nodes,' and finally suppurating glands above the elbow and in the axilla; these would be called scrofulous abscesses and scrofulous glands, yet they are simply tuberculous emboli from the finger.<sup>2</sup>

Anatomically, in the subjects of 'acute miliary tuberculosis' we find always, or nearly so, somewhere in the body, caseous foci which if seen alone would be called scrofulous. Examined microscopically, the evidences of chronic inflammatory change undergoing degeneration—the characteristic tubercle, the giant cell, the tubercle bacillus—are all found in almost all the lesions classed as scrofulous, though much less abundantly in some tissues, such as bone, than in others.<sup>3</sup> It is then wiser on all grounds to consider all scrofulous and strumous diseases as tuberculous, and therefore to be on our guard against the onset of tuberculosis in vital parts; for instance, the common chronic osteomyelitis of the finger may be the only discoverable lesion in an apparently robust child, yet that child is infected with tuberculosis and may at any time develop other foci, and may die of visceral tubercle; hence none of these diseases should be looked upon as trivial. It must, however, be remembered that there is much evidence to show that there is some antagonism between local 'scrofulous' lesions and general visceral tuberculosis, or rather that so long as the local lesion is unrepaired the internal organs escape, while recovery from the local disease may be followed by general infection. This has given rise to the view that the local disease acts as a sort of safety valve. The disease often lies dormant for years or for a long lifetime, and the patient may never show any further sign of tuberculosis; we

<sup>1</sup> *Vide* chap. on Joint Diseases for figures on this point.

<sup>2</sup> Treves looks upon scrofula as a phase of tubercle; the phthisical parent has scrofulous children. He found a history of phthisis in 38 out of 65 cases of scrofula.

A child begotten of parents, one of whom perhaps, especially the father, is at the time actively phthisical, is certainly exceedingly likely to be tuberculous. This we have seen most markedly. Tuberculosis may even occur congenitally. Dr. Morgan records a case of 'scrofulous sores' on the head and nates of a two-months foetus.—*Path. Soc. Trans.* vol. xviii.; and Dreschfeld has described a tubercular testis in a newly-born infant.

<sup>3</sup> Giesler, *Jahrb. f. Kinderheilk.*, B. xxiii., H. 1 and 2, looking for bacilli in cold subcutaneous abscesses in children, in a large number of cases found only a single bacillus, and inoculation of guinea-pigs and puppies gave negative results; hence he calls them scrofulous; not tuberculous. Eve's experiments, however, disprove Giesler's conclusions.

must therefore not condemn all these children as hopelessly tuberculous. Such children should be taken care of more watchfully than others need be, and no source of irritation, however slight, be allowed to continue; carious teeth, little patches of herpes or eczema, slight injuries, and so on, should be seen to at once, lest chronic inflammation should ensue and a tubercular nidus be established. The diet in all such cases should be especially nourishing, and the usual remedies of cod-liver oil as an article of food rather than a medicine, iodine in some form, iron, and, above all, sea air, should be provided where practicable. In the richer class of patients such children should go to school by the seaside.

Details of management of individual lesions will be found in the various special chapters.

**Tubercular Adenitis.**—As already pointed out, the lymphatic tissues are those most commonly and most extensively attacked by tuberculosis,<sup>1</sup> and lymphadenitis is commoner than lymphangitis,<sup>2</sup> since any solid material taken into the lymphatic vessels is apt to be arrested in the adjacent gland. Irritating matters passing up the lymph stream are not, however, by any means always arrested at the nearest gland, partly because the course of the lymphatics varies, and the most commonly affected glands may be avoided by a bye-route and those further on attacked, and partly because the material probably may sometimes pass through one gland and involve the next, or after one gland has become inflamed it may become a source of infection to the next in the chain. Hence search should be made for sources of irritation out of the usual path if none are found in the common positions. If one obvious enlarged gland exists the presence of others should always be suspected. The first thing, then, when a child is brought with an enlarged lymphatic gland, is to examine the whole area draining to that gland for some source of irritation past or present: this will be facilitated by the following table, where the principal lymphatic glands and their collecting areas are given.<sup>3</sup>

TABLE SHOWING THE DISTRIBUTION OF THE LYMPHATIC GLANDS  
AND THEIR DRAINAGE AREAS.<sup>4</sup>

GLANDS.	Head and Neck.	DRAINAGE AREA.
<i>Suboccipital</i> . . . . .	} drain posterior half of head.	
<i>Mastoid</i> . . . . .		
<i>Parotid</i> . . . . .	drain anterior half of head, orbits, nose, upper jaw, upper part of pharynx.	
<i>Submaxillary</i> . . . . .	drain the lower gums, lower part of face, and front of mouth and tongue.	
<i>Suprahyoid</i> . . . . .	drain anterior part of tongue, chin, and lower lip.	

<sup>1</sup> Greig Smith has remarked upon the frequency of lesions of 'red marrow' as an illustration of its lymphatic affinities.

<sup>2</sup> The thick lips and nose and the red patches and eczematous eruptions of children are looked upon by Curnow as 'reticular lymphangitis.' Under certain circumstances chilblains are probably a similar condition.

<sup>3</sup> Curnow, *Lancet*, 1879. Sappey, *Anat. : Phys. Path. des Vaisseaux Lymphatiques*, Paris, 1874.

<sup>4</sup> Mainly from Curnow and Treves.

GLANDS.	Head and Neck.	DRAINAGE AREA.
<i>Superficial cervical</i> . . . . . (lying beneath platysma)	drain external ear, side of head, and neck and face.	
<i>Retropharyngeal</i> . . . . .	drain nasal fossæ and pharynx (upper part).	
<i>Deep cervical</i> :		
Upper set along carotid sheath :	drain mouth, tonsils, palate, lower part of pharynx, larynx, posterior part of tongue, nasal fossæ, parotid and sub-maxillary glands, interior of skull, and deep parts of head and neck.	
Lower set in supra-clavicular fossæ :	drain upper set of lymph glands, lower part of neck, and join axillary and mediastinal glands.	

*Upper Extremity.*

<i>Supracondyloid</i> <sup>1</sup> . . . . .	drain three inner fingers.
<i>Axillary</i> . . . . .	drain upper extremity, dorsal and scapular regions, front and sides of trunk and breast.

*Lower Extremity.*

<i>Anterior tibial and popliteal</i> :	drain the deep lymphatics of the leg, and receive some vessels from the skin of the leg and foot, chiefly the outer side.
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*Inguinal* :

Femoral set (superficial) . drain superficial vessels of lower limb and partly of buttock and genitals, also perinæum.

Horizontal set (superficial) : drain abdomen below umbilicus, buttock, and genitals.

The deep vessels of the lower limb go to the deep glands along the femoral vein.

<i>Iliac</i> . . . . .	drain the pelvic viscera and the deep vessels of the genitals partly.
<i>Lumbar</i> . . . . .	drain all the lower glands, uterus, testes, ovaries, kidneys.
<i>Sacral</i> . . . . .	drain the rectum.

Roughly, the umbilicus is the watershed draining to the axilla and groin, but the vessels cross and overlap both vertically and horizontally.

Perhaps the most commonly enlarged glands are those of the neck and sub-maxillary regions, parts obviously much exposed to irritation ; thus eczema of the scalp, the irritation of pediculi, &c., give rise to enlargement of the occipital and upper cervical glands ; herpes about the nose to irritation of the

<sup>1</sup> Occasionally there are glands in the bend of the elbow.

parotid or submental glands, while carious teeth, ulceration of the gums, and so on, affect the sub-maxillary group. The upper set of cervical glands are found enlarged from irritation of the meatus externus in cases of otorrhœa and in cases of tonsillitis. As already mentioned, a lymph gland overlies the tonsil and is usually enlarged in affections of that structure, which is not perceptible from the neck under ordinary circumstances. Treves points out that those glands which drain areas rich in lymphoid tissue are the ones most commonly enlarged, hence the cervical, bronchial, and mesenteric groups are those most often affected.

The enlargement of lymphatic glands is sometimes acute at first, and they are then tender and painful; in other instances the swelling is chronic and painless from the beginning. The glands form hard, rounded, or oval masses freely movable in the deeper tissues and beneath the skin, unless there has been cellulitis around the gland (periglandular inflammation). In chronic cases the overlying skin is natural, and usually several glands can be felt; often a chain of them, varying in size from a pea to a walnut, can be traced. A mere transitory irritation may start inflammation in a gland, and then, though the local source has entirely disappeared, the enlargement may persist and other glands in the chain be affected, as already described, hence we must not conclude that there has been no primary source of irritation, and that the glandular affection is spontaneous because we can find no cause for the enlargement. Cold, or some trifling injury, a sore upon the skin or mucous surface, soon healed and forgotten, or perhaps never noticed, is sufficient to set up chronic tubercular adenitis, which may spread and last for months or years. Primary adenitis not due to absorption is probably very rare. Treves points out that cervical adenitis may be caused by extension from within the chest or other distant parts.<sup>1</sup>

After a time, unless the process subsides, the glands become very hard, and by their size and number give rise to great disfigurement and occasionally to more serious trouble. Goode, of Cincinnati, has recorded a case of death in a baby five months old from pressure of a caseous gland upon the carotid sheath. These swellings are seldom painful; after a time one or more patches of softening may appear, and as the process goes on the skin becomes red or livid, and finally thinned and perforated; thin, watery, sero-purulent fluid with flakes of lymph and cheesy matter then escape, more rarely fairly healthy-looking pus; occasionally the discharge is clear glairy fluid, like the contents of some mucous cysts, but in such cases there is almost always some more purulent matter at the bottom of the cavity, which can be squeezed out. The discharge may go on indefinitely, and an ulcer is formed which has little tendency to heal and is bounded by thin, livid, undermined, unhealthy edges. If healing does take place the scar is puckered and unsightly, often with bridges or tags of thin insensitive skin hanging from it, and little black spots due to accumulation of dirt and secretion in the hollows of the scar. Such is the condition seen in an old 'scrofulous neck.'

If such a gland as that above mentioned is examined in the early stages

<sup>1</sup> Teale believes that most of the so-called 'scrofulous necks' are due to drains, scarlet fever, mumps, and so on, and are not tuberculous; vide *Med. Times and Gaz.*, January 10, 1885.

of the process it will be found firmer and paler than in health, but not otherwise obviously altered; a little later patches of yellow cheesy material of various sizes will be found scattered through the gland, sometimes in one or two large foci, at other times in numerous small ones; the capsule of the gland is thickened. Later still these caseous foci break down, the greater part of the gland tissue is destroyed, and the gland itself becomes converted into a bag of cheesy or flaky pus and detritus with walls composed of the capsule, and more or less of the gland tissue remaining unsoftened. It happens, however, sometimes that, instead of the gland breaking down and softening in the centre, suppuration takes place in the cellular tissue round it—*periglandular abscess*; this burrows round the gland and isolates it, so that there is a solid mass of gland tissue lying in an abscess cavity, and perhaps attached to the surrounding tissues only by the structures passing to its hilus. In this last case, when the skin gives way, instead of a deep ulcer there is seen a round pinkish or yellowish-white mass projecting from the middle of a circular sore, the edges of which are loose, undermined, thin, and livid; there is often but little discharge and no tendency to heal, or indeed to alter much one way or the other. Where many glands are enlarged, all stages, from the first primary enlargement to the last-named condition, may be seen at once, and sometimes the whole neck from ear to ear is marked by ulcers, scars, and enlarged glands in various stages. In such cases it will usually be found that many teeth in one or both jaws are carious and acting as sources of irritation.

It must, of course, be remembered that all such glands do not go on to suppuration, and it is said that in children there is more chance of resolution than in adults; however, the majority do suppurate if they remain enlarged for more than a short time.

Coexisting with the glandular abscesses and sores will often be found superficial ulcers, round or irregular in form, often scabbed over, and only discharging at times. The edges of the sores are usually unhealthy and undermined, and their bases glazed or covered with coarse, unhealthy granulations and caseous detritus; some of the ulcers are no doubt caused by the discharge of broken-down glands, others are probably due to abscesses beginning in lymphatic vessels, due to tubercular lymphatic emboli or rather thrombi—tubercular lymphangitis, 'strumous nodes'; others again probably to local cutaneous tuberculosis.

*Diagnosis.*—Tuberculous adenitis and ulcers may be mistaken for syphilitic ulceration, which gives rise to very similar appearances, except that ulceration predominates over the glandular enlargement. It must be remembered that congenital syphilis and tuberculosis may coexist. The presence of other evidences of syphilis will nearly always clear up a doubt.

*Simple acute adenitis* is recognised by its short history and by the pain and great tenderness of the part as well as by the presence of an acute source of irritation such as an alveolar abscess or acute tonsillitis, and by the fact that usually only one gland is enlarged, though several may be tender.

*Simple non-tubercular chronic adenitis* may occur as the result of acute inflammation, but this usually rapidly subsides under treatment and affects but one gland; if the affection is obstinate, suspicion of its tuberculous nature should be aroused.

Lupous ulcers are the only other condition likely to be mistaken, and, as

these are also tuberculous, the mistake is of little importance. The presence of well-defined lupous tubercles is the distinguishing feature.

Tuberculous abscess of the skin, 'scrofuloderma,' 'scrofulous gumma,' or 'strumous node,' are the names applied to small tuberculous foci which, at first hard and solid, usually break down, though sometimes they are absorbed. These little swellings are often found in the thickness of the skin itself, about the limbs, face, or trunk. Occasionally the mischief spreads and a large cold abscess or tuberculous ulcer may result.

Chronic tonsillar hypertrophy is considered by Treves to be 'almost pathognomonic of scrofula'; though very common in tubercular children, we think it is often met with in those who show no other signs of tuberculosis; it may occur during the first few months of life. Infantile leucorrhœa and certain vulvar ulcers have been supposed to be tuberculous; no doubt many cases of aural suppuration are so.



Fig. 45.—Tubercular Ulceration of the Skin of the Foot, showing imperfectly formed scar-tissue overlying the tuberculous granulations.

*Treatment.*—The treatment of tuberculous adenitis consists at first in carefully removing all sources of irritation; carious teeth, enlarged tonsils, patches of eczema, nasal catarrh, otorrhœa, chafed heels, and so on, should all receive attention according to the seat of the enlarged glands and the source of the trouble. Next the general measures of diet and health already mentioned must be carried out. As to the local treatment of the glands themselves, this must be managed according to the stages of the disease. (1) In the early stage, before caseous foci have appeared, after removal of the source of irritation, the glands should be left quite alone, in the hope of their subsiding. If no improvement takes place in a fortnight the glands should have a piece of unguentum plumbi iodidi of the size of a small pea gently rubbed over them night and morning. The use of mercurial ointment and painting with tincture of iodine we do not approve of; the latter especially is apt to increase irritation rather than to lessen it. Should the enlargement

not yield to these means, and should the stage of caseation, known by a duration of two or three months with considerable enlargement and much hardening of the glands, be reached, the best treatment is to cut down upon and shell out the glands entire—a very easy operation at this stage where only one or two glands are involved, a much more difficult and sometimes impossible one where many glands in a chain are enlarged or there is periglandular inflammation. In favourable cases an incision through the skin and fascia, and then through the sheath of the gland, followed by pressure at each side with the fingers, will enucleate the mass quite readily. All the glands felt to be enlarged should be removed, all bleeding stopped, and the edges carefully brought together, a fine rubber or horsehair drain being used. The resulting scar is slight and much less unsightly than that left in cases where suppuration has gone on. Treves's plan of puncture with the thermocautery we have not found satisfactory; it is apt to leave intractable sinuses.

In the next stage, when the gland has softened down, if there has been no periglandular mischief, it may be still possible to dissect it out, and, if so, this is the quickest and best method; it is, however, impracticable if the glands have become matted to the surrounding tissues: in such cases the abscess should be opened by an incision about half an inch in length; a long incision is not necessary, but it must be sufficient for free manipulation and drainage. After opening the abscess a Volkmann's spoon is passed in and all the gland tissue carefully and thoroughly scraped away: if any is left the wound will not heal, but the part remaining will caseate, break down, and keep open a sinus;<sup>1</sup> hence, if all the gland cannot be scraped away, the most satisfactory plan is to enlarge the incision and dissect out the remaining parts. Where, as often happens, two or more glands, near, but not fused with, one another, have broken down, the further ones may often be reached, as pointed out by Mr. Teale, by thrusting the spoon through the adjacent walls and thus emptying all the cavities through one opening. The wound should be well dusted with iodoform and drainage provided for. When the abscess has already burst and left a sinus the same treatment should be adopted. Where ulcers have formed with undermined edges these should be scraped or clipped away flush with the healthy skin: a large wound may thus be sometimes left where there was but a small opening before, but the ultimate result will be a much less unsightly scar, as well as more rapid healing if this devitalised skin is removed; all the unsightly tags and bridges will be thus avoided.

Where there is a protruding isolated gland in the middle of a sore, if it is soft it may be scraped away; if not, we have found Golding Bird's little electrolytic caustic apparatus exceedingly good. The silver plate is fastened by a strip of strapping on to a neighbouring sore if there is one, or, if not, on to a surface made raw by a blister, and the copper wire is bent so that the zinc arrow can be plunged into the middle of the gland; a strip of strapping fixes the arrow, and a bandage is applied over all. The apparatus is left on for forty-eight hours, or more in some cases: at the end of that time the gland will look yellow and dry; the apparatus is then removed and a

<sup>1</sup> Some surgeons recommend a small opening, and leaving the abscess to slowly drain. Injection of chronic glandular abscesses with a solution of iodoform in ether is well worth a trial; we have seen them completely disappear under this treatment.

poultice applied for twenty-four hours, when the gland is usually found to come away ; if more glands remain, the apparatus may be reapplied. In this method there is a deposit of nascent chloride of zinc in the gland which quite painlessly and rapidly destroys it, and we have never seen any tendency to extensive sloughing, nor anything except good results, from this mode of treatment in suitable cases ; it is, of course, chiefly valuable where objection is made to removal of the gland by operation.

Mr. Teale has pointed out that where one superficial gland is enlarged and suppurating there is usually another, lying beneath the deeper fascia, and that, unless this is cleared out, the source of discharge is not removed and the sinus will not heal. It is necessary to look carefully sometimes to find the channel leading to the deep gland, but it is there and must be followed by the spoon, and the second mass removed. Mr. Teale uses a special dilator to stretch the sinus, but a pair of dressing or sinus forceps will usually be found to answer all purposes.

Iodoform is the best dressing to apply to these sores at first, and later on they do very well with iodide of lead ointment.

Where several sinuses are left in the neck it is a good plan to use, as advised by Treves, a gutta-percha or leather stock<sup>1</sup> to keep the parts at rest, and in other parts of the body efficient pressure by pads and bandages or by a truss is often useful.

Where depressed scars remain after gland diseases Adams' or Reeves' operations may be employed. The former loosens the skin by subcutaneous division of the scar, and by daily manipulation keeps it from becoming reattached till the hollow is filled up. Reeves props up the depressed skin upon a wire passed beneath it, which may be left in permanently, or removed if it sets up irritation. We have had a good result from the latter method.

Acute non-tubercular glandular abscesses in parts of the body other than the neck are often met with and require treatment on general principles. Where the popliteal or inguinal glands are involved the limb should be kept extended and fixed to a splint. Suppurating popliteal glands are apt to give rise to serious trouble, the matter tends to burrow far up the limb. In one case we had to amputate the thigh where an abscess, beginning in the popliteal lymphatics, as the result of an irritated chilblain, eroded the popliteal artery, opened into the knee-joint, and burrowed up to the pelvis.

Acute adenitis, if seen before suppuration has occurred, will usually subside if the source of irritation is removed and the part well fomented after smearing it with extract of belladonna. If pus forms it should be let out as soon as possible.

**Deep Cervical Cellulitis—Angina Ludovici**—is a very serious affection ; the mischief apparently begins as a periglandular inflammation, goes on to sloughing, and may perforate the cheek. There is at first a brawny infiltration of the submaxillary region ; the skin in milder cases is pale and marked by turgid veins ; in the more severe and acute cases, however, a deep brownish-red discoloration appears. The whole neck may be involved, and there is great swelling, with marked prostration, and sometimes dyspnœa or dysphagia from mechanical pressure. The disease is met with usually in children under three years of age, often in infants, and occurs under similar conditions to

<sup>1</sup> The sawdust collar will be found useful for this purpose.

cancrum oris. Early and free incision is urgently required ; usually much foul brown serum or sero-pus escapes. Free stimulation and abundant nourishment are required, with removal from insanitary surroundings. The mortality of these cases, which much resemble those of scarlatinal cellulitis, is considerable.

CASE.—Female, age 1 year 9 months ; neck swollen a fortnight ago ; on admission, right side of neck tense, hard, brownish-red ; swelling reaches to clavicle ; swelling incised, serum only escaped ; much fever before incision ; skin sloughed freely, and pneumonia set in, child dying on 7th day.

*Post-mortem.*—Abscesses in lungs and sanguineous pleuritic effusion.

**General Surgical Tuberculosis.**—A condition perhaps best described as ‘general surgical tuberculosis’ is common, the term being applied to those cases where there are tuberculous foci scattered far and wide over the body in various tissues. Thus children are seen with ulcers of the hands, abscesses or still unsoftened nodes along the course of the lymphatics of the fore-arm, and a supracondylar gland enlarged : perhaps a patch of ulceration on the cheek and submaxillary adenitis, phlyctenular ophthalmia, tubercular osteomyelitis of one tibia, with disease of the tarsus on the opposite side, and so on. Such a combination is by no means a rarity : at the time of writing we have in the hospital a boy with disease of one hip, one elbow, one ankle, and sacro-iliac disease ; in another the shoulder, ankle, and wrist were all excised for tuberculous disease. Such cases if they are neglected gradually lose strength and sink, but good food and sea air, combined with removal of the disease as soon as it is evident that spontaneous repair is impossible, will often work wonders.

Operation should be deferred till it is seen what nature can do, but if with the improvement in the child's health no progress is made locally, or if there is pain or much discharge, the affected tissues—bones, joints, &c.—should be removed. We have often been surprised at the rapid and complete repair effected in such children, and even in the cases looking most desperate locally, resections or scrapings will sometimes succeed and amputations prove unnecessary.<sup>1</sup> But in all these children relapses will occur if the health is again allowed to fail from bad food and hygiene.

As regards details of local treatment in such cases, we find iodoform dusted on or applied as ointment, and unguentum plumbi iodidi, the two best applications. Where operation is called for, all dead and carious bone should be excised or scraped and gouged away, all soft caseous and pulpy granulation tissue removed, and undermined livid edges of skin clipped off. The wounds should be left freely open : they often heal with great rapidity and leave but little deformity. Amputation is sometimes required for tarsal and knee-joint disease, but in the upper extremity we have never seen a case that required it, except in the fingers, though some have at first appeared hopeless enough. Caries of the spine in such children is the most serious condition, from its inaccessible position, but even this is not hopeless. It is not so common as might be expected to find visceral tubercle in these patients, and this is probably one of the reasons why they have been called scrofulous and not classed as tubercular. Surgical tuberculosis has been used to imply that operative treatment can do much for them, and that the lesions are external.

<sup>1</sup> See, however, chapter on Bone and Joint Diseases.

**CASE.**—Edward C., age 9 years 6 months. Admitted November 7th, 1885. No tubercular history. Always healthy, till 2 years ago, when an abscess appeared at the back of the leg, and others subsequently elsewhere; they have continued to discharge since. Four months ago he fell upon the elbow, and an abscess formed, which was opened, and has been discharging since; joint stiff. On admission, a sinus over the outer end of the left clavicle, leading to bare bone. Abscesses and enlarged glands in the neck; a sinus on the left buttock and another over the inner condyle of the left humerus. 26th, several small loose sequestra removed from the cavity in the clavicle, close to and involving the acromioclavicular joint; abscess in neck scraped out and a deep gland beneath the fascia scooped away; some caseous bone scraped from inner condyle of humerus. 27th, much pain in elbow, which subsided partially by the 29th; he did fairly well, and was sent out on December 11th with all the ulcers, &c., doing well, except the elbow, which remained swollen and tender.

**Anæmia.**—Children of all ages suffer from anæmia, due to causes known and unknown. In infants and young children anæmia is often associated with congenital syphilis, rickets, tuberculosis, and gastro-intestinal atrophy, and follows attacks of any acute disease, such as summer diarrhœa and broncho-pneumonia. In such cases the child is pallid and feeble, and the anæmia is often associated with œdema of the subcutaneous tissues; the backs of the hands and dorsum of the feet are puffed out and pit readily. An examination of the urine will probably show that there is no albuminuria, the œdema being simply due to an hydræmic state of the blood, which allows it to transude from the capillaries.

In anæmic children of all ages the spleen is often enlarged and hard; to such cases the term 'splenic anæmia' is sometimes applied; the enlarged spleen can be readily felt beneath the edge of the ribs, and its lower edge may reach as low as the umbilicus; an examination of the blood shows a marked diminution of the red corpuscles, with no marked excess of white, such as is found in leukæmia. Basic murmurs may be present. A tendency to slight irregular pyrexia often exists, the evening temperature being often 99°–100°; there is usually no tendency to hæmorrhages. With regard to the causation of such cases little can be said. Syphilis and malarial poisoning should be thought of, but the latter can generally be certainly excluded in Great Britain, unless the child has previously resided abroad.

Most of these cases improve after a while, but their course is very chronic; a fatal result now and again occurs; the tissues are then found almost bloodless and the spleen enlarged, hard, and on section of a purple colour.

In other cases of anæmia the spleen does not appear to be affected, and the condition resembles chlorosis in adults. Sometimes several members of a family are affected at the same time; thus we had three children under our care, two brothers and a sister, aged respectively 8½ years, 7 years, and 5½ years, who were intensely anæmic. Their mother also suffered in a similar way. They were languid, weak, and easily became out of breath; murmurs were heard in the veins and arteries of the neck. All three had an irregular, intermittent temperature, varying from 98° to 100°. They became fat during their stay in hospital and improved generally.

Girls at puberty are especially apt to suffer from anæmia, leading to a delay in the appearance of the menstrual functions. It is curious that boys also occasionally are anæmic at puberty. Anæmia is very apt to be a

marked symptom in those suffering from heart disease ; and Virchow has insisted that in some cases anæmia or chlorosis at puberty is really due to an undergrowth of the aorta and large vessels and of the heart. Undoubtedly a hypoplasia of the aorta is found in those suffering from stenosis of the mitral valve or from some forms of congenital heart disease, but whether there is an undergrowth of the large vessels which is primary and unconnected with heart disease may be open to doubt.

It must not be forgotten that children suffering from tuberculosis are often extremely anæmic.

*Treatment.*—Iron, arsenic, and cod-liver oil, especially the former, are the drugs most likely to be of service in anæmia, though the treatment must necessarily be modified according to the cause. The cachexia produced by syphilis must be treated by a combination of iron and mercury. Care must be taken to see that the bowels are acting normally.

**Idiopathic or Pernicious Anæmia** is apt to occur in children ; out of 102 cases published in the Guy's Hospital Reports for 1882 there were six between the ages of seven and fifteen years. It has been met with in children of all ages. Kjellberg has recorded a case in a boy of five years, Elben in a girl of three years, and W. Steffen in a girl of sixteen months. It is always fatal.

No cause can usually be assigned for the anæmia ; in one case coming under our notice the child had been much neglected and badly fed. Schopiro reports a case of a girl of 13 years who was supposed to suffer from pernicious anæmia, but began to improve after passing a tape-worm—*Bothriocephalus latus*.

The symptoms and course are exactly the same in children as in adults. The first symptoms are those of weakness, breathlessness, and pallor, coming on without cause. The anæmia becomes extreme, the skin is blanched and of an earthy tinge ; the conjunctivæ and mucous membrane of the mouth are pallid and the muscles weak and flabby. Usually there is no great loss of flesh. Vomiting is not uncommonly a marked symptom. In some cases there appears to be a slight rise of temperature at night,  $101^{\circ}$  or  $102^{\circ}$  ; in this respect pernicious anæmia resembles other forms of anæmia. Purpuric spots are sometimes present on the skin, and retinal hæmorrhages and optic neuritis may take place (S. Mackenzie). An examination of the blood reveals the characteristic appearances of ordinary anæmia, viz. a diminution of the red blood corpuscles ; some of the latter are very pale or may have their hæmoglobin separated from their substance and appearing as a rounded body by the side of the disc. The course is often acute, usually varying from one month to three months.

*Morbid anatomy.*—All the organs are in a bloodless condition, the muscles are in a state of fatty degeneration, and minute hæmorrhages are found on the surfaces of the organs. There is no further alteration found in the spleen or other organs.

*Treatment.*—The medicine most likely to be of service is arsenic. Drs. Pye Smith and Bramwell and Finny have recorded successful cases in adults. Phosphorus has also been used with some success.

**Scurvy.**—A scorbutic state may sometimes be met with in children as the result of a bad or improper food, especially if fresh vegetables have been excluded from it ; such are cases of true scurvy, similar in every respect to

those which used to occur so frequently among seamen. A similar condition is met with in association with certain depressing diseases such as tuberculosis. At other times when it occurs it is difficult to assign any cause.

The patient is usually anæmic, though he may be well nourished as far as subcutaneous fat is concerned; the gums are spongy and offensive, they bleed with the slightest injury, the teeth are loose and may fall out; hæmorrhage is apt to occur from the nose, kidneys and bowels; purpuric spots are common, and bruising occurs after the slightest injuries. The majority of the cases which come under our notice in hospital quickly improve with proper dieting and careful nursing. In one of our cases, where a scorbutic condition was present in a boy of ten years in association with fibroid phthisis, improvement took place on several occasions when we had him in hospital, but he eventually died from exhaustion, the result of frequent hæmorrhages. At the post-mortem a chronic tuberculosis was found, but nothing was found to explain the hæmorrhagic condition suffered from during life. A scorbutic condition is not infrequently associated with rickets in young children. (See Rickets.)

*Treatment.*—In all cases where there is anæmia, with spongy gums and a tendency to hæmorrhages, lemon or orange juice should be given, and fresh vegetables in some form or other should enter into the diet. Scraped underdone meat, beef juice, and eggs should be given. The gums should be carefully cleansed, and painted with glycerine of tannin, borax and tincture of myrrh or some other antiseptic. Iron and cod-liver oil should be given internally. Hæmostatics such as ex. hamamelis liq., gallic acid, and turpentine, will often be required.

**Purpura.**—Hæmorrhages from the capillaries beneath the skin, which pass under the name of purpura, occur in a variety of diseases. Thus purpura occurs (1) In malignant small-pox and measles, in typhus, and occasionally in scarlet fever, (2) In various anæmic conditions such as scurvy, pernicious anæmia, and Hodgkin's disease, (3) In hæmophilia, (4) In erythema nodosum, (5) In acute dysentery (see p. 69). In other cases when it occurs purpura is assumed to be a 'self-standing' disease, inasmuch as no cause can be discovered. Among these may be mentioned Morbus maculosus Werlhofii, and Peliosis rheumatica.

Under the first of these two forms have been described **Purpura simplex**, where the hæmorrhages occur beneath the skin only, and **Purpura hæmorrhagica**, when in addition to the bleedings beneath the skin there is oozing of blood from the nose and other mucous membranes; but the division is an artificial one, as one form may succeed the other. But little is known as to the cause of this condition; it is said to be more common in girls than in boys, and is especially apt to occur about puberty. Purpura appears at times to be caused by iodide of potassium. As a rule recovery takes place: indeed in most cases the patient is never really ill; occasionally, however, the course is acute, death taking place quickly without any cause being found for the fatal issue. This was the case in a boy under the care of Dr. Pye Smith at Guy's Hospital, who died in ten days from the onset.

The name **Peliosis rheumatica** is given to a condition in which there are purpuric spots on the skin, associated with joint-pains which are not rheumatic. The first symptoms are usually connected with the joints, the knees

or other joints are painful and tender to the touch, and in the course of a day or two patches of purpura make their appearance; the joint affection may go on to effusion. Heart complications do not occur (Baginsky). In some cases hæmorrhages from mucous membranes occur. Micro-organisms have been found in the blood. Purpura, however, does occur in association with true rheumatism, especially when erythema nodosum is present.

**Hæmophilia** is the name given to a disposition to bleeding which is hereditary, the males in a family suffering far more than the females. Children so disposed are liable to bleed after the slightest injury, and the bleeding may be difficult to stop. Severe hæmorrhages may follow a simple scratch or the drawing of a tooth. The slightest blow may be followed by a bruise. This disposition appears to be present chiefly when the child is in ill-health, and to disappear again during good health. In some cases there appears to be a disposition to effusion of blood into the joints, especially the knees: it may follow a blow or occur after prolonged exercise: the effusion may be succeeded by a chronic swelling of the joints. Extravasations into the pleural cavities are rare, effusion on the brain and into the peritoneum is more common. The tendency to hæmophilia appears to last for life, though many affected with it never reach adult age.

*Treatment.*—The most serious symptom in connexion with purpura is the loss of blood from the nasal mucous membrane, the gums, and the kidneys. Epistaxis may demand plugging of the nostrils, while at the same time some hæmostatic must be prescribed. Among the most valuable are turpentine (℥v–℥x), ex. hamamelis liq. (℥v–℥xx), ex. ergotæ liq. (℥v–℥xx), ergotine by subcutaneous injection, gallic acid (gr. v–gr. x), and acetate of lead (gr.  $\frac{1}{4}$ –gr. i).

**Hodgkin's Disease—Anæmia lymphatica.**—This disease is characterised by an enlargement of various groups of lymphatic glands and also of the spleen; there is progressive anæmia, and more or less intermittent fever. According to Gowers' statistics, 16 out of every 100 cases occur in children under ten years of age. The earliest symptom which calls attention to the disease is enlargement of some lymphatic glands, usually the cervical, though the axillary or mediastinal may be early affected.

The glands just behind, or in front of and beneath, the sterno-mastoid are frequently the first to be enlarged, or the group at the angle of the jaw; the glands at first are firm and movable, varying in size from time to time as if the vessels were gorged at one time and more empty at another. With the glandular enlargement there is usually a marked increase in size of the spleen, and the child becomes weak and pallid. The blood is thin and watery, but there is no marked increase of white corpuscles. A prominent feature of the disease is the occurrence of attacks of pyrexia; the temperature at times continues elevated for some days, or it may assume the intermittent type. Other groups of glands may become affected, there may be an extension into the mediastinum, and the glands may exert pressure on the trachea or large veins: the axillary and inguinal glands may also become affected. The course of the disease is very chronic, but the prognosis is unfavourable, and sooner or later the child dies exhausted. At the autopsy the spleen is found enlarged and infiltrated with an adenoid growth, while other organs, as the lungs, liver, and kidneys, are also infiltrated, only in less degree.

*Diagnosis.*—The diagnosis of Hodgkin's disease in an early stage is often extremely difficult where the patient is brought with a mass of enlarged glands in the neck or other part. If the glandular tumours vary in size from time to time, if there is intermittent pyrexia or enlarged spleen, Hodgkin's disease may be suspected. If the glands suppurate they are probably tubercular. (*Vide* chap. on Tumour Growths.)

*Treatment.*—Arsenic and phosphorus are the medicines most likely to be useful, but the disease generally progresses to a fatal termination.

**Leucocythæmia.**—Splenic leucocythæmia is a rare disease during childhood, but the possibility of its being present should be borne in mind when a pallid child with a large spleen presents itself. It occurs at all ages: babies at the breast have been affected, and also those more advanced in years; it cannot be said that anything certain is known about its etiology, though poor living, various depressing conditions, and malaria have been credited with producing it. The earliest symptom to call attention to the disease is abdominal distention, which is found to be due to a greatly enlarged spleen; with this there is dyspepsia, perhaps abdominal tenderness, and marked anæmia. An examination of a drop of blood clears up the doubt, as the white corpuscles are greatly in excess of their normal number: instead of only seeing two or three in the field, their proportion to the red may vary from 5 to 50 per cent.; normally they are 1 to 250 or 300. The disease is a chronic one and the prognosis unfavourable. Like Hodgkin's disease there may be enlargement of lymphatic glands and intermittent pyrexia. Later in the disease the anæmia becomes profound, œdema of the subcutaneous tissues takes place; and often there are hæmorrhages.

*Treatment.*—Arsenic, phosphorus, cod-liver oil, and iron are the most likely drugs to be useful. Mercurial inunctions may also be tried.

**Diabetes mellitus.**—Though diabetes is much less common in children than in young adults, yet it cannot be said to be rare, as Gerhardt has recorded 111 cases at various ages, from six months to fifteen years. Cases have been observed in infants at the breast, though the diagnosis in such cases may be open to doubt on account of the difficulty of obtaining the urine, and of the uncertainty of detecting small quantities of sugar in the urine. Little can be said about the etiology of these cases; a history of diabetes in the family may, however, often be obtained.

The symptoms noted are those which are present in adults. There is the harsh dry skin, red tongue, marked thirst, and voracious appetite. There is often incontinence of urine on account of the large quantities passed. The specific gravity of the urine is high, 1030 to 1040 or more, and perhaps 5 per cent. or even 10 per cent. of sugar may be found. The child usually wastes, especially if not carefully treated, and is apt to contract a fatal pneumonia. Tuberculosis or chronic phthisis may supervene as in adults. Diabetic coma has also been observed by several authors, and one has come under our own observation, though perhaps it is not so common as it is in the case of young adults. The symptoms commence with headache, dry tongue, and dyspnœa, followed by coma. It is well to bear in mind the possibility of being called to see a child who has rapidly passed into a state of coma without diabetes having been suspected.

The prognosis is mostly unfavourable, though cases are recorded which

made apparently a permanent recovery. In the fatal cases the duration varies from a few weeks to a year.

*Treatment.*—All starch-containing foods and sugar should be forbidden, gluten bread and saccharin being substituted. Milk in moderate quantities or cream may usually be allowed, as children are much more dependent upon milk as a food than are adults. Beef-tea, soups, fish, chicken, and butcher's meat, with gluten bread and green vegetables, will chiefly form the diet. Much difficulty is often experienced in keeping children to a rigid diet, as they hanker after bread and butter or puddings. With regard to drugs, codeia (gr.  $\frac{1}{8}$  to gr.  $\frac{1}{2}$ ) or opium should be given, while the bowels are carefully regulated with Carlsbad salts or Rubinat water. Great care should be exercised to prevent catching cold, or any of the zymotic diseases, since bronchitis, whooping cough, or scarlet fever, is almost certain to unfavourably affect the course of the disease.

**Polyuria—Diabetes insipidus.**—The etiology of this condition is for the most part quite unknown, and it probably owns a variety of causes. Cases of brain disease, of contracted kidney, and of functional diseases of the alimentary canal may be accompanied by polyuria. In the majority of cases no cause can be assigned, and we are obliged to speak of such as idiopathic, much in the same way as we speak of idiopathic anæmia. In a large class of cases polyuria is temporary only. Children, often girls between 3 and 6 years, are noticed to wet their beds, or make water in the day time far more frequently than they have been accustomed to. In the same way boys will wet their trousers frequently during the day when it was thought that they had grown sufficiently old to have learnt proper habits. An examination in such cases will probably show no abnormal constituent of the urine, but that it is of low specific gravity, perhaps 1005 to 1010, and passed in larger amount than usual. In the majority of cases this condition will be found to depend upon digestive derangements or improper feeding; it appears to be a reflex irritation of the kidneys, the source of irritation being in the intestine, the presence of an intestinal catarrh being the cause. Possibly also the deposition of uric acid salts in the kidney may be the cause of a large quantity of watery urine being secreted. The presence of thread worms or round worms in the intestine or rectum also appears at times to produce polyuria. In those rare instances of contracted kidney occurring in childhood large quantities of urine are sometimes passed: in such cases the specific gravity is low, but there will usually be some albumen.

In those cases to which the name of Diabetes insipidus is usually applied there is intense thirst, and large quantities of pale urine with a specific gravity of 1002 to 1005 are passed. A girl of 8½ years under our care, who had suffered for some six months, drank as much as 10 quarts in 24 hours and passed a proportionately large quantity of water. When restricted to 10 pints of fluid daily, she would in the night crawl under the beds to the bathroom to obtain water, or surreptitiously drink her own urine. Such patients have dry, rough skins, are anæmic, and of irritable temper. The course of such cases is exceedingly chronic and post-mortems are seldom obtained.

*Treatment.*—The treatment must depend on the cause. If simply reflex, dependent upon intestinal irritation, a calomel purge may be given and a carefully restricted diet prescribed. In confirmed cases of Diabetes insipidus

various drugs have been tried : opium, strychnine, valerian, and ergot usually fail ; in our own case no drug seemed to check the secretion of urine in the least—a temporary improvement took place during an intercurrent attack of tonsillitis. In all cases the patient should be warmly dressed and protected from cold, as a chill has the effect of checking the perspiration and so increases the secretion of urine.

**Rheumatism.**—Rheumatism, either in its acute or chronic form, is not common during the first four or five years of childhood ; it is commoner after this age, but typical attacks of acute rheumatism occur less often in children than in young adults. Concerning the etiology and pathology of rheumatism but little need be said : hereditary influences, the effects of cold and damp, the retention of waste products in the blood, and the poison of scarlet fever, seem in greater or less degree to predispose to or excite an attack of rheumatism.

**Symptoms.**—These in older children closely resemble those seen in adults, except that the attacks can rarely be called acute, but belong rather to the category of subacute, the attacks being less severe and of shorter duration. The illness sometimes begins with vomiting and chilliness, but more often the first thing complained of is pain and tenderness in the larger joints, which may become red and more or less swollen. The commonest joints to be affected are the larger ones, such as the knees, ankles, hips, wrists, and shoulders ; these are rarely all affected at the same time or indeed in the same attack : much more commonly one or both knees are distended with fluid, while subsequently a wrist or an ankle becomes red, tender, and useless. The joints of the cervical vertebræ are often affected, and occasionally some of the smaller joints, such as the fingers. There is not often much fever, the temperature rarely exceeding  $102^{\circ}$ . Usually there is not much sweating, the joints quickly recover themselves, and the pain and immobility disappear in a few days. Sometimes the only evidence of a rheumatic attack is a slight redness and tenderness about a single joint. It is the exceeding mildness of these attacks as well as the want of intelligence to localise their pains that make attacks of rheumatism readily overlooked in young children. A crying out when disturbed, with a certain amount of paresis or immobility about a limb, may be all there is to indicate an attack of rheumatism, which, mild as it may be, is yet perhaps accompanied by endocarditis which may inflict a life-long injury.

Distinct attacks, however, may be noted in young children, of which the following, a patient seen with Dr. Earle, may be taken as an example. A little girl of twenty-two months was going about as usual on March 22nd ; on being taken up the next morning she seemed in pain and was unable to stand, complaining (apparently) of her left ankle, which was supposed to be sprained. The next day, however, the right ankle appeared to be similarly affected, and during the succeeding two days her knees, elbows, and neck were attacked successively in the same way. On the 27th the knee-joints, especially the left, were considerably swollen and hot with fluid in the joints ; the next day both joints were equally enlarged. The general system was only slightly disturbed, there was no cardiac affection. The knees remained swollen for a few days, but gradually recovered, so that at the end of 13 days she could again walk a little.

In most attacks the child becomes anæmic. Children, like adults, are liable to relapses; usually fresh joints are affected, with the symptoms attendant on the primary attack.

The complications and manifestations of rheumatism are many and of great importance, as they all centre round **peri-endocarditis**, and it is the danger of these cardiac lesions supervening that makes us look with so much care and anxiety at all joint pains in children. As already remarked (see p. 280) it is the exception for children to escape suffering from endocarditis during an attack of acute rheumatism, and moreover peri-endocarditis may supervene with but very slight joint-pain, or the latter may come on later.

**Chorea** is another frequent associate of rheumatism, and may either precede or follow, or sometimes actually complicate, the rheumatic attack. It has been referred to elsewhere.

**Pleurisy** and **Pleuro-pneumonia** occur at times as complications of a rheumatic attack, especially when pericarditis is present.

**Erythema multiforme** and **Urticaria** occasionally occur in connexion with rheumatism and endocarditis. The erythema may take various forms, occurring sometimes as irregular patches of redness, at others as red or white papules. **Erythema nodosum** is not uncommon. In all cases where such forms of erythema occur, the heart should be carefully examined. **Purpura** occurs also at times in rheumatic attacks. Peculiar **nodules**, first described by Drs. Barlow and Warner, occur in some rheumatic cases, mostly in the neighbourhood of joints. They are subcutaneous, the skin being freely movable over them: they are most common at the back of the elbows and wrists, at the ankles, and by the patellæ. They are not painful, and vary in size from a split pea to an almond.

*Diagnosis.*—There is often much difficulty in distinguishing the synovitis which accompanies rheumatism from one or other of the many other forms of synovitis. Thus there is the acute suppurative arthritis of infants, the synovitis of septicæmia and scarlet fever, and the synovitis which is apt to go on to effusion and has a chronic course which chiefly attacks the knees; there are, moreover, the rarer arthritic attacks which accompany hæmophilia and purpura. It may be impossible definitely to say if some arthritic attacks are really rheumatic or not: their subsequent course perhaps may possibly clear up the doubt. In infants and young children it may be difficult to localize the seat of pain in a limb, and consequently a doubt may be raised as to whether in a given case where there is pain and helplessness the joints are affected or not. Such difficulty may arise in the epiphysitis of congenital syphilis and in the tenderness of the periosteum and occasional hæmorrhages which are associated with rickets.

*Treatment.*—On the least suspicion of any joint affection in a child it should be put to bed between the blankets and restricted to a milk diet. It is a comparatively small matter if we are over-cautious in our treatment, in keeping at rest in bed a child who has but slight joint trouble and who appears to the friends to ail little; while it is a grave matter to allow a child who is suffering from incipient endocarditis to get up and run about, or to suffer one to contract endocarditis in consequence of getting up. Knowing the readiness with which peri-endocarditis supervenes in mild attacks of rheumatism in children, it is our duty to warn the friends of this, and to

insist on placing the heart under the most favourable circumstances by giving it as little work to do as possible. This is best accomplished by keeping the child at rest in bed, perhaps for several weeks after all pain and tenderness have disappeared.

In the milder cases the only medicine required will be a simple saline such as citrate of potash ; the affected joints should be painted with extract of belladonna and glycerine, and surrounded with cotton wool. A small dose of Dover's powder may be given at night. In the more severe cases, where many joints are affected and there is much fever, salicylate of soda should be given ; five to ten grains may be given every four hours to children of from 6 to 8 years of age for two or three days and then given only every six hours or three times a day ; it may be prescribed with a saline or given with syrup of orange peel.

In all acute or subacute cases milk is the best form of food ; it may be given in combination with potash, soda, or seltzer water ; as long as there is any fever this should be adhered to. There is always a risk of a relapse if beef tea, soups, or meat are allowed too early during convalescence. Arrowroot, rice, and custards may be allowed when all pain has been absent for several days and the temperature has been normal for a week.

## CHAPTER XIX.

GENERAL DISEASES—*continued.*

**Rickets.**—Rickets is a disease that usually makes its appearance during the first two or three years of life ; it is characterised by nutritional changes and by deformities of the bones, weakness of the muscles and ligaments, and various peculiar nervous disorders. Dentition is retarded ; there is frequently enlargement of the liver and spleen.

The commonest time for rickets to manifest itself is from the first six months to the end of the second year, but it is not uncommonly noted during the first few months of life, and in rare cases infants may be born exhibiting undoubted rickety changes in their bones. Rickets appears to be connected in some way with the growth of the body ; it is during this period that rapid growth is taking place ; the bones are consolidating by the transformation of their softer tissues into bone, the muscles are increasing in size and strength and are becoming more and more under the control of the will, so that the child is passing from helpless infancy to the greater activity of early childhood. During the first year or two of life, even in health, the digestive system is worked to its utmost capacity, in order that it may be able to supply the system with sufficient nutrient material, not only for the exigencies of daily life, but also for the rapid building up of the tissues which is going on at this time ; an impairment of the digestive powers, a weakening of the digestive ferments, or food inadequate in quantity or of an improper kind, necessarily means that the tissues fail to receive the amount of nutriment they require. This failure of the nutrient powers is an important factor in bringing about the changes which characterise rickets. That a state of mal-nutrition does not always produce rickets is certain, but it is certainly true that it often does, and moreover in all cases of rickets of any degree of severity there is evidence of a pre-existing failure of the digestive powers. In some of the milder forms of rickets, when the ribs are seen to be beaded and the bones of the extremities deformed, without any of the symptoms which mark the severer grades, the child may be fat and apparently healthy, and there may be no evidence of a present or past mal-nutrition ; but inquiry will generally elicit some past illness or subacute dyspepsia, or a history of improper feeding, or some conditions which have tended to produce a mal-assimilation or imperfect digestion of the food. Rickets, like caseous glands, may continue to be present long after the exciting cause has passed away.

If it be granted, as we think it must be, that a failure on the part of the alimentary system to supply the rapidly growing body with suitable nutrient material is an important factor in producing rickets, there is yet much left to

explain, inasmuch as atrophy and tuberculosis and all wasting diseases of infants own a similar cause. Why, for instance, should a chronic intestinal catarrh lead on to rickets in one case, tuberculosis in another, gastro-intestinal atrophy in another, and final recovery occur in another? If rickets is produced by mal-assimilation, what are the steps in the process, or in what elements are the nutrient fluids wanting? These are questions that we think cannot be satisfactorily answered, and all we can attempt to do will be to discuss some of the influences which predispose or excite to rickets.

*Hereditary influence.*—Is rickets hereditary? Do parents who have suffered from rickets in their childhood have rickety children, in the same way that phthisical parents have children who readily become tubercular? One great difficulty in answering this question is that it is impossible in a large majority of cases to be able to satisfy one's self, as in the absence of any rickety deformities, whether the parents in any given case suffered from rickets when they were children or not, as they are hardly likely to know themselves and a trustworthy history of their infancy is often not obtainable. Moreover most infants suffer more or less from dyspepsia or have been exposed to conditions which may produce rickets: it is not easy to exclude such, and to say, dogmatically, that a rickety child must have inherited the tendency to this disease. Thus children who have been brought up at the breast of a healthy mother, and who are themselves fat and apparently strong, will sometimes exhibit beaded ribs and other evidences of rickets during their first year, which may be due to the mother's milk being thin and of an inferior quality, being deficient in fat and casein. In some cases, however, observed by Pfeiffer, who analysed the breast milk in eight such cases, this is not so, for in these there was no deviation from the normal amount of casein, fat, sugar, and salts; but there was a deficiency of phosphates in the ash. Pfeiffer believes that the tendency to rickets is hereditary and acts as a predisposing cause, whilst a deficiency, for some reason or other, of phosphates in the breast milk acts as an exciting cause.<sup>1</sup> While the observations are curious and interesting, we believe that in the immense majority of cases where nurslings become rickety it is because the mother's milk is poor, or it is of improper quality from her having taken little care in the matter of her own diet, and the infant has suffered in consequence. The breast milk of a weakly woman, especially at the end of the natural period of lactation, is apt to be poor in nitrogenous and fatty constituents, while the milk sugar is present in abundance and the nursling may be fat and yet weak and rickety.

While we do not believe that it has been satisfactorily shown that a tendency to rickets is hereditary, in the same sense that a tendency to gout or tubercle is hereditary, yet we are far from denying that hereditary influence plays some part in predisposing to rickets. We believe that if either father or mother, especially the latter, is weakly from any cause, their children will be more likely to suffer from rickets. A woman does much manual labour during her pregnancy, more than her strength will really admit of, or she lives under unhealthy conditions: the infant is weakly, is difficult to rear, and becomes rickety; we can hardly doubt that the influence of the mother's health

<sup>1</sup> *Jahrb. f. Kindhik.*, xxiv., H. 3.

has predisposed to rickets, or at least to the digestive troubles which precede rickets. We feel certain that weakly or premature infants may become rickety, even though the greatest pains and care have been bestowed in their feeding and bringing up. The fact that rickets may appear during intra-uterine life and the infant be born with beaded ribs and other symptoms of rickets shows that rickets can be produced apart from any improper feeding, and suggests that the influence of the mother's health during pregnancy may be an important factor in predisposing to the disease.

The influence of the mother's health in producing rickets is seen in large families, where the later children born are apt to be rickety. It happens also at times that first-born children are rickety, especially in those cases where the mother is very young.

Does syphilis in the parents predispose to rickets in the infant? Parrot asserted that rickets was the result of the syphilitic poison, that the latter when worn out or weakened produced rickets. Very few, even among his own countrymen, have accepted his views. Among the foundlings of Paris, and other large cities where syphilis is a common disease, it may be difficult or impossible to say exactly what influence syphilis exerts in producing rickets; in country districts, where syphilis is uncommon and rickets common, it is clearly seen that there is no connexion between the two, or only that the syphilitic poison has a depressing influence on the system and so predisposes to rickets as it appears to do to tuberculosis.

*Dietetic influences.*—It has been stated that infants nursed at the breast of a healthy mother rarely become rickety, we may say never suffer from severe rickets; while infants who have been artificially fed from the first, and who have suffered much from dyspeptic ailments, very frequently are affected. Infants who have suffered from diarrhoea, gastric catarrh, bronchitis, pneumonia, and especially those who have had a hard struggle for life, very frequently become rickety. Infants who were premature, and who have been reared with difficulty, are among those who often suffer. Infants who have been badly fed, and those who from ignorance or necessity have been deprived of fresh milk and have been fed on large quantities of starchy or other foods, are exceedingly likely to suffer from rickets. That improper feeding plays an important part in the production of rickets has been shown in the rearing of the young lions at the Zoological Gardens, and in the feeding of puppies and other animals on lean meat. These animals developed rickets, but improved at once when given milk and pounded bones.<sup>1</sup> The same thing may be seen again and again among our dispensary patients, a marked improvement in the symptoms following their admission to hospital, where a more suitable diet is given than the one which they have been taking.

The question of how far the absence of fresh milk from the dietary of infants, and the substitution of condensed milk, or the free admixture of starchy foods, produces rickets, is a difficult one. A child has been reared for the first five or six months of its life on condensed milk, and towards the end of the first year it is found to be rickety. It is easy to say that the rickets was produced by the infant taking the tinned milk in lieu of fresh milk, but further enquiry may elicit that it took condensed milk because every attempt to feed it on fresh milk, diluted or not, gave rise to vomiting.

<sup>1</sup> See Cheadle, 'Rickets,' Brit. Med. Assoc. Meeting, 1888.

of curd, and the friends were obliged to give it up. The child has suffered from gastro-intestinal catarrh, has evidently been weakly, and this may have been the cause of the rickets rather than the absence of the cow's milk which it could not digest. Moreover, typically healthy children, quite free from rickets, may be found who have been reared on condensed milk. The same remarks may be made with reference to starchy foods; the infants of the poor are frequently given arrowroot, sago, oatmeal, &c., made with milk and water, the reason often being that cow's milk by itself contains more curd than they can digest, and leads to vomiting or diarrhoea. We do not doubt that fresh cow's milk mixed with whey or barley or oatmeal water is the best food for infants in lieu of human milk when it can be digested, but children taking it will often suffer much from dyspepsia, and may become rickety in high degree. That starchy foods, excess of sugar, and excess of curd of milk, assist in causing rickets by setting up an intestinal catarrh, we do not doubt; at the same time we are inclined to think the influence of the first two have been somewhat exaggerated. It is probably the absence, or small quantity, of fat and digestible nitrogenous stuffs present in food, rather than the presence of starch, which gives rise to rickets. The presence of a gastro-intestinal catarrh which interferes with digestion and sets up decomposition in the food taken is probably a potent factor in producing rickets.

*Hygienic and climatic influences.*—The children of the well-to-do classes suffer less from rickets than those of the poor, and when they are affected it is in a milder degree; the same may be said of country children as compared to the denizens of the slums of our great cities. Rickets is more common in damp cold climates than in warmer ones. From these facts we gather that bad ventilation, and absence of fresh air and sunlight, are factors in producing rickets. That this influence is exercised through the digestive organs is very probable.

From the above remarks it is clear that we believe there are several factors in the production of rickets. Hereditary weakness, feebleness of the digestive powers, improper food, breathing vitiated air, exposure to cold and damp, will together, in some instances perhaps singly, produce rickets. Rickets abounds wherever the lower classes of the population are crowded together in courts and slums, where the mothers, from necessity or choice, are unable to suckle their infants, where fresh cow's milk is dear and of poor quality, and infant life is exposed to the various bad influences which poverty and ignorance are certain to produce. Rickets is a rare disease where the parents are strong and healthy, the mother able to nurse her infants, while taking care of her own health and diet, and where she is able to devote her whole time to the care and nurture of her offspring.

*Chemical theories.*—The older authors attributed rickets to the absence, or diminished quantities, of lime salts in the food, but very little observation was sufficient to disprove this. Others (Seeman) have supposed a deficiency of hydrochloric acid in the gastric juice, and that consequently the lime salts, instead of entering the blood, passed through the alimentary canal. Some have thought there was a deficiency of phosphoric acid or phosphates in the food, and that its absence from the blood prevented the formation of bone. The 'acid-theory' has also had supporters, who supposed there was an excess of lactic acid in the blood, which had been formed from the decomposition of

milk in the stomach—the presence of the lactic acid dissolving the lime salts of the bones and carrying them out of the body in the urine. We confess to being completely sceptical concerning all these hypotheses, and much doubt if they explain anything as to the pathogenesis of rickets.

*Symptoms and course.*—The premonitory or early symptoms of rickets may be absent, or so intermingled with those of dyspepsia that it may be impossible to differentiate them. In the slighter grades of rickets the first and perhaps the only signs of the affection are slightly beaded ribs and enlarged epiphyses at the lower ends of the radius and ulna. In the more severe forms of the disease the early symptoms are slight fever, the infant being hot and restless during sleep; abundant perspiration, more especially about the forehead and scalp, may then be noticed; at this time the infant may suffer from convulsions and not infrequently laryngismus. His bones may be more or less tender, so that he cries on being moved or danced about in the nurse's arms, and usually some beading of the ribs can be detected. In the majority of cases the abdomen is habitually distended with wind, and there is mostly constipation, though, on the other hand, the stools may be loose and curdy. The child may be anæmic and the spleen may be felt to be enlarged.

As time goes on it is noted that there is a delay in the appearance of the teeth; if the first two incisors have been cut, a long interval, perhaps many months, elapses before the appearance of the others, and the teeth that have been cut are apt to become carious, from a deficiency in their enamel. The muscular system is almost certain to suffer, the child cannot sit up from weakness of the lumbar muscles, and the spine bows out from laxity of the ligaments; the infant does not use its limbs like a healthy child, making no, or poor, attempts at crawling; its legs are weak, it cannot bear its weight on them or even put them to the ground.

Concurrently with many of these phenomena, marked changes are noted in the bony skeleton. The skull early shows these changes, though, if rickets does not supervene till the middle or end of the second year, the bones of the skull may escape. There is a marked exaggeration of the frontal and parietal eminences, with some flattening of the upper surface, so that there is a sort of table-land at the vertex, the head assuming a more or less quadrate shape. Sometimes there is flattening of the occipital bone behind, so that the back of the head looks as if pressed in. The fontanelles are widely open and may remain so long after they should be closing up, and the edges of the bones where they come together to form the sagittal, coronal, and lambdoidal sutures are thickened. Instead of, or in combination with, these hypertrophic changes at the eminences and edges of the bones, there may be atrophy or thinning of the central parts of the occipital or parietal bones, which has been termed *cranio-tabes*. These weak places can be felt by gentle pressure exerted with the finger on the occipital or parietal bones, of course avoiding the sutures, the bone perhaps bending and bowing in almost like parchment beneath the finger. It has been questioned to what extent *cranio-tabes* is the result of rickets, as it is present at times in undoubtedly syphilitic children, and also in those suffering from various wasting diseases. We doubt whether its connexion with syphilis is anything more than a casual one, but it is certain *cranio-tabes* may be detected in weakly infants a few months old who exhibit no other signs of rickets, and also in newly-born infants. Whether

it is always to be accepted as pathognomonic of commencing rickets is an open question ; but when present in infants over six or eight months of age it is almost always in our experience accompanied with signs of undoubted rickets.

Characteristic changes take place in the chondral ends of the ribs and in the shape of the chest, the latter being most marked in children who suffer from bronchitis. The ribs are enlarged or beaded where they join their cartilages : these may be felt or seen at a glance when the chest is exposed. The shape of the chest walls is altered in consequence of the softening of the costal ends of the ribs ; the rigidity of the chest walls is impaired at this spot, so that there is a falling in of the ribs on each side, while the sternum and cartilages are thrust forward (see fig. 46). The sides of the chest, especially the region included between the 4th and 8th ribs, bend or curve inwards so that a more or less broad vertical groove is formed on each side of the chest.

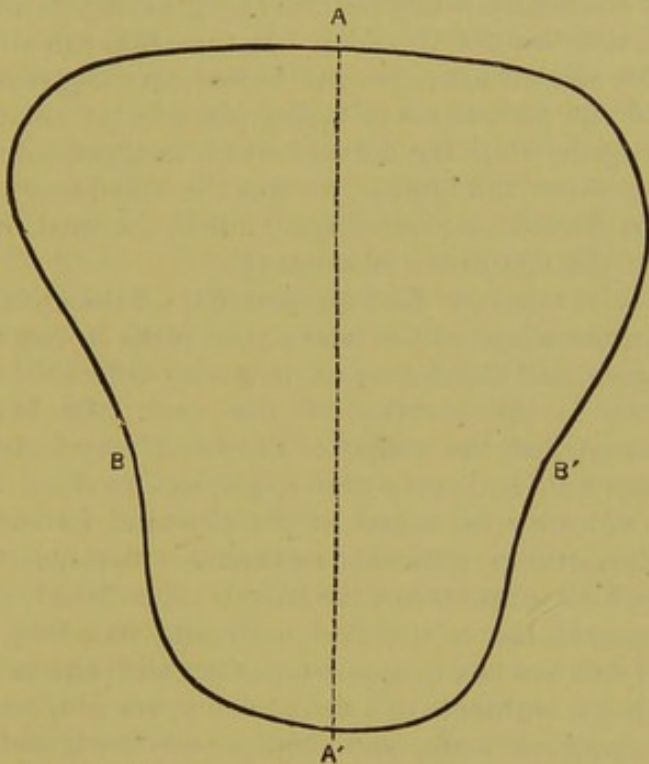


Fig. 46.—Tracing of Chest-wall of a Rickety Boy of 2 years of age.

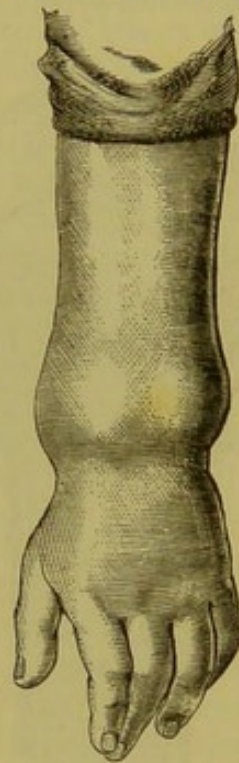


Fig. 47.—Enlargement of Epiphyses of Lower End of Radius and Ulna. Child of 18 months.

The angles of the ribs are often exaggerated or undergo a sharp bending or 'green stick' fracture at this spot. With these changes is mostly associated a widening of the arch which the ribs make inferiorly, and the abdomen is distended and round. If the child be watched, especially if there is any bronchial catarrh, the chest walls will be noticed to fall in at the groove on each side, and the tip of the sternum is drawn in during inspiration. All degrees of chest deformity may be present, from the extreme degree noted above, to a slight prominence or keel-like ridge in front, formed by the sternum, which makes what is called the 'pigeon-breast.' The clavicle often joins in the deformity, its normal double curve being exaggerated. The extremities show peculiar changes, more especially at the lower epiphyses of the radius and ulna, and the tibia ; the shafts are very apt to bend and in the worst cases

to fracture. The lower ends of the radius and ulna are swollen, the swollen portion involving the irregular layer of cartilage, in which calcification is proceeding (see fig. 48), which separates the cartilage of the epiphyses from the shaft; in the worst cases this enlargement is very striking (see figs. 47 and 48). The tibia is usually more or less bent, the curve varying in position and degree; the lower end is, however, most commonly bent inwards (being an exaggeration of the natural curve), so that the convexity is outward (see fig. 57 *et seq.*), a deformity which is produced by the child whilst sitting on the floor, with its legs crossed under it, and shuffling with its legs so as to change its position. The deformity often takes place before the child learns to walk. The deformity known as 'knock-knees' is produced later, after the child has begun to walk (see fig. 56). The other long bones, the femur (see fig. 51 *et seq.*), radius and ulna, and the humerus, are apt to bend: the bowed humerus is sometimes produced by the attendants lifting the child by grasping its arms,

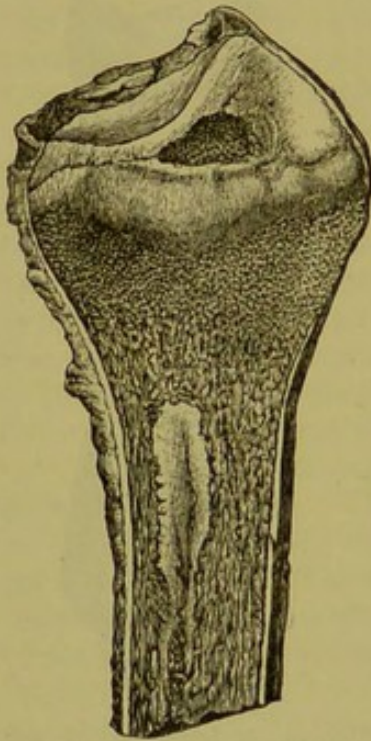


Fig. 48.—Section through Radius of case figured in fig. 47, showing exaggerated depth and irregular borders of the proliferation and columnar zones of cartilage.

just below the shoulder. If the child can sit up the spine is apt to become bowed, an exaggeration of the natural curve taking place in the cervical region, while the dorsal curve is exaggerated and involves the lumbar, so that the spine bows out backwards, a result largely due to the weakening of the ligaments (see fig. 55).

It must not be supposed that all the changes in the shape of the bones take place in any one case, and the degree of deformity differs according to the severity of the case. As before remarked, the shape of the head may be quite normal, and only the epiphysial swelling and deformity be noted in the ribs and fore-arms. Sometimes muscular weakness is the symptom which most strikes the friends: the child is dyspeptic, has a rounded belly and pale face, the teeth are late in appearing; the child, who is perhaps eighteen months or two years old, cannot stand or walk, and medical advice is sought because the parents think the legs are paralysed; or the child is brought to a doctor, as it is supposed he has spinal disease, on account of the bowing backwards of the spine; or the pigeon-breast is the most marked and striking

symptom which alarms the friends.

The phenomena noted in connexion with the nervous system in rickets are among the most important. The whole nervous system appears to be affected, the nerve centres are in an unstable condition and readily discharge on the slightest provocation. General convulsions are common, more especially during the early stages of the disease; they vary much in their severity, sometimes being slight and passing away quickly, but, on the other hand, it is no uncommon thing for a rickety child of a year, eighteen months, or two years to die in a few moments in a fit. Laryngismus is common, and indeed is almost confined to those who are rickety. Tetany

is also common in rickety children. A hypertrophic condition of the brain, with a large head, is not uncommon. Rickety children are exceedingly liable to bronchial catarrh and broncho-pneumonia, and in them all chest troubles are apt to be serious. They are liable also to suffer from dyspeptic troubles, especially diarrhoea.

In the severest forms of rickets the child is apt to become markedly anæmic, and when this is so there is usually enlargement of the spleen. It has been doubted if splenic enlargement is present in uncomplicated rickets, or in those cases only which are combined with syphilis. We certainly have seen cases, where the spleen is enlarged, where no history of syphilis could be obtained. With enlargement of the spleen there is frequently a marked enlargement of the liver.

The course of rickets is towards recovery, but progress is frequently very slow, especially in those cases where there is chronic derangement of the digestive organs. The child is certain to be late in walking; instead of 'feeling his feet' by the end of the first year, he is utterly helpless when his legs are put to the ground, and by the end of the second or even the third, rickety children may be seen who are quite unable to bear their own weight on their legs. All this time perhaps the child is incapable of much exertion and is easily tired. Many dangers attend rickets on account of the weakly state of the child. He is especially liable to catch cold, this may be followed by bronchitis and broncho-pneumonia; the latter is necessarily dangerous on account of the weakness of the ribs and feebleness of the respiratory muscles.

Bronchitis and collapse of lung, or broncho-pneumonia, is exceedingly apt to be fatal when it complicates rickets. One of the effects of rickets is to stunt the child's growth, as well as to leave him with many deformities, which will be discussed in detail later on. The lowering of the child's health produced by rickets may last for many years, but in the vast majority of cases the symptoms and signs of rickets, if they come under treatment, disappear and the child may grow up into a healthy adult.

*Fœtal rickets.*—*Congenital rickets.*—In rare cases children are born with deformed bones, enlarged epiphyses, and beaded ribs—a condition to which the name of rickets can hardly be denied. Other cases have been observed in which the bones have been soft and deformed, but which lacked the characteristics—both naked-eye and microscopic—of rickets. Hence some confusion has arisen, and the terms *infantile osteo-malacia* and *cretinism* have been applied, as it was thought they resembled these rather than rickets. There can hardly be a doubt, however, that children are born rickety or that they become so very shortly after birth. Such cases have been observed by Bode,<sup>1</sup> T. Barlow,<sup>2</sup> and Dr. Marshall (of Preston). In Bode's case the infant was still-born, the mother was healthy. The infant's head was hydrocephalic, the limbs were short and bent, the chest deformed, and the ribs beaded; the pelvis was narrow. The microscopical examination showed changes resembling those found in rickets. In Dr. Barlow's case there was a history of the infant being born with deformed limbs, which were also tender, and when seen at six weeks old the long bones and ribs were typically rickety, and there was a green-stick fracture of the humerus. Dr. Marshall's case was somewhat similar. (See Cretinism.)

<sup>1</sup> Virchow's *Archiv*, 93, H. 3.

<sup>2</sup> *Clin. Soc. Trans.*, vol. xxi.

The terms **acute rickets** and **infantile scurvy** are usually applied to a condition in which there is a high degree of anæmia present, with many of the symptoms of scurvy as well as the phenomena of rickets. Dr. W. B. Cheadle was the first, in this country at least, to recognise this condition, which he described as a combination of scurvy and rickets, and Dr. T. Barlow has largely added to our knowledge of it by his admirable description of a series of cases with post-mortems. The patients, who are commonly from six to eighteen months old, are extremely anæmic, wasted, flabby children, who have been brought up under conditions most suited to the production of rickets, or who have suffered from some acute or prolonged disease. It is usually noticed that they are very fretful, and that any attempt at movement or handling their limbs gives rise to expressions of pain. A careful examination leads to the discovery of a more or less extensive swelling of the limbs, the swelling being due to sub-periosteal or intermuscular extravasations of blood; in such cases incisions have been made in the belief that a sub-periosteal abscess existed. Very frequently purpuric spots or patches are present in the skin; the gums may be spongy, swollen, and hæmorrhagic. Fractures are apt to take place, the common position being just on the diaphysial side of the growing line. Besides the sub-cutaneous hæmorrhages just mentioned, bleeding may take place from various internal organs, more especially the kidneys.

Various opinions have been expressed with regard to the exact nature of such cases; Drs. Cheadle and Barlow both incline to the view that they are really examples of scurvy, brought on by improper food, more especially by the absence of fresh milk from the dietary, it having been noted that many such cases have occurred in infants who have been brought up on condensed milk, starchy and various patent foods. Others incline to the opinion that the condition is rather an exaggerated or excessive form of the anæmia which is usually present in severe rickets, and in our opinion there is much to favour this view.

These cases in some points resemble certain forms of congenital syphilis, but differ from them in the absence of any collateral evidence of syphilis, in the presence of extensive hæmorrhages, and in the age at which the disease occurs,<sup>1</sup> in the results of treatment, and in the acute pain that is present. They also differ in the absence of any joint effusion, and pathologically in the absence of the peculiar 'gelatiniform transformation' of the growing diaphysial extremity.<sup>2</sup>

*Morbid anatomy.*—The most striking appearances in connexion with rickets consist in the changes in the bones. In the first place chemical analysis shows there is a deficiency of lime salts in their constitution, and an excess of organic matters. Normally they contain roughly 65 per cent. of inorganic constituents and 35 per cent. of animal matters; in rickets all degrees of decrease of inorganic matters may take place, but in a severe and well-marked case the proportions are reversed, so that there is only about 35 per cent. of mineral basis and 65 per cent. of gelatinous or organic matters (A. Baginsky). That there is a deficiency in calcium salts is evident from the spongy nature of the bone, its softness, and the readiness with which

<sup>1</sup> Syphilitic epiphysitis usually occurs under six months of age, and may be foetal.

<sup>2</sup> For an account of this affection *vide* Barlow's paper, *Med. Chir. Trans.*, vol. lxvi.

it 'bends'; while the spaces between the bony trabeculae are seen to be filled with juicy material. If a rib taken from a well-marked case of rickets during the acute stage be examined it will be found not only to be wanting in rigidity, but it can be bent about like a thin lath, and if doubled up fractures or 'gives' with the greatest ease; the fracture may be only partial, or perhaps the ends of the bones are only held together by the fibrous and muscular tissues attached to them. In the same way the fore-arm of the cadaver may perhaps be bent by taking it in the two hands and applying moderate force, or it may 'kink,' and on dissection both

radius and ulna will be found to be fractured. Other long bones may behave in a similar way if sufficient force is applied. The ribs where they join the cartilages will be noted to be much swollen; fractures, recent and old, may be present at the angles and the lower ends of the radius and ulna where they join the epiphyses. A section can readily be made with a strong knife through the enlarged end of the rib, and if made in a direction from before backwards it will be seen in most cases that the pleural side is more prominent than the external side of the swelling, and, moreover, the enlargement is produced by the expansion of that portion of cartilage—the proliferation and columnar zones—in which certain changes are going on preparatory to the deposition of lime salts in the matrix of the cartilage. If a comparison be made with the rib end of a healthy child it will be seen in the latter that between the cartilage of the rib, which is yellowish and opaque, and the cancellous tissue of the rib, there is a line of translucent and bluish cartilage, about  $\frac{1}{8}$  in. in breadth at birth, and about  $\frac{1}{24}$  in. at a year or eighteen months old (Kassowitz); this line is perfectly regular and straight, the breadth of it depends upon the rapidity with which growth is going on, which is more rapid during the later months of foetal life and those immediately succeeding birth than it is later. In rickets the activity of these preparatory changes in cartilage is enormously increased, so that the multiplication of cartilage cells takes place with great rapidity, and with

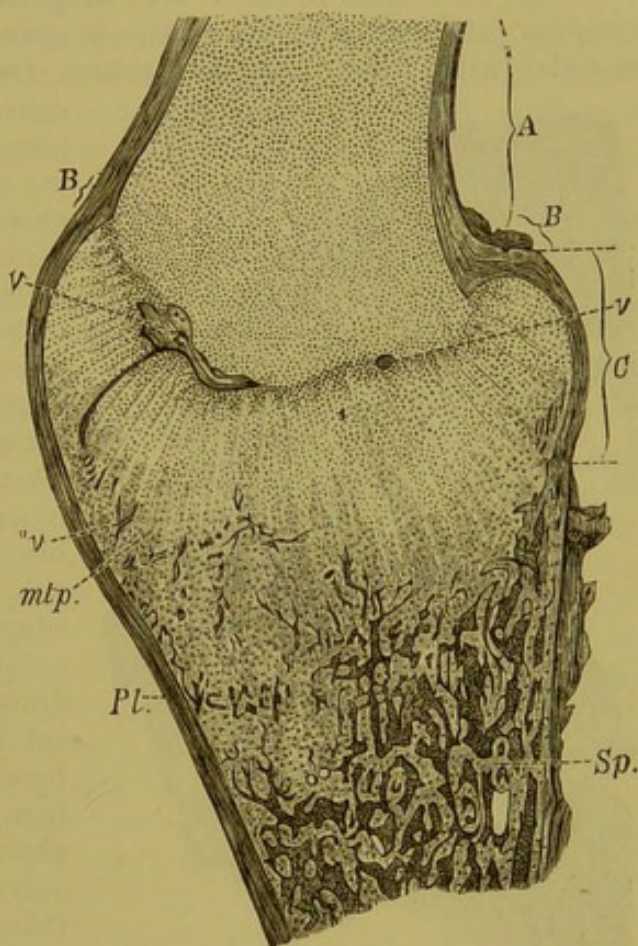


Fig. 49.—Longitudinal section through the junction of a Rib and its Cartilage, from a Rickety Child of 2 years.  $\times 10$ . (Kassowitz.) *Pl.*, pleural side; *A*, normal cartilage; *B*, proliferation zone, deeper than normal; *C*, columnar zone, depth and breadth much increased; *mtp.*, deposition of lime salts in the cartilage—'metaplastic' ossification; *Sp.*, spongy tissue, with wide spaces filled with soft grumous material, containing many cells; *v, v, v*, blood-vessels.

the cancellous tissue of the rib, there is a line of translucent and bluish cartilage, about  $\frac{1}{8}$  in. in breadth at birth, and about  $\frac{1}{24}$  in. at a year or eighteen months old (Kassowitz); this line is perfectly regular and straight, the breadth of it depends upon the rapidity with which growth is going on, which is more rapid during the later months of foetal life and those immediately succeeding birth than it is later. In rickets the activity of these preparatory changes in cartilage is enormously increased, so that the multiplication of cartilage cells takes place with great rapidity, and with

this there is a softening of the cartilage and matrix and a consequent increase in size of the proliferation and columnar zones, so that the translucent line seen in normally growing bone is increased in breadth to perhaps a  $\frac{1}{4}$ -inch or more, and there is a bulging or swelling in this position which is visible through the skin of the chest walls and corresponds to the junction of the ends of the ribs with their cartilages (see fig. 49). Not only does this normal line become a broad band of jelly-like looking material interposed between the cartilage and bone, but the boundary between it and the cancellous tissue is very irregular and ill-defined, inasmuch as an irregular calcification of the matrix is going on, and trabeculae of calcified material with wide medullary spaces are being formed instead of true



Fig. 50. - Transverse section through the Shaft of the Ulna from a Rickety Child of 13 months.  $\times 10$ . (Kassowitz.) Showing spongy tissue beneath the periosteum instead of the compact tissue of normal bone.

cancellous tissue. A spongy structure is built up which is wanting in strength and rigidity. Similar changes are going on beneath the periosteum: there is a calcification of the inner layer, and spongy bone is built up instead of the firm, hard, compact tissue which forms the outer shell of healthy bone (see fig. 50). It is clear that, if the compact hard bone which forms the shaft of the bone is replaced by trabeculae or arches of brittle, badly formed bone, the bone will readily bend and snap, and be simply held together by the fibrous periosteum and perhaps some of the fibroid material which forms in the substance of the bone itself. The bones may remain soft and brittle for many months, but finally they harden, perhaps in a faulty position, and a sort of sclerosis or eburnation of bone takes place, so that the compact tissue of the bone is abnormally hard. Should a fracture take place there is a large amount of callus formed at the seat of fracture.

The bones of the skull are abnormally soft, and can be readily cut with a knife, and are much more readily bent or doubled up than are healthy bones. Their edges are thickened and spongy on section, much juicy-looking fluid exuding; the ossifying centres are usually thickened, so that the frontal and parietal eminences are exaggerated. In some cases prominences or bosses may be present on the parietal or frontal bones, near the sutures, but it has been denied that these are really rickety changes, though they certainly do occur in rickety subjects. Instead of, or in association with, the hypertrophic changes just referred to, certain atrophic changes take place, the bone becoming thin, almost transparent, in places; this thinning of the bone is chiefly present in the

parietal and occipital bones. If the dura mater be stripped off and the bone held up to the light, it will be seen to be thin in places, perhaps almost as thin as parchment; at these spots it readily yields to the pressure of the finger, bending in under the slightest pressure. Rickety skulls are usually large ones, not only that they look large in consequence of the thickness of the prominences on the parietal and frontal bones, but their capacity is increased, the brains being larger than usual; it is possibly the pressure of the brain within that causes the atrophic changes in the bone.

The changes found in the internal organs are not usually very marked unless death has taken place, as it not infrequently does, from bronchopneumonia: then varying degrees of bronchitis, pneumonia, and collapse of lung are present. The brain is frequently found of large size, the convolutions well-marked, the substance fairly firm: such brains are said to contain an excess of the neuroglia elements. The liver and spleen are usually enlarged and firm, and the former on section has a 'gummy' or more or less translucent appearance. Concerning the blood but few observations have been made. Dr. Goodhart has observed in some of his cases a deficiency of corpuscles, in some deficiency of colouring matters, in some the blood crowded with a granular detritus, and in others the corpuscles were represented by four or five different sizes.

*Treatment.*—If rickets is due to the mal-assimilation of the products of digestion or to faulty digestive processes, we can hardly hope to discover any specific for its cure, but must direct all our efforts to secure that suitable nourishment in appropriate quantities is taken, and that the digestive apparatus shall be in good working order. Directly the first symptoms make their appearance, whether they are tenderness of the bones, sweating about the head, or enlarged epiphyses, we should carefully enquire into the diet, as it is probable that the child is either not digesting its food properly, or it is not being properly fed. The condition of the digestive organs and the state of the blood act and react on one another, the intestinal juices are weak because the blood from which they derive the materials to form their secretions is weak and poor in quality, and the blood remains of poor quality because the digestive juices are feeble and unable to convert albumen into peptones, and supply the first step towards converting the food taken into blood. The child suffering from rickets in the acute stages requires albuminous and fatty foods in the most concentrated and easily digested forms, while saccharine and starchy foods must be avoided or be taken in the most moderate quantities. Probably it will be found that a child so affected is suffering from dyspepsia, the abdomen is large and distended with gases given off during intestinal digestion, while large masses of undigested curd are being passed. The treatment must be commenced by cutting down the supply of curd of milk, by diluting it largely with whey, or giving peptonised milk gruel or Benger's oatmeal food. In the worst cases milk may have to be withdrawn entirely for a while, and raw or semi-cooked meat-juice with barley-water or Mellin's food substituted. In older children pounded raw meat may be given. Dextrin and maltose in any form are preferable to sugar in excess or starches. Cream in small quantity will often agree, though

fat in the form of cod-liver oil is often more readily digested than any other form. A well-made emulsion may be given at any time, beginning, if there is much digestive disturbance, with a few drops only, care being taken not to give an excessive quantity. Orange juice or lemon juice and glycerine, or other forms of fruit juice, are useful, especially in cases of so-called 'acute rickets,' in which there is a condition of scurvy.

The importance of fresh air, especially sea-air, in the treatment of rickets, cannot be over-estimated, and when the disease first declares itself a change to the seaside or into the country if the weather is warm enough is likely to be attended with the greatest benefit. In urging the friends to send the child out into the open air the tendency which rickety children have to bronchitis must not be forgotten, and the importance of warm woollen garments must be insisted on; especially is this important where there is much sweating. If the weather is cool, the child's feet should be carefully wrapped up while he is out in his carriage; a bottle of hot water at his feet will often prevent a chill.

The most careful handling must be practised in acute cases, as the bones easily fracture, or a hæmorrhage may take place. The prone position on soft cushions in a cot or carriage is better than much nursing in the arms, as the limbs are easily bent and the spine bows out if the child is allowed to sit up much.

Of medicines the most important are those which assist digestion or correct the faulty condition of the mucous membrane of the stomach and bowels, and those which aid nutrition and improve the character of the blood. Vomiting, constipation, dyspepsia, and diarrhœa must be treated by appropriate medicines: small doses of mercury and chalk, rhubarb and soda, pepsine or bismuth; care should always be taken to overcome the constipation so often present. Of tonics, cod-liver oil emulsion, or cod-liver oil in combination with malt extract, is by far the most important, though in practice it is common to find it is being given in excessive quantities and at a time when the digestion is enfeebled. In such cases it may be given by inunction. Phosphate of soda with tartrate of iron and glycerine is a useful tonic, assisting the action of the bowels and combating the anæmia so often present. Iodide of iron is also useful.

Small doses of phosphorus have been given by Kassowitz, Wegner, and A. Jacobi, who claim for it an almost specific action. Other physicians have been disappointed with the results obtained by its administration. It may be given in doses of  $\frac{1}{200}$  to  $\frac{1}{100}$  gr. in cod-liver oil, two or three times a day.

**Rickety Deformities.**—Distortions of the lower limbs as a result of rickets form a large and important group of the deformities of childhood. Most commonly all the long bones of the limb are affected, and there may or may not be distortion of the articular surfaces at the knee. In many instances the deformity is limited or at least most marked either in the shaft of the femur, the lower third of the tibia, or the lower end of the femur.

Curvature of the shaft of the **femur** takes place either with its convexity forwards or in severe cases forwards and outwards. There is then a wide space between the thighs, and the quadriceps stands out very prominently over the convexity of the bone; the patient is short and stunted-looking,

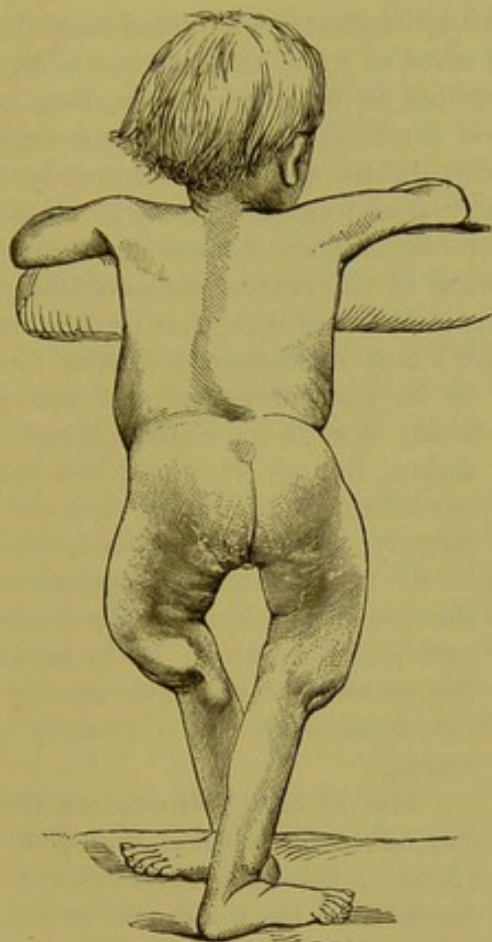


Fig. 51.—Rickety Deformity of the Femora, caused by the attitude shown in the next figure.

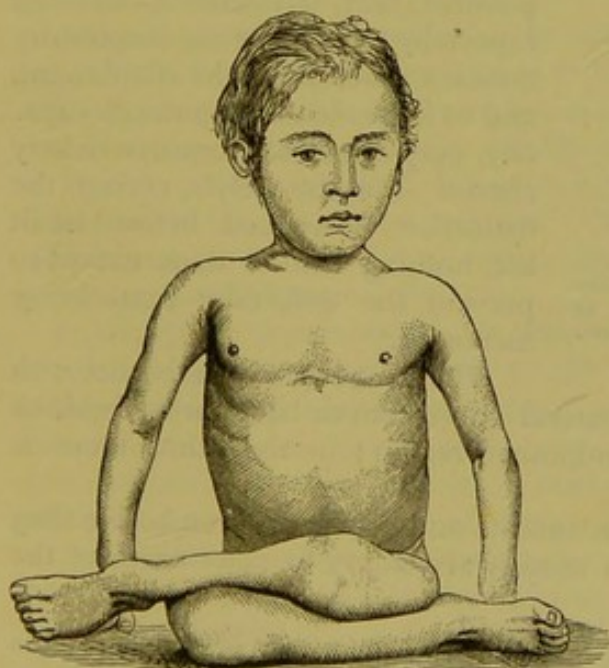


Fig. 52.—Shows the attitude habitually assumed by this child, which resulted in the deformity shown in fig. 51.

the gait waddling, and there is knock-knee or bow-leg to a greater or less degree.

The whole of the shaft takes part in the curve, as is seen in fig. 51. In this child the deformity was extreme, and was accompanied by so much rotation of the lower end of the femur upon a vertical axis that the leg and foot faced directly outwards instead of forwards.<sup>1</sup>

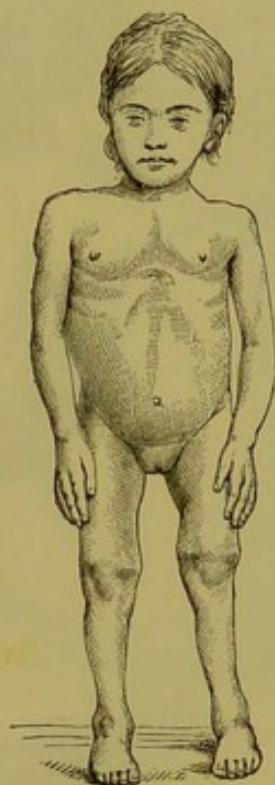


Fig. 53.—The same child shown in the last two figures. The limbs have been straightened by osteotomy.

Sometimes the curve is limited to the lower end of the diaphysis (*vide* Macewen and Mickulicz).

Rickety deformities of the **upper limb** are seldom of such extent as to interfere with the

<sup>1</sup> In this case osteotomy was performed at the most convex part, and the limb turned round as well as straightened, so that ultimately the feet were natural in position (fig. 53).

perfect use of the arms or to require operative treatment. Obviously this is because no such strain is put upon the arms as upon the legs in childhood. It is rare for even the application of splints to be necessary, and we have hardly ever had occasion to straighten forcibly, never to osteotomise, a rickety deformity of the arms. The distortions are most commonly produced by the child crawling upon the hands, and consist chiefly in bendings of the shafts of the bones. We have, however, seen a condition analogous to *genu valgum*, but reversed: i.e. instead of the normal outward obliquity of the fore-arm in extension, it was directed inwards so that the convexity of the bend was outwards at the elbow; this disappeared during flexion

as in *genu valgum*, and was probably due to a similar bony condition, though we could not satisfy ourselves of the exact seat of deformity. A similar condition may occur as a result of separation of the lower epiphysis of the humerus and irregular union. In the humerus the deformity consists usually in curvature with the convexity outwards.

The rickety deformities chiefly amenable to surgical treatment are those of the spine and limbs; distortions of the chest and pelvis can only be improved by general management of the health and prevented from getting worse, though it is possible that gymnastics, directed especially to exercise the inspiratory muscles other than the diaphragm, and to increase the inspiratory capacity, may somewhat improve rickety chests. For the pelvis, even if the distortion is noticed before adult life, nothing can be done except to prevent the deformity from being increased.<sup>1</sup>



Fig. 54.—A child aged 7 years, showing extreme stunting from premature Synostosis, as well as various deformities, all the result of Rickets. The child could not stand alone.

The **rickety spine** is met with in two forms: in one there is a general curve convex backwards, *kyphosis* (fig. 55), affecting the whole dorso-lumbar region; in the other there is *lordosis* (fig. 54).

The first form is that met with in infants and young children before they begin to walk; the other variety is usually secondary to deformities of the

<sup>1</sup> Chance, quoted by Noble Smith, found pelvic deformity in only 16 cases out of 600 rickety patients, while Reeves found it deformed in 210 cases out of 1,000. Lane believes the deformities of the lower limbs are all secondary to alteration in the shape of the sacrum.

lower limbs, and is therefore most frequently met with after the age of two years. Lateral curvature is considered later.

The kyphotic rickety spine is readily distinguished from other spinal curvatures by the age of the child, the evidence of rickets elsewhere, the extent of the curve, which is large and rounded, never acute or angular, and the flexibility of the spine, so that by laying the child flat or holding it horizontally by its arms and thighs, face downwards, the curve speedily disappears. Care must of course be taken in applying this test. Finally there is no pain, except in some cases the general rickety tenderness, and no evidence of caries in the shape of abscess, paralysis, &c. The attitude of a child suffering from rickety spine is well seen in fig. 55 as compared with that in caries (figs. 109 and 110).

All that is required in this condition is the general treatment of the rickets, and recumbency, not implying by this that the child is to be kept in bed in a stuffy room, but that it is not to be kept sitting up on its nurse's lap except for very short periods at a time. These means should be continued until the health is improved and the spinal muscles strengthened by friction and salt-water bathing. A sheet of gutta-percha or other material may be bandaged to the spine to keep it straight, if preferred, in the intervals of friction (Noble Smith). Unless neglected, the spine always recovers, and regains or rather develops its natural curves.

The lordosis of rickets may be mistaken for a secondary deformity due to hip disease, congenital dislocation of the hips, &c., but the absence of these conditions is readily made out, and other rickety deformities will be found present. Its appearance is seen in fig. 54, which may be compared with that of a case of congenital dislocation (fig. 125).

It should be remembered that lordosis always results from some cause tending to throw the upper part of the spine forward in standing, such as caries of the upper part of the column, stiffness of the hip joints, distortion of the legs, or undue weight in the upper part of the body or head; in very rare instances lordosis may result from caries of the spine directly, chiefly when the arches are the seat of disease: it is then due either to actual destruction of the arches or to muscular spasm. Lordosis combined with a lateral curve may result from unilateral deformity of the lower limb in infantile paralysis, loss or shortening of one leg, &c; all these possibilities should therefore be kept in mind before it is concluded that the condition is simply rickety.

As the lordosis is usually secondary, as already stated, to deformities of



Fig. 55.—Rickety Curvature of the Spine. The Antero-Posterior form.

the legs, its treatment must be secondary to that of the limbs, and no special applications or apparatus are required.

Where it is compensatory to angular curvature it is of course necessary, and does not admit of treatment.

**Knock-knees.**—Deformity of the lower end of the femur, resulting in knock-knee or *genu valgum*, occurs in several different ways besides the one already described. The inner part of the shaft at the epiphysial line sometimes grows more rapidly than the outer (Mickulicz), hence the inner half of the shaft is longer than the outer, the inner condyle descends lower, the line of the knee-joint becomes oblique, and the tibia is set at an obtuse angle with the femur.<sup>1</sup> Sometimes the same results follow from absolute overgrowth of the inner half of the epiphysis and the internal condyle as compared with the outer. In other instances, dependent upon the irregular



Fig. 56.—An ordinary case of Knock-Knee.

ossification characteristic of rickets, the outer condyle does not develop, and, though the inner half of the epiphysis is not absolutely larger than in health, it is so relatively to the aborted external part. Again, the soft, ill-developed rickety bone, though symmetrical at one time, actually wastes or is absorbed as the result of pressure, and a corresponding deformity results. No doubt in some of these children a yielding of soft ill-formed ligaments is the primary condition, and the bone changes only occur as the result of the slight obliquity produced by this yielding. The deformity is, however, sometimes congenital.

In explaining the cause of the particular kind of deformity it must be remembered first that the femur is normally set at an angle with the tibia,

and not vertically upon it; secondly, that these children often assume attitudes in which the weight of the body and limbs so presses upon certain parts of the shafts of the bones that they yield and curves result. Such deformities are produced by habitually sitting cross-legged, as is seen in figs. 52, &c. Other reasons are that in certain cases congenital inequality in length of the limbs throws the weight of the body both unequally and obliquely upon one leg;<sup>2</sup> and again, where the deformity has arisen before the age at which walking begins the pressure of the nurse's arms and the leverage of the weight of the limbs themselves acting over the nurse's arms may produce deviation. Congenital or acquired valgus, slight degrees of infantile paralysis, or any cause

<sup>1</sup> This condition may be due to premature synostosis at the outer half of the growing line (Ollier and Tripiër), a condition found so often in rickets, and explaining largely the stunted form of extreme cases. *Vide* figs. 54 and 59.

Reeves has laid stress strongly upon this fact.

tending to throw the weight out of the normal line, will in some instances prove the starting point. In all cases it is clear that as the bones are soft and unduly yielding a pressure that would have no effect upon a healthy bone will cause deviation in a rickety child, and that when once the curve is started it will always tend to increase more rapidly.

It is not improbable that the irregular ossification of rickets prevents the normal architecture of the bone from being built up and so weakens it, i.e. the special arrangement of arches and struts in the cancellous tissue is not preserved.

Sometimes knock-knee is due to distortion of the tibia rather than the femur, and it will usually be found that the upper tibial articular surfaces are misshapen and bevelled off. This is, however, generally a secondary condition.<sup>1</sup>

**Bow-leg**, *genu varum* or *genu extrorsum*, is a deformity which, though dependent upon the same general causes as knock-knee, differs from it in most instances in its mechanical causes; thus it is rarely dependent upon a local inequality of growth in the lower end of the femur, but is usually a general as opposed to a local curve of both femur and tibia, and is not limited to the region of the knee. It is most commonly found in one leg, the other being the subject of knock-knee, and in such cases it will nearly always be found that the knock-knee has appeared first and the bow-leg later: in fact, the bow-leg is the result of the knock-knee. If such a patient is stripped it will be found that the axis of the trunk is directed from one shoulder obliquely downwards and outwards to the hip of the knock-kneed limb: then the line of pressure, following the axis of the thigh of that side if produced, would pass through the region of the opposite knee: hence yielding to this pressure produces an outward bowing of the whole of the opposite limb. It is true that the curve of bow-leg is not quite even, and is usually sharpest at the weakest part of the leg—the lower third of the tibia; much more rarely there is a true *genu varum* or bowing out, mainly at the knee itself; in such cases the head of the fibula is usually very prominent.

Double *genu valgum* occurs when the changes in both legs begin at the same time, and go on at the same rate; double bow-leg results either from local changes exactly opposite to those of knock-knee, or more often is started by the position assumed in sitting by the child, and increased by the weight of the body subsequently. Thus it is common to see children sitting on the floor with both thighs somewhat abducted and rotated outwards: in this position the limbs rest on the hips and ankles, and the knees are quite unsupported. The weight of the limbs then tends to bend them outwards and produces bow-leg, while if the feet are crossed one over the other the curve will be most marked at the lower third of the tibia and the leg which rests upon the other will have more of an anterior and less of an external curve than its fellow (fig. 57).

Deformities of the **tibia** are more complex and difficult to explain than those of the femur; besides the general outward curve already described as a part of bow-leg there are found curvatures of the tibia alone, the femur remaining quite or nearly straight. The most common curve in the

<sup>1</sup> Noble Smith believes it to be a main cause of knock-knee.

tibia is a sharp bend with its convexity outwards and forwards at the lower third.

Sometimes there is a projection outwards and backwards of the upper part of the shaft, just below the tuberosities, giving almost the appearance of a subluxation backwards at the knee-joint. There is sometimes a condition of hyperextension in these patients, but the appearance is, we think, often due to the distortion mentioned (fig. 54).

In some cases there is a bend forwards and inwards at the middle of the shaft, or rather, as this is associated with *genu valgum*, it is to be described as a bending outwards and backwards of the lower half of the leg upon the upper.

It is common in severe cases of *genu valgum* to find a well-marked rotation of the tibia upon its vertical axis, just as already described in the femur, so that instead of looking inwards and forwards the inner or subcutaneous surface of the tibia looks almost directly forwards (or sometimes the rotation is inwards



Fig. 57.—Shows how sitting 'cross-legged' produces Curvature of the Tibiæ. The right foot is resting on the ground.



Fig. 58.—An ordinary Case of Bow-leg.

—Reeves); the upper third of the tibia may look almost directly forwards, the lower third inwards and backwards. In such cases the inner border of the tibia is very strongly marked, forming a prominent ridge somewhat spirally twisted, ending below at the convexity of the forward curve and above at the inner side of the internal tuberosity (fig. 59). In many cases, especially in those of long standing, whether this inner border is well marked or not, there is a prominent spur-like buttress of bone developed below the inner tuberosity at the insertion of the internal lateral ligament: this spur, the existence of which was, we believe, first pointed out by Mr. Clement Lucas, is probably the result of ossification of the ligament as a result of strain and irritation, just as in the case of 'rider's bone' and other instances of bony overgrowth at the attachment of greatly used muscles. The prominent ridges, as stated by Mr. Noble Smith, are most marked when the disease is arrested and the stage of hyperostosis has come on. Sometimes there is a flat surface of bone running up from the spur to the inner condyle of the femur (Macewen); in severe cases this is very striking, and the

spur reaches down far below the direct insertion of the ligament. Two other conditions associated with these deformities require notice: one is that the patella in severe cases of knock-knee tends to ride outwards upon the external condyle, and even to be dislocated quite to its outer surface during flexion of the limb. This is the result partly of deficient size of the external condyle and partly of the bony curves, so that the quadriceps, acting in a straight line, does not make traction in the axis of the bones. The patella may also sink so deeply into the intercondylar notch in flexion that its position may be marked by a depression. The other condition referred to is the direction and arch of the foot. In knock-knee the foot would naturally point outwards in consequence of the alteration in the axis of the limb, while in bow-leg the toes point usually, though not always, forwards or slightly inwards. Besides this there is in some instances flat-foot more or less severe. It has been asserted that flat-foot is really the cause of *genu valgum*, but that this is not so in by any means most cases is readily shown. Very often instead of flat-foot there is a condition of *pes cavus* together with a peculiar spasmodic contraction of the great toe. Both the cavus and the spasm of the flexor of the great toe are evidently due to the efforts made to obtain a firm grip of the ground in order that the instability caused by the knock-knee may be counteracted. Sometimes the great toe spasm exists when flat-foot is present, and it is seen in bow-leg and curve of the tibia alone as well as in knock-knee. The foot is inverted to prevent strain upon the internal lateral ligament of the ankle, the flexors of the toes, and tibialis posticus, as well as to allow the foot to be placed flat upon the ground; this tends to bring the bearing point upon the outer side of the foot and to remove the ball of the great toe from the ground: then, to compensate for this, the toe is flexed so that the last phalanx may take a share in the support of the body. These points are to some extent shown in the preceding figures.<sup>1</sup>

To summarise, then, the following deformities may exist in the lower limbs as a result of rickets.

1. Curvature of the shaft of the femur, with its convexity forwards, or



Fig. 59.—A case of severe Rickets, showing most of the commoner deformities, as well as dwarfing from Synostosis.

<sup>1</sup> Macewen believes that flat-foot occurs in children before walking, but that on walking the cavus and toe spasm are developed.

forwards and outwards throughout its whole length, together with rotation of the lower half upon the upper through a vertical axis.

2. Diaphysial overgrowth on one side of the growing line, absolute, or relative from synostosis of the other half.

3. Overgrowth of either condyle, with absolute or relative smallness of the other condyle.

4. Curvature of the lower third of the femur, with its convexity inwards (according to Macewen the commonest cause of *genu valgum*).

5. Curvature of the shaft of the tibia as a whole, the convexity being directed outwards.

6. Curvature of the upper part of the tibia, so that the convexity is directed backwards and outwards: possibly this distortion is sometimes at the epiphysial line.

7. Curvature of the shaft of the tibia at the middle, the convexity being directed forwards, or forwards and inwards.

8. Curvature of the shaft of the tibia at its lower third, the convexity looking forwards and outwards, more rarely directly forwards.

9. Rotation of the tibia spirally upon a vertical axis.

10. Overgrowth of the ridges on the tibia, especially the internal border and the region below the inner tuberosity; similar outgrowths sometimes occur about the internal condyle and along the concavities of the curves of the femur, as well as in the neighbourhood of any of the epiphysial lines.

11. Dislocation of the patella outwards.

12. Flat-foot, pes cavus, spasmodic contraction of the flexor longus pollicis.

13. The muscles and ligaments on the concavity of the curves in either direction may be contracted and shortened, those on the convexity stretched and weakened.

14. The pelvis and lower limbs may be stunted as a whole from lack of development or premature synostosis.

**Late Rickets.**—Though perhaps hardly coming into the category of children's diseases, mention must be made of the so-called 'late rickets,' or 'rickets of adolescence,' in which deformities, knock-knee, flat-foot, and more rarely bow-leg, come on between the ages of twelve and twenty years or thereabouts, the deformity being a bony and not merely a muscular or ligamentous one in the case of knock-knee.

This condition has been attributed to a disease allied to osteomalacia; it has also been described as relapsed rickets, and by Mr. Lucas has been said to be associated with masturbation and albuminuria. As to these alleged causes we may say that it is not often, we think, relapsed rickets, for we have seen many instances where there was no evidence that rickets had ever existed in childhood. It is not osteomalacia, for the patients never die of the disease, the process becomes arrested, and it does not occur under the conditions met with, nor attack the parts affected in osteomalacia. It is certainly not due to, nor even associated with, either albuminuria or masturbation in any means all instances. We have examined such patients a good many times, and in only one was there even a trace of albumen in the urine, and, as is well known, this may occur quite apart from the condition under discussion; in none of our cases was there any evidence of masturbation. It is, we believe, due simply to weak health, bad air, long standing, poor food—

in short, to bad hygienic conditions at a time when growth is active in the limbs—in fact, mainly to those causes which produce rickets in earlier life, but in consequence of the greater strength of the skeleton and its more complete ossification as a rule it only produces deformity in those parts on which the greatest strain is thrown ; in some cases there is well-marked enlargement of the epiphyses, of recent appearance, and not dating back to the usual time of rickets : this we have seen, and other cases have been recorded where both the external and microscopical appearances were identical with rickets.<sup>1</sup> The affection is, we think, best described as late rickets ; it furnishes a large number of the patients upon whom osteotomy in adult life is performed.<sup>2</sup>

*Summary.*—A child then suffering from knock-knee, the result of rickets, will present the following appearances in addition to evidences of rickets in other parts. As he stands the femora will be seen to project markedly forwards and outwards, the extensors of the thigh being firm and prominent. There is often some flexion of the thighs upon the pelvis, and of the legs upon the thighs ; and secondary lordosis, resulting in a peculiar doubled-up and crouching attitude. The legs are set at an obtuse angle with the thighs, the patellæ are displaced outwards, and the internal condyles of the femora look forwards and inwards instead of directly inwards ; the whole limb is, in fact, rotated outwards. The tibial ridges are unduly developed, and there is a spiral twist in the leg. The feet are directed outwards, though the toes are somewhat adducted, and spasmodically grasp the floor, the flexors being strongly contracted, especially that of the great toe ; the arch of the foot is exaggerated, or may, on the other hand, be lost. In walking one knee passes in front of the other, in severe cases to such an extent that the appearance is that of a person walking cross-legged. The patient's height is much less than it should be from the actual length of the limbs, and he is easily tired and complains of aching of the legs, especially on the inner side of the knee if the deformity is increasing. In other instances, however, though much deformed, the child is as active and sturdy as his fellows, and makes no complaint of pain or tiredness ; when this is so, the distortion is usually not increasing. On examining the knees more closely it is found that on flexion of the joint the leg can be brought into the same line with the thigh, a result due to the slipping back of the tibia from the more prominent part of the condyles to the posterior surface.<sup>3</sup> The internal condyle can be felt to be larger and to descend lower than the external, so that if the limb is placed in such position that the lower borders of the two condyles are on the same level the axis of the femur is much more oblique than in a healthy limb (Reeves). The patella in extension keeps its natural position ; while in flexion, as already noticed, it slips outwards and leaves the inter-condylar notch plainly perceptible,<sup>4</sup> the appearance being much that of

<sup>1</sup> *Vide* Clutton, *St. Thomas's Hospital Reports*, 1884, and Mickulicz referred to in Macewen's book.

<sup>2</sup> Mr. Reeves in *Practical Orthopædics* gives an elaborate account of the causation of these deformities, which we are not altogether able to follow.

<sup>3</sup> Other explanations have been given, such as that it is due to rotation of the femur at the hip (Noble Smith) ; but this is not very intelligible. Reeves gives Busch's view that it is due to obliquity of the axis of rotation.

<sup>4</sup> This occurs only in severe cases.

fig. 138. On attempting to straighten the limb during extension this will be found impossible, though a little lateral movement may take place, and the tendons of the biceps and the ilio-tibial band of fascia will become very tense. The head of the fibula is sunken and concealed deep within the angle between the tibia and femur. The seat of pain and the tubercle at the insertion of the internal lateral ligament have been already alluded to.

The degree of deformity present varies greatly, but never reaches nearly the extent in children that it does in adults; in an adult case we have seen the leg almost at a right angle with the thigh, and in another that we operated upon there was  $19\frac{1}{2}$  inches between the malleoli when the inner condyles were in contact. In double *genu valgum* 10 inches deviation would be an extreme case in a child, and five inches a severe one.

In measuring the deformity it is best to lay the child upon a flat, hard surface; the legs must then be fully extended and rotated inwards until the front of the lower end of the femur looks directly forwards; the two internal condyles are then to be put just touching one another. A vertical line is then drawn through the umbilicus and centre of the pubes downwards to the level of the malleoli, and in measuring the distance from the inner malleolus on each side to the vertical line the amount of deviation will be ascertained. In double *genu valgum* the line will, if the limbs are symmetrical, pass through the point of contact of the condyles, while in bow-leg it will lie far within the arc of the upper part of the limb, but may pass to the outer side of, or through, the ankle.

Knock-knee in children does not always depend upon rickets, and it is important to recognise this fact. It may simply be the result of lax ligaments without any primary or even secondary alteration in shape of the bones; thus a child may have marked *genu valgum* while standing up, but on lying down it may be possible to bring the legs perfectly straight, and to again produce the deformity by steadying the thigh and abducting the leg; a distinct gap will then be felt between the femur and tibia on the inner side, and lateral rocking may be easily shown. In such patients the deformity may after a time become permanent from stretching of the muscles and ligaments on the inner side and contracture of those on the outer aspect.

A similar deformity in one of our patients was the result simply, apparently, of hysterical contraction of the muscles on the outer side, with weakness of the internal set, '*muscular spasm*' (Guerin).

*Treatment of Rickety Deformities.*—The degree of deformity, the age of the patient, and the state of the disease, whether stationary or getting worse, and the amount of care and trouble that can be bestowed upon the child, are the points to be considered in the treatment of these cases. Thus it is useless to attempt to treat by instruments, and so on, a very severe case of distortion, while, on the other hand, it is rarely necessary to perform osteotomy upon a child under three years old because the application of splints with or without previous forcible straightening, if it is a case of curve of the tibia alone, will usually suffice for a cure. Again, if the deformity has been stationary for some time and it is probable, therefore, that the post-rickety sclerosis of bone has taken place, it is useless to think of straightening the leg without operation, while if the curvature is getting worse it is probable that the bones are still sufficiently soft to yield to pressure. Besides these considerations comes the

very important one of the amount of care and time that can be bestowed upon the child : it is not only justifiable, but necessary, to perform osteotomy upon many children who could be straightened perfectly well without operation if they could be seen frequently by the surgeon, be kept off their legs, and their splints properly applied, but who are neglected, allowed to get about anyhow, and their splints are applied wrongly or not at all. In such cases it is mere waste of time to do anything short of operation ; hence we have frequently osteotomised or forcibly straightened the limbs of children between two and four years old, and we entirely disagree with the view that it is barbarous to operate upon young children who could be straightened without operation if it were possible to give all alike the same care and time. At any rate it is practically a choice between their remaining crooked and osteotomy or fracture. The general constitutional treatment of rickets has been already considered elsewhere. The local treatment consists in operative and non-operative means.

*Treatment without operation.*—In a young child with the deformity increasing, but not very severe, who can be well looked after, the treatment of knock-knee consists in forbidding him to stand at all, in bathing and rubbing the limbs well to improve their circulation and muscular power, and in using firm, steady traction in the direction of straightening the limb, as if to break the leg across the knee, for ten minutes at a time night and morning, such force as can be borne without pain being employed, and care being taken that the limb is fully extended. For the rest of the day and at night the child should wear a light, slightly hollowed, straight splint, long enough to reach from the top of the trochanter to just below the sole of the foot. This splint should be fixed to the upper part of the thigh and the lower part of the leg by inelastic webbing straps, while over the prominence of the knee an elastic strap should be applied to draw the knee outwards against the splint ; we prefer this plan to bandaging only. As soon as the child's health is improved, or if the case is very slight, a shorter splint may be employed and he may be allowed to walk about wearing it.<sup>1</sup> If it can be afforded a light iron splint may be used instead of the wooden one.

If the distortion is at all severe a practical difficulty will be met with in applying and keeping on the wooden splint : it will be found that the splint slips round to the antero-external aspect of the limb instead of remaining at the outer side ; when this happens no traction is exerted upon the knee and the splint is useless. In such cases, if the iron cannot be obtained, a back splint rather broader than the limb and as long as the outside one should be first applied, and then the outside splint put on with its edge resting against the edge of the back splint : this will be found to prevent rotation. The two splints can be joined together so as to make a single half-box splint, a plan first used, we believe, at the Victoria Hospital, Chelsea. Thomas's knee-splint may also be used for these cases : its advantages are that the child can get about from the first, and that elastic traction can be employed with it ; its disadvantages that it is somewhat troublesome to get made correctly, except at a price of a guinea, and that it is somewhat difficult to prevent rotation in it. Many other forms of appliance

<sup>1</sup> We may here again remark, once for all, that a child may get fresh air and exercise without walking, and that in the poorer classes, where we chiefly find these deformities, it is useless to attempt treatment in at all severe cases if the child walks about.

may be bought, but the ones mentioned are in our opinion the best. Whatever splint is employed, complete extension of the limb is necessary for the apparatus to produce any effect.<sup>1</sup> For bow-leg it is only necessary to apply the splint on the inner side instead of the outer, and it is much easier to manage, since there is little tendency to rotation of the splint. Lateral curve of the tibia is treated in the same way, but the splint need not reach above the knee; the anterior curve requires a back splint with a foot-piece, and is more troublesome to manage, pressure being difficult to apply without causing pain at the heel. A simple anterior curve is, however, much less serious a deformity than the other, and much more prone to improve without apparatus.

*Operative treatment of rickety deformities.*—Operation is required in patients in whom the deformity is severe, in those who have recovered from the rickety process and whose bones are sclerosed, and in those who cannot be well looked after or submit to prolonged treatment.

Operative measures are of three kinds: fracture after partial division of the bone with saw or osteotome, forcible straightening without external wound, and straightening after tenotomy, &c. We may say at once that for anything except simple curves in the shafts of the tibia and fibula at the lower part of the leg in young children, before sclerosis has occurred, we consider forcible straightening utterly unjustifiable and unsurgical, and we shall make no further mention of it. For the cases mentioned it is a good and simple plan, resulting in a green-stick fracture just at the curve. It is, in any case suitable for it, easily done by taking the child's limb in one hand just above, and in the other just below, the deformity, taking care to have hold of the tibia and fibula, and not of the foot, otherwise the strain would come upon the ankle joint; the limb is steadily and forcibly bent straight by the hands; a certain amount of jerking is, however, sometimes useful. Tenotomy and subsequent straightening we look upon as only one degree better than Delore's plan of forcible straightening: it weakens the joint and only temporarily straightens the limb.<sup>2</sup> Other methods, Hueter's, &c., do not require further notice.

**Osteotomy.**—The general principle of an osteotomy is to partially divide with a saw or chisel the shaft of the bone in the neighbourhood of the deformity through a small wound, then to complete the fracture, straighten the limb, and treat it like an ordinary compound fracture.

Of the various operations devised by Ogston, Macewen, Chiene, Reeves, Schede, and others, for remedying genu valgum, in our experience that of Macewen and the section of the femur above the condyles by means of a saw from the outer side are the best. We occasionally do an Ogston's operation, but supracondyloid osteotomy with a fine Adams' or keyhole saw is we think the most generally useful method. Ogston's plan should be limited to those cases where the deformity is entirely due to condylar overgrowth. It is very seldom employed. In the case of osteotomy of the tibia we prefer to saw through the tibia and fracture the fibula forcibly, or, if that cannot be readily done, we divide the fibula with an osteotome through an incision over it.

After straightening the limb we put it up in a back and side splint, inner or outer,

<sup>1</sup> Hueter treats *genu valgum* by simple flexion, and Little thinks well of it, but suggests sitting *à la Turque* as useful.

<sup>2</sup> Vide Lannelongue, *Le Bull. Med.*; also *Annals of Surgery*, January 1888.

according to the deformity, and leave it for a week ; at the end of that time we take it down and mould it accurately into position under chloroform : the callus is soft and moulds easily ; the limb is then ready for a plaster of Paris splint, which should be kept on for five or six weeks and then taken off, and the limb well rubbed, the joints flexed, and then the splints replaced for another week ; after that the child may be allowed gradually to put his weight upon it. In heavy children an extra week should be given, and a light wooden splint worn for another month or so. It is a good plan to put on a Thomas's knee-splint after the first month, or even sooner.

In severe cases of tibial curve, especially in the anterior curve and in some of those at the upper part of the leg, the deformity cannot be remedied by a simple section, but requires the removal of a wedge of bone ; this is a very much more serious operation, and one that we think should not be performed for the anterior curve alone, for besides its severity it does little to remedy the distortion unless a great amount of bone is taken away, and the tendo Achillis divided as well. This anterior curve is also much less important than the lateral one. If it requires osteotomy the oblique section of Gowan is probably the best.

Osteotomy is a simple operation in most cases, but it has its dangers and its mortality. The popliteal artery has three times been wounded, severe bleeding has also occurred from the anastomotica magna, death has followed in some few cases, and gangrene of the leg in one at least—a case of our own, in which we removed a wedge from the upper part of the tibia. In this, our only serious casualty, no vessel was wounded, but either from pressure of the bones in their altered position, or from the splints being put on too tightly, the limb had to be amputated subsequently. There is no comparison between simple section and excision of a wedge in severity. For details of the various operations we must refer to the orthopædic and general surgical works.

Drilling holes in the bone and subsequent fracture, with modifications of this plan, have, we think, no advantages over the saw and osteotome ; which of these is used is nearly a matter of indifference.

Multiple osteotomies, i.e. section of femur and tibia at one or more points, are sometimes required ; when this is so we prefer to do one at a time on each limb, though Macewen has many times done several with perfect success. Deformities of the fibula from rickets are never important.

Osteotomy of the femur with a saw from the outer side is best performed by placing the limb upon a sand pillow, with the knee *slightly* flexed, and making a puncture with a large tenotome on the outer side of the limb, just in front of the border of the tensor vaginæ femoris, and a finger's breadth above the adductor tubercle. The knife is then carried across the limb, keeping as close to the bone as possible, taking care not to thrust it through the skin on the inner side. In this part of the incision the blade should be held flat, i.e. in the same plane as the surface of the femur ; as soon as the inner side of the limb is reached the knife is turned with its edge against the bone and withdrawn. It should during withdrawal be gently pressed against the bone so as to divide the periosteum and form a track for the saw. As soon as the knife is taken out of the wound the narrow saw is thrust sharply with a jerk into the skin wound and its point made to strike the femur ; it is then carried readily over the front of the bone and its point felt beneath the skin on the inner side. The limb is well steadied and the bone sawn ; care being taken to saw at right angles to the axis of the femur. In sawing, the hand should be tilted, so as to divide mainly the outer and front parts of the shaft, until nearly the whole thickness is sawn through. It is a matter of experience how far to saw—usually about two-thirds of the way through is sufficient ; a useful guide is the depth of the saw from the front of the bone as felt through the soft parts. When the bone is nearly divided the saw is withdrawn,

the thigh steadied by the hand nearest the patient's trunk, and the limb bent inwards by adducting the leg with the other hand. The bone sometimes snaps sharply and sometimes yields: in the latter case sclerosis has not probably gone so far, and the fracture is more or less greenstick. One of our house surgeons remarked that the patient had less pain after these yielding fractures than when the division was complete, no doubt because there was no complete separation and less mobility of the fragments.

Should the saw have been withdrawn too soon, and it is found impossible with reasonable force to fracture the limb, it is usually easy to reintroduce the saw and divide the bone further: the groove already made is usually found without much trouble; failing this, the best plan would be to enlarge the opening and divide the bone with an osteotome.

Section of the tibia is done in the same way, the puncture being made over the anterior border of the bone at the line of greatest curvature. It is usually possible to fracture the fibula; if not, it should be divided with an osteotome through an incision over it. Macewen's operation we need not describe, as for general use we prefer the method already mentioned, but we may say it consists in incomplete section of the femur with a graduated osteotome from the inner side, through an incision in the soft parts. His guides are 'a line drawn a finger's breadth above the level of the upper border of the external condyle, and a line drawn parallel to and half an inch in front of the tendon of the adductor magnus.' The point of intersection of these lines is to be the centre of the incision. In none of these operations is any ligature or suture required, and antiseptics should be rigidly carried out. The wound in the soft parts is healed usually in a week, or a point of superficial granulations alone remains, and it is only occasionally that the dressings require changing from oozing of blood. It is well to squeeze all the blood out of the opening before putting on the dressings.

The deformity resulting from non-apposition of the fragments after these operations gets modelled down after a few months just as in a fracture. Oblique section of the bone as in a splice, a plan suggested by Mr. Gowan, is worth trial; it appears likely to cause less immediate deformity, but would be somewhat more difficult to manage.

**Lateral Curvature of the Spine.**—This affection in its most common form is a disease rather of early adult life than of childhood, being seldom found before puberty, hence only the more important features will be considered here. There are, however, certain forms of scoliosis that belong to childhood more particularly: such are the rickety lateral curvatures and those due to empyema or unilateral limb-shortening, as well as, of course, the congenital cases. It must be remembered that in infants the normal curvatures of the adult spine do not exist.

It is now well recognised that the deformity is a compound one, that there is never a pure lateral curve without rotation, nor pure rotation without a lateral curvature, although it may in some cases require close observation to verify this, and the more so that rotation conceals to a greater or less extent the deviation of the spinous processes by bringing them nearer the middle line.

As soon as any lateral bending in one segment of the spine occurs two things necessarily happen if the child maintains the erect posture: first, compensatory curves must take place in the other parts of the spine to balance the primary curve and maintain equilibrium; next, the obliquity of the articular processes, and in the dorsal region the powerful rotation action

of the ribs when they are approximated, must result in rotation of the vertebræ upon a vertical axis.<sup>1</sup> Hence in a case of a lateral curvature we almost always see compensatory curves in the opposite direction, and invariably more or less rotation: the term *rotato-lateral curvature* is therefore the more exact title. *Scoliosis* is convenient as a short synonym. *Scoliosis* in children may be the result of—

1. Congenital malformation of the spine, in which imperfect segments of vertebral bodies are intercalated on one side of the spine only. (Bland Sutton, 'Med. Chir. Trans.' 1884.)

2. Congenital deficiencies in the limbs of one side, so that the action of the muscles and the weight of the normal limb are unbalanced.

Occasionally scoliosis is secondary to the form of congenital torticollis which is due to malposition in utero.

3. Shortening of one leg from any cause: for instance, a flexed, ankylosed hip or knee gives rise to shortening and compensatory scoliosis.

4. Imperfect development or sinking in of the chest-wall on one side, as in atelectasis or empyema.

5. Muscular and ligamentous weakness combined with faulty attitudes.

6. Rickets.

7. Caries, especially if one side of the bodies only is involved.

Various other types of scoliosis have been described, but they may all be practically grouped under one or other of the above heads.

The mode of production of *rotato-lateral curvature* by the above causes is obvious except in cases of Group 5, of which a word or two more must be said. It is usually stated that this form of scoliosis is a disease of the upper classes and is found in girls who loll about or sit in ungainly attitudes for long hours, writing or working, during their most active period of development, while at the same time no sufficient exercise is given to their muscles. While it is true that weak spines or slight degrees of curvature are often thus produced, the disease is common enough among the poor, and, as it is usually neglected in its earlier stages, is seen in much worse degrees. It is also not rarely found in muscular, well-developed people in early adult life. It is, moreover, at times produced in young girls by carrying heavy babies or other burdens too great for them.

<sup>1</sup> Judson of New York attributes the rotation to the fact that the ribs are attached to the spine behind the bodies—the latter, as it were, are free in the thoracic cavity, and therefore liable to rotate, while the spines form part of the thoracic wall.

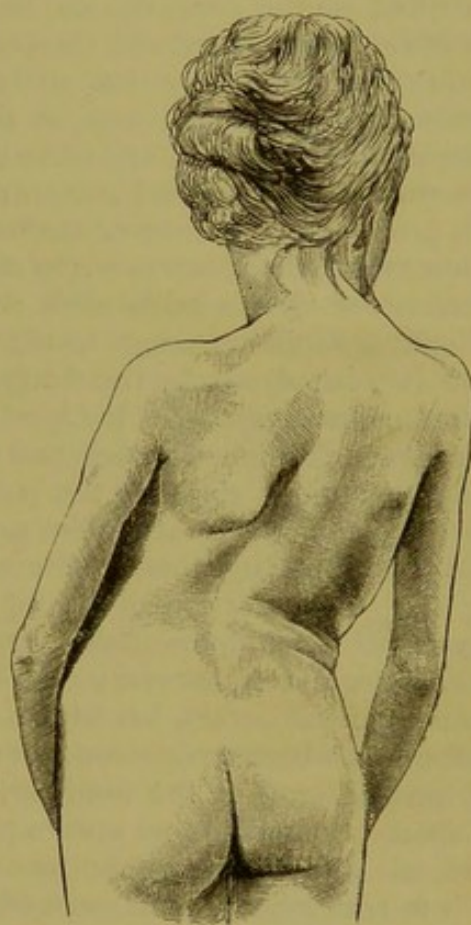


Fig. 60.—Lateral Curvature of the Spine.

If a weak or tired spine is examined with the patient stripped and standing or sitting upright<sup>1</sup> it will perhaps be seen at first to be held fairly straight, but often after a minute or two the weight is thrown to one side, the lumbar vertebræ curve with their convexity towards that side, and a compensatory dorsal curve appears with its convexity to the opposite, usually the right, side, while a slight alternating curve in the cervical region is sometimes readily seen. At the same time flickering contractions of the spinal muscles as they become tired are often visible. In an early case all these bends can be straightened out by an effort of the patient, or by bending forwards or by lying down. If, however, the patient is neglected the curves tend to become permanent, for the weak muscles become contracted on the concave side, the ligaments become shortened, the intervertebral discs thinned and compressed, and the shape of the vertebral bodies and articular surfaces at last altered. But while this is going on the vertebræ rotate upon a vertical axis so that the bodies come to face towards the convexity of the curve and the ribs become bent in such a way that there is a sharply convex bend backwards close to their angles on the same side: this produces a prominence also on the convex side, while in front, in order as it were to reach the sternum, the ribs are flattened and straightened out. The converse of all this takes place on the opposite side of the spine. There is still a further change resulting from this: the scapula on the convex side is pushed out by the bulging ribs and projects backwards, while it is raised or lowered above the level of its fellow according to the exact seat of the curve; this is so marked that 'growing out of the shoulder' is usually the first-noticed sign and the popular name for the affection. The scapula on the concave side also often projects sharply backwards and towards the mid-line, since it cannot rest evenly against the flattened chest-wall (*vide* fig. 60). A projection of the hip on one side or the other according to the curve will also be noticeable.

All degrees of deformity may be met with, from the mere weak spine, with no permanent curves, but with a tendency to collapse in any direction, to deformity, where the ribs on one side are overlapping one another and lying within the crest of the ilium, while the whole trunk is distorted and misshapen. Sometimes an antero-posterior curve (kyphosis) coexists with the scoliosis, and it is very important not to be misled by this; still more important is it to remember that in cases of caries there is sometimes a lateral curvature before any angular curve appears: this may occur either in caries of the bodies or, as pointed out by Reeves, where there is disease of the articular processes or costo-vertebral joints. The diagnosis is to be made by noting the rigidity of the spine and usually the greater severity of the pain in the case of caries, as well as by the history of the patient. The exact position of such curve is by no means constant, and, though a curve convex to the left in the lumbar and convex to the right in the dorsal region is the commonest condition, the lower curve may be dorso-lumbar or the sides may be reversed, and so on. This, of course, depends largely upon the cause of the curvature; thus in empyema the amount and position of the collapse will

<sup>1</sup> The whole spine should in all cases be carefully examined with the patient stripped, and the back should be inspected in different positions of curvature and of the limbs, the course of the spines and the level of the scapulæ and iliac crests being noted.

determine the curve. Sometimes, especially in rickety cases, and probably in those due to partial atelectasis, the curvature is local and the compensatory curves are so slight and diffuse as to be nearly imperceptible. In some cases curvature of the spine is to be looked upon as compensatory and advantageous, and not as a morbid condition: such are slight curvatures which make up for inequality in the length of the limbs and the slighter degrees of curve due to empyema; thus in one case the curve may help to hide the deformity and in the other assist in filling up a suppurating cavity.

Aching pain of greater or less severity, and a general feeling of tiredness with depression of spirits and tonelessness, are the principal subjective symptoms of lateral curvature. The pain is usually in the side and not in the back or chest and abdomen.

*Treatment.*—Scoliosis due to congenital malformation of the spine itself or to deficiency of an entire limb, as well as that due to collapse of the chest-wall after empyema or severe atelectasis, is necessarily not entirely and in many cases not at all remediable, while curvature due to rickets, weakness, bad habits, or a shortened leg may in its early stages be entirely cured and in almost any stage prevented from getting worse.

In any case the aim must be to first remove the cause tending to increase the deformity, to improve the general health, to strengthen the muscles and ligaments, and to avoid pressure and strain upon the weak parts. In the rickety scoliosis of young children the rickets must be treated and the child never allowed to remain sitting up for any length of time; its general posture must be flat upon its back or face, or upon its side, with pillows so arranged as to straighten out the curves. The principle is not to keep the patient lying down, which would of course in no way strengthen the muscles, but to give the parts just such exercise as will make them develop, and in the intervals give them complete rest.

Fresh air, friction to the spine, with frequent change of position and proper diet and medicine, will readily cure any case in which there are no fixed curves, while in the more severe cases in older children the same treatment must be adopted. In an ordinary case, the result of weak muscles and joints, and improper postures, the lines of management are to avoid tiring the muscles and ligaments, and yet to strengthen them by exercise; to avoid the postures which have produced the deformity; to counteract their effect by opposite positions, thus stretching contracted muscles and ligaments, &c. It is impossible here to enter into details of the various exercises required or of the different apparatus recommended, but it may be said that in addition to all means of strengthening the health and improving the tone of the muscles—friction, salt-water douches, general exercise, and so on—a careful examination should be made with the child stripped entirely to see what positions and movements tend to correct the deformity, and these should be made the subject of regular practice at intervals through the day. A reclining board such as that figured (fig. 61), or some similar one, horizontal bars, trapezes, dumb-bells, Sayre's suspension apparatus, and so on, are all useful as means of strengthening the muscles.

Regular walking exercise for frequent short periods should be taken, the patient lying down afterwards, and constant watchfulness to correct any tendency to loll must be observed. Busch's plan of making the patient lie

prone, with the chest and head over the end of a couch, then bending downwards and raising the front half of the body against gradually increasing resistance, is a good method of exercising the spinal muscles. For private patients much time is saved to the surgeon and expense to the patient by instructing a professed masseuse or gymnast to carry out such manipulations as the surgeon may order.

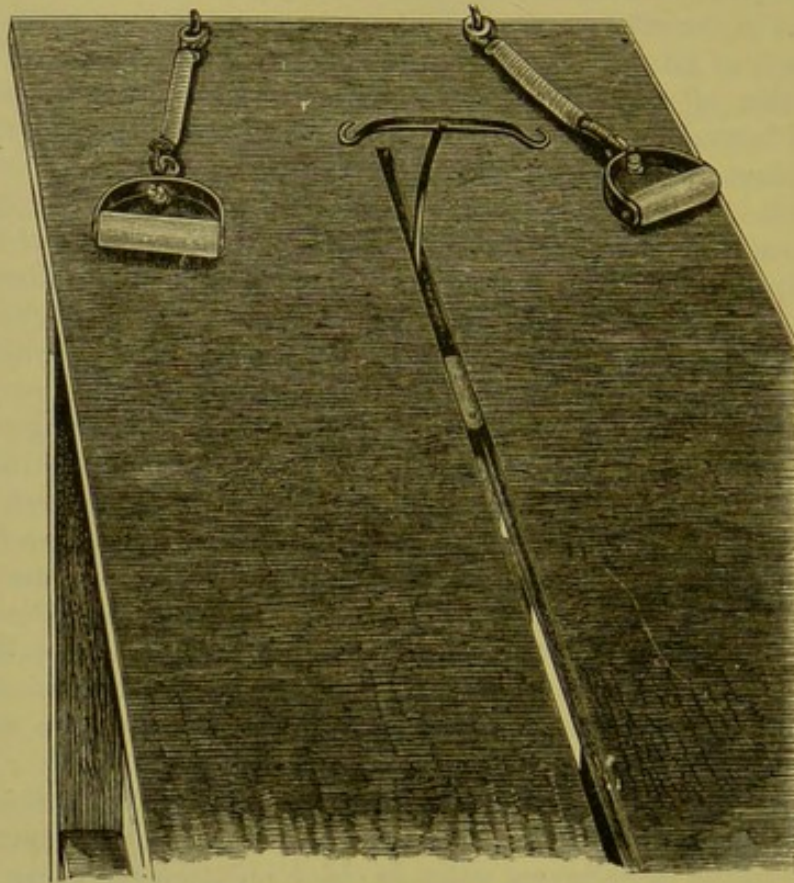


Fig. 61.—Reclining Board for Lateral Curvature, with Extension Apparatus for the Head and Arms. The head-straps have been omitted for clearness, and only part of the couch is shown. Both head- and hand-straps are fitted with india-rubber accumulators.

All spinal supports are to be reserved for cases where the deformity is extreme or rapidly increasing, and must be used with the greatest caution and never relied upon except in conjunction with the exercises and other means already indicated. As a means of treatment alone they are as harmful as in cures they are useful. No case of lateral curvature must ever be given up to the care of an apparatus-maker. For details as to spinal supports, modes of measuring the deformity, &c., the works of Reeves and others may be consulted, but as a rule, the less supports are used, the better.<sup>1</sup>

<sup>1</sup> The subject of 'Flat-foot' is, for convenience sake, considered in the chapter on 'Club-foot.'

## CHAPTER XX.

GENERAL DISEASES—*continued*.

**Syphilis.**—Infants and children may suffer from syphilis acquired in various ways after birth, or they may be the subjects of hereditary syphilis, the virus in this case being received from one or both parents during intra-uterine life, or the infant may be inoculated with the syphilitic poison at the time of birth.

**Acquired Syphilis.**—Can a healthy infant be syphilized by means of the milk of a wet-nurse? This is an important question and one which is often asked by parents before a wet-nurse is employed; there is no evidence that we know of to show that it can, and there is a strong probability that even if the virus was present in the milk it would not inoculate the infant unless introduced directly into the blood. That the infant can be inoculated if it have an abrasion on the lips and it draws blood from a sore nipple of a nurse suffering from secondary syphilis is certain, and it may, of course, be inoculated by the discharges from the genitals of the nurse, conveyed to it on the nurse's hands. It need hardly be said that in selecting a wet-nurse the most scrupulous care should be exercised in ascertaining that the would-be nurse is not suffering from any specific disease, a careful enquiry being made as to her health and the health of any children she may have had, especially with regard to any symptoms of syphilis.

Children of various ages may be seen in dispensary practice, suffering from chancres on the lips and genitals, who have been inoculated from their parents or others having specific sores, the virus being perhaps conveyed on the fingers. It is important to bear in mind that not only are the discharges from a primary sore liable to inoculate, but the discharges from various secondary lesions both in acquired and hereditary syphilis may also infect. Thus infants suffering from coryza or specific ulcerations about the mouth may inoculate the breast of a healthy wet-nurse, though they apparently never do that of their mother. No syphilitic infant should be wet-nursed by any one except its mother.

Syphilis has undoubtedly been on rare occasions inoculated by means of **vaccination**: abundant evidence of this exists in some epidemics of syphilis which have occurred, though such an accident is exceedingly rare, especially when we remember the frequency with which vaccination is done and the certainty with which such an accident is discovered. It may often happen that when vaccination is performed it is followed in a few days or weeks by symptoms of secondary syphilis, such as a roseolous rash, coryza, &c., but in the absence of a primary sore at the seat of vaccination these syphilitic

manifestations cannot be accepted as evidence of vaccino-syphilis, and evidence may most probably be obtained of syphilis in the parents or in some of the brothers or sisters. As the first symptoms of hereditary syphilis most frequently make their appearance at from six weeks to three months after birth, and as this is the usual time for vaccination, it is highly probable that vaccination and the secondaries will often exist together and yet have no connexion. If syphilis has been inoculated by vaccination, a month or six weeks later—during which time perhaps the vesicles have imperfectly healed—an induration makes its appearance at the seat of one or more of the vesicles, or there is an ulcer with an indurated base which has the characters of a hard chancre; this remains indolent, crusts over, and is followed in the course of a few weeks more by a specific eruption and other specific phenomena. In any case where vaccino-syphilis has taken place a well-marked scar is left at the seat of the puncture where the hard chancre has formed.

It is important to remember when investigating any case of supposed vaccino-syphilis that an interval of a month or six weeks elapses between vaccination and the formation of a chancre at the seat of inoculation (Hutchinson), and no case can be accepted as such unless this is the case.

**Hereditary Syphilis.**—In hereditary syphilis the foetus receives the poison at some period during intra-uterine life, and may be born with the evidence of syphilis on it, or it is born healthy, the specific symptoms making their appearance within a few weeks or months of birth. In these cases, unlike acquired syphilis, there is no primary sore. The part played by the father in transmitting syphilis to his progeny does not admit of a doubt: the more recently he has suffered, the more likely is he to transmit it in a severe form, though for many years he is liable to beget children who suffer from hereditary syphilis. The most usual way in which he transmits it is by means of the spermatozoa at the time of fertilisation of the ovum; or during the intra-uterine life of the foetus the mother may become infected by the husband, and she may infect the foetus through the placental circulation, though this appears to be rare during the later months of intra-uterine life. The mother may transmit the disease to the ovum or the foetus in utero, but this, as just stated, is rare after the seventh month of foetal life; or she may infect it during the act of birth. The mother, on the other hand, may apparently be infected from the foetus, though often she appears to escape; that is, a syphilitic father infects the foetus, the child is born and suffers from syphilis, the mother apparently escaping; but the escape of the mother is more apparent than real, inasmuch as such women appear to be insusceptible to syphilis and there is reason to believe that they do not escape, though the attack must certainly be slight.

A. Baginsky gives the following summary of the etiology of congenital syphilis:—

(1) If the father and mother are both syphilitic, a syphilitic infant is generated, or the mother may miscarry; the more severe and recent the syphilis is in the parents, the more likely is the foetus or infant to suffer severely.

(2) If the father is syphilitic and the mother healthy, the infant may be syphilized at the time of conception, and this may happen when the father is affected by tertiary as well as secondary syphilis. Under these circumstances

the mother may be syphilized either through the spermatozoa or from the foetus through the placental circulation ; she may apparently escape, but such women cannot be inoculated.

(3) If the mother only is syphilitic the children may escape ; certainly mothers with tertiary symptoms may bring forth sound children.

(4) If the father and mother are healthy at conception and the mother becomes affected during pregnancy, the foetus becomes infected through the placental circulation ; an infection during the act of birth is possible.

*Effects of the poison on the foetus.*—The mother may miscarry at any time during foetal life, a result due to disease of the foetus or placenta ; this is especially likely to happen if the father and mother are suffering from the disease in an active form. The exact nature of the lesions is uncertain: the placenta and internal organs, as the liver, lungs, &c., have been found diseased. The infant may be born at term, but dead, or may survive its birth but a short time; in the latter case it is puny, shrivelled, with blue extremities and a feeble hoarse cry. It may suffer from various skin eruptions, the most common being pemphigus; various internal lesions may be found, such as interstitial hepatitis, and there may be gummata, perhaps breaking down, in the thymus, heart, or lungs.

*Symptoms and course.*—The first definite symptoms usually make their appearance during the second month of life. These are often preceded by more ill-defined symptoms, such as restlessness, fever, peevishness, diarrhoea, and dyspepsia. The infant suffers from what appears to the friends to be a cold in the head: the nasal passages are obstructed by excessive secretion and the infant 'snuffles' during inspiration; in the more severe cases the breast is taken with difficulty, as respiration is impeded during sucking on account of the nose being blocked, and the infant has to stop to breathe through its mouth. The coryza is followed by a characteristic rash, which usually consists of an erythema or erythematous patches of various sizes, the favourite places being about the anus, genitals, thighs, and forehead. Instead of an erythema, the rash may be papular. When the eruption appears first it is bright red, the vividness fades in a day or two, and the skin desquamates, and becomes of a dull red or coppery hue. As the disease progresses the secretion oozing from the nose



Fig. 62.—Fissures around the Mouth in a case of Congenital Syphilis. The whole appearance of the face is characteristic.

dries up and forms scabs, the entrance to the nostrils becomes sore, and perhaps a sanguineous purulent secretion escapes from time to time. The upper lip may become excoriated and scabbed over. The corners of the mouth, which are constantly moist from the excess of saliva, become raw and perhaps ulcerated; fissures and scabs may form which heal but slowly, leaving radiating scars (fig. 62).

The mucous membrane of the larynx may become affected, being swollen and perhaps ulcerated, and the child in consequence has a hoarse cry; there may be marked anæmia and wasting, so that the child shrivels up and becomes reduced almost to a skeleton.

Infants occasionally die at this period, apparently from the intensity of the poison. This seems to have been so in the following case: our post-mortem notes are as follows (the child was not seen during life by any medical man). 'The mother states the infant, which was seven weeks old, "snuffled" a week before its death, and three days before a reddish rash appeared on the buttocks and around the mouth. It was found dead in its cot. At the autopsy the infant was fairly well nourished, there was a purulent discharge issuing from its nose, the skin around the mouth and nose was excoriated, apparently from the nasal secretion, and there were some excoriations and redness around the anus. The whole of the mucous membrane of the nose was in a foul, almost sloughy condition, the surface being dark-coloured and covered with muco-pus. On one tonsil there was a deep ulcer; there was no laryngitis; all the other organs in the body were healthy.'

While in the more severe forms the infant is the colour of *café au lait*, wizened and wasted, other infants may be seen who are plump and ruddy, yet who are undoubtedly syphilitic, and who subsequently develop a typical rash. In some who suffer later from syphilis no history can be obtained of coryza or rash, and we are driven to the conclusion that the secondaries are sometimes so slight as not to attract the attention of the friends and may even deceive the medical practitioner. The mortality of syphilitic babies is high; not only is the effect of the poison depressing, but the blood seems to be profoundly altered, the digestive organs are interfered with, and the infant wastes and dies. '*Congenital syphilis*,' '*mal-nutrition*' is written on the death certificate of many syphilitic babies.

On the other hand those who suffer in a less severe form and come under treatment early rapidly improve, gain flesh, and for a time at least all symptoms disappear. While such cases may apparently be entirely cured, yet, like the secondaries which occur in adults, the symptoms are very apt to reappear, especially during the second and third year. This relapsed syphilis may make its appearance in children in whom the symptoms following birth are slight, and consequently what is really relapsed syphilis is very apt to be mistaken for acquired syphilis. This recurrence usually takes the form of condylomata or ulcerations about the anus or tongue, and chronic fissures about the corners of the mouth and nose; various rashes may also be present.

During the next few years the child may remain fairly well, but on the approach of puberty symptoms which correspond to the *tertiaries* of adults may make their appearance. Children at this period often bear the marks of past lesions, and if seen for the first time there may be no difficulty in recognising them as subjects of congenital syphilis, as their flattened noses

and linear scars at the angles of the mouth, and typical pegged teeth, give them a characteristic appearance. They are apt at this time to suffer from periostitis, caries of bone, chronic ulcerations, ulcers of the mucous membrane covering the hard palate, which may involve the bone; ulceration and destruction of the soft palate; various affections of the eye, as iritis, keratitis, choroiditis; various skin diseases, as ecthyma, rupia, &c.; gummata in the superficial structures, and also in the liver and other internal organs. Deafness and partial dementia may be present, the latter accompanied by syphilitic arteritis of the brain. In the worst cases the child may suffer for years from disease of one or other of the bones (fig. 63).

Having sketched the course of the disease, we may now proceed to describe some of the phenomena presented by congenital syphilis more in detail.

*Skin.*—Pemphigus is one of the most characteristic of the syphilitic rashes, and when present at birth may be taken as certain evidence of hereditary syphilis. The seat of the blebs in syphilitic pemphigus is the palms of the hands and soles of the feet, but they may be present also on the extremities and trunk; their contents are purulent or sanguineous; they may be succeeded by deep ulcers. According to Roger non-specific pemphigus is rare before three years of age and most common after six years; the blebs are rarely numerous, do not occur on the palms of the hands or soles of the feet, and contain serum rather than blood or pus. The prognosis is bad in syphilitic pemphigus if the infant is born with the rash; as a rule, the later it appears, the better is the prognosis. The commonest rash in hereditary syphilis is a *roseola*, which may take the form of a bright-red diffuse rash with a sharply defined edge surrounding the genitals, with perhaps patches of similar redness about the body or face, or there may be roseolous spots or maculæ about the body, with a more diffuse rash on the soles of the feet. Its colour is at first a vivid bright red; in a few days it fades, becoming more of the tint of lean ham; the affected part then desquamates, leaving the skin smooth, shiny, and dry. The rash may be visible for weeks, assuming in its later stages a coppery colour. Instead of the roseola, the rash may consist of *papules* of a bright red colour, which are confluent about the genitals and buttocks, but scattered irregularly over the body. The rashes most likely to be confounded with a syphilitic roseola are those so commonly present about the genitals of infants, especially those produced in dyspeptic children by the irritation of fæces and wet napkins. The difficulty of diagnosis is only likely to arise in the absence of a characteristic rash in other parts of the body, or of coryza. It is needless to say that a red rash with excoriations and signs of irritation about the anus and genitals may occur in both syphilitic and non-syphilitic children, and no rash in this situation should be regarded as specific without confirmatory evidence elsewhere. *Psoriasis*, or *scaly rashes*, *vesicles*, *pustules*, and *ecthyma*, may occur in syphilis in infancy. Simple psoriasis rarely occurs before the third or fourth year, while syphilitic scaly rashes are not uncommon in early childhood, on the plantar and palmar surfaces, and on the face. Pustules followed by deep ulceration are not uncommon in cachectic children apart from the effects of syphilis; thus occasionally in chicken-pox the vesicles are succeeded by pustules or bullæ, and a deep ulceration is produced. In making a diagnosis several points must be borne in mind: syphilitic rashes mostly affect the genitals, palmar and plantar surfaces, and face; they are

usually bright red at first, then dull red and more or less of a coppery hue ; they are followed by free desquamation, and they cause no itching. Different varieties may be associated together.

*Mucoid patches and condylomata* when present are of great diagnostic value ; they may occur at all ages, but are especially common in relapses in children of two or three years of age. Their common seat is around or by the side of the anus, vulva, fold of the groin, corners of the mouth, entrance to the nares—less commonly the folds of the neck. They form where there is some irritation, where a surface of skin is fretted by some discharge and kept constantly moist. Mucoid patches may be present on the side of the tongue and soft palate.

*Coryza* is perhaps the most constant symptom present. The mucous membrane of the nose is swollen and congested, respiration is carried on with difficulty on account of the obstruction. The infant is very restless at night, waking at short intervals to get its breath. Later on a purulent discharge tinged with blood makes its appearance, which frets and irritates the skin in the neighbourhood, and ulcers and crusts form along the upper lip and side of the nose. Caries of the nasal bones may take place ; there may be a discharge of pus, which makes its appearance down the nose and at the corners of the eyes.

*Lesions of internal organs.*—Parrot has pointed out that an ulceration due to syphilis occurs occasionally near the median line inside the lower lip ; serpiginous ulcers occur on the tongue ; inside the lips, near the corners of the mouth, on the gums and soft palate ; they are mostly shallow, with a red and shiny base, surrounded by a raised, whitish, irregular border. Less often they are deeper and of a yellowish tinge. A peculiar desquamation of the tongue has been described. Deeply cut ulcers make their appearance on the hard palate in tertiary syphilis, the bone is quickly affected, and a communication with the nasal cavity established. A deep ulcer may form on the soft palate, and shortly a sharply cut hole be seen right through the velum palati. Laryngitis, mucous tubercles, and ulcerations along the edge and at the base of the epiglottis occur, but specific lesions of the larynx are less common in children than in adults. Specific lesions of the lungs are not common, though syphilitic infants frequently die of broncho-pneumonia. In the **lungs** of infants born dead, or dying soon after birth, gummata and fibroid indurations may be found and a form of chronic pneumonia which has been described as white hepatisation by Virchow. Patches of white hepatisation may sometimes be found scattered through the unexpanded lungs of infants born dead, and the mediastinal glands may also be enlarged and infiltrated in a similar way. The gummata are most often on the surface of the lung and are apt to soften in the centre (Parrot.) The **liver** of newly born infants may contain gummata : these may be of variable size, perhaps in some cases as large as a shilling on the surface, perhaps softening in the centre ; on section a diffuse infiltration may be seen. (See page 143.)

The **spleen** is frequently enlarged and indurated, especially where cachexia is a marked symptom, as pointed out many years ago by Gee. It is generally simply indurated, but miliary gummata have been found.

Syphilitic disease of the **bones** may occur both early and late in the disease. Caries of the nasal bones may follow the coryza, leading to the falling

in of the nose which is so common in syphilitic children ; or the bones may be completely destroyed. Caries of the hard palate and turbinated bones, as well as of the long bones, more especially the tibia, may occur. In the latter bone caries may follow periosteal nodes ; or thickening of the bones may be met with. Apart from caries a peculiar inflammation termed syphilitic epiphysitis is apt to occur near the epiphyses in the long bones, especially at the lower ends of the humerus, femur, radius, and tibia in infants who are suffering severely from hereditary syphilis. The mother notices that the infant does not move an arm or leg so freely as the other, and it screams as if in acute pain if the limb is handled or moved suddenly. An examination of the end of the humerus, if the arm is affected, may show it to be swollen and tender, and the limb hangs useless, so that the term 'pseudo-paralysis' has been applied. (See fig. 64.) The epiphyses of several of the long bones perhaps show an enlargement where the former join the shafts of the bones and sometimes a slight effusion is present in the joint. More rarely the phalanges of the fingers are also swollen.

The nature of this lesion has been studied with great care by Wegner, Parrot, Taylor, and Kassowitz. Separation of the epiphysis from the shaft and the formation of an abscess may take place, though in this country the latter accident is rare. Lesions in the cranial bones have been described by Wegner and Parrot; the former has found gummatous periostitis of the dura mater beneath the parietal bone, a possibility to be borne in mind when epileptiform attacks occur in syphilitic children; the latter has laid stress on the cranio-tabes found in syphilitic children and also on the overgrowth of bone, forming bosses or osteo-phytes, on the surface of the frontal and parietal bones. To what extent either of these lesions is directly due to the syphilitic poison is uncertain,

certainly cranio-tabes occurs in association with rickets and is also seen in wasted infants in whom evidence of syphilis is wanting. *Vide* chap. on Diseases of Bones.

The osteo-phytic growths have been noted both in infants and older children ; they consist of small rounded elevations of bone  $\frac{1}{2}$  in.—1 in. in diameter, most commonly situated near the longitudinal or fronto-parietal sutures, and can be felt by passing the hand over the infant's scalp. In some cases there is an excessive formation of bone at the frontal and parietal eminences, with furrows or depressions along the sagittal and fronto-parietal sutures, thus making a cross as it were on the vertex : the skull is then said to be nati-form. This condition also occurs in rickets.



Fig. 63.—Complete Destruction of the Nose, Upper Lip, and part of the Jaw, in Congenital Syphilis, in a boy aged 10 years.

The **teeth** of the second or permanent set are often misshapen and peculiar. The most characteristic changes are seen in the central incisors of the upper jaw ; they are more or less dwarfed, peg-shaped, i.e. they taper inferiorly, slant towards each other, and have a central notch in their cutting edge ; the other incisors may be more or less dwarfed and notched.

**Affections of the eyes** are most common about puberty, the commonest being interstitial keratitis, iritis, and choroiditis. The two former usually occur together, though they may occur singly. The first symptom noticed is watering and irritation of the corneal conjunctiva, then a steamy appearance or cloudiness of a portion of the cornea : this is followed by the formation of minute blood-vessels on the surface of the cornea, giving the steamy patches in some cases a reddish or salmon-coloured tinge. These patches

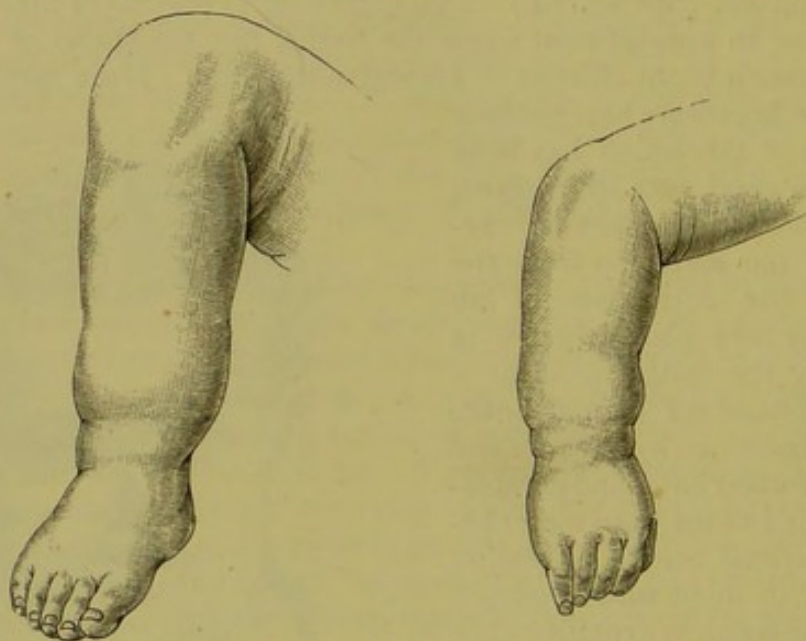


Fig. 64.—Swelling of lower ends of Tibia and Fibula, and also Radius and Ulna, from a syphilitic infant of 4 months old. The swelling lies at and above the line of junction between the epiphyses and shafts. (Compare with Rickety Enlargement, fig. 47.)

join the sclerotic, are generally symmetrical and are apt to relapse. Disseminated choroiditis may occur : in such cases small patches of atrophy of the choroid, of a white or grey colour, are generally seen scattered about the fundus of both eyes ; pigmentation is frequently present ; there is often the remains of a past retinitis and neuritis.

**Brain.**—Gummata are rare in the brains of children ; they have been observed by Henoch in a child two years of age on the surface of both cerebrum and cerebellum, and T. Barlow has described multiple syphilomas at the base of the brain, with thickening of the arteries. Chronic meningo-encephalitis, giving rise to idiocy, may occur, as may also chronic hydrocephalus (see p. 372).

**Diagnosis.**—This is often difficult and sometimes remains uncertain. In the infant care must be taken not to mistake, as students are very apt to do, an erythema about the genitals, which has its origin in the irritation caused by fouled napkins, for a specific rash, or, on the other hand, hastily to assume that an infant is *not* syphilitic because there is a certain amount of excoria-

tion and rawness about the anus caused by the fretting of the wet napkins. No rash can be taken as characteristic which is not present in other places as well as about the genitals, out of reach of the irritating effect of the urine or fæces. Coryza in an infant a few weeks old is exceedingly suspicious, especially in the absence of signs of catarrh of the bronchial tubes or larynx, and if it remains chronic is probably syphilitic, even though a rash may never be present. Tenderness and swelling of the epiphyses of the long bones in an infant are strong evidences of syphilis; we attach no importance to cranio-tabes, or bosses on the cranial bones or the natiform skull, as they may be undoubtedly present in rickets and perhaps other conditions. Syphilitic epiphysitis can hardly be mistaken for the enlargement of the epiphyses present in rickets. In syphilis the swelling is situated between the epiphysial line and the shaft (see fig. 64), while in rickets the swelling involves the epiphysis itself (see fig. 47). Syphilitic thickening occurs in infants of six weeks to three months old, while the rickety enlargement is rarely seen before six months of age and more commonly at a year or eighteen months of age.

*Treatment.*—In all cases where the parents are known to have suffered from syphilis, or some older child has been affected, antisymphilitic treatment must be commenced without waiting for the development of symptoms in the hopes of mitigating the disease or of preventing its development. The anti-symphilitic treatment of the parents who have had syphilitic children forms an important part of prophylactic management and may prevent the taint from being transmitted from the mother to the foetus. In the treatment of infantile syphilis it should be borne in mind that the effects of the poison are apt to impair the functions of almost every organ in the body, and in the worse cases there is a marked tendency in the direction of anæmia and gastro-intestinal atrophy. The dietetics of the syphilitic infant require the most careful attention, especially if it has to be artificially fed, as such infants are exceedingly likely to suffer from aggravated dyspepsia and mal-nutrition. It should if possible be suckled by its mother; if this is impossible it must be artificially fed, as a wet-nurse is not permissible on account of the danger of her becoming inoculated by the nasal or other discharges from the infant. As soon as the diagnosis is made or the disease suspected mercury must be given in some form or other. The usual plan is to give mercury and chalk powder in half-grain doses twice a day, this form of mercury being used on account of its mildness and its being less likely to disturb the bowels than calomel. If any looseness of the bowels follows its administration it may be combined with a grain of chalk and opium powder or the compound cinnamon powder. In a few weeks the dose may be increased from half a grain to a grain; this treatment should be continued as long as any of the special symptoms are present, or for some six weeks or two months, when the mercury may be omitted for a fortnight or so and the syrup of iodide of iron in five to ten-drop doses may be substituted. If there is much cachexia or mal-nutrition a few drops of cod-liver oil may be added. Instead of the mercury and chalk some prefer to give calomel in one-sixth to one-half grain doses combined with half a grain of saccharated carbonate of iron. In Vienna a combination of mercury and tannic acid is used (hydrarg. tannicum oxydulatum) when other mercury salts disturb the bowels;

the dose is the same as calomel. In obstinate cases, especially where the skin eruptions are chronic, sublimate baths as recommended by Baginsky may be used with good effect. A bath may be taken daily in which ten grains of corrosive sublimate are dissolved; the child should remain in the bath some five minutes, care being taken that none of the water gets into its mouth. The baths are more cleanly and preferable to the inunction of blue ointment, and act with greater certainty. During the time the infant is taking mercury the gums should be carefully watched, and any signs of stomatitis or sponginess about them should be the signal for at once discontinuing all forms of mercury.<sup>1</sup> The coryza should be treated, when the obstruction or secretion is excessive, by injections of weak solutions of nitrate of silver (gr. i ad ʒ i) or boracic acid; the dried secretion should be removed, and any soreness and excoriation about the nares or lips should be smeared with yellow oxide of mercury ointment, which may be applied on a small camel's-hair brush. Boracic acid may be applied locally as a dusting powder to the rash about the genitals or elsewhere. During the relapses mercury should be given in some form or other, and the mucoid patches and condylomata which so frequently accompany relapsed syphilis should be frequently dusted with finely powdered calomel. In the later stages during the tertiary symptoms the solution of bichloride of mercury in doses of half a drachm to a drachm, combined with iodide of potassium, should be given and continued for many months, when the syrup of iodide of iron may be substituted. Tertiary syphilis is apt to be very chronic, the ulcerations of skin and caries of bone and corneal affections remaining for months nearly stationary, and quickly relapsing when treatment is suspended. Iodoform and the yellow oxide of mercury ointments are the most useful local applications for the skin and conjunctiva, while a solution of nitrate of silver (grs. x ad ʒ i) may be used as an application to the specific ulcerations of the mouth and palate. During the treatment of syphilis, both in infancy and later childhood, the most generous diet which can be digested must be prescribed. Abundance of fresh air and change must be insisted on, and the most scrupulous care taken to promote cleanliness and to prevent any non-syphilitic individual from becoming infected by any discharges from the patient.

The mercurial treatment should be resumed after a fortnight or three weeks' interval, even if all the symptoms have disappeared, and it should be continued for at least six months.

In some cases of late congenital syphilis healing of ulcers or bone lesions will only be procured by the use of very large doses of iodide of potassium, either alone, or, better still, in combination with mercury. We have had to order twenty-grain doses of the iodide three times daily for a boy of about twelve before any material improvement was effected.

<sup>1</sup> It is, however, very rare for salivation to occur in children.

## CHAPTER XXI.

## DISEASES OF THE NERVOUS SYSTEM.

**Tubercular Meningitis.**—In tubercular meningitis there is an inflammation of the pia mater, set up by the presence of tubercles on the vessels, more especially at the base of the brain. While tubercles and meningitis are very commonly found associated together post mortem, it must be borne in mind that a simple or non-tubercular meningitis is not uncommon, and also that tubercles may be present on the vessels without any meningitis, though the probabilities are great that if tubercles are present they will sooner or later light up inflammation of the meninges. Another point must also be remembered: that a meningitis so called is in reality a meningo-encephalitis; the vessels which penetrate the grey matter of the convolutions are certain to join in the inflammation.

Tubercular meningitis is less common in children under the age of one year; simple or purulent meningitis is perhaps relatively more common, though the tubercular form certainly does occur, and on account of the difficulty of distinguishing between simple and tubercular meningitis in infants and young children we are rarely justified in making a differential diagnosis in the absence of a post-mortem. Between the age of one year and the commencement of puberty tubercular meningitis is a common disease.

It rarely happens that the pia mater is the first part of the body to become the seat of tubercle; a tubercular meningitis is in the large majority of cases preceded or at least accompanied by grey granulations or caseating tubercle in some other part of the body. A tubercular meningitis is mostly the closing act of a more general tubercular process; it may occur early or late, and then quickly brings the end. The post-mortem evidence of this is clear and decisive, for in the bodies of those dying with tubercular meningitis grey granulations or caseating tubercle will almost certainly be found in the lungs, bronchial glands, brain, spleen, or other organs. Clinically the same thing is also evident: children suffering from hip-joint disease, or spinal caries, or caseating cervical glands, or chronic tubercular peritonitis, are not infrequently cut off by an intercurrent attack of tubercular meningitis, or the latter follows whooping-cough, measles, or pneumonia. In the large majority of cases there is a definite history of ill-health before the actual brain symptoms supervene. An exception to this is, however, seen in the case of infants and children under two years of age, in whom occasionally the attacks are sudden, supervening in the midst of apparent health.

What determines the growth of tubercle on the pia mater and the subsequent meningitis? No certain answer can be given to this question. It is

easy, and perhaps natural enough, to attribute it to over-excitement of the brain, or excessive brain-work ; and possibly this may be so in some cases in tubercular children, who have been badly fed, and subjected to unfavourable life-conditions, while their brains are being driven at the highest pressure ; but such cases must be exceptional. It must be borne in mind that tubercular meningitis attacks children a few months old, and children in hospital, and under conditions in which it is impossible that over-brain-work can have had anything to do with the supervention of the meningitis. We cannot say why the tubercular process should in one case attack the brain and in other cases the peritoneum, pleura, or lungs.

*Symptoms and course. Premonitory.*—The onset is insidious and the early symptoms are ill-defined, being those of general malaise rather than of actual disease. In most cases there is a history of ill-health for several months, perhaps succeeding an attack of measles or hooping cough, during which time the child has wasted or lost flesh and become flabby. There may have been cough, dyspepsia, constipation, loss of appetite, otitis, enlargement of glands, or more or less feverishness, especially at night ; such symptoms are not in any way distinctive and are often the result of a chronic intestinal or gastric catarrh : yet, if there is a family history which suggests tubercle, they necessarily excite suspicion. In some cases definite brain symptoms precede by many weeks the actual attack of meningitis, and then perhaps pass away or remit for a while. Among these may be mentioned headache, squint, a staggering gait, an unusual tendency to fall, a temporary loss of control over the sphincters. The late Dr. Oxley records a case in which the boy's disposition entirely changed, and he showed a constant tendency to bite on the least provocation ; often there is extreme irritability, which is all the more suspicious if it occur in a good-tempered child. Such symptoms are possibly due to the irritation caused by the presence of tubercle on the vessels or in the brain, which may perhaps precede for some time the attack of meningitis ; or it is quite conceivable that a temporary congestion or even a patch of meningitis may occur.

It is impossible during the premonitory stage to do more than suspect the onset of tubercular meningitis or tuberculosis in some form or other ; in a large number of such suspected cases recovery gradually takes place without any definite diagnosis having been arrived at ; in these cases, however, we are hardly ever warranted in assuming that our treatment has been the means of warding off an attack, or in making any definite diagnosis. In some cases, especially in infants, there are no preliminary symptoms : the infant while in apparent health begins to vomit and gradually becomes comatose, or almost the first symptom which attracts attention may be a hemiplegia. In such cases a simple meningitis is suspected, but the post-mortem may show it to be tubercular.

The premonitory symptoms gradually pass into the first of the three stages into which the attacks are usually divided, namely *the stage of excitement*. At the commencement of this stage the symptoms may be chiefly gastric, or they may be definitely cerebral from the first. In the former case the most prominent, and indeed sometimes for several days the only symptom, is vomiting. This may begin after a meal and be attributed to some improper food, but it continues in spite of the most careful dieting, is

usually accompanied by a clean tongue, and, while aggravated by food, often recurs accompanied by much retching and nausea when the stomach is empty. Too much stress must not be laid on the character of the vomiting, and perhaps for a few days a doubt may be entertained as to its true nature, whether due to cerebral disease or gastric irritation. The vomiting of meningitis is usually erratic, coming and going without any apparent cause. At this stage the child may be perfectly intelligent and no direct cerebral symptoms may be present. Constipation is usually present: the abdomen, which is at first rounded, becomes flabby, and later retracted, from the contraction of the intestinal walls which takes place. Before long other symptoms, more directly pointing to the head, become developed. There is headache, giddiness, great irritability, intolerance of light and noise. The child likes to be nursed by its mother, lies on her lap, and resists the interference of others. Its temper has completely changed, and it no longer cares for its toys.

The symptoms may be more definitely cerebral from the first, and the vomiting may not be a prominent symptom. The child complains of headache, which is often intense; there is giddiness and staggering gait; sleep is disturbed by dreams, or it wakes up with a shrill cry of distress, often of a piercing character, and known as the 'hydrocephalic cry.' The child neglects its toys, preferring to lie quiet and undisturbed. The pulse is usually quickened, the temperature raised a degree or two at night, and the tongue becomes coated with fur, which has often a brown or yellowish tinge. Remissions are apt to occur, and for a while perhaps the little patient is again himself, bright and chatty, and ready for his toys, but to the intense disappointment of the friends the old symptoms return with greater intensity. So far the symptoms have been those of cerebral excitement, caused in all probability by the inflammatory congestion of the pia mater which is present; following this, comes the stage in which effusion is taking place and the brain functions become more and more effaced.

The *second stage*, often called the *stage of transition*, is marked by the commencement of drowsiness. The child becomes more and more dull and heavy; it is no longer found on its mother's lap, but in bed, in a half-drowsy state. It likes to lie quiet, does not wish to be disturbed, and if roused it answers in a snappish manner and then curls up again and is off to sleep. The vomiting now is usually less urgent or perhaps ceases; the abdomen is retracted, the bowels confined. The pulse is usually slower than in the earlier stages, and is frequently irregular and hesitating. Commencing optic neuritis may often be observed, but the child in this stage will often keep its eyes spasmodically closed, so that observations on the discs are rendered difficult. The edges of both discs appear blurred and indistinct, from the presence of swelling; the veins become distended and tortuous, but the changes are never so marked as they are when a cerebral tumour is present. The intensely congested and swollen discs, with various minute hæmorrhages so often seen in other forms of cerebral disease, never occur, possibly because there is not sufficient time for these extreme changes to develop. Miliary tubercles may be present in the choroid, but these, as far at least as our experience goes, are only present in cases of general miliary tuberculosis. Various other phenomena are apt to supervene, such as convulsions, muscular twitchings, paralyses, and spastic contraction of the muscles of the neck and

back, less often of the limbs. The convulsions may be general and bring about a fatal result, especially in young children. The paralysees may involve the muscles of the eye, face, or limbs of one side. Retraction of the head is very common: it is sometimes so extreme that the back of the head comes in contact with the spine, the back is frequently arched. There is often a spasmodic contraction of the masseters, so that the child grinds its teeth, making a peculiar and unpleasant grating sound. There is apt to be incontinence of the urine and faeces. As the child becomes more and more drowsy the respirations become altered in character, approaching the 'Cheyne-Stokes' type, i.e. the inspiratory movements become shallower and shorter, until they cease; then a distinct pause in the respirations takes place, to be followed by a deep, sighing inspiration, which is again followed by a series of shallow inspiratory movements.

From a condition of drowsiness the child passes into the *third stage* or *stage of coma*. It can no longer be roused or recognise its friends; the conjunctivæ become insensible, the pupils dilated and sluggish, and now the optic discs can be examined without difficulty. The tongue is now coated with a thick brown fur, and sordes appear on the teeth and black crusts on the lips. The skin is harsh and dry, and the wasting becomes extreme. Excessive secretion takes place from the conjunctivæ, so that the eyes become smeared with mucus or pus. The pulse becomes weak and rapid. The coma is usually profound, so that the child cannot be roused even for a moment, but usually the power of swallowing is retained to the last. In this miserable condition the patient lasts for many days, perhaps a week, and even after it appears moribund slight improvement may take place. The total duration of the disease is usually about three weeks, but, especially in small children, death may take place much sooner.

The temperature throughout the course is most uncertain, always of an irregular, intermittent type, sometimes varying three or four degrees during the twenty-four hours; at other times the flights are much less marked. The temperature is of course modified if there is an extensive tubercular process in progress in the lungs and other parts. The paralysees which are apt to occur are seldom marked, often only temporary, being rather paresis than paralysis; sometimes, however, when extensive softening takes place in one hemisphere from thrombosis of some large vessel, the paralysis of an arm, or arm and leg, may be complete. Anæsthesia is rarely if ever present; hyperæsthesia is not uncommon in the early stages, but more as a part of a general irritability than anything else.

Whilst in typical attacks the various stages are fairly well marked, cases are frequently met with which are extremely irregular, where the typical symptoms are absent, and no diagnosis is made until the child is comatose and moribund. In such cases the symptoms may be indefinite for a week or two, then a marked improvement takes place, which gives hopes that our diagnosis of meningitis is incorrect, when suddenly convulsions and coma supervene and death speedily occurs. The fact that a remission of many of the symptoms may take place, the child being decidedly improved for a while, must be constantly borne in mind. In other cases the course is short and sharp, in this respect resembling some cases of simple meningitis.

Thus, for instance, a boy of eight years, who came of a tubercular family, attended at school till April 23, though for the last few days he had not felt well. He then stayed at home on account of cough and weakness ; he began to vomit on May 3 ; the next day he became drowsy, gradually passing into coma, and died on May 8. At the post-mortem miliary tubercles, with some pneumonia, were present in the lungs and in the abdominal organs ; there was also tubercular meningitis, with much fluid in the lateral ventricles and subarachnoid space.

In infants of six months and under the symptoms are often the reverse of characteristic ; the infant perhaps vomits food, but in other ways appears quite well, and the vomiting is not unnaturally looked upon as due to some gastric irritation ; then perhaps some rigidity about the muscles of the neck and slight retraction of the head is noticed, and the infant gradually passes into a condition of drowsiness and coma. Muscular twitchings of the facial muscles or frequent clonic spasms of the muscles of a limb or arm may be present. In other cases the infant appears to be 'teething,' there is some slight fever and restlessness, nothing to indicate cerebral disturbance ; then suddenly convulsions come on, followed by paralysis of an arm and leg, followed by coma. The state of the fontanelle is often a help in diagnosis in doubtful cases, as is also the rigidity of the muscles of the neck and consequent retraction of the head. The fontanelle is full and bulging, and in the later stages the veins on the forehead may be more prominent than usual, and the head may actually enlarge from the presence of an excess of fluid in the lateral ventricles. The retraction of the head is not absolutely diagnostic, it occurs in cases of chronic meningitis, and in rare cases it appears to be the result of reflex irritation from the pulmonary and abdominal viscera. Hutton has noted it in a case of commencing pneumonia in an infant.

**Simple Meningitis.**—Simple meningitis is not so common a disease as tubercular, though it doubtless is more common than is usually thought, as there is little doubt that it is often mistaken for the tubercular variety ; indeed, it may be quite impossible to distinguish one from the other during life. It is perhaps most common during the first and second year, though it is by no means confined to these periods. It may be idiopathic, arising without any discoverable cause ; there is, however, often a history of a fall or blow on the head, and it is also apt to supervene during an attack of pneumonia, pyæmia, or typhoid fever, or to arise from an otitis or from carious bone in other positions. It appears to occur in hot weather, especially after exposure to the sun. It is said also to occur in the course of rheumatism and erysipelas. We have once seen it in scarlet fever, death taking place on the twenty-first day, but unfortunately there was no post-mortem, and, as the girl had also discharge from both ears, it was probably due to an extension of the inflammation from the tympanum to the membranes of the brain. It occurs both sporadically and also, in epidemics, in connection with meningitis of the cord or cerebro-spinal meningitis. Syphilis is a cause of meningitis, but this is rarely acute ; it gives rise to a chronic basal meningitis, or a local meningitis in the neighbourhood of a gumma.

**Symptoms.**—It is unnecessary to state the symptoms of simple menin-

gitis in detail, inasmuch as they closely resemble those of the tubercular variety ; it will be more useful to point out the typical forms in which meningitis occurs.

**Acute form.**—In some cases, both in infants and older children, the attack may run a very acute course, death from convulsions taking place in two or three days. The acute meningitis in some of these cases is associated with a pleuro-pneumonia or peritonitis. As an instance of rapid death from what was probably an acute meningitis, though the post-mortem examination showed no effused lymph, the following case may be taken as an example. *Case.*—Beatrice B., aged five and a half years, was a healthy child till six months ago, when she was taken with pain in the head, fever, and vomiting, but recovered in a day or two. Two days before admission, when playing in the street, she ran in, complaining of pain in the head, and vomited ; she continued to vomit constantly for two days ; she had a fit shortly before admission. There had been no injury to the head ; the weather was hot at the time (August). On admission she looked ill, her face having an expression of anxiety : two hours after admission she was convulsed and died. Her temperature was not taken. At the post mortem all the organs were healthy, the capillaries of the brain were intensely injected, and there was much clear fluid in the lateral ventricles ; the arachnoid membrane was somewhat opaque.

In this case microscopical examination showed that the capillaries of the meninges and grey matter of the brain were distended and gorged with blood, and, though it cannot be certainly assumed that this congestion was primary and inflammatory, there is a strong probability that the case was one of acute inflammatory congestion of the brain and membranes. Similar cases of rapid death from acute hyperæmia of the brain after exposure to a hot sun are recorded by Lewis Smith and Soltman. Hensch mentions a similar case in a girl of five years, the attack beginning in the same way, with headache and vomiting, death taking place within forty-eight hours, preceded by convulsions and coma. At the post mortem a purulent exudation was present on the convexity and at the base of the brain.

In another case with an acute course, admitted to hospital under Dr. Hutton, the child, a girl of three and a quarter years, was seized with vomiting and purging (in August) ; the next day, when admitted, she was in a semi-collapsed condition. A few hours afterwards she lapsed into unconsciousness. She was delirious, and there were muscular twitchings. Death took place rather suddenly at the end of the second day of the illness. At the post mortem the pia mater was intensely congested, the arachnoid opaque, the Sylvian fissures were glued together with lymph, there were no tubercles ; there were patches of congestion in the intestines and commencing pneumonia of the base of the right lung.

These extremely acute cases are exceptional, and a doubt may often surround the diagnosis, as acute meningitis in the early stages may with difficulty be distinguished from the onset of some zymotic disease, as scarlet fever or typhus, or perhaps more likely of pneumonia ; and if the course terminates early in a convulsion it may be impossible even at the post mortem to say with certainty what has been the exact nature of the case. Death from a convulsion, accompanied by spasm of the glottis, gives rise to

a mechanical engorgement of both lungs and brain, and caution is required in positively asserting that an early meningitis or pneumonia is present.

In the majority of cases acute meningitis runs a course of a week or ten days, the symptoms resembling those described under tubercular meningitis. There may be a history of an injury, or of a past otitis, or of exposure to the sun, or possibly of excessive brain-work. The early symptoms are those of intense headache with injection of the conjunctivæ, vomiting, delirium, strabismus, and often high fever, perhaps as high as  $103^{\circ}$  to  $105^{\circ}$ . Later, the pulse becomes slow and hesitating, the abdomen is retracted, the cervical muscles are rigid, and Cheyne-Stokes respiration, coma, and various paralyses ensue. At the post mortem a more or less intense, perhaps purulent, meningitis is found affecting the convexity and base of the brain.

**Subacute form.**—In other cases the symptoms are less intense and the course longer. Infants are often the sufferers in these cases. The meningitis may be secondary, coming on in the course of other diseases, as, for instance, broncho-pneumonia; instead of the infant improving, as was expected, cerebral symptoms, such as vomiting, drowsiness, retraction of the abdomen, and cervical opisthotonos, make their appearance. The infant may remain for weeks in a semi-comatose condition, being able to swallow, and at times perhaps appearing sensible and recognising those about it; it gradually wastes, the cervical opisthotonos becomes extreme, possibly the legs draw up, the head enlarges, bed-sores form, and the child dies convulsed. At the post mortem the base of the brain, including the pons and cerebellum, is glued to the bone by organising lymph, the lateral ventricles are intensely distended, the choroid plexus dilated and covered with lymph, and possibly the aqueduct of Sylvius is occluded. In such cases the possibility of the meningitis being due to syphilis must be borne in mind. A subacute meningitis may occur in older children, and recovery from what are apparently such attacks takes place. Thus in a case of our own, that of a boy who died suddenly in apparent health, and on whom a coroner's inquest was held, an acute hydrocephalus was present, with some adhesions between the brain and the skull, apparently the remains of a meningitis from which there was a history of the boy having suffered some months before.

As an example of a simple subacute meningitis following an injury, the following case of Dr. Hutton's may be referred to. *Case.*—William C., aged eight years, fell into a cellar, striking the back of his head, some three months before admission. He vomited off and on for a day or two, but did not lie up; he suffered from pain in the back of his head almost constantly after the fall. He was admitted with squint, and pupils of unequal size; he had convulsions, optic neuritis, and lapsed into a semi-comatose state with Cheyne-Stokes respiration. He died twenty-four days after admission. At the post mortem the dura mater was thickened and congested, there was much lymph at the base and between the hemispheres, and also between the latter and the cerebellum; the lateral ventricles were much dilated and distended with serum. There were no tubercles anywhere.

**Cerebro-spinal Meningitis.**—Cases in which an inflammation of the meninges of the cord is associated with meningitis occur both sporadically and in epidemics. Sporadic cases are not uncommon, especially in infants; epidemics are rare in this country, but limited outbreaks have occurred in

Dublin and Glasgow. The symptoms of cerebro-spinal meningitis in infants closely resemble those of simple meningitis, but usually there is more marked rigidity of the cervical muscles and muscles of the spine, the legs may be rigid and drawn up, and there may be more or less rigidity about the muscles of the arm and forearm. Sometimes there is opisthotonos resembling tetanus. In older children pain in the back and limbs may be complained of, being more especially referred to the back of the neck or sacrum; sharp shooting pains may be complained of in the limbs. There may also be general hyperæsthesia. In the epidemic form purpura and herpetic eruptions are common. Pneumonia is a common complication. The diagnosis between cerebral meningitis and a cerebro-spinal meningitis in infants is very difficult, often impossible, as it is difficult to localise pain and to arrive at a conclusion as regards a general hyperæsthesia. Retraction of the head and more or less rigidity in the limbs may be present in both, but they are most marked when the spinal meninges are affected. Both tetanus and tetany may be mistaken for it; in the former there is marked trismus before the onset of the opisthotonos, and the temperature is normal or only slightly raised; and in the latter the peculiar spasm of the muscles of the hands and feet, and normal temperature, suffice to distinguish the two diseases.

**Latent form.**—Meningitis, like peritonitis and pleurisy, may be present without giving rise to any very definite cerebral symptoms; this is especially so when it occurs secondarily, and the symptoms to which it gives rise may be overshadowed by the primary disease. It may occur in association with acute pneumonia or peritonitis, or acute intestinal catarrh, without its presence being suspected, partly because the headache, delirium, and fever are naturally attributed to the more obvious disease present, and there is necessarily a difficulty in unravelling the complex association of symptoms and referring each to its cause. In some few instances a meningitis may exist without there being any cerebral symptoms whatever, as in the following case. An emaciated child (boy) of 4 years of age, who had recently suffered from hooping-cough, was admitted to hospital with some dulness at the base of one lung. There was a history of diarrhœa, and during the fortnight preceding his death he had five or six diarrhœal stools daily. There was a hectic temperature, no vomiting, headache, or optic neuritis; he was perfectly intelligent, and died apparently of exhaustion. It was supposed that there was general tuberculosis. At the post mortem the lungs were found adherent to the diaphragm; some inspissated pus was present at the left base, evidently the remains of a small empyema; there were no tubercles anywhere. There was some purulent lymph covering the inner surface of the dura mater, the convex surface of the brain, and covering the vessels in the transverse fissure and bathing the surfaces of the lateral ventricles; the base of the brain was matted with lymph. There was clear fluid in both tympanic cavities, but no pus.

It is in wasted, anæmic children that such lesions as purulent meningitis, pleurisy, or peritonitis may exist without giving rise to marked symptoms.

**Prognosis.**—As soon as a diagnosis of tubercular meningitis is made there is little hope of recovery. In any case the hope must be rather that our diagnosis is wrong than that a permanent recovery can take place from

tubercular meningitis. Yet undoubtedly the meningitis produced by the presence of tubercle does not always kill at once, and moreover in any case there is the hope that the meningitis is a simple one without the presence of tubercle. We have seen at least three cases—in which there was good evidence to show that they were suffering from tubercular meningitis—recover for a time and die subsequently of a second attack or of a general tuberculosis; one of these cases may be shortly referred to. *Case.*—Mary S., aged 6 $\frac{3}{4}$  years, was quite well till a month or two before admission to hospital, when several ‘cold abscesses’ formed on her legs and discharged. Lately she has had headache, been giddy, staggered in her gait, and rambled at night. For several nights after admission she was restless, and screamed with pain shooting through her head; an internal squint was noted in the left eye; she was fairly sensible in the daytime, but complained of headache, and frequently passed her motions under her; there was occasional vomiting. She was treated with ice to her head and complete rest in bed, and bromides. There was slight optic neuritis, which gradually subsided during her stay. She gradually improved, and was discharged after a 3 months’ stay, apparently quite well. She was readmitted 6 months after with undoubted signs of meningitis, and died after a fortnight’s illness. The post mortem showed miliary tubercles in the lungs, cheesy nodules in the liver, recent tubercles on the vessels at the base of the brain, and recent lymph; there was also very distinct fibrous tissue at the base, as if resulting from a past inflammation; the interpeduncular space was matted, so that the third and fourth nerves had to be dissected out and cleaned of fibrous tissue, and the lobes along the Sylvian fissures were firmly matted together. The history of the case and the post-mortem appearance made it clear that a recovery had taken place from a basal meningitis in a tubercular subject. A permanent recovery from an attack of tubercular meningitis means in the vast majority of cases a recovery from a general tuberculosis, a result which is exceedingly improbable.

The prognosis becomes bad in the extreme where the patient has sunk into a drowsy condition and Cheyne-Stokes respiration is present, though several days may elapse before the end comes.

The prognosis in simple meningitis is certainly more hopeful, especially in the subacute or more chronic cases. In those with an acute onset, high fever and delirium, but little hope can be entertained, while the subacute may pass into a chronic hydrocephalus and a possible idiocy. Nevertheless cases which are looked upon as almost certainly fatal will occasionally recover.

*Diagnosis.*—In a disease which begins so insidiously and assumes such varied forms the diagnosis is necessarily difficult. It must be in the experience of most to have made mistakes in diagnosis, in suspecting the onset of tubercular meningitis, where the patient is only suffering from some dyspepsia or intestinal catarrh, and on the other hand making light of the anxieties of the friends when subsequent events have justified their fears. As regards diagnosis in the early stages too much stress must not be laid on irritability, grinding the teeth at night, loss of appetite, wasting and sleeplessness, as these may be symptoms of a perfectly recoverable disease. On the other hand, sickness, giddiness, frequent stumbling, staggering gait, temporary squint, loss of power of the sphincters, even though they remitted after

a while, would justify grave suspicions. They may indicate the presence of tubercle or some irritation of the brain which may be quickly followed by definite symptoms of meningitis.

The principal errors which are likely to be made may be summed up as follows :

1. Mistaking the vomiting of meningitis for some form of gastro-intestinal disturbance.

This is a very common mistake in the early stages in cases of meningitis which begin with much vomiting.

The vomiting of meningitis, like the vomiting of gastric catarrh, usually follows the ingestion of food, but is more likely to follow any disturbance of the patient ; it may occur when the stomach is empty and the tongue clean. It is not very amenable to treatment and is indifferent to the character of the food taken. The vomiting of a gastric disturbance mostly ceases after the stomach and bowels have been unloaded. In any case of causeless vomiting in a child a careful look-out must be kept for more definite brain symptoms, such as convulsions, dilated sluggish pupils, retracted head, and retracted abdomen. The past history of the patient is often important. The vomiting and convulsions present at times during dentition may be a source of difficulty.

2. The mistake may be made of attributing to meningitis cerebral symptoms due to the presence of some febrile disorder or reflex irritation. A child cutting his teeth may be irritable, heavy, drowsy, may start in his sleep, and be feverish, simply from the effects of dentition or from undigested or improper food in his alimentary canal. The presence of fever of short standing is against meningitis, as also is evidence of dyspepsia, such as flatulence and colic ; the condition of the gums should be carefully examined. A few days would decide the diagnosis. The diagnosis between typhoid and meningitis is not usually difficult, that between typhoid and acute miliary tuberculosis being often much more so. The symptoms presented by a child sickening for typhoid may not be unlike those presented in the early stages of meningitis ; vomiting, however, is not a symptom of typhoid : the fever present and the condition of the abdomen would usually decide the diagnosis. The possibility of a simple meningitis occurring in the course of typhoid or pneumonia must be borne in mind, though it is not a common complication in either case.

3. At the end of certain exhausting diseases, such as acute diarrhœa, marasmus, &c., in infants, cerebral symptoms due to arterial anæmia of the vessels of the brain are apt to arise, such as convulsions, coma, contracted pupils, convergent squint, &c. This condition has been called 'false hydrocephalus.' The history of the case, the depressed fontanelle, the almost pulseless condition of the infant, and the rapid onset and course of the disease, would usually distinguish it from meningitis.

The differential diagnosis between tubercular and non-tubercular meningitis is often impossible. A family history of tubercle or a history of the individual having suffered from caseous glands or other tubercular manifestations, or having recently suffered from hooping-cough or measles, would naturally favour a diagnosis of the tubercular variety, as would also an insidious onset. On the other hand, the history of a blow, or an otitis, or

exposure to a hot sun, and a stormy onset, would favour the diagnosis of the non-tubercular form.

The diagnosis between acute meningitis and otitis is often difficult, and yet it is of the greatest importance. The relation between the two conditions is somewhat complex: a meningitis may undoubtedly arise from contiguity of diseased bone in the ear or acute suppurative otitis; a purulent meningitis may exist with suppuration in both tympanic cavities, or the latter cavities may contain cloudy fluid only, under circumstances which make it probable that the meningitis and otitis are both dependent on the same cause, and are not related as cause and effect. There is much reason to believe that an acute suppuration in the middle ear may closely simulate acute meningitis, and there is little doubt that they have often been mistaken one for the other. Cases which have been diagnosed as acute meningitis have quickly recovered after a discharge of pus from the ear, either bursting through the tympanic membrane spontaneously or being relieved by incision. In cases of double suppurative otitis there may be intense pain in the head, fever, delirium, convulsions, optic neuritis, and deafness. The point of greatest diagnostic importance is the deafness without facial paralysis; for, as Gowers points out, meningitis 'never gravely injures the auditory nerve without the adjacent facial nerves;' nevertheless the diagnosis between otitis and otitis with superadded meningitis is exceedingly difficult and often impossible.

*Morbid Anatomy.*—The bodies of those who have died of tubercular meningitis are usually wasted in a high degree, but in some acute cases they may be fairly nourished. On removing the skull cap and exposing the convex surface of the brain the veins on the surface will be found to be unusually full of blood; the convolutions are flattened, having been compressed by the distended lateral ventricles, and their surfaces are dry and sticky. More or less purulent-looking lymph is present: it may be usually seen on the lateral, less often on the convex surface. On examining the base, the effusion of lymph will be found to have taken place much more freely than on the convex or lateral surfaces. The Sylvian fissures will be seen to be matted with lymph; the interpeduncular space, with the optic commissures and tracts, the 3rd, 4th, and 8th nerves, and the inferior surface of the pons, and cerebellum, will be found in the same condition. Lymph may generally also be found around the medulla and spinal cord. An examination of the small arterial branches will show that they are studded with minute grey or yellowish tubercles; the lumen of some may be occluded with thrombi.

In some cases hardly any lymph will be found, but instead the arachnoid is opaque and there is more or less effusion of cloudy fluid beneath it, while the brain substance is oedematous and watery.

Important changes are also present in the lateral ventricles. The vessels in the ventricles and great fissure forming the choroid plexuses and velum interpositum are studded with tubercles and besmeared with lymph; the lateral ventricles are distended with fluid, while in the majority of cases the parts around, the corpus callosum, fornix, and optic thalamus, have undergone white softening and may be washed away or ragged out by a stream of water. The presence of fluid in excess in the lateral ventricles is due to the inflammatory processes going on in the choroid plexuses; this

gives rise when in excess to dilatation of the ventricles, softening of the surrounding parts, and flattening of the convolutions. It was these mechanical effects which so struck the older observers like Whytt, who overlooked the presence of tubercles as the primary cause and saw only in such cases an 'acute hydrocephalus' or 'water on the brain.' What further justifies these older observations is that in some cases the amount of lymph is very small and tubercles are found with difficulty, while there is much subarachnoid fluid as well as distention of the ventricles, and the brain substance is soft and œdematous. In a few cases large tracts of the superficial or central parts of the brain are softened and diffuent, the brain substance being yellow or plum-coloured from the presence of extravasated and altered blood, effects due to thrombosis or some disturbed condition of the circulation. A microscopical examination of hardened portions of the grey matter will show tubercles and effusion of leucocytes around the capillary arteries which enter the surface of the brain.

How do the symptoms during life correspond with the appearances found after death? The older writers were probably correct in ascribing the excitement during the first stage to the inflammatory engorgement of the arterial system of the brain; the later stages of drowsiness and coma to the effusion of fluid into the lateral ventricles, which gradually compressed the surrounding parts and interfered with their blood supply; the hemiplegia paralysis of facial, &c., to the softening which so frequently takes place. The retraction of the head and stiffening of the limbs are also due, we are inclined to think, to the pressure exerted on the motor tract by the ventricular effusion.

Other tubercular lesions are constantly found in association with tubercular meningitis, the commonest of these being caseous mediastinal glands. The lungs also are rarely free.

In non-tubercular meningitis the distribution of the lymph, which is often purulent, is less exclusively basal, more often being found over the convex surface and between the hemispheres in the longitudinal fissure. In the more chronic cases the base of the brain and cerebellum may be adherent to the skull, and much fluid may be present in the lateral ventricles.

*Treatment.*—The prophylactic treatment of tubercular meningitis is pretty much the same as that of tuberculosis generally. All children who are so inclined require the most constant care in all the relations of life. Residence in cities must be prohibited and country or sea-side life insisted upon. A farm-house where pure milk and cream &c. may be had, in a not too bleak but bracing situation, may be selected as a residence. All book-work should be stopped and all forms of excitement be strictly prohibited. The diet should be carefully regulated; fats, if they are found to agree, should be taken in fair quantities.

The child should be warmly clad and carefully protected from changes of weather. The bowels, if they are inclined to be constipated, should be carefully regulated with hyd. c. cret. or rhubarb and soda. The slightest suspicion of cerebral symptoms should be met by putting the child to bed in a darkened room, giving it a calomel purge, and an exclusively milk diet, and by the free administration of bromides. One or two grains of calomel with some sugar may be given, and some saline such as a quarter or half

a seidlitz-powder the following morning. Five to ten grains of bromide of potassium should be given every four hours. The vomiting is best treated by purging smartly and giving peptonised milk prepared with Benger's peptonising powders, or Savory and Moore's tinned peptonised milk. If persistent vomiting follows the giving of food, all food must be stopped by the mouth, and Brand's extract, or peptonised milk and bromide, must be given by means of an enema. Nothing is gained by continuing to purge after the initial dose of calomel has emptied the bowels thoroughly. If there is much cerebral excitement, larger doses of bromide may be given with the tincture or succus hyoscyami. We doubt very much if blisters, setons, or leeches are of any service in tubercular meningitis, though in simple meningitis, if the excitement or delirium is severe, a leech applied to the temples will certainly relieve. Cold to the head is of undoubted value and in all cases should be applied, an ice-bag of india-rubber being used in preference to any other form. Leiter's tubes form a convenient method of applying cold to the head, and they can be used where ice cannot be obtained. Mercury given freely in the form of perchloride is of all drugs the one most likely to be of service in simple meningitis. Iodide of potassium is frequently prescribed, though with doubtful advantage.

**Chronic Meningitis.**—A chronic inflammatory process affecting more especially the convex surface of the brain occurs occasionally during infancy, apparently also during intra-uterine life. In such cases the surface of the brain becomes adherent to the dura mater, a thickening of the membranes taking place, resembling the pachymeningitis of adults. A membranous exudation may be thrown out and blood may be effused. Such a condition may be associated with a chronic hydrocephalus. The symptoms present in such cases are frequently not distinctive, or they may be simply those of chronic hydrocephalus; there may be defective intelligence or idiocy, probably also convulsions; retraction of the head and rigidity and flexion of the limbs are likely to be present if the child lives any length of time. The etiology of such cases is doubtful: they are always suggestive of hereditary syphilis. As there is often chronic hydrocephalus associated, a diagnosis of hydrocephalus is probably all that can be made during life.

A meningitis during intra-uterine life, by interfering with the growth and development of the brain, may produce various results, such as hydrocephalus, mal-development, or an abnormally small brain. Thus in a case<sup>1</sup> of Dr. T. Barlow's an infant dying at seven weeks of age, whose head measured only 10½ inches round, the brain only weighed 9 drachms; the convolutions were hardly recognisable over the greater part of the convexity, and the pia mater and cortex beneath it were invaded with calcareous plates; the choroid plexuses of the lateral ventricles were also partially calcified. In this case there seems to have been an intra-uterine meningitis, followed by calcification of the effused lymph and some atrophy of the subjacent brain tissue. In a case recorded by Dr. E. Holt<sup>2</sup> in a child of thirteen months the symptoms were those of a chronic hydrocephalus, from which the child had suffered since three months old. The enlargement of the head was only moderate; there was some rigidity of the posterior cervical muscles, but no paresis or contractures in the limbs. At the post-mortem the dura mater

<sup>1</sup> *Path. Trans.*, vol. 38, p. 8.

<sup>2</sup> *Arch. of Pædiatrics*, Dec. 1887.

was found firmly adherent to the convexity of the brain ; lymph and blood had been poured out on the surface. All the cavities of the brain were dilated. See also Sclerosis of Brain.

**Hydrocephalus.** **Acute hydrocephalus** occurs only in association with an acute meningitis. In the majority of cases of acute meningitis, whether tubercular or simple, there is an excess of fluid in the lateral ventricles, the result of an intra-ventricular meningitis, and a consequent and excessive exudation from the vessels of the choroid plexus. In exceptional cases the meningitis is confined to the ventricles. In those rare cases where an acute or subacute meningitis ends in recovery a chronic hydrocephalus may be

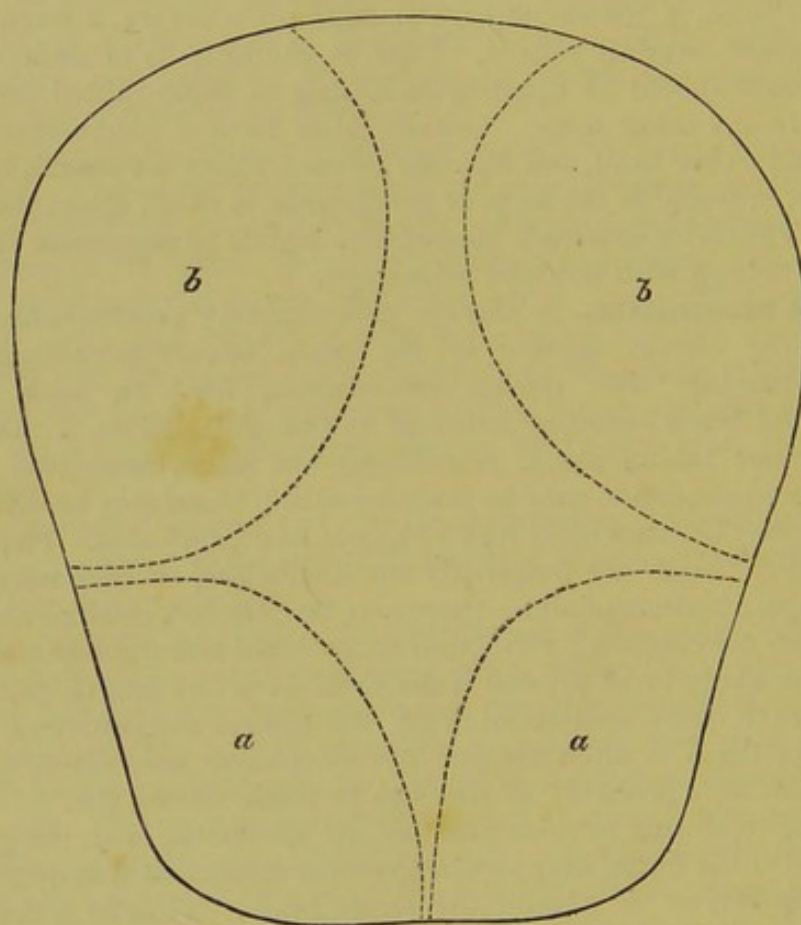


Fig. 65.—Outline of head in Chronic Hydrocephalus. *a a*, frontal bones ; *b b*, parietal bones.

left ; in these cases the head slowly enlarges in succession to the symptoms of a meningitis. Excess of fluid may be found in the subarachnoid space in acute meningitis.

**Chronic Hydrocephalus.**—The accumulation of an excess of fluid in the ventricles of the brain is by no means an uncommon condition in infants and children. (1) It may be congenital, the accumulation taking place before birth, and it may give rise to difficulty in the extraction of the head. (2) It may follow an acute meningitis. (3) It may arise without any apparent cause. (4) It may be the result of a tumour, as for instance a tumour of the cerebellum, compressing the veins of Galen, and in other ways interfering with the circulation.

In the majority of cases the child is born healthy and the enlargement of the head is first noticed when the infant is a few weeks to a few months old; usually no cause can be assigned, but some of the cases are syphilitic, and it is not improbable that syphilis plays an important part in the production of hydrocephalus by means of a chronic syphilitic meningitis. Enlargement of the head is preceded in a few cases by distinct cerebral symptoms, as convulsions, fever, and drowsiness, so as to suggest the probability of the meningitis perhaps being local rather than general. As the fluid accumulates in the ventricles the head enlarges, the bones forming the vault of the cranium become thinned and open out, so that the fontanelles are enlarged and the edges of the bones at the sutures are separated from one another (see fig. 65). The fontanelles are bulged and have a fluctuating feel, the occipital and parietal bones may be so thin that moderate pressure with the finger is sufficient to bulge them in. The cranium assumes a spherical form, and its increased size contrasts with the child's face, which may be thin and sunken, giving the child a characteristic appearance. The forehead is rounded and projects so as to overhang the face; the parietal and occipital bones assume a similar shape, so that the head has a globular or rounded form. There may be nystagmus. The general rounded contour is broken by the prominence of the frontal and parietal eminences; at these spots the bone is thick and solid, and consequently cannot be bulged out like the thinner bone elsewhere. The skin of the forehead and scalp is thin and shiny from being stretched, and the cutaneous veins are distended, especially when the infant cries; the eyes project: their axes may be divergent, and there may be difficulty in closing the eyelids. The infant cannot raise its head, and if propped up the head rolls over in a helpless sort of way. The condition of the intellect varies considerably: in the majority of cases, where the hydrocephalus is moderate in degree, the intellectual powers are surprisingly good when it is considered what amount of compression and flattening out the grey matter on the surface of the brain is exposed to by the accumulation of fluid in the lateral ventricles. In extreme cases there is certain to be marked intellectual defect, perhaps amounting to idiocy. The limbs are mostly paretic, and the lower extremities especially are rigid, being flexed upon the abdomen; permanent contractures are apt to follow, a result probably due to compression of the pons. Atrophy of the optic nerves may take place from compression or stretching of the optic tracts or commissure.



Fig. 66.—Chronic Hydrocephalus in a boy aged 6½ years.

The course of the disease is usually chronic, and infants will live for months or even years, but ordinarily they gradually waste and die. The child shown in fig. 66, who was  $6\frac{3}{4}$  years of age, had suffered from chronic hydrocephalus since three months old; he was well nourished; his head measured thirty-one and a half inches in circumference; he was a complete idiot. The legs were bent at the knee and flexed on the abdomen, but the spasm of the muscles varied from time to time; the hands were kept closed, and the elbows were flexed and more or less rigid. We have known recovery to take place, even after rigidity of the legs has come on.

In older children, when the disease comes on after the closure of the fontanelles, the head enlarges more gradually, thinning the bones and even opening up the fontanelles and sutures; in these cases the hydrocephalus is mostly due to a cerebellar tumour; blindness and imbecility gradually supervene.

*Diagnosis.*—This is not difficult when the disease is well advanced; difficulty, however, occurs in the early stages when the accumulation of fluid is small, and when hydrocephalus may be mistaken for a rickety skull, or simply a large head without distention of the lateral ventricles such as occurs in rickets. The friends of patients often ask whether a child who has a large head has 'water on the brain.' A diagnosis can only be made when the head enlarges under observation, the bones becoming thinned, the fontanelles bulged and fluctuating; the globular shape which it assumes distinguishes it from the misshapen head of a typical case of rickets with the prominent eminences, flattened vertex, and thick edges of the bones. In the simply enlarged head, from the presence of an abnormally enlarged brain, there is no opening out and bulging at the fontanelles, nor usually any evidence of a thin skull.

*Morbid anatomy.*—In those cases where the excessive quantity of fluid in the ventricles is caused by a cerebellar tumour the mechanism is tolerably clear, for any stretching of the tentorium cerebelli must compress the straight sinus which runs along at the base of the falx cerebri, and consequently check the onward flow of blood in the veins of Galen and inferior longitudinal sinus. As the veins of Galen return the blood of the choroid plexus, it is easy to understand how a chronic hydrocephalus may be thus produced. In these cases the lateral ventricles are distended with a clear fluid of low specific gravity, the third and fourth ventricles join in the dilatation, and the iter is also enlarged. In those cases which form the majority, where no tumour is present, or no evidence of a past or present meningitis, the mechanism of the hydrocephalus is by no means clear. In these cases the lateral ventricles and their horns may be enormously dilated, the grey matter on the surface is flattened out and reduced in some cases to the thickness of cardboard, the convolutions being lost or only traced with difficulty. The contained fluid is clear, of s.g. about 1005, with a small quantity of albumen and salts; the third and fourth ventricles are dilated; the pons is often flattened by the pressure of fluid in the fourth ventricle. The cause of this ponding up of fluid in the ventricles is by no means clear; it has been attributed to the closure of the aperture by which the ventricles communicate with the subarachnoid space, which is situated near the inferior boundary of the fourth ventricle (Hilton). A local meningitis at this spot would readily seal up the opening. We doubt if this explanation suffices for those extreme cases of hydrocephalus so often met with: the mere obstruction to the escape

of fluid will hardly account for the accumulation of large quantities of fluid which must be secreted under great tension. It seems more likely that there should be some obstruction to the escape of blood from the choroid plexuses, or some lesion of the latter which gives rise to an excess of cerebro-spinal fluid being secreted. It must be remembered, however, that the fluid drawn off from cases of hydrocephalus is of much lower s.g. than serum, or the fluid drawn from a chronic inflammatory effusion, as in chronic pleurisy.

*Treatment.*—The treatment of chronic hydrocephalus when once established is unfortunately unsatisfactory, and but little can be done to influence the progress of the disease. In any case in which there is reason to suspect syphilis some mercury should be given internally, and some ung. hydrarg. applied to the head, or strips of mercury plaister, to effect a moderate compression, while some of the drug will be absorbed. Some cases in infants appear to be benefited by this treatment; but, presuming there is a chronic syphilitic meningitis, it is by no means certain to be influenced by anti-syphilitic treatment. Both mercury and iodides should certainly be tried, especially as there is no other drug which affords any chance of success. Some measure of success has been claimed for compression of the head by means of strips of plaister or an elastic bandage; if it is decided to try this method its risks must be borne in mind. The circulation through the scalp is interfered with by its compression between the skull and bandage, the brain is also compressed between the skull and the fluid in the ventricles. We have seen extensive sloughing of the scalp in a case of hydrocephalus, the result of a too tightly applied elastic bandage. No real compression can be of any service, and is decidedly risky; but a lightly applied elastic bandage may be of use as a support, though no marked decrease of the fluid can be looked for. Puncture with a fine trocar through the anterior fontanelle, avoiding the superior longitudinal sinus, offers more chance of at least temporary relief. It is usually harmless, though if too much be withdrawn there is a risk of collapse of the brain substance, with perhaps convulsions and sudden death. Half an ounce to an ounce or more may be removed, and a strip or two of plaister, or a band of elastic webbing applied.

**Hypertrophy of the Brain.**—Rickety children often have abnormally large heads, a condition which is frequently attributed to 'water on the brain.' In reality such abnormally large heads are not hydrocephalic, their increased size being due in some cases to the prominent frontal and parietal eminences, but more often to an enlarged brain. The cause of this enlargement is not known, and the nature of the enlargement in the brain, liver, or spleen, which is apt to take place in rickets, is not clearly understood. In several cases coming under notice of children in their second and third years, with large heads, who have had rickets in a severe form and who have died in convulsions, the brains have been large, the convolutions well-marked, the brain substance fairly firm, and the microscopical examinations revealed no change that we could detect. Such brains are usually very vascular, but, as death often takes place through convulsions, it is hardly safe to assert that the vascularity is anything more than a secondary effect, resulting from the manner of death. In some cases the increase in size has been attributed to an increase of the connecting elements, the neuroglia, but it is needless to say it is a very difficult matter to decide if this is so in a brain

in which the enlargement is general ; in our own cases, certainly, there was no striking change. It is certain that enlargement of the brain in these cases is not accompanied by any precocity of intellect ; indeed, it is rather the reverse, as such children are mostly backward, not only in physical, but also in mental development. If the quantity of brain matter is large, the quality is certainly poor.

**Atrophy of the Brain ; Sclerosis of Brain.**—This condition is more often local than general, and is mostly secondary to some inflammatory lesion or softening which has preceded it either during intra-uterine life or after birth. Among the local regions which suffer may be mentioned the cerebellum, or one half of the cerebellum ; a portion of a hemisphere may be atrophied, so that there is a marked depression where the convolutions are absent, which has been called *Porencephalus* ; or almost any part of the brain may be affected. In rare cases the whole or greater part of the brain is shrunken and indurated, as the result of a meningo-encephalitis during

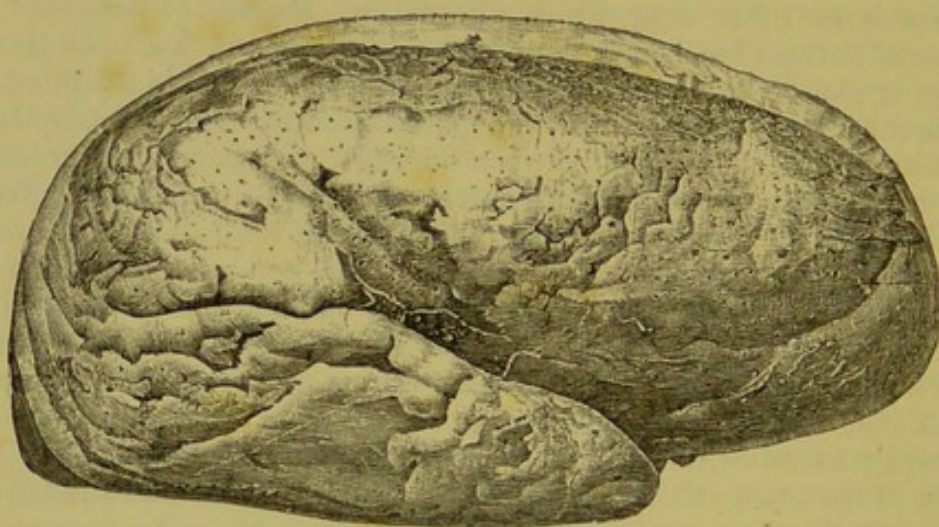


Fig. 67.—Sclerosis of Brain. From a Boy of 20 months. The convolutions have disappeared, the surface of the brain resembling a hob-nail liver.

intra-uterine life, or shortly after birth : such cases are probably syphilitic. As an instance of an atrophied or sclerosed brain the following may be mentioned. A child who died at the age of twenty months had been a complete idiot from his birth, and had suffered from convulsions ; he was blind and deaf, the legs and arms were drawn up and stiff. At the post mortem the brain was found hard and shrunken over the convex surface ; the convolutions had completely disappeared, the surface being simply grooved by the vessels and granular like a 'cirrhotic' liver ; at the base and median surfaces the convolutions were fairly well marked. The pia mater consisted of many tortuous vessels which could be dissected off. On vertical section it was seen that the grey matter and white matter also were hard and shrunken, and hardly distinguishable from one another. Microscopical examination showed an increase of connective tissue and a disappearance of nerve elements. There was descending degeneration in the pons and cord.

The brain may be of abnormally small size, and yet the brain substance

normal; in such cases there is usually more or less mental defect. See Mental Affections in Childhood.

**Tumours of the Brain.**—While cerebral tumours are by no means uncommon during childhood, the different varieties found are few. In the vast majority of cases the tumour or tumours consist of caseous masses formed by a local tubercular process. These tubercular masses especially have a marked predilection for the cerebellum, but are found also comparatively frequently in the pons, basal ganglia, and cerebral hemispheres, both on the surface and in the connecting white substance. Cysts of uncertain origin are also found, especially in the cerebellum. The pons seems the favourite seat of gliomas when they occur. Other new growths, such as epithelial carcinomata, may be occasionally found growing from the choroid plexus or pia-mater. Periosteal sarcomata growing from the bone are not uncommon, compressing the grey matter. No age is exempt; tubercular tumours have been found in infants a few months old, though they are more common somewhat later. Demme found a cheesy mass in the cerebellum of a newly born child, so that tumours may form during intra-uterine life. Little is known as to the cause which determines the growth in the brain or its coverings; it appears certain, however, that an injury acts as an exciting cause. A fall or blow on the head is followed in the course of a few weeks or months by cerebral symptoms. On the fatal termination a cheesy tumour is found in the cerebellum. How the injury can have given rise to this can only be surmised; possibly there is a local bruising and punctiform hæmorrhage. The most common tumour to follow a blow is a tubercular tumour, but then tubercular tumours are vastly more common than any others; a cyst or a syphiloma or a periosteal sarcoma appears to follow a blow at times.

*Symptoms.*—The *general* symptoms include: 1, persistent headache; 2, paroxysmal vomiting; 3, optic neuritis; 4, convulsions. The *local* symptoms are those caused by the tumour interfering with the function of some region, and causing some local paralysis or spasm, or incoordination of movements, or pressure on some venous channel and consequent disturbance of the circulation.

*Headache* is almost constantly present, though in young children who are unable to complain or describe their feelings its presence or absence cannot be determined. Its locality may help to indicate the seat of the lesion, but for this purpose it is an uncertain guide; it may be either frontal or occipital in tumours of the cerebellum, and it may shift about from time to time, but if fixed and constant at one spot it is of some value for localisation. It is usually tolerably constant, or not absent for long together, but is apt to be much worse at some times than others. It is mostly made worse by movement, and being up and about, and is better when the child is at rest and lying down. Percussion over the seat of the headache usually makes it worse or gives acute pain, but it is seldom of any diagnostic value in children. The headaches most likely to be mistaken for those due to a tumour are the hysteroid headaches, which are often very persistent and severe.

*Vomiting* is a frequent and very characteristic symptom, and is present in tumours of all parts of the brain, especially of the cerebellum, pons, and medulla, when the root of the pneumo-gastric is involved. The vomiting

usually comes on suddenly without warning, and without much nausea, and may be repeated daily or several times a week without any cause being detected : such vomiting is very suggestive of cerebral disease, though it must not be forgotten that hysterical vomiting also occurs, especially in girls about puberty. There may be nausea and constant sickness with much retching in the later stages of a cerebral tumour. It is often paroxysmal, coming on and lasting for several days almost constantly, being not amenable to treatment, and then suddenly improving.

*Optic neuritis* occurs in the majority of cases sooner or later, and is especially common in tumours of the cerebellum, less common in the frontal regions. The discs become swollen, so that to examination the edges appear at first blurred, and then all distinction between the edge of the disc and retina is lost, even to the direct method of examination. The veins become distended and tortuous, and hæmorrhages occur ; finally, after some months, the discs gradually pass into a condition of atrophy. The exact cause of optic neuritis is uncertain ; it is caused by the presence of tumours in all parts of the brain, but may be absent from first to last ; it has been known to occur in otitis and in disease of the cord without any discoverable cerebral lesion. In a case of our own, of acute otitis, there was optic neuritis, and no lesion of the brain was discovered post mortem. The neuritis appears to be in some cases a descending one, passing along the sheath of the optic tract and producing an intense inflammation at the papilla ; but this can hardly be the case often : it is much more likely to be a reflex inflammation, such as herpes facialis, which so often appears on the lips and face in inflammatory conditions of the respiratory tract. Optic neuritis, it is important to remember, may occur without any loss of sight, though as atrophy sets in the sight is certain to be damaged. It is often of great diagnostic importance, its presence being of much value as an indication of a cerebral lesion, though its absence in any given case where other symptoms point to some cerebral lesion does not necessarily negative the diagnosis. Optic neuritis may come on either early or late in the disease.

*Giddiness* is often complained of, most commonly in disease of the cerebellum and pons.

*Convulsions*.—The first symptom may be a convulsion which may never be repeated, or convulsions may be frequent during the course of the disease, and may occur in the case of tumours of any part, but more especially when the growth involves or compresses the motor cortical centres than when the cerebellum is involved. Such convulsions may be epileptiform, but without special aura. In some cases the nature of the aura and the commencement of the fits in some special part affords some indication of the seat of the tumour which is situated in the cortex. The convulsions which commence in one part may quickly become general.

*Paralysis*.—The various paralyses and other local symptoms will be referred to more especially later on under the regional symptoms.

**Tumours of the Cerebellum.**—One of the common seats for a cheesy mass is in one of the lateral lobes of the cerebellum. It is not uncommon to find these masses varying in size from a pea upwards in one of the lateral lobes in a child dying of tubercular meningitis, without any definite signs of its presence during life. In cases of cerebellar tumour which

have proved fatal, a cheesy mass may be found which has, perhaps, become adherent to the posterior fossa of the skull and tentorium, and has, perhaps, extended across the middle line, encroaching on the medulla, and so compressed the motor tracts passing downwards to the cord. Another pressure effect is the compression of the straight sinus by the stretching of the tentorium, and a consequent ponding up of the blood in the *venæ Galeni* and chronic effusion of fluid in the lateral ventricles. A large cerebellar tumour is almost certain to be accompanied by chronic hydrocephalus, the lateral ventricles are greatly dilated, the skull thinned, and perhaps the pons may be more or less compressed and flattened by the pressure of the fluid. A tumour of the middle lobe is more likely to compress the motor tracts in the floor of the fourth ventricle than one in the lateral lobes.

A simple cyst in the cerebellum is not uncommon.

*Symptoms.*—The early symptoms are headache, mostly occipital, optic neuritis, vomiting, and giddiness; less often internal squint, nystagmus, and convulsions. If the tumour is on the middle lobe there is unsteadiness of gait, from a difficulty in maintaining the balance, a sort of swaying motion when the patient attempts to stand or walk, resembling the movements of a drunken man. It must not be forgotten that a simple paresis of the legs will produce a stumbling, swaying walk not dissimilar to a drunken gait, though in the latter case there is no increased difficulty in maintaining the equilibrium with the eyes shut. The frequent blindness of the patient often renders the diagnosis between a mere paresis and a difficulty in balancing almost impossible. Both hydrocephalus and direct pressure on the medulla may give rise to paresis of the lower extremities. As the disease progresses, which it usually does slowly, the headache increases, so that the patient is glad to spend most of his time at rest, he feels fit for nothing, and takes little interest in toys or his playmates. The vomiting at this time is often troublesome. The optic neuritis passes on to atrophy, the sight is gradually lost, and the pupils dilate. In the later stages, when there is chronic hydrocephalus, the patient is bedridden, his legs being too weak for him to get about or perhaps bear his weight, and he is utterly helpless. The head enlarges; the younger he is, the more marked does the enlargement become; there is exaggerated tendon reflex: he is perhaps unable to sit up or hold up his head, as all the muscles are parietic. Other pressure symptoms may finally make their appearance: these may include facial paralysis, deafness, bulbar paresis, and sloughing of the cornea and eyeballs. The mental condition in the later stages, when the hydrocephalus is extreme, is generally that of imbecility, or apathy to what is going on around, and later still may pass into a condition of unconsciousness and coma, in which he may remain for weeks, or even months, gradually wasting to a mere skeleton, and deep bedsores forming over the sacrum and buttocks. There is another phenomenon which is much more marked in some cases than in others, and that is rigidity of the muscles of the neck, back, and limbs, the result probably of pressure on the motor tracts; as a rule the tonic spasm follows paresis of the muscles, but sometimes rigidity is noted from the first. The muscles of the neck may become rigid, and the head retracted so that the head is thrown back and kept in this condition; the arms are bent at the elbows and rigid, the legs are drawn up, while the feet assume the position of equinus.

Sometimes there is marked pain, shooting down the neck and back, especially when the middle lobe is affected. It is difficult to explain why in one case there should be paresis, in another rigidity from the first, but it must be borne in mind that the pressure on the motor tracts is sometimes direct by the tumour itself, at other times by means of a chronic effusion in the lateral ventricles.

The following case in a patient of thirteen years (under Dr. Hutton's care) well illustrates the symptoms present when there is direct pressure of the tumour itself on the pons and medulla. The girl was healthy till August 1884, when she began to suffer constant pain in the back, relieved only by lying down; she vomited frequently, especially in the early morning and after food; her gait gradually became somewhat staggering, and her sight dim; for some time before admission she complained much of pain in the back, and the head was retracted. The pain was in all probability due to spasm of the muscles of the neck and back. On admission, February 25, 1885, there was marked optic atrophy, with impaired sight; she could walk unaided when her eyes were directed to the ground, more unsteadily if the eyes were shut; when tired there was a marked tendency to fall to the left; there was ankle clonus and exaggerated knee-reflex on the left side. During March there was much paroxysmal pain in the head and lumbar region, the head being retracted and the whole back arched, so that only her head and buttocks touched the bed; a few days later the tonic spasms had disappeared and she could get about the ward; she suffered from pins-and-needles in her feet and jumping pains in knees and ankles. In April the occipital pain and spinal tenderness returned from time to time, and it was noted there was ankle clonus in both legs and exaggerated knee-reflex; there were also tremors in the legs; her gait was also hurrying, resembling paralysis agitans. She died suddenly early in May, having been ill about nine months. At the post mortem the whole middle lobe of the cerebellum was occupied by a cystic tumour, covered by a thin layer of cerebellar substance, except above and below; it projected downwards, flattening and expanding laterally the pons and medulla.

Caseous tumours of the cerebellum run a chronic course in most instances; life may be prolonged for many months after the patients have lost their sight, and are bedridden and emaciated. They may live many weeks in an unconscious state.

**Tumours of the Pons and Medulla.**—Tubercular masses not infrequently invade the pons, being situated in the central part, or small masses may be found in the floor of the fourth ventricle. They are apt to cause symptoms, less, perhaps, by their direct pressure effects, which act but slowly, than from the softening which often surrounds them. At the post mortem, when the size of the cheesy mass is discovered we have often been surprised how little paralysis was present during life. Gliomas of the pons are not rare in older children.

*Symptoms.*—The symptoms present in disease of the pons may be manifold on account of the close relations of the motor tract: the motor strands are gathered up together, and the centres of various cranial nerves are in close relation. The symptoms vary according to the position of the lesion in the pons; thus in a case of our own, in which a glioma commenced in the right

lower border, there was 'alternate hemiplegia,' viz. a left hemi-paresis with paralysis of the right external rectus, and right facial paralysis, optic neuritis, and vomiting. Cheesy masses are often more centrally situated, and may after a while involve the medulla; there may then be double facial paralysis, perhaps more marked on one side than the other; the saliva dribbles from the mouth, the speech is thick, and there may be difficulty in swallowing. There may be paresis and rigidity of the limbs, squint, sloughing of the cornea from interference with the fifth. The paralyses produced by disease of the pons are apt to be bi-lateral on account of the right and left motor paths and nerve centres being near together.

**Basal Ganglia and Internal Capsule.**—Cheesy masses may be present in the caudate or lenticular nucleus or thalamus, but they only produce a definite hemiplegia when they involve the internal capsule. In one of our own cases a villous growth from the choroid plexus compressed the left thalamus and internal capsule, and produced a paresis of the right arm and leg, with marked rhythmical shaking movements when voluntary action was attempted, so much so that his mother said his arm used to 'work like a clock'; contractures, facial paralysis, and optic neuritis supervened before death. The rhythmical tremors were no doubt produced by gradual pressure on the motor path which passes along the internal capsule. In children there is rarely loss of sensation: this occurred, however, in one of our cases, in which two large cheesy masses involved the whole of the posterior limb of the internal capsule, the arm and leg of the opposite side being contracted and anæsthetic.

**Tumours of the Cortical Layer.**—Irritation of any part of the motor area of the cortex, which includes the ascending frontal and parietal convolutions and the anterior portion of the superior parietal lobule, gives rise to convulsions which begin in the arm, leg, or face, according to the part affected. Destruction of this region, as by softening following embolism, or the presence of a tumour, gives rise to a hemiplegia affecting the face, arm, and leg, a partial destruction giving rise to a partial paralysis. The presence of a syphiloma, a tubercular mass, or pressure by a tumour growing from the membranes, is likely to give rise to epileptiform seizures, the convulsions starting in the arm, leg, or face, though they are not necessarily confined to the limb in which they start, but may become general. In the later stages a hemiplegia results.

**Tumours of the Frontal Lobe** produce no paralysis unless they encroach upon the ascending frontal convolution: in that case they may produce a paresis of the leg, arm, and face, according to the part involved. A tumour involving the posterior third of the left frontal convolution causes aphasia.

*Prognosis.*—The prognosis in cerebral tumours is exceedingly unfavourable, whatever their nature may be, unless perhaps syphilis may be excepted. Undoubtedly tubercular masses may cease to spread and become cretaceous, though against this must be set off the chance that other masses may form or the child die of tubercular meningitis or tubercle elsewhere. Every other form of tumour is certain to progress from bad to worse. In the majority of cases the progress is slow, often lasting over a year or more. Death may supervene from intercurrent disease, as tubercular meningitis, or other form of tubercle; it may be sudden in tumours of the pons and cerebellum (see

p. 378), or it may be exceedingly slow, as in cases of cerebellar tumour and chronic hydrocephalus. Occasionally cases in which the diagnosis of tumour is made partially recover, or remain stationary for many years. Gowers records a case of a girl of fifteen years who suffered from hemiplegia, headache, hemianopia, and optic neuritis of gradual onset; she gradually recovered, except the hemianopia and paresis of arm, and was well, with these exceptions, six years after.

It is not uncommon to find cretaceous masses in the brain, evidently the result of the shrivelling up of a tubercular mass. This was so in the following case. A boy aged eleven years was admitted into hospital, November 1881, with internal squint, optic neuritis, and almost complete blindness. He was intelligent and walked about; there were no signs of any paralysis, he had no headache or vomiting; during his stay he got better, and was discharged (January 1882) apparently in good health, though quite blind from optic atrophy. He was readmitted February 1883, having suffered for six months with pain in his head, and recently he had lost power in the right side; the right elbow was semiflexed, the wrist pronated and flexed, the fingers over-extended, except at the metacarpal joints; the knee was bent, and the ankle in the position of equino-varus; there was loss of sensation also on the right side, and the boy had some difficulty in finding the right arm with his left. In March there was some difficulty in swallowing, with paresis of left side of face and arm, followed by death. At the post mortem there was a small cyst with thickened cretaceous walls on the inferior surface of the right frontal lobe, evidently the remains of a tubercular mass; there was a cheesy mass involving the left caudate nucleus, and optic thalamus and internal capsule; there was a second cheesy mass involving the lenticular nucleus and internal capsule of the right side. In this case there is no doubt there was a cheesy mass in the right pre-frontal lobe on the inferior surface, which gave rise to optic neuritis and internal squint, and which passed into a quiescent state; subsequently other tubercular masses formed which, with a general tuberculosis, caused his death.

*Diagnosis.*—The most important point to be decided is whether there is a cerebral lesion, or the symptoms are due to functional disease; the question as to the nature and seat of the lesion is of less practical importance. The cases which at first sight present a superficial resemblance to cases of cerebral tumour are those of chronic headaches in children at puberty, which are often severe and are sometimes accompanied by vomiting or nausea. The latter, however, are never accompanied by optic neuritis, by sudden vomiting, are rarely acutely painful, and are improved, or lost for a time, by active exercise in the open air. The headaches of a cerebral tumour are severe, sometimes make the patient scream with pain, and are made worse by active exercise.

The vomiting in a case of cerebral tumour is causeless, coming on the first thing in the morning, perhaps being constant for a day or two or more, then passing away for a while without any apparent reason. The paralysees of hysteria are not often hemiplegic, being more often paraplegic and never accompanied by optic neuritis.

When fits are present there may be a difficulty in distinguishing between epilepsy and a tumour, especially as a hemiparesis is apt to remain after a fit. In these cases, if the convulsions have constantly a local commencement

they are probably due to a tumour, and later on optic neuritis or some paralysis would decide the diagnosis. The presence of more tumours than one may make the differential diagnosis difficult.

*Treatment.*—Except in the case of syphilomas of the brain, the treatment of cerebral tumours by medicines resolves itself into a treatment of symptoms. Wherever there is the least chance of the tumour being syphilitic, iodide of potassium should be given in full doses ; though in children syphilitic disease of the brain is rare. If it is supposed that the tumour is tubercular, cod-liver oil and iodide of iron may be prescribed, while the child is kept at rest and placed under the most careful hygiene.

For the headaches, bromides, Indian hemp, and opium, may have to be prescribed. The vomiting, which is so often troublesome, must be treated by perfect rest in bed, peptonised milk or ice-drinks being given in small quantities. Hydrocyanic acid may be given. The vomiting is exceedingly erratic, coming and going without any apparent cause. In some tumours at least the question of operation may be entertained (see *infra*).

**Cerebral Abscess.**—In children as in adults the common cause of abscess of the brain is injury or ear disease ; less often it is the result of suppuration in a distant part, as an empyema or abscess of lung. Abscess is most common in the cerebrum, less frequent in the cerebellum or pons.

*Symptoms.*—The early symptoms are those more or less of meningitis, namely headache, fever, vomiting, and perhaps convulsions ; they may, however, be very slight and readily overlooked. The later symptoms, those of the chronic stage, vary according to the seat of the abscess and are more or less those of a cerebral tumour, including optic neuritis, headache, vomiting, convulsions, and varying paralyses, possibly hectic, and emaciation. The diagnosis of abscess from meningitis or tumour is sometimes very difficult, as the following cases show. A girl of two years of age was admitted into hospital under Dr. Hutton, who had had a discharge from her right ear for three months, but was otherwise well and strong, till fourteen days before admission, when she had a right-sided convulsion lasting four hours, followed by unconsciousness ; four days afterwards she had a similar attack : she squinted, and was more or less blind after it. On admission there was almost complete motor and sensory paralysis of the right arm and leg, with loss of sensation on the left side of the face and ptosis on the left ; she became convulsed, the convulsions beginning in the right side, and was unconscious before death. At the post mortem an abscess cavity was found in the left temporo-sphenoidal lobe, extending into the occipital lobe and reaching the internal capsule : it contained three ounces of pus. The left tympanum was full of pus. In the following case the abscess followed a perforating wound of the orbit. A boy aged six years was playing in a hayfield when by accident he was wounded above the left eye with the prong of a hayfork ; the eye swelled, but no external wound was found. During the next few weeks he was irritable and frequently vomited. Six months after he was brought for advice, as his sight was failing. On admission he was quite blind (atrophy of discs) and somewhat dull of comprehension ; he could walk well ; the right hand was weak, but not paralysed ; he remained much the same for a month, when he died suddenly. At the post mortem the left frontal lobe was larger than that of the opposite side, its convolutions including the superior, middle,

and inferior, with more or less of the ascending frontal and parietal flattened ; its inferior surface was adherent to the orbital plate and of a yellow tinge ; and there was an abscess containing four or five ounces of greenish pus. It was clear there had been a penetrating wound through the orbital plate into the brain.

*Treatment.*—When pus has formed there is little hope in any method of treatment, except operation.

*Surgical treatment of cerebral lesions.*—Our knowledge of the operative treatment of tumours of the brain is still very limited, but enough has been learnt to justify a short account of the subject being given here. At present only those growths which lie on or near the surface of the cerebrum have been successfully dealt with ; tumours at the base of the brain, or involving the basal ganglia, may be looked upon as inaccessible to surgery at present, and, though cerebellar growths are not beyond our reach, but little has yet been done for their removal. Surgery chiefly deals with growths situated in the motor area of the cortex, since the localisation of the tumour is most satisfactorily to be made out in this region. Again, only those growths which are of limited size are suitable for removal, since the destruction or disturbance of large areas of the brain would lead to as great evils as the tumour itself. Assuming that the presence and exact position of a tumour have been ascertained by the symptoms presented, the following are the steps to be taken for its removal. If time permits, at least twenty-four hours should be devoted to preparation of the patient for the operation. The entire scalp should be shaved and thoroughly cleansed with turpentine ; after this a compress soaked in solution of corrosive sublimate, 1 in 3,000, or carbolic acid, 1 in 20, should be kept applied to the head until the time of operation. The utmost precautions should be taken to have all instruments and anything likely to come into contact with the field of operation thoroughly aseptic. After the child has been anæsthetised a large flap of integument, having its centre over the seat of the tumour, should be reflected and the bone laid bare. Next a large circle of bone should be removed with a trephine or gouge and the dura mater exposed ; all bleeding must be arrested. The surface of the dura mater should then be carefully examined as to its colour, as to the presence of pulsation, and as to any tendency to protrusion through the aperture in the skull. We have noticed in a case of cerebral tumour thinning of the bone over the seat of the growth, with engorgement of the diploic vessels, but this can only be expected to be seen when the growth is large and superficial. Should the tumour be extra-dural, its removal may be now accomplished, but if it is truly cerebral a crucial incision should be made in the membrane and the surface of the brain inspected and felt with the finger for evidence, either visible or palpable, of the mass ; if the growth is seen, its size and connections should be studied and the question of the possibility of its removal decided upon. If it is determined to proceed with the operation, the substance of the cortex must be separated from the growth, and the mass removed with as little injury as possible, both to brain substance and to the vessels of the part. If there is softening (encephalitis) of the brain round the growth, the prognosis is bad, but any actually disintegrated brain should be removed. All bleeding is then to be arrested, the dura mater sutured over the brain, and the portion of

skull removed, which should have been kept lying in warm carbolic lotion (1 in 80), cut up into pieces about the size of canary seed, and replaced on the surface of the membrane ; or the whole disc of bone may be replaced entire. Provision is to be made for drainage, the wound closed and dressed antiseptically in the ordinary fashion. After the operation the child is kept absolutely quiet in bed, and fed on weak animal broths and diluted milk in small quantities. If the case is doing well, there will be no need to disturb the dressings for a week or ten days, when the wound will be found healed, with the exception of the drain opening. Should no growth be found, or should there be very extensive encephalitis, or if the tumour be too extensive for removal, the operation must be abandoned. Such are briefly the general rules to be adopted in dealing with brain tumours, and a large part of the description will also apply to operations for cerebral abscess or for those cortical lesions which give rise to epilepsy or other troubles and necessitate surgical measures. A few additional remarks may be made on the two last-mentioned subjects. As to cerebral abscess, it is the result, apart from tuberculosis, most commonly of injury or disease of the ear ; in the case of traumatic abscess the seat of the abscess will usually, though not always, correspond with the seat of the external injury, though the evidence should be, of course, supplemented by the indications given by any paralyses that may be present. The steps of the operation are those already described ; should, however, no evidence of the abscess be seen on exposing the brain, careful systematic exploration to a depth of from one to two inches should be made in every direction from the centre of the part exposed. This is best done with a grooved needle, fine trocar and cannula, or director. Should pus be found, the opening must be enlarged and the abscess cavity drained, and the operation completed as above described. (For further details of cerebral abscess, the result of otitis, *vide* chapter on Diseases of the Ear.)

Where trephining is done for Jacksonian epilepsy it must be remembered that pressure or irritation may be due to a depressed or thickened portion of bone, to a local pachymeningitis, or to a cicatrix, or to local inflammation of the cortex of the brain itself. If the irritant is cranial, the offending bone must be removed. So also, if a local thickening of the dura mater is found, it should be excised. If, however, the lesion is in the brain itself, the question arises whether it is so extensive that removal of the injured part can be effected without an extent of paralysis following which would render the patient's condition worse than it already is. The details of the operation are the same as in the case of tumour or abscess. For further information we must refer to the papers of Dr. Macewen, Mr. Horsley, and others. There is no doubt that, on the one hand, the brains of children are more tolerant of operation than those of adults, and, on the other hand, that brain lesions which would prove fatal to adults are not only recovered from in children, but may leave little or no permanent effects, even if left to nature. Each case must be judged on its merits.

The dangers of hernia cerebri and diffuse encephalitis or meningitis are no doubt considerable, but with thorough antisepticism these risks may be generally avoided. It has been shown by Dr. Macewen that hernia cerebri, though it may result from imperfect wound management, may also be due to a pre-existing encephalitis, even in the absence of any septic condition of the

wound. Should hernia cerebri appear, it is best dealt with by pressure applied over the wound by means of a plate of sheet-lead laid outside the inner layer of dressings.

The subject of operative measures in disease and injury to the spinal cord is still more in its infancy than that of cerebral surgery, and no definite rules can be laid down ; some account of the matter will be found under the head of Spinal Caries.

It must be looked upon at present as a much more serious matter to open the spinal theca than to incise the dura mater, hence greater hesitation should be felt in dealing with cases requiring so severe a measure.

## CHAPTER XXII.

DISEASES OF THE NERVOUS SYSTEM—*continued.*

**Infantile Hemiplegia. Acute Cerebral Paralysis.**—There are several different lesions occurring during infancy and childhood which may give rise to hemiplegia ; some of these are peculiar to, or at any rate occur most frequently, at this time of life, while others are common to all periods of life. The principal lesions may be enumerated as follows. A hemiplegia may date from a *meningeal hæmorrhage* taking place during birth, but such hæmorrhage or injury is usually bilateral, so that a paraplegia or a general paralysis is produced. The *brain-softening* which follows thrombosis in tubercular meningitis is a not uncommon cause of hemiplegia, the latter setting in a few days or a week before death. *Embolism* of the middle cerebral artery, *thrombosis* of the cerebral sinuses, the pressure of a *tumour* or an *abscess* on the pyramidal tract, may give rise to hemiplegia. A hemiparesis may follow an *epileptic fit* or severe *chorea*. An *anterior poliomyelitis* may be of hemiplegic distribution.

The hemiplegia which is most characteristic of early life is a form which is apt to follow or accompany an acute illness of some kind, either some well-recognised febrile disorder, or an indefinite febrile attack to which no name can be given, and which when it passes away leaves the child with a more or less complete hemiplegia.

Sometimes the primary illness is measles, zymotic diarrhœa, pneumonia, diphtheria, hooping cough, or scarlet fever ; more often, perhaps, the attack cannot be referred to any one of these, and the principal symptoms consist in convulsions, coma, and high fever, which are looked upon, by the friends at least, as pointing to 'brain fever' or 'congestion of the brain.' In some cases there is a history of a fall.

Of the zymotic diseases which precede the paralysis, measles appears to be the most common, judging from the recorded cases, but measles, we must bear in mind, is the commonest of the specific fevers which occur in infancy and childhood. Scarlet fever, according to Gowers, also commonly precedes paralysis, but we cannot recall any such case, and we must remember that endocarditis is not uncommon during scarlatinal nephritis, and consequently embolism of the middle cerebral artery may take place from dislodgment of thrombi from the inflamed valves ; a hemiplegia is thus produced, but it belongs to a different class to those under discussion. In the majority of cases of infantile hemiplegia coming under our notice, if the history could be relied on, there was no history of any antecedent specific fever.

The convulsions which precede the paralysis are often one-sided, affecting the side which is afterwards paralysed ; the child may be unconscious

for some days ; the hemiplegia may be accompanied by aphasia and facial paralysis ; occasionally there is loss of sensation.

Most of the attacks occur during the first two years of life ; it is not uncommon for infants a few months old to be attacked.

As an example of an acute hemiplegia associated with measles, the following case occurring in a healthy boy of twenty months, a patient of Mr. Wilson's of Cheadle, which came under our observation, may be taken as an example. Mr. Wilson's notes are as follows. 'The measles rash was first noticed on May 10 ; convulsions commenced at noon on the 11th : these consisted of clonic spasms of the left arm and leg and right side of the face ; the eyes were turned to the right side and fixed ; the pupils were dilated, the temperature rose to  $105^{\circ}$ , the pulse was too fast to be counted ; the convulsions continued during the morning ; at 1 P.M. the temperature was  $107^{\circ}$  F., when the patient was put into a cold bath ; it was again  $107^{\circ}$  at 4 P.M., when he was bathed again and five grains of quinine given by the rectum ; at this time an examination of the lungs showed pneumonia at one base ; at 6 P.M. the temperature was  $103^{\circ}$  and the mother noticed he had lost the use of his left side ; at 8 P.M. it was noted that the left arm was completely flaccid, paralysed, and apparently anæsthetic ; the leg was rigid, but on tickling the sole of the foot the toes moved slightly. Pneumonia developed the next day ; the child died on the 13th, the arm and leg remaining in the same condition ; unfortunately no autopsy could be obtained.' In the absence of a post-mortem no definite conclusion can be come to as regards the lesion in this case ; in connexion with it, it is interesting to note Dr. T. Barlow's case of measles and pneumonia in an adult (aged 23), accompanied by disseminated myelitis, the foci being confined in his case to the cord and medulla ; was there in our own case a similar lesion in the motor area of the brain ? We are, however, rather inclined to believe that the symptoms are best explained by a thrombosis or embolism of the right middle cerebral artery, the result of a high temperature and altered condition of the blood.

The following case, though not associated with a high temperature, is interesting, as death occurred seven months after the onset of the hemiplegia and an examination was obtained. A boy of one year old, who had suffered since birth from marked cyanosis due to obstructive pulmonary disease and constant dyspepsia, was seized one night with vomiting and convulsions, followed by paralysis of the left arm and leg. When seen on the following morning, the head and neck were turned to the right side, the eyes were suffused and blinking, as if some foreign body was present, the right pupil was smaller than the left, but both acted to light ; the child was apparently quite blind ; there were no retinal hæmorrhages, and the optic discs were normal. The face was drawn to the right side ; there was complete loss of power, and apparently loss of sensation, in both arm and leg of the left side ; no cry could be elicited on pinching or pricking the skin of either limb. The child was drowsy, but not unconscious, as he appeared at times to know when he was in his mother's lap. He was apparently deaf for the first twenty-four hours, though there was necessarily some difficulty in ascertaining this ; by the next day, though remaining blind, he knew the voices of his friends and turned towards the direction of their voices ; it was clear, also, that he heard with both ears. Within a fortnight sight had returned,

so that he could recognise his mother and his toys. His friends thought he regained his sight first in his right eye. By the end of six weeks sensation had returned, as far as could be judged, in the arm and leg, and some power was returning, as he moved both limbs of the left side. A week or two later he could hold a rattle in the left hand, but not raise it to his mouth; the leg showed a tendency to draw up, and the knee reflex was much exaggerated. The child was quite intelligent and bright. Before death (seven months after seizure) much improvement had taken place: the child could put out its hand, but there was some rigidity both in the arm and leg. The child died of bronchitis. *Post-mortem*.—On removing the brain, it was evident the right hemisphere had shrunk, being slightly smaller than the left, and that there was a large cyst (porencephalus), containing clear fluid, occupying the central part of the convexity of the right hemisphere (see fig. 68); the cyst corresponded with the distribution of the middle cerebral artery, excepting the branch to the inferior frontal convolution. The

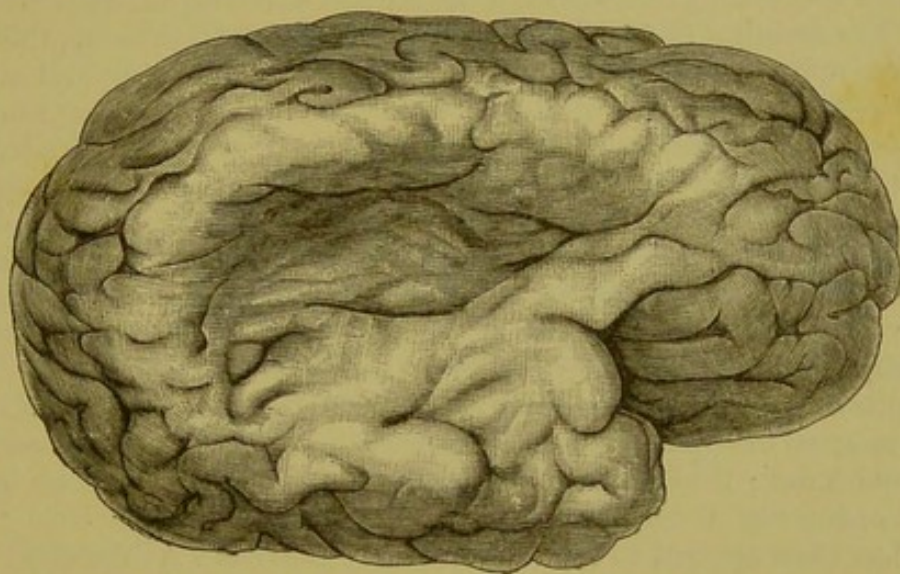


Fig. 68.—Cyst formed by softening of brain substance, secondary to obstruction of the middle cerebral artery beyond the first branch (to inferior frontal convolution). The cyst-wall has fallen in from escape of its contents. Child 19 months old; death 7 months after onset of paralysis.

middle cerebral artery beyond its first branch was impervious and contained old clot. It was quite clear in this case that there had been thrombosis or embolism of the middle cerebral, with a subsequent softening of the area supplied by it; a horizontal section showed that the internal capsule had been compressed.

No emboli were found elsewhere; there was no endocarditis of the mitral or aortic valves, but a much contracted pulmonary artery and open foramen ovale.

The following case may be given as illustrative of one which recovered from the immediate effects of the acute attack. A child of 13 months who was cutting her lateral incisor teeth was suddenly seized with vomiting, diarrhoea, and high fever; then a series of convulsions came on which lasted 8 hours, the right side working most; at the end of this time it was noticed she had completely lost the use of the right arm and leg, and the face was drawn. Her speech was affected, so that she could not say any of the

words she had learnt. For more than a month she lay quite helpless. Seven months afterwards, when 20 months old, she could not walk or rest her weight on the right leg ; the arm was bent at the elbow, the hand clenched, but the facial paralysis had disappeared ; she could say a few words, but was backward in intelligence. At the age of four years she had much improved : she could walk quite well, having apparently regained power in her leg, though there was slight equino-varus, but the right arm remained stiff and weak, the elbow flexed, the wrist bent and pronated, and the fingers clenched. The fingers closed spasmodically, so that she was in the habit of placing things with her left hand between the fingers of her right, where they were held without effort. She could talk and was very intelligent.

These cases may be taken as types of acute cerebral paralysis ; the symptoms in such may be varied, but they all three agreed in that convulsions were present and the paralysis set in suddenly and unexpectedly, as a surprise to the attendants. In the first and last there was high fever.

For the succeeding few weeks, if the patient survives, he remains helpless, though the condition gradually improves ; if there is anæsthesia, this passes away ; the aphasia, if present, disappears ; the face improves, and still later more or less power returns in the muscles of the leg. The arm remains in part permanently paralysed, and in the course of some months contractures come on ; the greatest improvement takes place in the muscles about the shoulder ; the elbow is flexed, the wrist flexed and in a position of pronation, the fingers are bent up, enclosing the thumb. The amount of paresis and contracture varies considerably, according to the severity of the case. Peculiar movements often occur in the paralysed limbs, more especially in the hands, a condition to which the term 'athetosis' has been applied. The movements as a rule are quite unlike chorea ; they are slow, consisting in alternate contraction of opposing muscles, giving rise to irregular movements of the fingers and hand ; they are involuntary, and take place in muscles in which there is ordinarily a certain amount of tonic spasm. The term 'mobile spasm' has been applied to this condition by Gowers. As the latter author points out, the interossei and lumbricales muscles (which flex the metacarpophalangeal and extend the phalangeal joints) are mostly affected ; less often the long extensor, and never the long flexor of the fingers.

In consequence the hand is apt to assume the interosseal position. The movements may take place independently in the interossei, so that one or more fingers may be extended at a time, or all the fingers may be extended and separated, and the slow irregular movements of the extended fingers suggest the movements of the tentacles of a cuttle-fish (Gowers). The movements are involuntary, but are made worse by attempts at voluntary movements.

The paralysed arm is apt to grow more slowly than its fellow, so that it is shorter and smaller, and often blue and cold. The leg, following the usual course in hemiplegias, recovers more quickly and perfectly than the arm ; there is more or less equino-varus, and there may be some shortening, but the child can get about fairly well.

The intelligence often remains impaired ; sometimes there is complete idiocy, more often only impaired mental powers or backwardness. Epilepsy is also common, the convulsions being chiefly one-sided at first, but in the

more violent fits all the limbs become affected (see Epilepsy, p. 408). Such children may grow up, as the general health is not necessarily greatly affected; the leg often recovers sufficiently to allow the child to walk.

A sudden hemiplegia may be caused by meningitis, the immediate cause being softening following thrombosis or obstruction of the vessels; the meningitis is usually tubercular. Thus a boy of 6 months of age, who had been apparently healthy, suffered for a week or two from febrile disturbance, dyspepsia, and irritability, attributed not unnaturally by his friends to 'teething': one evening at 8 P.M. he was convulsed, the right arm and leg twitching most: this was followed by right hemiplegia, including the face. At 3 A.M., when seen, the infant was unconscious, with contracted pupils, Cheyne-Stokes respiration, the face drawn to the left, the right arm and leg completely powerless. Death took place 3 days later, the temperature rising in the meantime to  $105^{\circ}$ . The post mortem showed a basal meningitis (tubercular), much fluid in the lateral ventricles, and softening of the left hemisphere and corpus striatum.

Another lesion (this a rare one) giving rise to hemiplegia is an aneurism of the middle cerebral artery, the result of embolism, in cases of acute endocarditis; this was the case in a girl of 9 years under our care who suffered from intermittent pyrexia and albuminuria, and in whom a loud systolic murmur was present. To these symptoms were added acute pain in the frontal region, coming on suddenly. An ophthalmoscopic examination showed large retinal hæmorrhages surrounding the disk. A week later there was paresis of the right arm, no paralysis, but exaggerated tendon reflex of the right leg. Six weeks later she fell back unconscious while sitting up in bed: there was now right facial paralysis and paralysis of the right leg. Death followed 10 days later. An aneurism the size of a small walnut, on the second branch (to the ascending frontal convolution), near its origin from the trunk of the left middle cerebral artery, which had ruptured and given rise to meningeal hæmorrhage, was found post mortem.

*Pathology.*—It is by no means clear what the lesion usually is in acute infantile hemiplegia: very few cases with post mortems in an early stage having been reported, though a considerable number of examinations have been made on those dying many years after the acute attack. The theory which has attracted most attention recently is that of Strümpell, who assumes that a polio-encephalitis, or inflammation of the cortex of the brain, similar to the inflammation which occurs in the grey matter of the cord (anterior-polio-myelitis), takes place, and finally cicatrisation and induration of the motor centres affected ensues. Strümpell's theory, however, rests on no definite post-mortem evidence, and until such evidence is forthcoming it is unsafe to assume the existence of a local encephalitis, a lesion which is almost unknown in the brain as a primary disease. It must, however, be said that clinically some of the acute attacks, accompanied as they are by fever and convulsions, have a close resemblance to the acute attacks which precede anterior polio-myelitis. It is an important question how far the symptoms which usually include high fever &c. are due to the brain lesion, or to what extent the brain lesion is secondary to some other acute disease and caused by the high fever and poisoned state of the blood. In many cases, at least, it is evidently secondary, following measles, pneumonia, or an

acute intestinal catarrh ; but in the majority the history is only obtained from the friends, and no exact observations are made of the acute attack, and thus statistics compiled as to whether the brain lesion was primary or secondary are deprived of much of their value. It is important to note that in several recorded cases a high temperature,  $105^{\circ}$ – $107^{\circ}$  F., was noted before the onset of the paralysis.<sup>1</sup>

Some cases of hemiplegia are without doubt due to embolism followed by softening, especially in those cases occurring during rheumatism or scarlatinal nephritis, diseases which are known to be frequently accompanied by endocarditis. A typical case of this kind is recorded by Dr. F. Taylor. A boy of 5 years, two weeks after an attack of scarlet fever, was seized with hemiplegia of the right side ; the urine was albuminous. Death occurred from diphtheria 9 weeks afterwards ; embolism of the left middle cerebral artery, with extensive softening of the left hemisphere, was found. There was endocarditis of the mitral valve. Abercrombie reports a case of a boy aged 6 years who was under treatment for diphtheria, and who on the 15th day was seized with general convulsions and left hemiplegia ; he died 11 days later. The middle cerebral artery was found plugged with an embolus ; infarcts were also found in the spleen and kidneys. There was no heart disease, and it was difficult to understand the source of the emboli, unless formed in the cavity of the heart or in the pulmonary veins ; this might be possible in paresis of the respiratory muscles and disturbed innervation of the heart, following diphtheria. In our own case (see p. 388) it does not seem improbable that thrombosis of the middle cerebral occurred, as we must bear in mind that the cerebral veins and sinuses would be congested on account of the obstruction at the pulmonary orifice. On the whole we think the symptoms in these cases are best explained by assuming that obstruction of one or other of the middle cerebral arteries has taken place, followed by softening of the area supplied ; and in non-fatal cases a gradual cicatrization takes place and descending changes occur in the spinal cord. Whether the obstruction is due to thrombosis or embolism it is difficult to decide : we are inclined to agree with Gowers that in those cases where no endocarditis exists it is probably the former.

The lesions found in cases of long standing have been various, but mostly there has been an atrophy or cicatrization of the motor region of the cortex on the side opposite to the paralysis. The cortical region is depressed and indurated with descending changes along the motor tract into the cord. In some instances a cavity has been found in one of the cerebral hemispheres opening on to the cortex, a condition to which the name of porencephalus has been given. The basal ganglia may be indurated or atrophied. These conditions are probably the result of a past softening of the brain, secondary to thrombosis or embolism.

*Treatment.*—The early treatment of acute cerebral paralysis must depend, to a large extent, upon the disease with which it is associated. Speaking generally, when paralysis has set in, the patient should be kept absolutely at rest in bed, with the head and shoulders slightly raised so as to favour the cerebral circulation. Ice to the head should be applied if the temperature

<sup>1</sup> See p. 388 ; also Gibney, *Medical Record*, October 9, 1886.

is high, as it so often is in these cases. A moderate purge should be given, sufficiently large to act freely on the bowels; a piece of mustard-leaf may be applied to the back of the neck if the child is unconscious, care being taken not to leave it on long enough to produce a sore. The drugs most likely to be of service are small doses of digitalis, to steady and increase the power of the heart, and bromide in full doses if there is any tendency to convulsions. The paralysed limbs should be wrapped in cotton wool. As the patient is recovering from the effects of the attacks, nux vomica, iron, and syrup of the hypophosphites may be given. In the later stages, when contractures are setting in, massage should be diligently and intelligently employed; but the patient's friends must be warned that a cure is not likely to be effected by any form of treatment, and that rubbing, as also galvanism, are only palliative. Every effort should be made to bring out the patient's voluntary power. The deformities resulting may be improved by division of tendons and the application of splints.

**Thrombosis of the Cerebral Sinuses and Veins.**—Thrombosis of the cerebral sinuses or veins is not a common occurrence during infancy and childhood. It may occur in the superior longitudinal, lateral, or cavernous sinus. It is most likely to occur in extreme anæmia, after exhausting diseases as acute diarrhœa, where the force of the heart is weakened and a stasis or slowing of the venous current takes place. Thrombosis may also occur in the surface veins under similar circumstances, or the clotting in the veins may be the result of meningitis. The immediate result of the obstruction to the veins or sinuses is to distend the venous branches behind the obstruction to their utmost capacity, and possibly also to give rise to punctiform hæmorrhage and softening of the brain. Thrombosis of venous channels may take place in the neighbourhood of some inflammation, as in otitis, and pyæmia may result.

*Symptoms.*—There is a condition of great exhaustion and pallor, and to these are added cerebral symptoms and venous obstruction. The fontanelle is tense, the veins of the forehead, nose, and face are distended; there is epistaxis and probably convulsions; perhaps, also, rigidity and retraction of the neck, and paralysis of one or more extremities. In making a diagnosis, it must be remembered that the so-called 'false-hydrocephaloid' or cerebral anæmia gives rise to convulsions, stupor, and coma, and is infinitely more common than thrombosis. We are only justified in diagnosing the latter when there is distention of the veins of the face and forehead, or some definite paralysis. Thrombosis of the cavernous sinus is most likely to occur in some local lesion, as a tumour, as a periosteal sarcoma of the sphenoid bone, or caries; the eyeball is prominent, there is œdema of the eyelids and distention of the veins of the forehead.

*Treatment.*—The action of the heart must be strengthened by stimulants, and digitalis, and the tendency to exhaustion and syncope must be combated by beef-tea and highly concentrated forms of nourishment. The patient should be kept in the prone position as much as possible, with the shoulders and head raised. The prognosis is necessarily extremely grave.

**Post-partum Meningeal Hæmorrhage. Spastic Paraplegia.**—We have already treated of meningeal hæmorrhage (p. 17) occurring during or immediately after the act of birth, and attributed it to asphyxia, the vessels

of the pia mater being gorged with dark venous blood, a leakage takes place, the blood oozing from the distended vessels. The damage done by the pressure of the clot forming on the convex surface of the brain may be sufficient to permanently injure the cortical motor or other cortical centres. The newly-born infant's brain is exceedingly soft and readily injured, as any one who has attempted to remove one post mortem without damage knows; if the slightest injury is done to the brain by the saw in dividing the skull, the brain substance will ooze out of the saw-cut almost like clotted cream. Now, not only may a considerable damage be done to the brain by a comparatively small surface hæmorrhage, but the cortical centres are imperfectly developed at birth, and the pressure of a clot or a rupture of their substance may readily prevent their growth and development. The consequences of this brain damage are various, but are often not very apparent for some months or more after birth. Possibly the mental powers never properly develop, though the limbs are strong, and the child is congenitally weakened or an idiot; or the lower extremities are stiff and weak, or there is a paresis of hemiplegic distribution, the child generally also being mentally deficient. In all a history of a prolonged labour, or of being 'born blue,' can be obtained.

A whole family is often more or less affected when the mother has a narrow pelvis, or for various reasons has difficult labours; some of the infants may escape if born before being fully developed. First-borns are apt to suffer the most, as can readily be understood.

The following history of a family may help as an illustration of the damage which may be done by difficult labours. Mrs. G. has always difficult labours in consequence of a narrow pelvis. She has had seven children born at or near full time.

1. Willie, eight years old, suffers from spastic paraplegia and is mentally deficient (fig. 70). (An inmate of the Royal Albert Asylum.)
2. John died at thirteen months of convulsions, 'head never was right.'
3. Clara, six years, is all right.
4. Baby, died soon after birth.
5. Baby, born dead.
6. Boy, two years old, is all right.
7. Girl, four months old; both legs semi-rigid, exaggerated tendon-reflexes, ankles rather stiff.

In this family of seven, two appear to have escaped uninjured; of the remaining five, two are living, having sustained a brain damage, and three are dead, their death no doubt being directly due to a birth-injury to the brain.

*Symptoms.*—The most common symptom which immediately follows the meningeal hæmorrhage is convulsions; sometimes there is paralysis, and there may be rigidity. In the great majority of the cases there is no marked paralysis immediately following birth, or at any rate it escapes the mother's attention, and it is only at the end of the first year that it is noticed there is stiffness about the legs, which prevents it from walking or from making any attempts to walk. Mostly, however, when the infant is a few months old a careful examination of the lower extremities will reveal an exaggerated knee-reflex and a stiffness of the ankle-joints. In some cases there is over-action of the adductors of the thighs, so that the legs are con-

stantly crossed, with probably also more or less talipes-equino-varus. Both arms may be affected, or an arm and leg only ; there is usually backwardness in talking. When the symptoms are fully developed, as they usually are at 2 or 3 years of age, the rigidity of the limbs, most frequently the legs, is very characteristic ; there is 'spastic paraplegia.' In a severe case the child cannot walk or stand unaided and lies helplessly in bed ; the knees are semi-flexed, with adductor spasm, the tendo Achillis is drawn up, so that the foot is

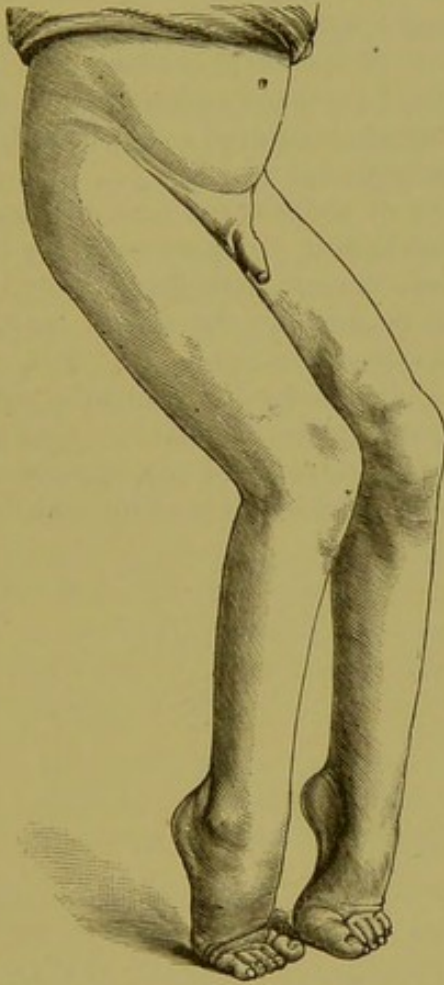


Fig. 69.—Spastic Paralysis, the result of Meningeal Hæmorrhage at Birth. Willie G., aged 8 years. The weight of the body is partly supported by being held up by the arms, partly by resting on the toes.

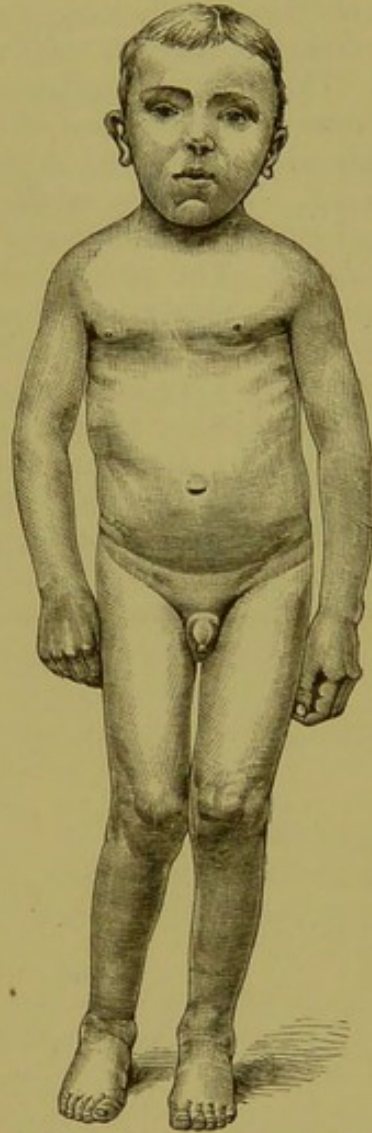


Fig. 70.—Willie G., after division of the tendo Achillis and forced dorso-flexion.

in a position of equino-varus, there is exaggerated knee-reflex and ankle clonus. In some instances the child, though unable to stand or walk without help on account of the talipes equinus present, can crawl, and may learn to do this fairly well ; this was the case with Willie G. (see fig. 69). This condition may remain throughout life, and occasionally adults belonging to this class may be seen crawling on all fours in the streets, and gaining their livelihood by begging.

Many, perhaps the majority of cases, learn to walk in some sort of a fashion, but with difficulty, on account of the spasm of the gastrocnemii and the

consequent tendency there is to fall forwards, and the awkwardness and want of control over their movements. The arms are more rarely affected than the legs ; sometimes there is slight rigidity in one only or in both, which interferes with their use, or the elbow is flexed, the wrist flexed and pronated, and the fingers flexed at the metacarpo-phalangeal joints. There may be present the irregular movements known as athetosis (see p. 390). Sometimes there is slight facial paralysis, only noticeable when the child laughs or cries ; we have never seen it well marked.

The child is usually backward in talking, and in some cases where the mental defect is marked they never can utter anything but meaningless sounds. The mental condition is various : sometimes there is complete idiocy, more often some loss of intelligence, or the child is emotional, being easily roused to anger, and if going to school is teased and tormented by its companions. The shape of the head is mostly unaltered ; occasionally it is small and more or less flattened in the parietal regions.

*Treatment.*—The preventive treatment of these cases is of the greatest importance, viz. timely interference during labour so as to save the infant from becoming asphyxiated and to prevent damage from being done to the motor centres. Very little or nothing can be done in the way of treatment after birth, and in the majority of cases no diagnosis is made at first. It is only some months after birth that some rigidity of the limbs may be noticed. At this time gentle friction of the limbs may prove of service. Galvanism is of doubtful use. As the child grows older constant rubbing, exercise of the muscles, and correction of the deformities by division of tendons and the use of splints is all that can be done.

## CHAPTER XXIII.

DISEASES OF THE NERVOUS SYSTEM—(*continued*).

**Chorea.**—Chorea is a disease which occurs chiefly in children between the ages of 6 and 15 years, and is characterised by irregular spasms of the voluntary muscles, and in some cases by paresis of the arms and mental weakness.

**Ætiology.**—Chorea can hardly be said to be hereditary, but undoubtedly a tendency to neuroses or 'weak nerves' runs in families, and instances might be adduced of emotional parents having children who suffer from chorea; moreover, it is a common experience to find several sisters or brothers suffering from chorea, or perhaps one or more are neurotic or hysterical.

Chorea is not common before the age of 6 years, and after the age of 15 years the liability to attacks becomes very much less. It is more common in girls than boys, in this respect resembling hysteria and other emotional diseases. Analysing 633 cases which have attended at the Children's Hospital, we find that 454 were girls, and 179 were boys, giving a proportion of five girls to two boys; these figures closely correspond to the statistics collected by other writers.<sup>1</sup> In 252 cases the ages of the patients were analysed, giving the following result :—

Under six years . . . . .	15 = 3 boys and 12 girls
Between six and ten years . . . .	102 = 35 boys and 67 girls
Between ten and fifteen years . .	135 = 44 boys and 91 girls

The youngest child was a girl of 4 years of age.

The children most apt to suffer are the nervous and excitable, those who are easily frightened, especially if they are suffering from ill-health the result of unfavourable life-conditions or rapid growth.

By far the commonest exciting cause is a fright; in 38 cases out of 252 there was a definite history of the patient being frightened, the symptoms following in some cases next day, in others within a few days or a week. The causes of the fright were various: in one case, that of a boy, the symptoms followed three days after seeing a man with his throat cut; sometimes the attack was ascribed to a 'dog having flown at the child,' or the patient was frightened by a policeman, or the child had been caned by the school-mistress, or had had a fall downstairs. In such histories there is often something it is necessary to discount: probably the scoldings at school were the consequence and not the cause of the chorea; but, on the other hand, it is certain

<sup>1</sup> See Fagge's *Principles and Practice of Medicine*, edited by Pye-Smith. 2nd edit.

that chorea may follow within a few hours of a serious shock to the nervous system.

Mental strain, as working hard for an examination, in some cases appears to excite an attack; this has occurred too often in our experience to be attributed to any mere coincidence. Given a fast-growing and delicate girl, of excitable disposition and not too well fed, who is at school for many hours during the day and has to divide her attention between home lessons and various domestic duties, so that she becomes little else than a drudge, it can hardly be surprising that she suffers from a nervous breakdown. 'School-made chorea,' as Dr. Sturges calls it, is not by any means confined to the poorer classes, and, although among the better-to-do classes there is no question of poor food and household drudgery, yet there is often much forcing exercised to enable a girl, of perhaps delicate health, to keep pace with or run ahead of her stronger and more robust class-mates.

In some instances children who are convalescent from various depressing diseases such as acute rheumatism, enteric fever, or scarlet fever, are attacked with chorea. Rheumatism excepted, enteric fever in our experience more often than any other disease predisposes to chorea; other nervous disorders, such as dementia, mania, aphasia, are not uncommon after enteric, and are no doubt due, as is also the chorea, to the anæmia and exhaustion caused by the long drain on the system during the disease. For the connexion of rheumatism with chorea, see p. 400.

Heart disease in some instances precedes the attack of chorea, or, in other words, chorea makes its appearance in children suffering from cardiac disease (see p. 400).

It sometimes happens that a source of irritation in some part of the body is the exciting cause of an attack of chorea; thus we have seen a temporary chorea occasioned by suppuration in the middle ear, the choreic movements ceasing when the discharge made its appearance. In other cases it happens that chorea is an early symptom in pericarditis—this we have also seen; in one case, in a little girl of four years, choreic movements preceded by a few days the physical signs of a pericarditis which proved fatal. We cannot help thinking that in such a case the chorea was symptomatic of the pericarditis, the latter being the primary lesion, rather than that the heart lesion was secondary to the chorea.

*Imitation* in some cases seems to be a factor in the production of chorea. On one occasion five cases occurred in a girls' school immediately after the admission of a child suffering from chorea; in such cases, perhaps, it may not be imitation so much as fright at seeing others affected, as Gowers suggests. We have never known children in the same ward to become choreic in consequence of a bad case being admitted, but we have seen cases of chorea apparently made worse by association with a bad case.

*Symptoms.*—Most of those who suffer from chorea are in some way or other weakly, or at least not in robust health; they are often anæmic, rapidly growing girls. Not infrequently it occurs in girls who have gone out to service and who are undertaking work which is beyond their strength. Often the first symptoms are a loss of control over the muscles, especially the flexors and extensors of the fingers and wrists, and a want of precision in the movements of the hands. The patient drops crockery on the floor, is

unable to do needlework, fumbles sadly when she attempts to tie a piece of string, or spills her food when she passes it to her mouth. Sometimes, especially in younger children, the first thing noticed is that she 'makes faces,' her mouth screwing up so as to make grotesque grimaces, while she fidgets with her fingers, and when she attempts to dress herself makes useless, clumsy, ineffectual movements. All this may go on for many days, perhaps weeks, without the friends thinking the child is really ill, and perhaps she gets scolded both at home and at school for her clumsy ways and inattention to her work. Sooner or later the movements become too obvious to escape attention, indeed it is apparent to every one that something is wrong. The movements, as Dr. Sturges points out, are much more vigorous in the upper part of the body than the lower, the hands suffering most of all. The fingers are opened and shut, the extensor and flexor muscles being constantly worked; the arm is passed behind the back, then brought to the front; if asked to shake hands, it is thrust rapidly forward, being directed with difficulty to the hand to be grasped. The tongue is protruded with a jerk and perhaps drawn back again in a moment with a quick movement. The muscles of the face are frequently spasmodically contracted, so that queer grinning grimaces are constantly being made. The muscles of the neck are frequently contracted and relaxed, so that the head is moved from side to side or rotated. When the child walks, the feet join in the spasmodic movements, so that the gait is altered, the legs being thrown forward quickly, or if the patient stands the feet are restless, being shifted about from place to place. When the patient is at rest in bed she will lie still if not disturbed, but directly she is interfered with, as, for instance, to examine the chest, the movements begin, the hands, face, and trunk muscles being thrown into a state of clonic spasm. The muscles of respiration do not escape: the child takes a deep sighing inspiration, then perhaps there is a series of shallow irregular respirations. The irregular respirations may affect the pulse, so that it is irregular and intermittent. The movements cease during sleep, though sleep is not readily obtained; indeed in the worst cases the patient only sleeps when under the influence of chloral or opium, which has to be freely given in order to secure rest. In the milder cases the movement may be confined to one side; this, however, is never the case when the movements are severe, though it is very common to have the clonic spasms more vigorous on one side than the other. A **hemichorea**, in which the movements are vigorous and entirely confined to one arm or leg, is probably due to some organic cerebral disease.

The temperature is usually normal throughout, sometimes subnormal; if there is any fever, peri-endocarditis or rheumatism should be suspected. In the most severe cases the temperature may be raised a degree or two.

There is often marked paresis of an arm or leg, far more commonly the former; not only is the grasp feeble, but the arm is weak and powerless, though complete or indeed well-marked paralysis does not occur. This paresis of an arm is sometimes the most prominent feature in the case, but in all cases more or less of clonic spasm may be detected in the fingers or in the facial muscles. These cases have been spoken of as 'paralytic chorea.'

The *electric irritability* of the muscles in cases of hemichorea has been studied by several observers, most recently by Gowers, cases of hemichorea

being selected on account of the possibility of comparing the muscles of one side with the other. In some cases no difference can be detected, but in others there has been noted an increase of irritability on the affected side, the muscles contracting with a weaker faradic and also voltaic current than those on the unaffected side.

The speech is affected, in some cases from the muscles of the tongue, jaw, and larynx not being under efficient control. In other cases the mental weakness frequently present may be the cause. Headaches are often complained of; sometimes, especially in cases of 'hysterical chorea,' there is hyperæsthesia or anæsthesia.

Optic neuritis has been observed by Gowers, slight in degree in some cases; in one case there was a sufficient degree to make it comparable to the neuritis seen in a case of cerebral tumour. In the vast majority of cases there are no ophthalmoscopic changes.

The mental state is often peculiar. There is a vacant, listless expression on the face, in many cases a dulness of comprehension. The child may cry on the slightest provocation. There may be actual dementia or, on the other hand, maniacal excitement.

In the worst cases the movements are severe: the child constantly wriggles about, and the arms and legs move sufficiently violently to throw the patient out of bed. The constant movements of the limbs chafe the skin on the extensor surfaces, so that unhealthy-looking sores may result. We have seen such in a fatal case become actually gangrenous before death. The patient is sleepless and becomes anæmic and completely exhausted. Death, however, may not result from actual exhaustion, it may occur in consequence of pyæmia or pericarditis. Among over 634 cases there were 5 deaths, but one of these died, not from chorea, but from an intercurrent tubercular meningitis. All five cases were in girls; indeed, fatal cases in boys are very rare. Dr. Fagge relates the case of a boy who died in 9 days, and another boy of 12 years who died from obstructed breathing due to glossitis, the tongue having been severely bitten.

Chorea is a chronic disease lasting for many weeks, often many months, but it is usually not equally severe throughout this period. Ten weeks is often stated to be the average; it certainly is often much longer. Relapses are exceedingly common; it is not uncommon for children to have three to five attacks, but the tendency passes off after puberty.

*Complications.*—In the majority of cases of chorea the **heart** is in some way or other affected. In some cases chorea appears to supervene in children who are suffering from chronic heart disease, in a few cases it appears to be brought on by an attack of pericarditis, but in the majority of cases the heart complication comes on during the course of an attack of chorea. Out of 252 cases of chorea, nothing abnormal was noted in the heart's action in 79, in 54 there was irregularity or reduplication of the sounds, in 119 bruits, mostly heard at the apex more loudly than at the base, were detected. Some of these bruits were, no doubt, anæmic, inasmuch as they were present only at the base; it is seldom, however, possible to say dogmatically that a bruit heard during the course of chorea is simply hæmic, and it is necessary to have the patient under observation for a long period during convalescence before we are in a position to say if a so-called hæmic

bruit is due to organic disease or not. It is well also to remember that endocarditis may occur and yet no bruit be produced; thus we have sometimes failed to detect bruits in cases of chorea, but some months afterwards have noted undoubted organic murmurs. Both mitral and aortic valves may be affected; though the former are far more commonly affected than the latter, while many of those in whom bruits are heard during chorea have suffered from rheumatism, this is by no means the case with all.

**Acute or sub-acute rheumatism** was associated with chorea in 46 out of 252 cases, while 20 more, according to their friends' account, suffered from 'rheumatic pains.' Statistics with regard to the association of chorea and rheumatism vary considerably, but this is hardly surprising, inasmuch as we are largely dependent upon the histories given by friends, and their ideas concerning rheumatism are apt to be vague; moreover, the symptoms of rheumatism are often less well-marked in children than in adults, and rheumatic attacks may be easily overlooked, or at least may not be recognised as rheumatic. The association of rheumatism and chorea is undoubted and cannot be a mere coincidence; not only do we see children suffering from chorea attacked with rheumatism, and *vice versa*, but not infrequently we see a sister suffering from chorea and a brother from rheumatism, or attacks of chorea and rheumatism alternating in the same individual.

A **paresis** of one arm not infrequently takes place in chorea: such cases have been described as *paralytic chorea*. It consists in weakness rather than paralysis, and not infrequently precedes the other symptoms of chorea. A **peripheral neuritis** in rare cases appears to follow chorea, as it does also rheumatic attacks, the principal phenomena being muscular wasting and paresis, indefinite pains such as 'pins and needles,' and in some instances anæsthesia.

In some cases there is sufficient excitement of the brain to merit the name of **maniacal chorea** or **chorea insanilens**. This condition is most common at or about puberty. There may be violent delirium and excitement, so that the patient has to be controlled by her attendants, the attacks resembling acute mania. Often these attacks are closely allied to or resemble hysteria. The following case appears to have been one of this kind. The patient was a girl of fourteen years of age; both her sister and herself had chorea a year and a half before the present attack, which lasted for some time, and for which she was treated in the Derby Infirmary. She was readmitted with choreic movements of moderate intensity, but they were readily controlled by the will, and she was perfectly rational. She got worse, the movements being more violent; there was difficulty of speech, she became extremely emotional and at times maniacal. When she was moved, as, for instance, when her bed was made, she would struggle and run her nails into the attendants. Two months after admission the knees became semiflexed and rigid, and there was incontinence of urine and fæces. She was so troublesome that she was sent home after about three months in hospital.<sup>1</sup> Shortly after, she was admitted to the Children's Hospital. At this time she had sordes on her lips and teeth, she was much emaciated; both knees were semiflexed and rigid, the hips were semiflexed and rigid; the patellar reflex could not

<sup>1</sup> These notes were kindly furnished by Dr. W. Benthall, of Derby.

be obtained on account of the excessive rigidity. There were slight choreic movements of the arms and face; she passed her urine and fæces into bed. She was extremely emotional, and there was some hyperæsthesia, especially about the joints and muscles. She gradually began to improve in a week or two, having more control over the sphincters, and the legs became less rigid and she gained flesh. A fortnight after admission the bedsores had healed, and she was less emotional. In a month she could walk with help, and in three months she was discharged quite well.

In this case there seems to have been aggravated hysteria associated with chorea, though at one time the girl looked very much as if she was suffering from organic brain disease. The emaciation, bedsores, and rigid legs seemed to point to an organic lesion; this was, however, negatived by her complete recovery.

In some rare cases, instead of paresis, there is muscular spasm, which may persist for some time after the choreic movements have disappeared. The following case illustrates this. A boy, aged ten and a half years, was admitted to the Children's Hospital suffering from chorea, which was attributed to a fright, he having seen a 'ghost at a show.' Three sisters had also suffered from chorea, one having died during an attack. His attack was a moderate one; no bruit was heard, there was some paresis of his right leg. He was discharged in a month's time quite well. He was readmitted two months later, the choreic movements being pretty much confined to the right arm, which was markedly weak; the right knee-joint and ankle were rigid, the muscles being in a state of spasm; there was no pain or tenderness. There was a systolic bruit at the apex. He was discharged in six weeks; the choreic movements had disappeared, but the spasm in the right leg persisted. He had another attack of chorea eighteen months afterwards; before this occurred the muscular spasm had entirely disappeared.

**Hemichorea.**—In many cases, as already pointed out, the movements are confined to one side of the body, or at all events they are more marked on one side than the other. Hemichorea is in some instances post-hemiplegic, following some months or more after the hemiplegia, when contractures are present as in the case of cerebral tumours situated near and involving the internal capsule or pyramidal tracts; choreiform movements may take place on the opposite side. In hemichorea symptomatic of brain disease the movements are vigorous and grotesque, the fingers, hands, feet, and extremities being twisted and jerked about. In one of our cases, in a boy of five years of age, who had a cheesy tumour in the right optic thalamus, at first sight the child appeared to be affected with the ordinary form of chorea. His left arm was in constant movement, the result of short, irregular, jerky contractions of the muscles of the forearm and arm, following one another with great rapidity, and closely resembling those seen in a severe case of chorea. When the boy was at rest the arm was quiet, only a sort of fumbling movement of his hand being noticed, but on asking him to sit up or give his hand vigorous, almost violent, movements began again. Some of the movements were produced by all the muscles of the arm, yet some of the muscles acted more continuously and powerfully than others, so that the arm tended to be held to the side and more or less behind, while the forearm was pronated and the wrist flexed, the fingers being in continual movement. This con-

dition of hemichorea differs from 'athetosis' or 'mobile spasm,' already described (p. 390).

*Morbid anatomy.*—Various minute changes have been described in the brain in fatal cases of chorea, but it is quite certain that no constant and invariable lesion has been discovered. Embolism and thrombosis of the minute vessels of the cortex and basal ganglia have been described; minute spots of softening, changes in the nerve cells, and enlarged perivascular spaces have also been found. We cannot say that any of these observations throw any light on the morbid anatomy of the disease, especially when we remember that on various occasions competent observers have found nothing of importance in their examination of the brain and spinal cord in fatal cases. Many of the changes described are no doubt secondary, the result of a hyperæmia of the nervous centres.

The frequent association of chorea with rheumatism and endocarditis suggested to Kirkes the idea that chorea was the result of minute embolism of the brain by fragments of fibrin washed off the mitral valves. This hypothesis, however, is quite inadequate to explain the phenomena presented by the disease; thus chorea has followed within a few hours of a sudden fright, and moreover fatal cases have been recorded (though rarely) in which no endocarditis has been found. Embolism will not explain those cases of 'reflex chorea' in which the exciting cause is an acute otitis, or when chorea follows some injury or accompanies pregnancy; we find that pericarditis and perhaps endocarditis act as exciting causes operating through the nervous system, just in the same way as some gastric-intestinal irritation may be the exciting cause of convulsions in infants.

In considering the pathology of chorea we must take into account the associations of chorea, though it cannot be said they help us much in coming to a conclusion. Chorea is associated on the one hand with rheumatism and endocarditis, and on the other with hysteria and mania; the former association would suggest a blood-change, the latter simply a functional disturbance of the nervous system. Pathologists in formulating their theories have leaned either to the one or to the other. Sometimes chorea has been explained as secondary to endocarditis, as a result of capillary embolism, or as the result of a 'rheumatic' condition of blood, in which some chemical poison has been present in the blood which has a specific action on the nervous system. At other times chorea has been looked upon as an emotional disease and, like hysteria, a purely functional disease, or, as it has been termed, an 'insanity of the muscles' or motor region of the brain, just as mania or other forms of insanity affect the seat of the mind.

There has been also much difference of opinion with regard to the seat of the disease; it has been placed in the spinal cord, basal ganglia, and cortex of the brain. The fact that the face is usually affected, and that moreover the choreic movements are frequently one-sided, would almost certainly point to the seat of the disease being within the cranium. The tendency of recent researches in physiology has been to deprive the corpus striatum of its alleged function as an originator or coordinator of motor influences, and to assert that it has little or nothing to do with the discharges of motor force. On the other hand, there is strong reason to believe that the choreic movements are the result of irregular discharges from the motor region of the

cortex ; for the time being the will or the inhibitory influence of the frontal regions is in abeyance, and irregular purposeless discharges are given out from the cells in the motor region of the cortex. There is much reason to believe that the functions of the cortex are impaired in chorea, as shown not only by the spasmodic movements, but also by the paresis which sometimes occurs, and the mental dulness and emotional disturbance so often present. It can easily be understood that if there is impaired nutrition of the nerve centres a sudden fright, or an irritation at some distant part, may start the irregular discharges from the cortex, which it may soon be beyond the power of the will to control.

With regard to the cardiac complications found in fatal cases, we cannot do better than quote Dr. Sturges, who sums up as follows :—‘Vegetations, new or old, on the auricular surface of the mitral valves, with or without similar deposits on the aortic valves, and sometimes with pericarditis, are met with in the great majority of cases dying of, or with, or shortly after chorea. This condition, however, does not, as a rule, contribute directly to the fatal issue ; it is found equally amongst those that die *with* and those that die *of* chorea, and in some of the most marked and typical cases of fatal chorea the valves of the heart have been found absolutely healthy.’

*Diagnosis.*—This is not usually difficult, though it must always be borne in mind that the choreic movements present may be symptomatic of some serious brain lesion, or of some distant disturbing influence such as pericarditis. We have seen on one or two occasions, in girls about puberty, choreic movements followed by emotional disturbance and paresis of limbs, attributed not unnaturally to hysteria, where the onset of optic neuritis and amblyopia has made it clear that the case was really one of cerebral tumour. We have seen also the onset of chorea in a girl of 4 years followed in a week by pericarditis and death in a few days.

Any brain lesion which presses upon the pyramidal tract may give rise to movements similar to chorea ; we have several times seen this in cheesy tumours of the optic thalamus which compressed the internal capsule : in such cases a ‘hemichorea’ is produced (see p. 381). It must be borne in mind that in true chorea, if at all intense, the movements are general, though perhaps worse on one side than the other, but they are never confined to one side as in the case of a cerebral tumour.

In some of the special varieties of the disease the diagnosis may be difficult ; thus in the case related (p. 401), where there was contraction of the limbs and bedsores, one might readily assume that chronic meningitis or other cerebral lesion was present. In a case under our care where tubercular meningitis supervened in the course of chorea the diagnosis was uncertain for a few days. The presence of optic neuritis would strongly point to organic disease, though, as already stated, Gowers has observed optic neuritis in a case of chorea. In cases of paralytic chorea the chief symptom may be simply paresis of one arm ; but usually a slight examination will detect short clonic spasms, either in the affected arm or elsewhere.

*Prognosis.*—Recovery follows in the vast majority of instances. The principal danger is from some heart complication, as pericarditis, and from exhaustion in consequence of the violence of the movements, want of sleep

and nourishment. The more severe the case, the longer will be its duration. Maniacal and hysterical choreic cases are usually very chronic.

*Treatment.*—The most important element in the treatment of chorea is rest. It is necessary to secure for a patient suffering from chorea complete rest for the body and complete absence of excitement of all kinds. In all but the mild cases it is well to begin the treatment by keeping the patient for a few days or a week in bed completely at rest. We must bear in mind that voluntary movements of all kinds (in severe cases at least) make the involuntary movements more marked and more completely beyond the control of the will. On the other hand, the movements cease during sleep, and the more quiet the patient can be kept, the better chance there is of a better nutrition of the body and the nervous centres. Any excitement or mental effort is certain also to make matters worse, so that all forms of mental work must be avoided, while the surroundings of the patient must be made as agreeable as possible. When the movements are severe, so that the patient cannot sleep, some narcotic must be prescribed, and of remedies of this class chloral is probably the best, but it must be given in full doses to be of use. Ten or fifteen grains may be given, and repeated in four hours if the restlessness continues. Bromide of potassium may be combined with the chloral, though most agree that chloral is more useful than the bromide. Morphia seems at times to add to the excitement present. Inhalations of chloroform are often useful to get the patient off to sleep. Great care must be taken to protect the patient from injuring herself by tumbling out of bed, and it may be necessary to protect the limbs by wrapping them up in cotton wool, or to surround them with some soft material; or padded boards may be placed on each side of the bed, or a mattress may be placed on the floor. The patient should be given a fair amount of liquid nourishment and also stimulants. Frequent spongings are of great value in getting the skin to act and calming the patient.

Even in the less severe cases of chorea it is well to confine the patient to bed for a week or two in the early stages; the movements are always less when the child is at rest in bed, and these means are almost certain to shorten the duration of the attack. When improvement occurs the patient may be allowed to get up for a few hours a day and to be taken out into the fresh air, but too much exercise should be prevented.

The drug which is most used at the present time is arsenic; sulphate or oxide of zinc, cannabis indica, iron, calabar bean, and conium, have also been used. We confess to some scepticism with regard to the value of medicines in chorea, and feel sure they occupy only a subsidiary place in treatment. Arsenic is certainly of use in the dyspeptic conditions which so often accompany chorea, but it requires to be given in increasing doses as the stomach becomes more and more accustomed to it. Two or three-minim doses may be given three times a day at first, and increased at the rate of an extra minim every week till six or seven minims are given. It is better not to continue the administration for too long together, as a temporary darkening of the skin is apt to take place. The administration may be omitted for a week or two and then recommenced. In the latter stages iron may be useful, given in combination with arsenic.

Great care should be taken to regulate the bowels; constipation is the

rule, and this must be overcome by small pilules of extract of aloes or some elixir of cascara sagrada.

In chronic cases a change of scene, such as residence at the sea-side, is often suggested by the friends, but in our experience this change often makes the movements worse and prolongs the attack, in consequence of the excitement attending the change and the patient attempting to do more than her strength permits. A change to the sea-side should be deferred till the movements have nearly ceased and can be controlled entirely by the will. The same may be said of gymnastic exercises and rhythmical movements: they are of the greatest use when the movements tend to become habitual, while the health of the patient is good; they are certainly not desirable in the earlier stages. Massage has been employed with good result by Goodhart and Phillips, and in some of our own and our colleagues' cases the result has been satisfactory.

All through the course of chorea moral treatment is of the greatest importance. Chorea in many cases is closely allied to hysteria, and a firm but kindly demeanour towards the patient is called for; and she should be encouraged to control the movements as much as possible by an effort of will. In all severe cases a nurse should be provided, as the patient's mother is often the last person who should have charge of her.

In all stages of the attack a nourishing, easily digested diet is necessary.

**Epilepsy.**—Convulsive seizures of various degrees of severity are common during childhood and youth, and when they are idiopathic, that is without assignable cause, no cerebral or other lesion being discoverable, the term epileptic is applied to them. It is difficult to say in what proportion of cases children who suffer from convulsions during infancy become confirmed epileptics, certainly the majority of those who suffer from infantile convulsions lose this tendency to convulsive seizures as they grow older. In only about  $12\frac{1}{2}$  per cent. of cases of chronic epilepsy is there a history of the fits commencing during the first three years of life, and in a smaller percentage ( $5\frac{1}{2}$ ) during the first year. (Gowers.) According to statistics collected by Gowers, in one-fourth of the total number the attacks begin before the age of ten years, and nearly one-half between the ages of ten and twenty years. These statistics show that there is always the possibility that children or infants who suffer from reflex convulsions may become epileptics; yet there is a strong probability, if the child does not suffer from any cerebral defect, or has no hereditary tendency in the direction of epilepsy, that he will not grow up an epileptic. Hereditary influences certainly predispose: a family history of epilepsy or insanity is obtained in about one-third of the cases of epilepsy, in others it may be found that they come of neurotic families in which members have suffered from chorea or hysteria.

Of the exciting causes there is little to be said. The first fit may be described by the friends as being due to a 'sunstroke,' or a 'blow on the head,' or a 'fright;' but it is unsafe to place much reliance on such statements, as they may be merely coincidences and certainly are not sufficient in themselves to produce epilepsy. In the large majority of cases, it must be confessed, no immediate cause can be discovered. Epilepsy sometimes commences after scarlet fever and other zymotic diseases, but beyond the fact that these fevers leave a certain amount of weakness behind, and so may

predispose, there is nothing to suggest that they act as effectual causes. The approach of puberty is a time when the nervous system is in an excitable state, especially in girls, and epileptic fits are very apt to commence at this period, notably in cases where menstruation does not commence at the usual period, but is delayed by any cause. Constipated bowels and a sluggish condition of liver certainly act as predisposing causes.

*Symptoms.*—Two forms of attack are usually described: the minor form, or *petit mal*, and the major form, or *grand mal*; but these two forms insensibly pass into one another and there is no marked line of demarcation between them.

The precursory symptoms differ very much: frequently the first fits and the succeeding fits come in the midst of perfect health and neither the patient nor his friends are aware that a fit is imminent. On the other hand the child may be unusually irritable, easily put out, and nothing pleases it; it may be feverish, dull, and stupid. In some cases the fit is preceded by some warning or aura, by which the patient becomes aware, by past experience, that an attack is at hand. These auræ are more common in adults than in children, or at any rate adults are better able to describe their feelings and have a larger experience of fits to fall back upon. The auræ are very diverse in character: they may be sensations referred to an arm or leg, or to the throat; there may be headache, vertigo, or faintness.

*Petit mal.*—These minor attacks are very slight in character and are often not admitted to be epileptic by the friends, who usually connect 'fits' with the more severe and decided form of seizure. They are often spoken of as 'faints' or 'attacks.' There may be no real convulsion or tonic spasm; the child may stumble when walking from a momentary impairment of consciousness, a peculiar look crosses its face, and for a moment it is dazed and forgets what has happened. Sometimes the face becomes pallid for a moment and there is a slight convulsive spasm of the facial or other muscles. The urine is rarely passed in these seizures, nor is there any cry. Sometimes the attack is succeeded by drowsiness or stupor. In older children the behaviour may be very peculiar: after one of these minor seizures a mild mania may seize the patient, he becomes mischievous or strikes other children without provocation, or behaves in a hysterical manner.

*Grand mal.*—The seizure may begin with a sharp cry or scream, as of sudden fright; in many cases this cry is absent, the patient falling precipitately on to the ground in an unconscious state. The face is pallid and tonic spasms of the muscles begin. Sometimes these are one-sided in distribution: the muscles of one side of the face, neck, arm, and leg of the same side are thrown into contraction, the head is usually rotated to the affected side. In other cases the spasms are general. The legs are usually extended and stiff, the elbows partially bent, the wrists flexed, and the fingers in a position of interosseous flexion. (Gowers.) The respiratory muscles join in the general tonic spasm, and, as the inspiratory muscles are more powerful than the expiratory, the breath is drawn in and held so that the face becomes congested and the lips blue. There is usually spasmodic contraction of the muscles of the jaw, so that the tongue is bitten and held between the teeth; frothy, perhaps blood-stained, saliva runs from the patient's mouth. Death may take place from asphyxia during this stage. Usually, however, after the

stage of tonic spasm has lasted from a few to thirty seconds, the continued spasm of the muscles relaxes, and clonic or intermittent short contractions succeed. The muscles of the face twitch so that the patient appears as if he were making grimaces; the limbs 'work,' alternately flexing and extending—sometimes so violently that the head and legs are banged about and become bruised and injured. In other cases the clonic spasm is not so vigorous, there being only short, sharp, muscular contractions. The urine and sometimes the fæces are passed. The period of the clonic spasm is variable: it may last many minutes or even hours; the patient gradually recovers consciousness and has no recollection of what has passed. He probably is dazed and sleepy, goes off to sleep, and wakes up tired and sore. The fits vary much in intensity: often the stage of tonic spasm is short and not well marked, and the whole duration of the fit is not more than half a minute.

**Hysteroid Fits.**—Some minor attacks closely resemble hysteria in that the spasmodic movements are of a purposeful character, as if directed by the will, and, moreover, the child appears to be conscious or semi-conscious during the fit. This form of seizure is common both in boys and girls. The phenomena which take place are exceedingly various: the child may commence by barking like a dog or mewing like a cat, or may attempt to bite the attendants; the head may be banged about and the legs and arms thrown widely about, as if the child were directing the movements. The patient may stiffen out and arch his back as in opisthotonos. Sometimes the actions are still more co-ordinated. Thus in a girl of seven years, in hospital, when an attack came on she would jump up in bed, turn round once or twice, sit down again and arrange the bed-clothes, smoothing them carefully down, and yet be unconscious during the fit, and have no remembrance of it afterwards. A sharp word or the prick of a pin will often arrest these fits. That some of these cases are closely related to epilepsy is shown by the fact that they may alternate with true epileptic fits, or they may supervene at puberty in children who have suffered from chronic epilepsy.

**Post-hemiplegic Epilepsy.**—Children who suffer from hemiplegia which dates from birth or within a year or two of birth are very apt to suffer from epileptiform attacks. Convulsions are very apt to attend the onset of the hemiplegia: the child may continue to have fits, and be subject to them for the rest of its life. In other cases a period of months or years may elapse between the onset of the hemiplegia and the commencement of the epileptic fits. It is often about puberty that they recur. As a rule, the convulsions affect the paralysed side only, but in severe cases the convulsions may be general. An aura or warning of the approaching fit is more common in post-hemiplegic epilepsy than in idiopathic epilepsy. In these cases it is common for there to be mental backwardness.

*Course.*—As already stated, the epileptic fits may date from infancy, the child having suffered in the early months or years of its life from convulsions, and these have been succeeded by chronic epilepsy. More often the child has been free from convulsive seizures during infancy and early childhood, and it is only during the second dentition or as puberty is approached that it has begun to suffer from fits. The health prior to the commencement of the fits may have been excellent, there may be no history of epilepsy in the family, and it may be quite impossible to explain the onset of epileptic fits. At first the friends are loth to believe the fits epileptic, and attribute

them to rapid growth, dentition, weakness, or some injury. In other cases the health may have been indifferent or the temperament peculiar, the child having been of a strange disposition, nervous, easily frightened, morose, or backward in mental development, or may have shown signs of idiocy, and then, as puberty approaches, commences with epileptic fits. The health of the child after the commencement of the fits varies according to their frequency and severity. In the milder forms the children may enjoy the best of health, may be merry, romping children, able to take their part in rough school games, and be of average or more than ordinary quickness and intelligence. In other cases, especially when the fits occur frequently, the health suffers, the patient becomes sallow and anæmic, his digestion and appetite are poor and the liver and bowels sluggish. The memory is apt to fail more or less, and in the worst cases a condition allied to dementia may supervene. The intervals between the fits differ considerably, not only in different patients, but in the same individual; sometimes many months or even years will pass without a fit, at other times the fits follow one another at intervals of a few minutes, so that the patient is no sooner out of one fit than he is into another. To this latter condition the term 'status epilepticus' has been applied. In the *petit mal* the fits usually occur oftener than in the more severe attacks. Fits are apt to occur at any time in the twenty-four hours, at night or by day, but there seems to be a special tendency for them to recur in the early morning when the patient is getting up.

*Prognosis.*—The prognosis is bad in those who have suffered from fits from infancy, and who are mentally deficient or in whom some mental change has taken place. The chance of the entire cessation of the fits is a poor one in those who have fits frequently. The less frequent the fits, the greater is the probability that they may cease altogether. Even in those who have only suffered from fits at long intervals a cautious prognosis must be given, as those who have so suffered are never safe, and a recurrence may at any time take place. The danger to life is least in the minor attacks, but as time goes on the major attacks may supervene. There is always the possibility that the fits may cease when the epoch of puberty is passed, and in the case of girls when menstruation is thoroughly established. It must always be borne in mind that epileptics may at any time meet with a sudden death from injuries received during a fit: they may fall into the fire, or into water, or they may be suffocated in bed at night. Less often death takes place in the fit from asphyxia, due to prolonged spasm of the glottis and respiratory muscles.

*Diagnosis.*—In some cases of *petit mal* the attack may be so slight that a doubt may exist whether the fits are really epileptic or not; but all recurring 'faints' or attacks of giddiness must be looked upon with great suspicion, and if there is a loss of consciousness, however short, they are almost certainly epileptic. Difficulty may often arise in distinguishing hysterical attacks from true epilepsy, especially the attacks described as hysteroid. It may be simply a matter of opinion whether some of these attacks are best classed with epilepsy or hysteria; in any given case careful inquiry must be made for typical epileptic fits, which sometimes occur immediately before the hysteroid fits. The diagnosis is usually easy between typical epileptic and typical hysterical fits; it is often very uncertain in atypical ones. Loss of consciousness, biting the tongue, or tonic followed by clonic spasms, if

present, are decisive in favour of epilepsy. There may often be considerable difficulty in distinguishing between reflex convulsions and epileptic fits. Under three years of age, if there are the signs of rickets, the probabilities are strongly in favour of their being reflex. After this age reflex convulsions may occur at the commencement of some zymotic disease, or possibly as the result of cutting the permanent teeth, or from worms; but the chances are immensely in favour of epilepsy if they are on the type of those in idiopathic epilepsy; in all cases where the attacks were epileptiform in character, in which there was loss of consciousness, spasm followed by stupor, even though the child was cutting one of the permanent teeth or had worms, we should be inclined to believe they were really epileptic. Parents naturally like to believe that the fits are due to dentition, to rapid growth, to a disordered liver or stomach, especially in those cases where there are no hereditary tendencies present, but we cannot accept these as anything more than exciting causes, and in all such cases there is only too much reason to fear that there may be a recurrence of the attacks. Convulsions may occur as the result of brain disease, recent as well as old. A tumour or syphilis may be present in this case; there may be some marked aura, especially visual or auditory; the convulsions will be mostly one-sided; moreover, there is headache, giddiness, vomiting, paralysis, and optic neuritis.

*Treatment.*—A child subject to epileptic fits should be placed under the most favourable conditions possible, and should be most carefully guarded from excitement, over-fatigue, and over-feeding. A healthy country life with plenty of out-door exercise and sufficient employment for the mind should be enjoined. A moderate amount of brain work should be allowed, but no forcing of any kind should be permitted. It is well to allow no work and not much exercise before breakfast, as at this time there appears to be an especial liability to fits. The diet should be simple and unstimulating; in some cases coming under our notice children have done better when butcher's meat has been excluded from their diet or only taken sparingly. How useful a regular life is, is seen by the improvement which nearly always takes place on the child's admission to hospital. It is needless to say that all children subject to fits should be carefully watched: a public or large school is certainly not the place for them, as they require more individual attention than is possible under such conditions. There is always the possibility that they may fall into the fire, or into water, or be suffocated in bed by a fit occurring during the night. The state of the bowels should be most carefully attended to, as there can be no question that constipated bowels predispose to the attacks. Effervescing citrate of potash, magnesia, or cascara, with occasional small doses of calomel, are useful. Of all medicines which check the tendency to fits the bromides take first place. Bromide of potassium or sodium may be given in doses of 10 to 40 grains a day, according to age and to the frequency of the fits. The saline taste is readily covered by well diluting with water, and adding syrup of orange peel, aromatic sp. of ammonia, or liq. ext. of liquorice.

( 29 )

Bromide of potassium . . . . .	2-8 grains
Syrup of orange-peel . . . . .	10-40 drops
Orange-flower water . . . . .	ʒi to ʒii

to be given three times a day after meals.

Sometimes a laxative may be combined with the bromide to counteract its constipating action : sulphate of magnesia, tincture or infusion of rhubarb, or 'cascara cordial or elixir,' may be used, but, as a laxative can be given as required, it is usually unnecessary to combine one with the bromide. The bromide should be administered for a month at least after the fits, and then may be reduced in quantity ; but it will be well to continue the use of bromide in gradually smaller doses for six months at least after the last fit ; it may be combined with digitalis or tonics such as cinchona, iron, or nuxvomica.

Large doses of bromide give rise to a lethargic heavy condition in the patient : there may be slow drawling speech and a slow circulation. Acne is apt to make its appearance after a few doses of bromide in some patients.

There is no other drug that at all approaches bromide in epilepsy. Nitrate of sodium, belladonna, zinc oxide or lactate ( $\frac{1}{2}$  to 5 grs.), borax (5 to 10 grs.), nitro-glycerine ( $\frac{1}{200}$  to  $\frac{1}{100}$  of a grain) and strychnine, have all been used with more or less advantage when bromide fails.

The question of surgical interference must depend upon the diagnosis ; in idiopathic epilepsy trephining or ligature of the carotids is hardly justifiable. If there is reason to believe that a tumour in the cortex exists, an operation may be considered (see p. 385).

**Infantile Convulsions. Eclampsia.**—Infancy predisposes to those irregular nerve discharges which go by the name of 'convulsions' or eclampsia. The undeveloped state of the cortical centres during infancy, and the consequent absence or imperfection of the controlling or inhibitory influences exercised by these centres in later life, allow the 'lower grade' centres in the pons, medulla, and cord to discharge their stored nervous force, when stimulated, in a way which does not occur in later years, when the higher centres are fully developed. The reflex actions exhibited by the brainless frog are more easily provoked and more vigorous than the reflex actions exhibited by a frog with the brain intact ; the higher centres appearing to exercise a controlling influence.

While infancy is the time of life in which convulsions are most easily provoked, yet healthy infants do not become convulsed unless the stimulus is strong ; it is the delicate ones who suffer, and those who have inherited neurotic tendencies. The commonest predisposing cause, however, is rickets, though in what way it acts is uncertain ; yet it is certain that all the tissues in rickets are badly nourished and built up, and the nervous system is no exception to this : the nerve-centres are, in fact, in unstable equilibrium and apt to discharge their nervous force in a purposeless and irregular manner. In the large majority of children who suffer from convulsions between the ages of 6 months and 3 years the signs of rickets are present.

An anæmic condition, great exhaustion from any cause, as well as hereditary tendencies, predispose to convulsions during the whole period of childhood, but more especially during the first few months of life.

The *exciting* causes of convulsions are mostly *reflex* : the irritation takes place at some distant part, the stimulus passes up to the nerve centre along some afferent nerve, giving rise to a discharge from a nerve centre or centres, the impulse travelling along the efferent nerves to the muscles. The exciting cause may be direct, acting on the centres, as when poisons circulating in the blood, uræmia, or a high temperature give rise to convulsions.

Reflex convulsions may be said to be disorderly physiological reflex acts.

In a normal reflex act the nervous mechanism is in order, and a useful movement takes place; in a convulsion there is an irregular and wasteful discharge of nerve force which fulfils no useful end. An infant's movements consist almost entirely of reflex acts of the simplest character, the nerve centres in action being of the 'lower grade' group, situated in the spinal cord, medulla, and pons: such are the acts of swallowing, sucking, crying, breathing; in each case there is some form of irritation or a stimulus acting on the nerve centre and transmitted to it by an afferent nerve, and an impulse is sent along an efferent nerve to a muscle or group of muscles, and a definite, perhaps complex, act is performed. In morbid states of the nerve centres an afferent impulse calls forth a series of irregular muscular movements, mostly in the form of clonic spasms, which may be limited to one group of muscles, or may implicate almost all the voluntary muscles in the body. Thus the presence of a hard lump of curd in the stomach or bowels, instead of provoking vomiting or increased peristaltic action, as physiologically it should do, acts as a stimulus over a wide area and some distant nerve centre or perhaps many nerve centres are thrown into activity. As a consequence of the irritation in the alimentary canal, the facial muscles may twitch, the legs be drawn up, the eyes roll about, the fingers be clenched; there may be spasm of the respiratory muscles, and all the muscles of the extremities may be thrown into clonic spasm. Possibly the respiratory muscles only may be involved, and spasm of the glottis and of the respiratory muscles may result. Dyspepsia or the presence of indigestible food is a fertile source of infantile convulsions in the newly-born; newly-born infants when fed on artificial food frequently suffer from convulsions, which disappear at once when a wet-nurse is obtained. In making post-mortems on infants and young children who have died in convulsions it is no uncommon thing to find an overloaded stomach, and possibly pieces of meat or other indigestible food, in the stomach.

Dentition is another not uncommon cause; the pressure of the advancing tooth upon the gum, or the tension of the tooth in its socket, may through the branches of the 5th nerve produce general convulsions. Bronchitis or pneumonia may be the exciting cause, though the latter sometimes produces convulsions in consequence of the high fever that is present.

The exciting cause of the convulsions may act directly on the centres themselves. Thus the onset of meningitis or any part of its course may be marked by convulsions; an infant has a series of convulsions which are perhaps more or less one-sided, and when they cease it is noticed to be hemiplegic. The acute stage of infantile paralysis may be attended with convulsions. Convulsions may be caused by chronic brain disease. An altered condition of blood may be the exciting cause: thus a temperature of  $104^{\circ}$  or  $105^{\circ}$  is exceedingly likely to be accompanied by convulsions, the convulsions ceasing when the temperature falls, and being perhaps repeated when it rises again. Heat-convulsions are exceedingly apt to be fatal. A hyper-venous condition of blood excites convulsions as seen in infants born in a condition of asphyxia. The onset of some zymotic disease, as scarlet fever, or measles, is sometimes marked by convulsions.

*Symptoms.*—The convulsive attacks vary greatly in their severity, and in the extent of the muscles involved. There may simply be slight jerky

movements of the head and neck or a limb, or there may be slight twitchings of the muscles of the mouth or eyelids. The fingers may jerk and the thumbs turn in, movements which go by the name of carpo-pedal contractions. Such slight convulsions are often spoken of by nurses and parents as 'inward fits'; they are most common in young babies with dyspepsia, or those who are suffering from some abdominal trouble.

A typical convulsion closely resembles an epileptic fit, but the stage of tonic spasm is usually shorter, while the clonic spasms or muscular twitchings are more prolonged and vigorous.

The commencement of a fit is frequently marked by spasm of the glottis, so that the nurse thinks for the moment the infant is choking; at other times the rolling upwards of the eyeballs and twitchings of the facial muscles first call attention to the child. The face becomes pallid, the eyes are turned up so as to show 'the whites,' the limbs are extended and stiffened, the hands are clenched, the neck and back are arched, the jaw closes spasmodically; in a few moments the lips and face become of a bluish tinge from the respiratory spasm; the tonic spasm quickly passes into clonic, the hands, feet, and face 'work' for a few seconds or more, and the child becomes quiescent and the fit is over. The child becomes unconscious during the fit, and may remain dazed for a few minutes to half an hour after.

The fits may be severe, much on the type of a major epileptic fit, the tongue being held tightly between the gums or injured by the teeth, the child frothing at the mouth and becoming cyanosed, and remaining comatosed or drowsy for some time.

On the other hand, the convulsions may be partial only: one side may be affected, the leg, arm, and side of face twitching, or the laryngeal muscles or respiratory muscles alone may suffer.

The frequency with which fits occur differs very much: a child may have a single one, and it may never be repeated; or they may recur daily, or there may be a constant succession of fits for twenty-four or forty-eight hours, the child never becoming conscious.

Death may take place in the fit from spasm of the glottis. In other cases death seems to be caused in some way through the nervous system, as after death no evidence of asphyxia can be found.

Convulsions in older children are indistinguishable from epileptic fits, and doubtless many of such cases for which no cause is found are really epileptic, or at any rate showing a tendency in that direction.

Convulsions may be associated with idiocy or some mental defect, and it is not always easy to say to what extent the convulsions depend upon the presence of some cerebral lesion or malformation, or whether the mental defect is produced by the frequently recurring fits. It is not uncommon to see children of a few months to a year old who are frequently convulsed, and who are evidently idiots, not able to sit up or hold anything in their hands, and not recognising their friends. In these cases the prognosis as far as the mental development is concerned is grave, though the fits often become less frequent or cease as the infant develops.

*Prognosis.*—This must always be uncertain, and naturally depends upon the exciting causes. The first fit may prove fatal through spasm of the glottis; on the other hand, it is common to get a history of children being as

infants constantly convulsed and yet growing up into comparatively strong children. Naturally much must depend upon what the exciting cause of the fit is : if it suggest commencing meningitis the prognosis is necessarily bad ; if there is hyperpyrexia and commencing pneumonia, it is very grave. Convulsions following on some exhausting disease as diarrhoea are mostly fatal. Convulsions associated with laryngismus are always serious, and the prognosis must be very guarded. In those cases where the fits in young infants are frequently repeated it must be borne in mind that they may prove to be epileptic or associated with mental deficiency, and a guarded prognosis must be given. If there is reason to believe that the convulsions are due to dyspepsia or are symptomatic of rickets, the prognosis as far as the cerebral development of the child is good, but there is always the risk of its dying in a fit.

*Diagnosis.*—The exciting cause of the convulsions may be difficult or impossible to determine. Convulsions in infants shortly after birth may be due to a hypervenuous state of the blood resulting from congenital heart disease or atelectasis ; if these can be excluded there is a strong probability that the fits are due to some digestive disturbance, especially if the infant is being artificially nursed. In infants over 6 months of age, with the symptoms of rickets, the fits are in all probability reflex and due to some dentition or alimentary troubles ; but the possibility of their being due to commencing meningitis or to the presence of tubercles in the brain must always be borne in mind, even in the case of fat, healthy-looking infants. Vomiting, irregularity or hesitation of the pulse-beat, or an unnatural softness of the abdomen would suggest meningitis. The possibility of the convulsions in infants being followed by a hemiplegia or a paralysis of one or more limb must not be forgotten. In convulsions in young children the chest should be carefully examined and the temperature taken, and the skin inspected to ascertain the presence or absence of a rash. In frequently recurring fits there is a possibility the child may grow up mentally deficient, and a careful inquiry should be made as to the child's intelligence.

*Morbid anatomy.*—Convulsions *per se* leave no trace in the dead body, though usually there are the signs of death from asphyxia, the latter being most marked in those dying suddenly in strong health. The veins on the surface of the brain are full of dark blood, and the brain may be unusually full of blood and wet from excess of cerebro-spinal fluid on the surface and in the lateral ventricles, but these are due to death taking place through stasis of blood in the lungs and a consequent engorgement of the general venous system. The post-mortem examination of the state of the cerebral vessels gives us no clue to their condition, whether of engorgement or anæmia, during the fit itself, except such as are produced by venous obstruction. In many cases the post-mortem throws no light on either : on the cause of the fit or the conditions which accompanied the fit. In others the appearances of commencing bronchitis or pneumonia or acute intestinal catarrh may be found. Difficulties are, however, likely to be met with at the post-mortem in distinguishing between early pneumonia and the sodden and œdematous lung often present which is due to the manner of death, namely asphyxia from obstruction to the entrance of air into the larynx.

In making an examination for medico-legal inquiries as to the cause of death, whether from a convulsion or from some other cause, great caution

must be exercised in coming to a conclusion, especially in infants. An infant may have been 'overlaid,' i.e. suffocated beneath the bedclothes in consequence of the mother going to sleep with the infant at the breast, the mother perhaps alleging that the infant had died in a fit. In both cases the post-mortem appearances may perhaps be much alike, namely those of death from asphyxia. In many cases, however, a distinction may be made between a rapidly produced asphyxia, as in death from a fit, and a more slowly produced asphyxia, as in slow suffocation beneath the bedclothes: in the former the lungs are simply gorged with dark fluid blood, in the latter case the lungs are sodden and œdematous, containing a large amount of frothy fluid. In any case where the tongue is held between the teeth and has been injured, and there are signs of rickets, the lungs gorged with dark fluid, and the veins on the surface of the brain overfull, there is a strong probability that the child has died in a fit. It must not, however, be too hastily assumed that a convulsion has not been the cause of death, because the typical signs of asphyxia are not present; death appears to take place in some cases probably through the nervous system, before asphyxia takes place.

*Treatment.*—The treatment of convulsions must necessarily be chiefly directed to removing the cause. During the convulsion itself, if there is a high temperature ( $104^{\circ}$ – $106^{\circ}$ ), no time should be lost in placing the infant or child in a tepid bath and pouring cold water over the child and into the bath in order to lower the temperature, which is probably exciting the convulsions, and antifebrin or quinine may be given. In reflex convulsions in a robust child, especially if there is colic or abdominal disturbance, a warm bath, or a mustard bath so as to redden the skin, is likely to prove of service, or the child's socks may be wrung out of mustard and water and placed on the feet. If there is reason to suppose the convulsions are due to cerebral disease, or the convulsions come on at the end of an exhausting illness, the warm bath is not likely to be of any service and may be injurious. If the child has taken any indigestible food, which is lying in the stomach or in the bowels, an emetic or one or two grains of calomel should be administered, according to the effect desired. If the gums are swollen and tender, an incision, or simply scarifying them, may do good. If there is otitis, it may be well to puncture the membrane.

The inhalation of a few drops of chloroform or nitrite of amyl will usually check the violence of the convulsive spasms, and should certainly be tried if the convulsions last any time or are violent. Of medicines which diminish the irritability of the nervous centres, the bromides, chloral, and belladonna hold the first place. Bromide of potassium or sodium must be given freely if the convulsions recur time after time. If the child can swallow, 3 to 5 grains may be given to an infant of 6 months to a year old, and repeated every hour or two for several doses, according as the convulsions are present or not; smaller doses, less often repeated, should be given if improvement takes place. No harm is likely to ensue by pushing the bromide. The bromide may be given by the rectum if necessary. Choral is also useful, but must be used sparingly: a 2 or 3 grain dose may be given to an infant under a year, and repeated in an hour if the convulsions are still present, but its soporific effect must be watched. Bromide, chloral, and cannabis indica are often given in combination with advantage in convulsions. Cold to the

head in the form of ice or wet cloths should be used if meningitis is suspected, and the infant should be carefully protected from all excitement.

Convulsions in infants a few weeks old, who are artificially fed, are due in the large majority of cases to dyspepsia, and no time should be lost in procuring a wet-nurse, or at any rate in giving the infant the most suitable food that can be procured.

**Hysteria.**—Functional nerve disturbances, both in the form of sensory derangements, paresis, contractures, and eclampsia, are by no means uncommon in children. Hysteria when it occurs during early life mostly affects girls, but it occurs also in boys; the approach of puberty is the most common period.

A tendency to hysteria runs in families, and is transmitted from parents to children, but the injudicious way in which children are often brought up, their weaknesses being pampered and all their ailments being intensified by an injudicious sympathy, often tends to aggravate a hereditary tendency to nerve disorders. While it most frequently happens that hysterical children come of neurotic families and in the well-to-do classes, yet such may be found in country districts among country folks, where neurotic tendencies might be least expected. 'Fasting girls' who have had a temporary notoriety, 'cataleptics,' and religious maniacs have been found in cottage homes and among surroundings that one would have supposed were little likely to produce hysterical affections.

Hysteria in its milder or severer forms is often associated with other diseases, such as epilepsy, chorea, and various mental affections; it may also be engrafted on to organic brain disease, such as meningitis or some spinal affections.

Hysterical phenomena are rare before the age of six years and are most common about puberty, especially in those cases where menstruation has failed to become established.

*Symptoms. Sensory disturbances.*—Perhaps the most common form of hysteria in girls is hyperæsthesia: there is a complaint of tenderness or pain which cannot be accounted for except by a neurosis. There is some local tenderness about the spine or one of the joints, especially the hip, the girl screaming with pain when the joint is moved; the thyroid gland or front of the larynx is sometimes hypersensitive. Headaches are very common: these may be frontal or occipital, or may take the form of the 'clavus' of adults. Hysteria is apt to mimic various diseases which are normally accompanied by severe pain, such as peritonitis, pleurisy, rheumatism; it must, however, be always borne in mind that there may be some actual disease present, and the sensory disturbance is only an exaggerated condition of what would normally exist.

Anæsthesia is much less common in children than hyperæsthesia; but hysterical hemianæsthesia involving the special senses occasionally occurs. Sleeplessness is not uncommon, the patients asserting they cannot sleep, and only perhaps dozing off when it is time to get up.

*Motor disturbances.*—Paralysis or rather paresis is common; the larynx is perhaps most frequently affected, but paraplegia is not infrequent. Hysterical aphonia in girls has the same characters as in adults: there is loss of voice, the patient always speaking in a whisper; sometimes the voice is entirely lost.

Paraplegia may come on suddenly after a convulsion, or the legs may gradually give way under the child, until it can no longer stand and is therefore confined to bed. There may be loss of sensation, but in our experience this is uncommon. The loss of power is never complete: the patient moves the legs in bed, and often some attempt will be made to stand with help, or she may draw up the legs to prevent them touching the ground, and will sink to the ground rather than support her own weight. The electrical reactions are normal, and usually the knee-jerk is also normal, and there is no ankle-clonus. In other cases, more especially those which have lasted some time, there is more or less tonic contracture of the legs; the hip and knee-joints are semiflexed, and the foot takes the position of equino-varus. In this condition, if the spasmodic contraction is not too marked, there may be excessive knee-reflex, and ankle-clonus may be present; if there is marked contracture, no knee-reflex can be obtained on account of the rigid contracture of the opposing muscles. The contracture is present during sleep, but usually goes off when the patient is under chloroform.

In hysterical paraplegia there is no incontinence of urine or fæces; this is certainly the rule, but retention of urine will occur, and in some conditions, such as 'hysterical chorea,' both urine and fæces will at times be passed involuntarily. We have seen on several occasions girls who were suffering from hysteria, simulating hip-disease or peritonitis, pass their water into bed, so that the bed and linen have been saturated with stinking urine, rather than use a bed-pan, as they were afraid of being moved on account of the pain it caused. In such cases bed-sores may form and the patient become emaciated.

*Convulsive attacks.*—These are of the usual hysterical type. There is a fit of screaming or crying or violent laughter, tonic contraction of the muscles, more especially of the back, so that opisthotonos is produced; the arms and legs are dashed about and the head perhaps made to strike the pillow or bed violently. The patient remains conscious during the attack, and she rarely injures herself, and the tongue is not bitten.

The so-called 'hysteroid' fits have already been referred to (p. 408).

*Cerebral symptoms.*—Hysteria is closely allied to some forms of insanity, and various forms of hysterical insanity occur in girls about puberty. One of the commonest of these is a refusal of food. The girl's appetite becomes poor, she gradually grows thin, and this excites the sympathy and alarm of her friends. The morbid craving for sympathy becomes intensified. She resists all their entreaties to take food, and clenches her teeth when it is offered, or only takes the smallest quantities, and frequently is guilty of deceit, concealing food in her clothes. She gradually wastes, till she becomes a perfect skeleton, the skin is rough and harsh, the abdomen flattened, and the breath foul. Bed-sores not infrequently form. In some of these cases there is melancholia or eclampsia. Morbid conscientiousness is sometimes present: the girl perhaps takes away marks from herself at school, or accuses herself of having told untruths or of having stolen her school-fellows' things.

*Diagnosis.*—The first step in diagnosis is necessarily to attempt to exclude organic disease, which hysteria so often mimics. In sensory hysterical disorders, such as headaches, and in various forms of paralysis, the question is

whether or not there is cerebral tumour or spinal disease. Probably the commonest mistake is to assume that organic disease exists when the condition is one of hysteria only ; but, on the other hand, we have known the symptoms in the early stages of a cerebral tumour attributed to hysteria. It is often necessary to wait before a definite diagnosis can be arrived at. But it is always necessary to bear in mind that an organic lesion may exist and yet undoubted hysterical symptoms be present.

*Treatment.*—The treatment of hysteria in its worse forms is principally moral. The management of the patient must pass from the parents to a suitable nurse, or, better still, the patient should be removed to hospital or into lodgings away from her friends. If once the child is under firm control, is deprived of the morbid sympathy it craves for, and is at the same time encouraged to put forth all its voluntary power, an improvement in its condition will immediately begin. In cases of paralysis, in addition to isolation from the parents and all sympathising friends, massage and faradisation are of much advantage. The patient must be made to use the weakened limbs in moderation and encouraged to believe that they will get entirely well.

In less severe cases change from city to a healthy country life is of great importance. Life at a farm with its many out-door attractions and occupations is perhaps the best adapted for hysterical children. Effort must be made to interest them in many things outside themselves in order to break the vicious habit of dwelling inordinately on their own feelings and ailments. In many of these cases the general health is poor and menstruation delayed. In such, iron in the form of bromide of iron, as in Fletcher's syrup, is useful, while the bowels should be regularly acted on by small doses of aloes or some mineral water such as Rubinat or Hunyadi Janos.

**Headaches.**—Children, especially girls of 7 years of age on to puberty, are very liable to headaches, sufficiently severe to lay them up for part of a day or perhaps longer. These headaches may arise from various causes, and it is important to try, if possible, and ascertain their origin ; diagnosis is frequently by no means easy, as pain is referred to the forehead in many different morbid states and conditions. Frontal headache is by far the commonest form of reflected pain. It is important in the first place to exclude hypermetropia as a cause of frontal headache. Straining the accommodation of the eyes, especially when the subject is below par, may give rise to frontal headache, aching being referred to the eye-balls, while at the same time when an attempt is made to read, the letters run together and the eyes easily water. A diagnosis is easily made with the ophthalmoscope, examining the retinal vessels by the direct method, as well as by the use of test-types.

Headaches are very common in rapidly growing children, who are, to use an ordinary expression, 'out-growing their strength.' Such headaches may be due merely to weariness or to the irritable state of the nerves which comes on when over-tired or fagged ; or they may be due to anæmia or dyspepsia. The latter is probably the most frequent cause. The appetite may be good or capricious, more food is taken than the digestive organs can cope with, and dyspepsia or a subacute gastric or intestinal catarrh is the result. A sick headache is complained of, the child looks heavy and dark about the eyes, there is nausea or actual vomiting, perhaps some fever, and it takes a day or two to regain the ordinary state of health. Headaches due

to overwork of the eyes and brain are especially common in schoolboys and girls when preparing for examinations and taking too little exercise and recreation. With the headache there is often sleeplessness at night, anæmia, and more or less dyspepsia. There is usually no difficulty of diagnosis here, as the history of the case will render its nature plain.

There is a form of headache which is by no means uncommon, which is distinctly neurotic, and which does not appear to be connected in any way with dyspepsia, sluggish liver, overwork at school, or organic disease. The child is usually a girl of 10 or 12 years of age, who suffers with a severe headache, often accompanied with sickness, once or twice a week, perhaps oftener, which comes on at irregular times, and is sufficiently severe for her to take to bed or to lie on the sofa for most of the day, and to incapacitate her for all work or play. Such headaches are made worse by noises and exertion; at times there is violent sickness or retching, and perhaps giddiness in the erect posture. The bowels are usually constipated, the tongue clean, and in the intervals between the attacks the child is in good health and able to go to school and take moderate exercise. The causes of such headaches are very difficult to discover; a tendency to such is often hereditary, and, while worse during the period of puberty, the tendency may remain throughout life. They are often very obstinate, and medicine fails to relieve as long as the patient remains at home, leading a sedentary town life; they are almost always better during the holidays spent away at the sea-side, or whilst leading a healthy country life, but recur again when a return is made to town life, with school and the ordinary home routine.

In some other cases the headaches are more distinctly hysterical, the pains being described as of a 'shooting' or 'boring' character, and coming on when the spirits are depressed or there is some unpleasant duty or distasteful study to be undertaken. On the other hand, all headaches are forgotten if the patient is roused by some excitement or the prospect of some unusual pleasure. When the headache is present, the patient demands the sympathy of all her friends, and is apt to lapse into a chronic invalid, expecting to receive the commiserations and attentions of the whole household. She objects to go out or ride or drive; the least noise or loud talking brings on the headache. The appetite perhaps becomes poor, she becomes thinner and the whole health suffers, or, on the other hand, in some cases the appetite is not affected. These hysterical headaches are commonest at or about puberty, when menstruation is commencing, but they may be present in boys and in girls of 9 or 10 years of age.

The most important question in connection with diagnosis is with regard to the presence or absence of organic disease. Are tubercles forming in the meninges of the brain? Is there a cerebral tumour, or are the headaches either reflected from the digestive system or purely nervous in character? The diagnosis between cerebral disease and functional disease is usually not difficult if the history given by the friends can be relied upon, or if there is an opportunity of watching the patient for a few weeks. The headache accompanying the early stages of tubercle of the meninges is associated with irritability, wasting, hectic fever, loss of appetite, shivering, and cough; and a few weeks more or less will almost certainly see developed more marked cerebral symptoms, such as squint, vomiting, and involuntary passage of

faeces. The headache due to cerebral tumour is mostly constant, though worse at times than at others ; it is always made worse by movement ; there is irregular causeless vomiting and optic neuritis.

*Treatment.*—The treatment of headaches is naturally directed to removing the cause. The treatment of headaches of rapidly growing children will mainly consist in the avoidance of over-exertion or fatigue, a very moderate amount of brain-work, a healthy country life, and a careful regulation of the diet. The digestive organs are probably being given more work than they are able to perform, a gastric or intestinal catarrh is set up, and the disordered state of digestion is expressed by a frontal headache. Vomiting in these cases nearly always relieves the headache ; if it does not take place, perhaps there is feverishness and nausea and headache for a day or two. When these headaches are coming on, the simplest and best remedy is an emetic such as a tea-spoonful or two of ipecacuanha wine, to be followed by a little judicious starvation or the lightest possible diet for a few days. For the avoidance of such sick headaches meat should be allowed in only moderate quantities, and it should be well cut up and masticated slowly, and care should be taken to regulate the bowels from time to time with some effervescing citrate of potash, Rubinat or Carlsbad water, before breakfast. In the neurotic forms of headache, arising independently of digestive derangements, the treatment is often very unsatisfactory. When the attack comes on, and is evidently severe, bed is the best place, with a wetted handkerchief to the head in the hopes of getting the child to sleep ; coffee, effervescing citrate of caffeine (1 to 2 grains of the pure salt), monobromide of camphor (1 to 2 grains), ex. guarana liq. (10 to 15 drops), cannabis indica ext., or bromides may be tried. Antipyrin (2 to 5 grains) has been used with good effect. In the intervals between the headaches the most important treatment relates to regulating the bowels and to insisting on a simple but nutritious diet. In some cases good has followed the entire avoidance of butcher's meat. A healthy country life or change of scene is often of the greatest service and generally effectively cures, for a while at least. In hysterical headaches the patient should be encouraged to struggle against them.

## CHAPTER XXIV.

DISEASES OF THE NERVOUS SYSTEM—*continued.*

**Speech-anomalies.**—By the end of the first year of life a healthy child begins to make some progress in acquiring articulate speech. At this time it can mostly make some sort of sounds, and begins to use these sounds for expressing its wants or to show that it recognises its friends and toys. Thus sounds such as *M-m*, *bá-bá*, *dá-dá*, *ná-ná*, may be repeated in a meaningless sort of way at first, but before long are applied to persons or things. During the second year the vocabulary increases fast, and the child quickly imitates and repeats the words it hears, so that by the end of the second year it not only uses a number of words, but can string a few nouns and adjectives together, or has learnt the meaning of short sentences. At this period, and for the next year or two, words are indistinctly or improperly pronounced, with a tendency to clip them short or to drop consonants. Some consonants present greater difficulty to the young child than others, and are constantly dropped out of words; thus *s*, especially when it precedes another consonant, is omitted, as *cool* for *school*, *kwēk* for *squeak*, *nō* for *snow*. Difficulties often arise with the aspirate dentals as *th* and *sh*: *Ruth* becomes *Roof*; the vibratory consonant *r* is a great stumbling block, and the distinct pronunciation of it is, perhaps, never acquired: *grub* is apt to become *gwub*, and *roof*, *woof*.

Some children are more backward in talking than others, and are at the same time behindhand with walking and with their teeth, and it is only after the end of the second year is passed that they begin to make progress. This may happen with rickety children, or with those who have had some serious disease to contend with. Other children not only do not begin to talk when the usual time arrives, but as months and years go on make no attempt, or their articulation is indistinct and imperfect for their age. In another class of case the child learns to talk fairly well or imperfectly, then an illness comes on and it loses the power of speech. The principal causes of imperfection, or absence, of speech may be tabulated thus:—

1. *Deaf-mutism.*—The infant may be born wholly or partially word-deaf, or may become so from the effects of disease. The child is mute because it is deaf.
2. There is some physical defect in the formation of the mouth, or vocal apparatus.
3. The child may be feeble-minded, or have some defect of the brain.
4. There may be aphasia associated with right hemiplegia or due to some functional cause.

5. The difficulty of speech may be due to stammering or hesitancy of speech.

**Deaf-mutism.**—Deaf-mutes are those who cannot speak because they cannot hear: the deafness may be due to congenital defect, or they may become deaf through illness before they have learnt to talk; as a rule, if the child becomes deaf before he is seven years of age, dumbness will result. The *congenital* variety appears mostly to be the result of hereditary taint, congenital deafness having occurred previously in the same family. It is doubtful if the marriage of cousins has anything to do with it. The morbid anatomy is very uncertain, as there are but few post-mortem records of such cases; in some cases there is reason to believe that congenital deafness is the result of inflammation of the internal ear during intra-uterine life. How early is it possible to detect deafness? The diagnosis is necessarily very difficult during the first few months of life, especially when we remember that congenital deafness is rarely complete, the ringing of bells, whistling, &c., being heard when the ear is quite incapable of detecting articulate sounds. 'Word-deafness' is congenital as well as the result of disease. During the first few weeks after birth the healthy infant gives no response or signs of recognising sounds, but loud noises will wake it up. It is only during the third and fourth months that the infant appears to recognise sounds and voices, but, as some infants are more backward than others with regard to perceptions, it is only after six months of age, or from that to a year, that a definite knowledge can be come to with regard to deafness. When the infant is a year old and has never uttered an articulate sound, while it shows no want of intelligence in other ways, and its muscular power and growth is in accordance with the normal standard, there is strong reason to believe that its speech defect is due to deafness. The diagnosis between a failure to speak due to partial deafness or word-deafness and failure on account of mental feebleness is often extremely difficult, perhaps, in certain cases, for a time impossible, in the absence of other signs of mental defect.

**Acquired Deaf-mutism.**—When a child under 7 years loses its hearing in consequence of disease, its speech becomes indistinct and more or less unintelligible, and it loses the power of speech altogether, either quickly or gradually, according to its age and intelligence. The loss of speech will necessarily depend to some extent upon the amount of deafness. According to Hartmann it is possible, if the child is intelligent and great care is taken to correct its mistakes in talking and to induce it to talk, that speech may be retained.

The lesion which commonly produces deafness is an inflammation of the labyrinth, either idiopathic or secondary to meningitis, scarlet fever, typhoid, or hooping cough. The difficulty of distinguishing between acute otitis and meningitis has already been pointed out (p. 369), and consequently the extent to which deafness is produced by one or the other is uncertain. Attacks of cerebro-spinal meningitis undoubtedly frequently produce deafness, as does also scarlet fever. In this country scarlet fever plays a more important part than other diseases in destroying the auditory apparatus. Hartmann believes that an inflammation of the labyrinth and consequent injury to the terminal apparatus of the auditory nerve, and not suppuration in the middle ear, is the cause of deafness; though the latter frequently takes

place, it is not necessarily present. A naso-pharyngeal catarrh seems to be an occasional cause of labyrinthine disease.

The hearing power of deaf-mutes is usually tested with a bell and tuning-fork, the two ears being tested separately. Statistics collected by Hartmann show that in 865 cases of deaf-mutism in different institutions 60 per cent. were totally deaf, about one fourth (24·3 per cent.) heard sounds such as the ringing of a bell, while 15 per cent. heard words or vowel sounds when pronounced loudly close to their ears.

2. **Physical defects in the mouth.**—Parents not infrequently bring a child to consult a medical man with regard to his backwardness or indistinctness in speech, which is attributed to his being tongue-tied or to some deformity of the mouth or palate. In the majority of such cases no physical defect can be detected, the defect being rather in the nervous mechanism of speech. It is quite conceivable that a more than usually attached frænum may be present and interfere, however slightly, with the movements of the tongue, and the dentals, *t*, *d*, *s*, are badly pronounced.<sup>1</sup> A highly arched or deformed palate may render speech imperfect, the child speaking like one with cleft palate; but it must not be forgotten that weak-minded children may have high palates and the defective speech be due to mental feebleness. Defective speech is also present in those with large tonsils and post-nasal adenoids; there is a characteristic 'stuffiness' about the voice, and difficulties with the resonants *m*, *n*, *ng*, inasmuch as in the pronunciation of these the nasal chambers act as a resounding cavity. Paresis of the soft palate may be present especially after diphtheria, the voice having a nasal twang and difficulty being experienced in pronouncing the explosive labials *p* and *b*, as the air escapes into the nasal cavity, the soft palate failing to act.

3. **Mental defect.**—Perhaps the commonest form of defective speech is that connected with the nervous mechanism. The child perhaps appears perfectly intelligent and bright, no defect can be discovered in the mouth, yet his pronunciation of certain sounds is defective, as if he used his tongue or lips imperfectly, or had not them under perfect control. He may have especial difficulty with the dentals, such as *t*, *d*, *s*, *n*, and consonants which require great precision in the use of the tongue; or the difficulty may be with the labials, as *p*, *b*, *f*, *m*; or he may lisp in an exaggerated manner. All degrees of difficulty of speech may exist: it may be so marked that the child avoids conversation as much as possible and expresses his assent or his wants by signs. This form of difficulty of speech is often hereditary. It is possible that in some of these cases the hearing is at fault and the child suffers from partial word-deafness, in a similar way to a child suffering from colour-blindness.

If, however, instead of imperfect speech, the child of 5 or 6 years of age does not talk at all, there is probably some mental defect, the child failing to understand what is said, or although it may understand the speaker, yet there is a failure in the process of converting thoughts into words.

4. **Aphasia.**—Children, like adults, may suffer from aphasia due to organic disease, or from a functional aphasia. In the former the aphasia may be the consequence of embolism of the left middle cerebral artery, and be

<sup>1</sup> See 'Some Forms of Defective Speech,' Warrington Haward, *Lancet*, vol. i., p. 111, 1887.

associated with a right hemiplegia, or a tubercular tumour may compress the left third frontal convolution.

Functional aphasia is not uncommon and occurs usually after exhausting fevers ; as, for instance, in typhoid after the febrile stage is passed many months may elapse before the child speaks. It may occur after pneumonia: thus a child of  $2\frac{1}{2}$  years suffered from inflammation of the lungs in October ; his mother said, 'His talking left him while getting better.' He didn't speak a word till the following April, when he said 'drink;' the following month he began gradually to talk again.

The power of speech is lost suddenly at times in consequence of a nervous break-down. Dr. Langdon Down records the cases of two brothers, who had spoken well and understood two languages, completely losing the powers of speech at the period of the second dentition.

5. **Stammering** is rare before the period of the second dentition, though we have met with one case of a child of 3 years who occasionally stammered. Boys are far more commonly affected than girls. It is especially apt to supervene in boys who are overworked at school, and who inherit neurotic tendencies.

*Treatment of defective speech.*—The treatment necessarily depends on the cause of the defective speech. Surgical treatment may be required in the first place : enlarged tonsils must be excised and post-nasal adenoids removed, defects in the hard or soft palate must be remedied as far as possible by surgical and mechanical means. Special instruction in articulation, especially directed to the difficult sounds, must then be practised. For this purpose the teacher faces the pupil, showing him by exaggerated movements of his own lips, tongue, or larynx the positions they should assume to form the desired sounds, and practising the pupil in these movements. In fact, the method of oral instruction now so commonly in use for the instruction of deaf-mutes must be practised in all cases of defective speech.

The education of deaf-mutes has received much attention of recent years, more especially in Germany, and schools are now established throughout the country where the education of deaf-mutes is carried on on the oral system. By this system the senses of sight and touch are made as far as possible to take the place of the defective sense of hearing.

If the patient has become deaf after it has learnt to speak, everything must be done to assist it to retain the faculty of speech and to discourage the use of sign-language. The child must be encouraged to speak, the words that are wrongly pronounced being corrected as far as possible by showing the child the exact position of the mouth, lips, tongue, or larynx, and by making it repeat the word until it has pronounced it correctly. New words are taught in a similar manner, and by showing the child the objects or pictures of the objects taught.

The instruction of congenital deaf-mutes is most usefully commenced at 6 years of age ; before this time it is difficult to fix the child's attention for sufficiently long together, indeed many children do not manage to learn much till they are 7 years of age. It need not be said that the training of deaf-mutes in the use of oral language is a tedious and difficult process, requiring a special training and much patience on the part of the teacher. The deaf-mute has not only to learn to speak, but also to understand what is said to

him by watching the movements of the speaker's lips. After many years of training the cleverer deaf-mutes are able to leave school and converse with others sufficiently to enable them to learn a trade and earn their own living.<sup>1</sup>

**Mental affections in childhood.**—All degrees of intellectual feebleness are met with during infancy and childhood, ranging from complete amentia, the result of an ill-developed or damaged brain, to mere backwardness or dulness of the mental powers. The classification of such is roughly made when we speak of idiots, imbeciles, and backward children, though in using these terms, it must be borne in mind that no sharp line can be drawn between idiots and imbeciles, and, moreover, there are objections to both terms, inasmuch as the one is a term of reproach and the other is frequently applied to those who are the subjects of senile dementia. Dr. Langdon Down has proposed a classification based upon etiology, and which has the merit of simplicity, and is often of practical value with regard to treatment and prognosis. His classification is as follows :—

- |                                   |                       |
|-----------------------------------|-----------------------|
| 1. Congenital idiocy.             | 4. Cretinism.         |
| 2. Developmental idiocy.          | 5. Backward children. |
| 3. Accidental or acquired idiocy. |                       |

1. The **congenital** group includes by far the largest class, those in whom some mal-development of brain or some brain-damage takes place early in intra-uterine life, and who in consequence are never in possession of an average amount of brain power. The members of this group usually show within a few months of birth that they are not like ordinary children. The mother notices that the infant when a month or two old does not take notice as it should ; it pays no attention to a bright light or sound, it does not recognise its friends by a smile, or appear to hear its nurse's voice. As time goes on, it makes no attempt to sit up or hold toys in its hands, its muscular system is weak, and its face wears a vacant expression. At a year or eighteen months old it has made no progress in walking or in using its limbs, or perhaps it cannot utter any articulate sound ; it salivates continually, the saliva running from its mouth on to its frock, and it has no control over its urine and fæces. As its muscular power gradually increases, it learns to walk, perhaps to say a few words, and, if carefully looked after, to become more cleanly in its habits.

The physical characters as well as the degree of intelligence possessed by congenital idiots are very various. They mostly have coarse, harsh skins, slow circulations, and suffer from constipation. They are exceedingly apt to suffer from various tubercular manifestations. They nearly always remain stunted in growth. Congenital idiocy may be associated with a peculiar formation of the skull, corresponding roughly to the configuration of the brain inside ; while some crania are small, it must not be supposed that small heads are constantly present in congenital idiots : in some cases the head is symmetrical and well-shaped, and of average size. Congenital idiots may have micro-cephalic (Aztec type) or small heads, macro-cephalic or large heads, dolicho-cephalic or long heads, brachy-cephalic or broad heads (Mon-

<sup>1</sup> For details of the methods of oral instruction, see *Deaf-Mutism*, by Hartmann (Cassell's translation).

golian type). Sometimes there is a want of symmetry on the two sides of the cranium, or there is a deficient development of the frontal or occipital region. Various conditions of the mouth found in congenital idiots have been especially emphasised by Langdon Down; these, it is needless to say, are not universally present. The palate is inordinately high and arched, and often unsymmetrical; the tongue is usually large, and its movements are apt to be badly coordinated and awkward; the fungiform papillæ are hypertrophied; the mucous membrane of the pharynx is apt to be thickened and congested, the tonsils hypertrophied, and post-nasal adenoids may be present. Slavering due to paresis of the muscles of the lips and tongue, as well as to the hypertrophy of the glands of the mouth, is very common. Dr. Langdon Down looks upon slavering as of some diagnostic importance, being nearly always connected with mental feebleness. The teeth are late in appearing and quickly become carious.

2. **Developmental.**—In this group are included those who show no marked signs of being wanting in intelligence during infancy, but who during childhood or youth may show signs, often suddenly, of a mental breakdown and arrest of the development of the mental powers. This change may come at any time during childhood, but more especially on the approach of puberty. This sudden change often comes as a great surprise to the friends; the child's head is well-formed, he looks intelligent, quite unlike the appearance of an idiot, and they are at a loss to account for the change, or attribute it to some trifling disorder. Sometimes the first intimation of the crisis is that the child ceases to talk: such was the case in a little boy seen by us,<sup>1</sup> who was perfectly intelligent and bright up to 4½ years, when he suddenly ceased to speak and gave over playing with toys, his principal employment being to throw his toys on the floor and proceed to kick them about the room; he hardly seemed to know his mother, though at other times he appeared to understand. He eventually recovered.

In other cases the change comes at the second dentition or at puberty: such children are apt to be morbidly conscientious, believe they have told lies or stolen, or, on the other hand, they become wayward, mischievous, unkind to their brothers and sisters, and disobedient. (See Hysteria.)

Epileptic fits are apt to appear at this period. Dr. Langdon Down has noticed that these cases often have a scapho-cephalic head, which is 'prow-shaped' anteriorly, the prow corresponding with the inter-frontal suture, which forms a prominent ridge. Such cases according to this author are apt to break down by over-pressure at school or from over-excitement during childhood.

3. **Accidental or acquired.**—To this class those belong who do not inherit any insane tendency, and who would become healthy, intelligent children, but for some accident which damages the brain at birth, or some lesion at a later period. Reference has been already made to cases of post-partum paralysis (see p. 393) due to meningeal hæmorrhage occurring during birth: such are often not only paralysed, but mentally feeble. There is strong reason to believe, as already stated, that damage done to the convolutions on the surface of the brain by a meningeal hæmorrhage when an infant is in a con-

<sup>1</sup> A patient of Dr. Herbert Renshaw's, of Sale.

dition of asphyxia is the cause of the feebleness of intellect, and possibly such may escape paralysis, the motor centres escaping damage. In another class of case the infant is quite well, and its development is satisfactory, till it has some acute illness with cerebral symptoms, mostly during its second year. This may be followed by hemiplegia (see p. 387), or there may be no paralysis, but the mental development is interfered with. Such children often suffer from convulsions and finally become epileptics.

4. **Cretinoid Idiocy. Sporadic Cretinism.**—Cretinism is endemic in mountainous districts of Europe, especially in the Swiss Alps; it is comparatively rare in this country, though examples may be met with in the hilly parts of Derbyshire, Yorkshire, and Somersetshire. Examples of this form of cretinism may be met with in asylums. Dr. Shuttleworth records a remarkable case, who died at the age of 20 years in the Royal Albert Asylum at Lancaster. In such cases there is usually, but not universally, an enlarged thyroid gland, and goitre usually prevails in the same localities. The form of cretinism of most interest is the form which was described by Hilton Fagge under the name of 'sporadic cretinism.' Examples of this form have been met with in all parts of the country, and it does not seem to be more common in hilly districts than in large cities or in level country districts.

In many of the cases which have come under observation there has been a history of the child being born of healthy parents, and of being well till some illness occurred such as measles or typhoid fever, after which the child ceased to grow, and gradually developed the peculiar physiognomy of cretinism. In one of our own cases the boy was said to have been well till an attack of enteric fever at 7 years of age; in a case recorded by Fletcher Beach the disease dated from hooping-cough at 20 months. In other cases the history points to the child having been affected from birth. There is reason also to believe that cretinoid changes are in operation during pregnancy, and that some of the cases in which softening of the bones is supposed to be due to infantile osteo-malacia are in reality foetal cretinism.

The physiognomy of cretins is very peculiar and characteristic. They are dwarfs, being markedly stunted in growth: in one of our own cases, that of a boy aged 12 years, he measured 34 inches high and weighed 28 pounds. In two cases of Hilton Fagge's, one, aged 16½ years, was only 32 inches high; another, 20 years old, was only 28 inches in height.

Their heads are large and broad, often flattened at the vertex; the face is broad, the eyes wide apart, the nose flattened, and the lips are large and pouting. The tongue is strikingly large and thick, and sometimes hangs from the mouth; the belly is tumid, the lower limbs are disproportionately short as compared with the body, the gait is awkward and waddling. The skin is coarse and thick, and of a sallow colour; in some the subcutaneous tissues are thick and myxœdematous. Usually no thyroid is present, or, if present, is very small, but in almost all cases described peculiar fatty tumours are present in the posterior triangles of the neck, behind the sterno-mastoid muscles and immediately above the clavicles. These tumours are soft, movable, and lobulated; they send processes behind the sterno-mastoid muscles and also beneath the clavicles.

The degree of intelligence in these cases differs: mostly they are childish in their ways rather than imbecile. In one of our cases the boy was employed

by his father, who was a butcher, to stand outside the shop on Saturday nights and shout out the price of meat. His peculiar appearance and quaint remarks always attracted customers. Cretins are apt to suffer from tuberculosis both of the bones and internal organs.

5. **Backward children.**—The name sufficiently indicates this class of case. It is often difficult to say whether a child is only behindhand in development or his mental powers are deficient. In most cases time will decide this. Backwardness is at times associated with epileptiform fits, or other nervous troubles. Children of this class are a constant source of anxiety to their parents; they go to school and always gravitate to the bottom of their class, being perhaps left behind by their younger brothers or children many years younger than themselves; out of school they are bullied or teased by their playmates. It is often difficult to know what to do with them; certainly neither a large school nor home life is suitable. They are best educated in a small school where backward boys are received and special attention paid to them.

*Morbid Anatomy.*—Space will not allow of any description of the malformations or lesions found in the brains of idiots or imbeciles. The varieties of malformation found are very numerous; the brain may be abnormally small, the frontal or posterior lobes may be ill-developed, the two halves may not correspond, or the corpus callosum or commissures may be absent. In another class of case there may be chronic meningitis, pachymeningitis, or atrophy of the cortical centres.

*Treatment.*—The physical and intellectual training of children of deficient mental power is best undertaken in some institution specially equipped for the purpose. Home is certainly not the best place for their education. In the large majority of instances they are either over-indulged or neglected by their parents, brothers, and sisters. The association of the cleverer brothers and sisters often produces a feeling of discouragement in the feeble-minded, and of hopelessness at the wide gap which separates them from others. The discipline of a well-managed school or institution is of the greatest advantage in teaching them self-control and self-respect, and the companionship of those who are more or less on an equality as far as intelligence is concerned is calculated to bring out their mental powers far more than is the association with those who are greatly their superiors. If a school education is necessary for the children of parents who are in comfortable circumstances, how much more is the shelter of an institution necessary for the feeble-minded among the lower classes? The Board school refuses to be troubled with them: they are teased and worried by their companions in the streets, while they are alternately over-indulged or scolded and neglected by their parents; their life is miserable, and they grow up useless members of society and an encumbrance to their friends. Unfortunately the several excellent public institutions for the training and education of feeble-minded children in this country are too few in number for the work they have to do. Moreover they labour under an unfortunate name, viz. 'Asylums for Idiots and Imbeciles,' when as a matter of fact they are not asylums for providing a home for useless members of society, but schools where weak-minded children are trained to take their part in the battle of life. These circumstances undoubtedly operate in the minds of parents, who might otherwise be not averse

to sending their children to training-schools, but who shrink from branding them as idiots or imbeciles.

As an example of what a training-school can be, the 'Albert Asylum' at Lancaster may be taken as a model. Children are received of all degrees of mental deficiency, from the most feeble-minded idiot to the merely backward child; the children of the poorest, who can contribute nothing towards their maintenance, are admitted; while there is an attached private house for the reception of the children of the wealthy, replete with all the luxuries of home life.

It is needless to say that children who are idiots or weak-minded need a plentiful supply of good food; that especial care must be taken to keep their apartments warm as well as ventilated, as they are exceedingly prone to suffer from pneumonia and tuberculosis.

No provision is made in this country for the education of the dull or backward children of the lower middle or working classes. For children of ordinary intelligence the Board schools of our large towns provide an excellent education, but no special classes are formed for those of dull comprehension; they are refused admission to the ordinary classes, and frequently mope away their time at home, with no education at all. There can be little doubt that in all large towns in this country, as in Norway and Sweden, small classes should be provided for the dull and backward scholars, so as to obviate the necessity of refusing them an education as is done at present. In the worst cases of this class, where there is real mental deficiency, education away from home is unquestionably the best.

## CHAPTER XXV.

DISEASES OF THE NERVOUS SYSTEM—*continued*.

**Spina bifida.**—Spina bifida is a congenital malformation in which there is non-union of the laminae of one or more vertebrae, together with a protrusion of a sac composed of the spinal cord or its membranes through this opening.<sup>1</sup> The protrusion may occur at any part of the spine, and may extend throughout nearly its whole length; usually only three or four vertebrae are involved and the lumbar or sacral region is the part most commonly affected.<sup>2</sup> Very rarely the bodies of the vertebrae are divided, and the hernia projects forwards or laterally. In some instances there is no protrusion, though the laminae have not united ('spina bifida occulta'), and occasionally there is more than one hernia.

Three kinds of spina bifida are recognised:—

1. Protrusion of the spinal membranes only: 'spinal meningocele.'
2. Protrusion of the membranes together with the spinal cord and nerves: 'meningo-myelocele.'
3. Protrusion of the membranes and cord, the central canal of the latter being dilated to form the sac: 'syringo-myelocele.'

To these should be added the cases where the medullary plates fail to coalesce—'myelocele'—and the central canal opens upon the surface, a condition incompatible with life for more than a few days. Also a meningocele may coexist with a 'syringo-myelocele,' constituting 'syringo-meningocele,' and finally there is 'spina bifida occulta.'<sup>3</sup>

The second kind of deformity is much the most common, forming 63 per cent. of all the cases.

In the first form the swelling is usually small, and may protrude merely between two almost normal spines; the cavity of the sac is the subarachnoid space, the swelling is often covered with well-formed skin, and paralytic complications are often absent.

The vertebral laminae vary much in development: the gap may be very wide and the laminae much stunted, or they may form prominent everted borders to the orifice.

The central canal of the cord is often dilated in the first two forms as well as in the third, and the position of the cord in the sac varies: it may be

<sup>1</sup> The deformity may be considered as due to a failure of the mesoblast to interpose itself between the spinal and cutaneous epiblast with or without lack of coalescence of the medullary folds themselves.

<sup>2</sup> 89 cases out of 125 collected by the Clinical Society were lumbar or sacral.

<sup>3</sup> *Vide* Bland Sutton, *Lancet*, February 25, 1888.

slung up in the sac by a sort of mesentery, but in any case is very imperfectly developed, and is occasionally transfixed by a bony process crossing the canal.

Syringo-myelocoele is very rare ; the sac is composed of spinal membranes *plus* the cord, and, the cavity being the dilated central canal, the nerves are embedded in the sac wall and do not cross the cavity.

The fluid in a spina bifida consists of 989 parts of water with soluble salts and a trace of sugar, or at least some copper-reducing substance: also small quantities of globulin ; it is, in fact, cerebro-spinal fluid. Where, however, the cavity of the sac is continuous with the subdural space, no sugar will be found.<sup>1</sup>

In meningo-myelocoele, the common form, the sac is formed of dura mater lined by arachnoid (both 'layers'), hence the cavity is the subarachnoid space. The spinal cord traverses the sac and blends with its roof ; from the flattened thinned-out cord the spinal nerves arise and pass across the sac to their respective foramina. The surface of the sac may be covered entirely with skin, or may be thin and transparent, only consisting at its upper part of the membranes, or membranes covered with an imperfect epidermic layer, while at the sides the skin is usually better formed. Sometimes a dimple or longitudinal furrow in the middle line marks the attachment of the cord and shows its presence in the sac, an important point in the question of treatment. Sometimes the sac is loculated.

The tumour resulting from spina bifida is median in position,<sup>2</sup> usually sessile, fluctuant, translucent in varying degree, according to the amount of healthy skin covering it. The contents can be partially reduced into the spinal canal, unless the communication has been shut off (false spina bifida). The surface is not uncommonly ulcerated, and is sometimes marked by nævoid tissue as in the case of meningoceles. The swelling becomes tense on the child crying, and there is often some associated deformity : hydrocephalus, meningocele, talipes, harelip, a peculiar webbed condition of the thighs ('siren'), or other deformity, may coexist, and the subjects of spina bifida are often marasmic and soon die ; in other cases, however, they are fat and hearty. We have seen them too fat, the subjects of a sort of diffuse lipomatous condition such as is sometimes seen in cases of talipes. On the whole, paraplegia, talipes, and hydrocephalus are the three commonest complications.

*Diagnosis.*—The diagnosis of spina bifida can only be doubtful where there is a complete skin covering to the tumour. In such cases congenital sacral, or other tumours—hygroma, teratoma, or lipoma—may be mistaken for spina bifida, and the possibility of the communication with the spinal cord having been shut off must also be borne in mind. The presence of solid masses in a median tumour and the absence of general fluctuation would point to a teratoma or lipoma, while a hygroma is more spongy, usually flatter, and often not exactly median. The presence of nævus stains may raise the question of whether the whole swelling is not nævoid. The fixity of the tumour to the spine, its reducibility, the possibility of feeling the edges

<sup>1</sup> A case of this nature was reported by Pearce Gould in the *Clin. Soc. Trans.*, 1882. Injection cured the patient.

<sup>2</sup> Lateral meningocele has been, however, met with.

of the opening in the laminae, and the co-existence of other deformities may throw light upon a doubtful case. In some instances puncture with a fine needle and examination of the fluid drawn off may be required; a highly albuminous fluid would be inconsistent with spina bifida. Non-congenital tumours cannot, of course, be confounded with spina bifida. The persistence of communication with the meningeal cavities can be determined by variations in size of the swelling. The term 'false spina bifida,' usually limited to cases where the sac no longer communicates with the subarachnoid space, is sometimes applied to any median congenital tumour along the spine.

*Prognosis.*—Nearly all cases of spina bifida left to themselves die, mostly from meningitis after rupture of the sac, or from marasmus; some, however, recover completely, the sac shrinking up and forming a mere puckered cicatrix. Occasionally spontaneous cure takes place *in utero*, and even rupture is not universally fatal. Cure of the spina bifida, it must be remembered, does not imply cure of paralysis or other complications.

*Treatment.*—Though simple repeated tapplings, pressure, ligature, and excision have all occasionally proved successful in the treatment of spina bifida, the Clinical Society's report shows that the safest and most generally applicable plan is that of injection, and probably Morton's fluid<sup>1</sup> is the best for this purpose. Either ligature or excision is almost necessarily fatal where the case is one of meningo-myelocoele, and, as this is the most common form,<sup>2</sup> and it is impossible to be sure in any given case that a simple meningocele is present, the plan should never be adopted.<sup>3</sup>

Treatment by injection is managed as follows:—The child should be held back downwards, and a fairly fine injecting syringe should be charged with Morton's fluid; the needle is then passed in obliquely through the skin and from 15 minims to a dram of the fluid injected. Care must be taken that the puncture is made through skin and not through thin membrane, and that it is well away from the middle line, both to diminish the risk of subsequent leakage and to avoid injury to the cord or nerves. After the injection the child must be kept upon its back, the puncture sealed with collodion, the tumour packed well round with absorbent wool and a flannel bandage applied. It is perhaps better to withdraw some fluid before injecting, and the child must be kept entirely in the supine position, to prevent the fluid from passing into the spinal canal. If the tumour does not shrink and no ill effects follow, the injection should be repeated at intervals of a fortnight.

Injection may fail to produce any effect, may result in immediate death, may be followed by leakage or by hydrocephalus; a single injection may cure, or several may be required. This plan should be employed in all cases unless the child is obviously marasmic or dying from rupture of the

<sup>1</sup> Iodine, gr. x, iodide of potassium, gr. xxx, glycerine, ʒi. The amount of iodine may be increased up to gr. xxx.

<sup>2</sup> Prescott Hewett found only one case out of twenty in which there was no nerve element in the sac.

<sup>3</sup> Mr. Mayo Robson, of Leeds, and others, have had some successful cases, but the facts remain as above stated.

sac, or unless the tumour is quiescent and giving rise to no trouble ; or, of course, if it is shrinking spontaneously, no treatment should be adopted.

Sometimes a spina bifida is ruptured at birth, or sloughs shortly afterwards from pressure ; nothing can be done for such a case except to dust it over with iodoform and protect it carefully from pressure and contamination with the child's discharges. We have not seen a case recover when the sac has been ruptured in this way. Superficial ulceration is less serious and should be managed in the same way. Even if the spina bifida is cured by injection, it is not rare for hydrocephalus to appear later ; hence the mortality direct or indirect, among these cases, is very high.

As already mentioned, in certain cases the sac becomes shut off from the general cavity of the membranes and the cyst remains without com-

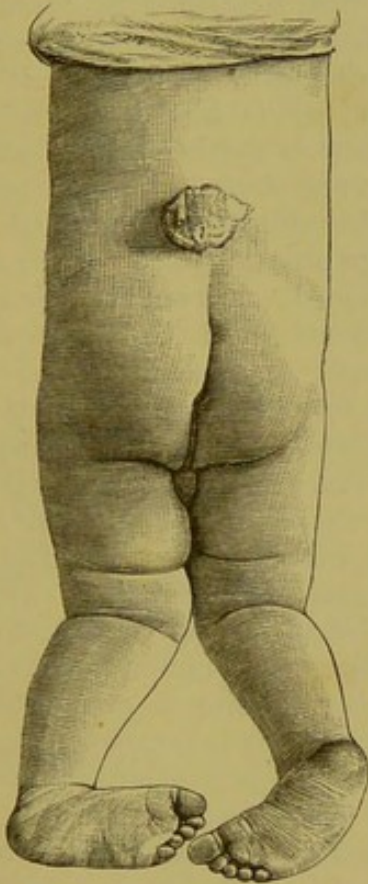


Fig. 71.—A case of cured Spina Bifida (by injection), with co-existing Talipes.

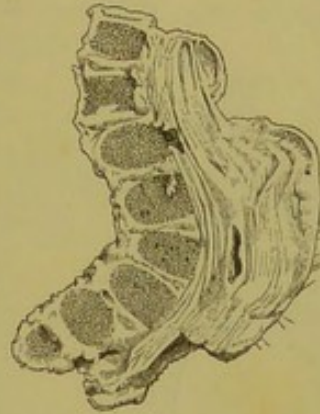


Fig. 72.—Shows a section through a Spina Bifida cured by injection. A small cavity still remains. The child died some time after of scarlet fever.

munication with any important structures : such result can only occur in meningoceles ; the tumour then usually requires no treatment ; it may, however, be tapped and injected or excised, with probable impunity.

These cases and sacral spina bifida are the ones most likely to be successfully treated by excision.

In connection with spina bifida must be mentioned the so-called sacral or coccygeal dimple described by Lawson Tait and others. This is a small dimple or depression in the skin over the lower part of the sacrum or upper part of the coccyx ; it can often be obliterated by traction upon the skin. It probably results from imperfect obliteration of the dorsal furrow, a sort of incomplete spina bifida. Fig. 73 shows a more marked condition of the same thing, which was associated with talipes. It has been pointed out by Dr. Dunlop of Jersey <sup>1</sup> that the dimple may be associated with bending

<sup>1</sup> *Lancet*, May 6, 1882.

back of the coccyx. Another view of the origin of this little depression, which is quite commonly to be found, is that it represents the 'posterior umbilicus,' or 'blastopore.' Congenital sacral fistulæ are a more marked condition

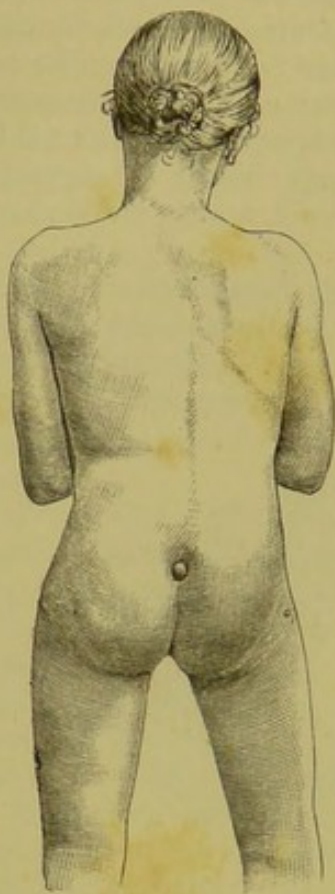


Fig. 73.—Slight sacral Spina Bifida which had undergone spontaneous cure. The girl had also Talipes and was mentally dull. There was an ulcer on the dorsum of the foot.

of the same thing: they may cause trouble by retention of sebaceous secretion and require removal; a tuft of hair or 'caudal appendage' has been found in the neighbourhood of these fistulæ (Terrillon, Gueniot, &c). The case here figured (fig. 73) appears to be an intermediate condition between the ordinary spina bifida and the rare condition described as 'spina bifida occulta,' in which the laminæ of one or more vertebræ are deficient, but there is no hernial protrusion. In 'spina bifida occulta' the site of the deficiency is marked by a local overgrowth of hair, and there appears to be usually a coexisting (resulting) tendency to the development of perforating ulcer of the foot and pes varus. In such cases endarteritis and neuritis of the affected foot have been found, with great hypertrophy of the muscular coat of the arteries. For further details we must refer to Mr. Bland Sutton's paper in the *Lancet* for July 2, 1887; *vide* also Recklinghausen, *Arch. f. Kinderh.*, Bd. viii., H. 6, abstracted in 'Archives of Pædiatrics,' February 1888.

**Meningocele.**—Malformations corresponding to spina bifida are not rarely met with in the head. The most common form is a hernia of the meninges forming a meningocele, the cavity of which is the subarachnoid space. In other instances the protrusion contains brain substance as well—encephalocele, or hydren-

cephalocele, or meningo-encephalocele; the last is, according to Treves, the commonest, and pure meningocele the rarest form.

These herniæ are most common in the occipital region, the protrusion taking place through a median opening corresponding to the space between the centres of ossification of the supra-occipital bone. In other instances it occurs at the root of the nose, through the suture between the frontal and nasal bones, or at one or other angle of the orbit, or at other parts,<sup>1</sup> the pharynx, &c. The general characters of these cysts need no further description here, they are precisely those of a spina bifida, except that the skin over a meningocele is more often normal. The fluid is often partially or wholly reducible, and its reduction may give rise to pressure symptoms; the swelling becomes more tense when the child cries, and is more or less translucent according to its contents, whether fluid or cerebral. The course of

<sup>1</sup> The late Dr. Carrington has recorded a case of interparietal hydrencephalocele, *Clin. Soc. Trans.*, 1881; and the protrusion sometimes takes place through the foramen magnum, Holmes, *St. George's Hospital Reports*, 1866: in this case the cyst was loculated.

these cases is often the same as that of a spina bifida : the swelling grows and ruptures, and the child dies ; sometimes, however, it shrinks after or without rupturing.

*Diagnosis.*—The diagnosis is in most cases easy : the swelling is in the position of a weak spot in the skull ; it is congenital. The opening in the skull can usually be felt, and the other characters mentioned suffice to distinguish it. Sometimes, however, especially when small, it is difficult or impossible to distinguish meningoceles from dermoid cysts, or cysts connected with nævi, especially as nævoid patches are common on the surface of meningoceles. Dermoid cysts sometimes cause perforation of the skull beneath them, and hence are very difficult in such cases to diagnose with certainty ; they are, however, usually more mobile and less affected by pressure than meningoceles. The deformity is often accompanied by idiocy, paralysis, or spastic contractures, and other malformations. In some cases the protrusion may attain enormous bulk, the greater part of the cranial contents being lodged outside the skull. Most museums contain specimens of this sort, which have, however, no practical surgical bearing.

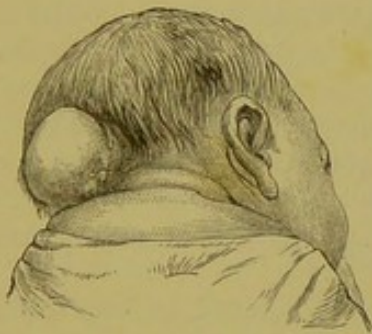


Fig. 74.—Occipital Meningocele.



Fig. 75.—Frontal Meningocele. Spontaneous cure, with resulting deformity of the nose. (Dr. Moritz's case.)

*Treatment.*—Unless the tumour is enlarging, no treatment except protection is wise ; should anything be desirable, repeated tapplings or injection, as in the case of spina bifida, is the best course for meningoceles. Attempts have been made to excise the tumours, but with hardly sufficient success to encourage further trials, though an attempt is quite justifiable in desperate cases. If excision is attempted the skin should be as far as possible dissected back from the membranes, and the latter either tucked into the skull or removed and their edges stitched together. Our colleague, Mr. Hardie, has done some cases which did well for a time, but died later ; in one case even part of the cerebellum was removed without any ill effect till a fortnight afterwards.<sup>1</sup>

Schatz reports favourably of the treatment of occipital meningoceles by puncture and pressure, and records a cure in three cases by constriction of the pedicle with clamps. (*Berlin. Klin. Woch.*, 1885, No. 28, p. 371.)

<sup>1</sup> Mr. Jessop of Leeds records a successful case of excision, but there was no distinct communication with the interior of the skull, hence it has little bearing on the general question. *Brit. Med. Jour.*, December 30, 1882.

Much deformity is sometimes produced by the presence and shrinkage of a meningocele (fig. 75, kindly given us by our friend Dr. Moritz).

Occasionally meningoceles protrude through the roof of the pharynx or nasal cavities : in such cases mistakes as to the nature of the swelling have led to speedily fatal results after operation.<sup>1</sup>

**Spinal Meningitis.**—Spinal meningitis mostly occurs in its acute form in association with cerebral meningitis, and in its chronic form in connection with spinal caries. Acute cerebro-spinal meningitis has already been referred to (p. 364), and the symptoms of spinal meningitis, when super-added to those of cerebral meningitis, discussed. The dissociation of the symptoms of each is not easy, as cerebral disease gives rise to symptoms closely resembling those given by a spinal lesion. Thus basal meningitis, especially when it occurs low down around the pons, medulla and cerebellum, will produce tetanoid rigidity with spasms of the muscles of the back and neck. A tumour of the middle lobe of the cerebellum may produce acute pain referred to the spine and spasm of the erector spinæ (see case p. 380). On the other hand, spinal meningitis, either tubercular, simple, or purulent, may be found post mortem, having given no definite symptoms during life, certainly not those usually associated with spinal meningitis.

The most characteristic symptoms of spinal meningitis are shooting pains down the limbs and round the body, with hyperæsthesia of the skin, rigors, quickened pulse, and fever. There is rigidity about the limbs, retraction of the head, and tenderness about the spine. The diagnosis is often difficult : hysteria, tetany, and the cramps associated with acute intestinal catarrh, as well as cerebral meningitis, may be mistaken for it. Synovitis of the vertebral joints may resemble meningitis of the cord. If the spinal meningitis pass into the chronic stage, paresis of the upper and lower extremities may come on.

Spinal meningitis is necessarily a disease which tends to a fatal termination, but not so certainly as cerebral meningitis ; certainly cases diagnosed as spinal meningitis recover. Cases such as the following are not altogether uncommon. A girl aged 13 years complained six days before admission of pain in the back ; her head was drawn back, she could not sleep for the pain. On admission she was evidently acutely ill : she lay on her side in bed, with her legs drawn up, and there was great retraction of the head ; there was much pain along the spine, aggravated on movement ; pain shooting along the arms was complained of, the pulse was 108, the temperature varied from 98° to 102° Fahr. She was given chloral hydrate, and an ice-bag was applied to the spine ; for 5 or 6 days she continued acutely ill, the temperature varying from 97° to 102° ; there were several rigors on succeeding days : the head was retracted, any forcible movement forward caused pain, there was exaggerated knee-jerk, and ankle-clonus was present. The symptoms gradually subsided about a week after admission, leaving her very weak and emaciated. In six weeks she was discharged well. Such cases may be open to the suspicion that the inflammatory lesion present was in the vertebral joints or spinal muscles rather than in the spinal canal, but on the

<sup>1</sup> For tables as to the frequency of different varieties, &c., *vide* Treves's *Manual of Surgery*, vol. ii.

other hand none of the other joints or muscles were affected, and there is no reason why a spinal meningitis should not occur and get well again.

*Treatment.*—Rest in bed, with perfect quietness, is essential. Ice to the spine is probably the best local application that can be used. The pain must be relieved by small morphia injections, or opium may be given by the mouth. Instead of opium, bromides and chloral may be first tried.

*Paraplegia.*—By far the commonest cause of paraplegia during childhood is compression of the cord from caries of the bones of the vertebræ. Other forms of paraplegia may occur which may be due to myelitis, pressure on the cord by a tumour, a neuritis following diphtheria or other zymotic disease, an acute atrophic paralysis affecting both legs, and some other anomalous paralyses of uncertain origin. There is also the spastic paralysis of cerebral origin and hysterical paraplegia.

*Paraplegia from Pott's disease.*—It is important to bear in mind that the paraplegia which occurs in association with caries of the spine is less often due to direct pressure from the deformity produced by the falling together and bending of the vertebræ than to the inflammatory products which are thrown out around the cord. We may therefore have a paraplegia without the slightest external deformity of the spine, and, moreover, a perfect recovery may ensue in a given case by absorption of the inflammatory products, a result that could hardly be expected if the compression was due to the direct pressure of a bent spine. The inflammatory process which commences in the body of a vertebra is apt to spread, so that lymph or curdy pus is effused outside, the dura mater between the latter and the bone, or inside the dura mater and the cord, is compressed or the cord may also be affected by the inflammatory process. Pressure on, and inflammatory changes in the cord itself may take place in any part of the cord—cervical, dorsal, or lumbar region. Pressure is also exceedingly likely to affect some of the nerves, the latter being surrounded and compressed by inflammatory products as they pass through the dura mater and foramina.

*Symptoms.*—Symptoms of compression of the cord or its branches may come on early or late in the disease. In the majority of cases the early symptoms are those connected with deformity of the spine and perhaps irritation of the sensory nerves, and it is only late in the disease, when the deformity has been well marked for many months, that symptoms of pressure on the cord supervene. In the minority of cases it is the weakness and paresis of legs with exaggerated knee-jerk that suggest the onset of spinal caries. It is important to bear in mind that a paraplegia may exist for many months without any deformity of the spinal column being present, the latter eventually supervening, and explaining the cause of the paraplegia which had remained in doubt. Gowers mentions the case of a patient who had complete paraplegia for 6 months; an experienced surgeon who examined him was unable to detect the existence of spinal caries, and yet a few months later undoubted symptoms of bone disease set in.

The motor paresis usually comes on gradually: the child is weak upon its legs, quickly tiring, and supports itself whenever possible by the help of chairs or tables. When the dorsal cord is compressed the reflexes are exaggerated; if the sole of the foot is tickled as the child lies in bed the foot is sharply withdrawn; if the knee is bent by holding the ankle in the operator's

hand, a sharp tap on the patellar tendon gives rise to an exaggerated 'knee-jerk'; ankle-clonus can usually be readily obtained. Gradually a spastic paraplegia comes on: the child cannot walk, or later cannot stand, without help, and when lying down in bed the knees tend to draw up and the feet to be extended in consequence of the rigidity of the calf muscles. Usually there is no loss of sensation. The sphincters may be affected and bladder troubles may ensue if the lumbar cord becomes involved by descending inflammation. Prior to the onset of motor or cord symptoms, there may be various shooting pains experienced along the intercostal nerves; children with commencing caries of the spine will complain of 'belly-ache' or refer the pain to the pit of the stomach or sternum. Thus pain referred to the umbilicus suggests that there is irritation of the 10th dorsal nerves (8th dorsal vertebra) or pain at the ensiform cartilage to the 6th and 7th nerves (4th and 5th dorsal vertebrae) or over the thorax to the upper dorsal nerves. There may be hyperæsthesia or anæsthesia of the skin.

When the cervical region of the cord suffers the symptoms are apt to be more marked than when the dorsal region is affected; there may be pains shooting down the arms, shoulders, neck, and scalp, according to the position of the lesion; hyperæsthesia and later anæsthesia of the skin. The sensation of pins-and-needles is often complained of. There is gradual loss of power in one or both arms, and wasting of the muscles. The shoulder muscles, serratus, flexors of the elbow and supinators are affected when the 5th and 6th are involved; the extensors of the wrist and fingers when the 6th and 7th; and the extensors of the elbow, flexors of the wrist and fingers, pronators, when the 7th and 8th are involved. A spastic paraplegia may come on as in disease of the dorsal cord.

When the lumbar enlargement is compressed, or its branches, there is paraplegia, the reflexes are not exaggerated, but are abolished, and no knee-jerk can be obtained, that is, if the pressure is severe enough to interfere with the functional activity of the grey matter of this region. The sphincters both of the bladder and rectum are likely to become paralysed if a compression myelitis of the lumbar cord takes place.

The course of the disease varies exceedingly, and depends upon the extent and chronicity of the inflammatory processes in the bones. Recovery from the paralysis may take place after the patient has been bed-ridden and helpless for many months and even years, and where recovery was hardly thought to be possible. On the other hand, the progress may be from bad to worse, there being a gradually extending myelitis, so that the sphincters become paralysed and the patient suffers both from incontinence of urine and fæces. Sensation may become impaired, and the patient at last dies of exhaustion or the results of cystitis, or not infrequently of tuberculosis or lardaceous disease. For treatment see Disease of Spine.

**Myelitis.**—By far the commonest inflammatory lesion of the cord in children is that form which is localised in the grey matter of the anterior horns, which has received the misleading name of 'infantile paralysis.'

An acute transverse myelitis occurs in children as well as in adults, but it is apparently less common. Disseminated or focal myelitis appears sometimes to occur during some of the zymotic diseases, as typhoid fever or measles. Transverse myelitis is rare before the age of 10 years; it seems

mostly to follow exposure to cold or accidents such as occur to school-boys in the football field. In one of our cases, that of a boy of 8 years of age, it followed paddling in the water.

The *symptoms* are much the same as in adults ; the ultimate chance of recovery is, however, greater, as the cord seems to recover itself more readily in early life than in later years. There is usually a feeling of 'pins and needles' in the feet, and sometimes rheumatoid pains followed by loss of muscular power. At first this may be slight, but after a few hours it becomes more marked, and within 24 or 48 hours it has reached its height. There is loss of sensation as well as motion, varying in extent according to the length of cord affected. There is also incontinence of urine and fæces ; if the lesion is above the lumbar enlargement, the sphincters contract normally, but the control exercised by the will is cut off. The commonest part of the cord to be affected is the dorsal region ; often there is some feverishness.

All degrees of motor and sensory paralysis may be present. In severe cases almost all power is lost and the legs fall about in a helpless way, though usually some power of movement is retained in the toes. The reflexes may be completely absent. After a variable period, if the lesion is above the lumbar enlargement, the reflexes return and become excessive ; there is ankle-clonus, the knee-jerk is abnormally vigorous, and a condition of spastic paraplegia comes on. Sensation, if it has been absent, usually returns before recovery of motor power.

The amount of recovery which takes place is variable ; we have seen complete recovery eventually ensue in cases where from the amount of motor and sensory paralysis present in the first instance we had not thought it possible. Many months in bed are necessary to effect this ; the intense spastic paralysis gradually lessens and may eventually disappear.

If the lumbar enlargement is affected, not only is there complete motor paralysis, but the muscles waste rapidly, the rectal sphincter is completely relaxed, and the urine dribbles away from paralysis of the sphincter of the bladder.

If the cervical enlargement is affected, the arms are paralysed, the pupils may be affected, and death is apt to ensue from interference with the nerve supply to the muscles of respiration.

As an instance of a transverse myelitis occurring in the cervical region followed by partial recovery, the following case may be related. A healthy boy when a year old was exposed to cold by lying on the damp grass ; he woke crying during the following night, the parents thinking he had pain in the stomach ; he was not convulsed ; next morning both his arms and legs were limp and useless, he could not move them or sit up ; there was no facial paralysis. Recovery gradually took place, the arms recovering completely, the legs partially. When seen at 2 years of age, the arms had completely recovered, but both legs were weak, so that he could not bear his weight on them, but could crawl, dragging them after him ; sensation seemed impaired in the legs, there was ankle-clonus and exaggerated tendon reflex. The child was perfectly intelligent, and was well nourished, but the muscles of the leg were somewhat flabby. He has since been lost sight of.

As instances of what were probably cases of subacute myelitis, one occurring after measles and another after what was said to be a 'cold,' we may

mention the following case. Gertrude H., aged 4 years, was quite well till she contracted measles in August 1882; when convalescent it was noticed she could not stand by herself. She remained bed-ridden till admitted to the hospital in December. At this time she could not bear the weight of her body without help; the knee-jerk was exaggerated, the front-tap contraction was present, there was no ankle-clonus. She slowly improved, and by February 1883 she could stand alone and walk with help, throwing her legs forward. She finally entirely recovered after some months.

George C., aged 13 years, was quite well till May 1882, when he caught a cold and had a feverish sore throat; after this his legs became weaker, though he could always walk with help. He was admitted September 1882: his legs were both weak, but he could walk, swaying from side to side, bending both knees very much; no loss of sensation, muscles react normally to both continuous and faradic currents; knee-jerk exaggerated, the slightest touch producing a jerk; there was no evidence of any spinal disease. He remained much in the same condition till January 1883, when he went home. He finally completely recovered, after attending as an out-patient for some months.

It is difficult to account for the symptoms in these two cases except on the supposition they suffered from either compression or disseminated myelitis, which eventually got well.

**Landry's Paralysis** or acute ascending paralysis is said to occur occasionally in children; the following case in many respects resembled this form as it occurs in adults:—Edward M'L., aged 11 years, had good health till January 1881, when he became ill from the effects of cold; in a few days he became drowsy and had twitchings in the legs, which were said by a doctor to be due to St. Vitus's dance; the movements ceased and left his legs paralysed; eight days afterwards he lost the use of his arms, and he complained of pain in the head and was delirious for a week; the weakness in the arms improved, but got worse again. When admitted in March 1881 his arms were weak, he moved his legs with difficulty, could just manage to raise them in bed; no loss of sensation; the knee-jerk was almost absent; no ankle-clonus. He gradually improved, so that by April he was able to walk without difficulty, but swayed to and fro. He finally completely recovered. It is possible that this case was in reality one of peripheral neuritis rather than any spinal lesion.

*Treatment.*—Perfect rest in bed is of the greatest importance in the inflammatory stage, all movements and excitation of the spinal cord being avoided as much as possible. The patient should lie on his side or his face in preference to his back, so that the spine should not be the most dependent part. Of local applications the spinal ice-bag is probably the best, though some prefer the application of moist heat with counter-irritation, such as mustard poultices, so as to redden the skin. Probably there are no medicines which can control or moderate the inflammatory lesion. Aconite, ergot, the bromides, have all been used with varying success. Both mercury and iodide of potassium have also been prescribed.

Great care must be taken to prevent bedsores, perfect cleanliness must be observed, and pressure taken off any spot where the skin becomes red. The incontinence of urine and fæces is always a source of difficulty, as the urine and damp bed-linen fret the skin and give rise to sores. The best

position for the patient is on his face, so that the urine as it dribbles away may be received into a bed-pan. Boracic or iodoform cotton-wool may be used to surround the genitals and absorb the discharges. If there is retention of urine, the catheter must be used. No good can be expected from the application of the faradic or galvanic current in the early or inflammatory stages, indeed harm may not improbably be done by exciting and frightening the child. The more at rest the cord is allowed to remain, the better chance is there of absorption of the inflammatory material and recovery of function of nerve elements.

In the chronic stage good may be done by gentle friction applied to the muscles, and by the application of blisters or the actual cautery over the region corresponding to the disease. A change to the sea-side, the patient being wheeled out in the open air in a recumbent position, is likely to expedite recovery by improving the general health.

**Hereditary Ataxic Paraplegia** or **Friedrich's disease** is the name given to a form of ataxia which commences for the most part during early life, and which tends to affect several members of the same family. It most commonly appears during the period of the second dentition or from that on to puberty. The most characteristic feature of the disease is a reeling gait, the patient swaying about both in walking and standing, a condition made more apparent by the closure of the eyes. As in other forms of ataxy, the knee-jerk is quickly lost. Failure of muscular power takes place as the disease progresses. The muscles of the head and neck as well as the arms become affected mostly with tremor, so that when a voluntary movement is attempted irregular jerky movements take place. Nystagmus is a common symptom. The progress of the disease is usually very slow. The lesion in the cord consists of sclerosis of the posterior and lateral columns; the anterior column may also be affected.<sup>1</sup>

**Anterior Polio-myelitis. Acute Atrophic Paralysis. 'Infantile Paralysis.'**—*Etiology.*—The disease which is usually known by the name of 'infantile paralysis' occurs most frequently during early childhood, but, as a form of paralysis exactly similar occurs during the later years of childhood, and also during adult life, the name ought certainly to be abandoned. It most frequently occurs during the first three years of life, at least four-fifths of the cases occurring at this period (Gowers). It is less frequent during the first six months than it is during the last half of the first year and during the second.

Very little is known as to its cause, and, while it occurs both in the strong and weakly, in the majority of cases in our experience it has been met with in typically healthy children, with a good family history, and who could not be said to ail anything; and no reason could be assigned for its onset. It certainly appears to be commoner during the warm quarter of the year than at any other period. It appears occasionally to follow exposure to cold, such as sitting on damp grass, or it may apparently result from an injury. It is said to follow occasionally as a sequela of measles, scarlet fever, typhoid, pneumonia, acute diarrhoea. Dentition has been credited with being a cause, but of this there is no sufficient evidence. Perhaps the most likely exciting cause is over-exertion in children who have only recently learnt to

<sup>1</sup> See Gowers, *Diseases of the Nervous System*, vol. i.; and J. S. Bury, *Brain*, July 1886

use their legs, though this can hardly be a cause in children under a year old. The etiology at present remains uncertain.

*Symptoms.*—The course of the disease may be conveniently divided into stages, and, following Gowers, they may be stated thus :—

(1) An initial stage, during which the paralysis occurs, usually accompanied by fever, and lasting a few hours to a week. (2) A stationary period, which lasts from a week to a month. (3) A period of 'regression,' during which the paralysis disappears in certain of the affected muscles, leaving others still paralysed; this stage usually occupies one to six months. (4) A chronic stage, during which atrophy occurs and deformities and contractures are developed. Some improvement may take place during this stage.

1. The initial stage is usually ushered in with fever, restlessness, convulsions, muscular twitchings, and cerebral disturbance. The severity of the attack differs much in different cases: it has rarely been closely observed, being usually attributed to dentition or gastric disorder, and only when the paresis has supervened has the importance of the attack been recognised. The pyrexia is rarely high, perhaps  $101^{\circ}$  to  $102^{\circ}$ ; there may be muscular twitchings of the face or the affected limb; drowsiness, delirium, or convulsions may be present. The acute attack may be entirely absent, or, what is more likely, ill-defined, so that it is overlooked by the friends, and the only history obtained is that the child was put to bed well, and that in the morning a limb or limbs were found powerless and limp. The paralysis is usually first noticed after the acuteness of the attack is passed, and in infants it is very likely to be overlooked at first, or thought to be due to weakness only. The paralysis reaches its height at once, at any rate in a few days or under a week. It is difficult to say what proportion of cases die in this stage, for probably the nature of the disease would not be recognised, and the attack attributed to 'convulsions,' or the early stage of some acute disease. Nevertheless such cases have been recorded, and lesions found in the grey matter of the spinal cord.

There seems to be no relation between the severity of the initial attack and the extent of the paralysis which follows it, some of the most extensive and severe paralyses being accompanied by hardly any febrile disturbance. It is not certain whether the febrile symptoms are due to the inflammatory lesion taking place in the cord, or the lesion in the cord as well as the fever and convulsions are the result of some unknown process going on in the body.

In some cases there is an acute attack, which passes away, leaving no definite paresis; another similar attack follows, and when this clears up a paralysis is noted. This was the case in the following instance. A boy aged 2 years, a patient of Dr. Sutcliffe's of Stalybridge, was quite well and running about when one day he was taken suddenly ill, crying, vomiting, and feverish; the following evening he was convulsed; he was put to bed, and continued ill for two or three weeks with apparently some brain trouble; this attack left him very weak, but he gradually recovered and was able to run about again. He continued well for 2 months, when the same symptoms returned; he cried with pain, vomiting, and fever followed with convulsions; he remained ill for 14 days, and just as he was being got up and about again it was noticed that his right leg was paralysed. When seen two months

after, there was wasting and paresis of the right buttock, thigh, and dorso-extensors of the foot.

2. After the paralysis has reached its fullest extent, a period during which the paresis of the muscles is stationary ensues, varying from 2 weeks to 6 weeks or 2 months. At this time the affected muscles are limp and powerless, so that the limb or limbs hang quite useless and flail-like. In the more severe cases almost all the muscles in the body appear to be involved: the child cannot sit up, its head falls to one side through paresis of the muscles of the neck, its cry is weak or almost lost through weakness of the diaphragm and intercostals, and its respiration is shallow and rapid, its limbs relaxed and motionless. The paralysis may be confined to one limb or a group of muscles in a limb: thus an arm may hang useless by the side, and if raised above the head falls flail-like by the side. One or both legs may be powerless and may be flexed, extended, or rotated without any resistance from the tonus of the muscles. Hemiplegia is rare. The reflexes both superficial and deep are lost, so that tickling the sole of the foot or percussing the patellar tendon meets with no response. It is difficult to judge if there is any loss of sensation or at least sensory paralysis. In the most severe cases we have noticed sensation is not as acute as usual: a spoon which to a normal skin is unbearably hot can be borne without eliciting any expression of pain on a recently paralysed foot, and in the same way a painfully severe application of faradism will be borne without flinching. It must be borne in mind, however, that the circulation in the skin is interfered with by the lesion in the cord, and, moreover, it is much more difficult to test the sensations of an infant 6 or 8 months old than it is those of an adult. The functions of the sphincters of the bladder and rectum are rarely interfered with.

The irritability of the muscles to the faradic current becomes lessened during the course of the first week or ten days, and usually becomes entirely lost in those muscles where a permanent paralysis has taken place, and thus the careful testing of the muscles may be of importance for prognosis. To the continuous current the muscle irritability is increasing during this period, though it gradually is lessened as the muscles waste, and may disappear during the atrophic period. The quality of the muscle irritability differs from normal, presenting the 'reaction of degeneration'<sup>1</sup> due to the degeneration of the nerves to the affected muscles.

In the majority of cases one limb only is affected, and one group or groups of muscles more affected than others; in some few cases the paresis at first involves not only the limbs, but the diaphragm and intercostals. The most severe case coming under our notice was the following:—A girl of 9 months was quite well and healthy till June 21st; she was able to raise herself up in her cradle, and could support herself with help on her feet. She was suddenly seized with convulsions in which her face and arms twitched; this was followed by a discharge from one ear, and at the same time she was completely prostrated, her voice was hardly audible, she lay in bed perfectly

<sup>1</sup> 'Reaction of degeneration' = faradic irritability lost: voltaic irritability altered in character, so that closure-contraction occurs as readily, or more readily, when the positive pole is placed on the muscles as when the negative pole is so placed; and contractions occur more readily when the circuit is broken than in the normal state.

motionless, except a rolling of the head from side to side. She was admitted to hospital on July 30, when the following notes were made by Dr. Kershaw: 'She is a well-nourished child; lies in bed quite helpless; the lower extremities are completely paralysed; there appears to be some loss of sensation, as only the application of the strongest faradic current appeared to cause pain. She can bear without crying the contact of a hot spoon, too hot to be held in one's own hand; can move right arm at the shoulder and elbow, but not the hand; the left arm is completely paralysed, though she seems to be able to move the fingers slightly. There is paresis of the intercostals, respiration mainly abdominal. No reactions to the strongest faradic current were obtained in the legs, some response could be obtained in the flexors of the forearm. She died of pneumonia on August 7, 47 days after seizure.'

3. The *stage of 'regression'* or improvement now commences, the improvement continuing for several months: many muscles being completely restored, while others become more and more flabby and atrophic. In rare instances all the paralytic muscles may recover. The child's health at this time is usually good, it is as bright and cheerful as usual, and there is apparently nothing amiss with it except its paralysis. The muscles, which are gaining in power, respond more readily to the interrupted current than at first, while the atrophic muscles fail entirely to react.

4. After some months improvement ceases; or, at least, any improvement which takes place six months after the onset is usually very slight indeed. The atrophy mostly goes on, and certain contractures, especially affecting the leg below the knee, leading to deformities, are apt to take place. At this period it is possible to make a forecast of the amount of paralysis which is likely to be permanent, and take stock, as it were, of the real damage which has taken place, which is probably much less than at first appeared likely. This permanent paralysis may affect a whole limb, though it rarely does this, some groups being entirely powerless, others only slightly weakened or not affected at all.

Sometimes the groups affected are associated together in their actions, as when the *upper arm type* of Erb is present, the deltoid, spinati, biceps, and supinators being affected, while the muscles of the forearm, excepting the supinators, escape, the lesion in the cord being situated on a level with the 5th and 6th cervical roots. It is important to remember that the groups have no relation to their peripheral nerve supply, such as would be present if the paralysis was extra-spinal. Very often the muscles paralysed have no relation to one another, being picked out as it were at random.

In the *lower limb* the muscles below the knee usually suffer more complete paralysis than those of the thigh or buttock. The peronei usually suffer most, the result being that the heel is drawn up and the foot turned inwards (*talipes equino-varus*) by the unbalanced action of the gastrocnemius; as time goes on the contracted condition of the calf muscles, aided by the shortening of the leg, becomes permanent in consequence of a fibroid degeneration taking place, and the foot can no longer be dorso-flexed. In the same way *talipes valgus* may be produced by paralysis of the *tibialis anticus*, more rarely *talipes calcaneus* by the paralysis of the gastrocnemius. Both legs below the knee may be paralysed, both extensors and flexors; and

the patient cannot stand, but progresses by crawling on hands and knees, dragging his wasted legs after him.

Of the thigh muscles, the rectus, vasti, and adductors are more often parietic than the hamstrings, and thus flexion of the knee may result and become permanent. The gluteal muscles and rotators of the hip are often weak, so that the child in walking gives way at the hip.

In the *upper extremity* the muscles of the shoulder suffer most frequently, the deltoid being especially prone to attack; usually the supra- and infraspinati, biceps, triceps, and supinators are associated together: in such cases the shoulder droops from the weight of the arm, and the head of the humerus may slip readily out of its socket. The serratus magnus, pectoral muscles, and intercostals may also be affected. The forearm muscles, both extensors and flexors, together or singly, may be affected—less often those of the hand. Contractures are less often present in the arms than in the legs.

The muscles of the spine, sacro-lumbalis &c., those of the neck and diaphragm, are rarely permanently paralysed. Lordosis is present if the sacro-lumbalis is weakened. Lateral curvature may be present.

The paralysed muscles are always atrophied, though at times much subcutaneous fat may give a delusive appearance of solidity to the muscle. In the most wasted muscles there is a complete loss of faradic irritability: there is usually more or less present in those only partially paralysed. The irritability to the continuous current gradually disappears as atrophy progresses, and in the wasted muscles becomes completely lost.

*Arrest of development* of the limbs which are paralysed also takes place; the bones appear to grow more slowly on the paralysed side. Other bones such as the ribs and pelvis may be affected. The *joints* often become more movable from relaxation and stretching of the ligaments, as well as from the loss of support afforded by the normal muscles; the articular ends may become deformed. The circulation through the skin of the paralysed limbs becomes slow, the surface has a blue or purplish appearance and feels cold to the touch. Chilblains and ulcers are apt to form on the paralysed limbs and be slow to heal. The bones themselves frequently degenerate; in some cases little true bone may remain, fat taking the place of the osseous tissue. Injuries, operative or accidental, of such limbs are slow in healing; on the other hand, acute inflammations rarely attack the tissues.

*Pathology.*—There is an acute inflammation, the greatest stress of which falls on the anterior cornua of the grey matter in the cervical and lumbar enlargements. In severe cases the grey matter of the dorsal cord is also affected. There is strong reason to believe that, in severe cases at least, the inflammation is not confined to the anterior cornua, but involves more or less the whole cord; but the principal damage caused by the effusion of blood and inflammatory products occurs in the most vascular part of the cord, and this is in the anterior cornua where the large nerve cells are situated. During the acute stage of the attack, when there is perhaps a high temperature and convulsions, there is probably an inflammatory engorgement of the whole cord, possibly of the whole of the nervous centres: then an exudation of inflammatory material takes place which leads to both temporary and also permanent damage to the motor cells in the anterior cornua of the cervical or

lumbar enlargements. During the next few months an absorption of inflammatory material and perhaps also repair of damage by the formation of new nerve-fibres or cells goes on, while a certain amount of muscular power which has been lost is regained. Finally a sort of cicatrisation or shrinking takes place, leaving a permanent paralysis of the muscles supplied by the nerve centre which has been destroyed.

Very few observations have been made on the cords of those dying during the acute attack or at the onset of the paralysis. In Drummond's case,<sup>1</sup> that of a child of 5 years who died in a few hours, the vessels supplying the anterior horns were distended with blood, the microscope showing minute extravasations of blood and changes in the nerve elements. A case recorded by Charlewood Turner, dying six weeks after the attack, showed softening of the anterior horns, spots where the grey matter had undergone complete degeneration, and an exudation of leucocytes had taken place from the vessels. In our own case, p. 444, similar changes were visible in the grey matter of alike lumbar, cervical, and dorsal portions of the cord, and changes such as effusion of leucocytes from vessels were noted in the white matter, as well as the grey. Moreover, even in the medulla it was evident that an engorgement of the vessels had taken place.

Degenerative changes take place in the nerves which are connected with the damaged centres in the cord; the muscles also waste: their connective tissue becomes hypertrophied, so that in extreme cases very few muscular fibres are left. The muscles which antagonise the paralysed muscles mostly also waste, their muscular fibres becoming replaced by connective tissue.

*Diagnosis.*—The diagnosis during the acute attack is always difficult, mostly impossible; the fever, delirium, and convulsions sometimes present naturally suggest some cerebral disease such as meningitis or the onset of scarlet fever or pneumonia. It is only when paralytic symptoms present themselves that the diagnosis is made; even then the paralysis may be overlooked, especially in young children, it being supposed that the child is simply weak as the result of the acute attack. When once the paralysis has set in, diagnosis is easy, though when paraplegia is present the distinction between transverse myelitis of the lumbar region and polio-myelitis may not be easy. In transverse myelitis there will be certainly loss of sensation; this is said not to occur in cornual myelitis, though in the case recorded (p. 444) there was undoubted slight loss of sensation. In transverse myelitis of the dorsal region, its commonest seat, there will be no loss of faradic irritability, and after a few days or a week the reflexes will return and become excessive, and ankle-clonus can usually be obtained.

In cerebral paralysis there is no loss of faradic irritability, and no muscular wasting takes place.

*Treatment.*—The treatment of anterior polio-myelitis in the early stages is that of an acute inflammatory lesion of the cord. The child must be kept as quiet as possible in bed, given a milk diet, and good may possibly be done by applying mustard poultices to the spine. If there is fever, aconite and bromide of potassium may be given. When the acute stage has passed away, and the child is left in a prostrate condition, the greatest care

<sup>1</sup> *Brain*, April 1885.

must be taken to keep the child at rest as much as possible, all excitement of every kind being avoided. It must be borne in mind that, in patients dying, many weeks or even two or three months after the onset evidences of the inflammatory lesion may still be found in the cord, and during this period absorption of inflammatory material is going on, and the object to be aimed at in treatment is to secure the recovery of as much of the damaged cord as possible. A variable amount of nerve tissue has been certainly irretrievably damaged, but some of the damage done is recoverable, and, the more the general health is maintained and the child kept at rest, the more is it likely that recovery will take place.

It may be doubted if there are any medicines which have any direct influence over the nutrition of the cord or directly influence any morbid processes going on. Perhaps the most likely drugs to be of service are sedatives such as belladonna, and bromides in combination with iron or quinine.

The question of how soon should massage or electrical treatment be begun is an important one, for, on the one hand, the paralysed muscles are quickly wasting on account of their nerve centres being damaged, but on the other hand the disturbance of the child, the fright and excitement of the daily application of the battery, are not unlikely to do harm. The application of the battery current is hardly likely to modify or favourably influence the lesion in the cord, but it may help to maintain the nutrition of the muscles while recovery is taking place in the cord. On the whole we are inclined to believe that gentle rubbing or massage of the paralysed limb or limbs may be practised from the first, and voltaic currents may be used within a month or six weeks. It is wise to begin with a very weak current, at first using large wetted sponges as electrodes, and frequently interrupting the current, which after a few applications should be just strong enough to secure a contraction. The application should be made daily for many months, especial care being taken to select the paralysed muscles in the limb.

An important part of the treatment is to encourage the patient to put forth as much voluntary power as possible, and he should constantly try and use the weakened limb. We believe that systematic attempts to use the paretic muscles, combined with shampooing of the limb, are more likely to promote recovery than any electrical applications. The circulation in the paralysed limb is certain to be slow and defective: friction of the skin, with kneading of the muscles, is certainly beneficial; while a well-selected series of movements attempted on the part of the patient, or carried out by an attendant, assists the return of power in the muscles. These measures must in most cases be persevered in for many months, if not years, in the hope of improvement.

The paralysed limbs must be warmly clad and carefully protected from cold.

Much may be done in the chronic stage by means of mechanical devices, such as the application of artificial muscles and splints to correct deformities and support the limb. Division of the tendo Achillis, plantar fascia, and other resisting structures is often required.

**Tetany.**—The term 'tetany' is applied to a form of tonic spasm mostly affecting the extremities, which, like spasm of the glottis, consists in a reflex

contraction of a group of muscles, the result of irritation in some distant part. Tetany may affect both children and adults, though it is commoner before the age of 3 years than after this period. It is frequently associated with rickets, in this respect resembling convulsions and laryngeal spasm; it rarely makes its appearance in healthy children, but in those who have suffered from some exhausting disease, especially some affection of the alimentary canal, as diarrhœa or acute enteritis; prolapse of the rectum may be an exciting cause. Difficult dentition appears to be an occasional cause. One of the most severe cases we have seen was associated with a fatal attack of acute enteritis. It has been observed in rare instances as an early symptom in pneumonia and other diseases, in this respect resembling convulsions. It has sometimes prevailed epidemically among school-girls.

*Symptoms and course.*—The attacks consist in cramps of the muscles of the extremities, more especially of the forearms and legs. There is no loss of consciousness, or usually no spasm of the facial muscles, though there is mostly an expression of pain on the face when the cramps come on. In the severer cases the arm is adducted at the shoulder and fixed to the side, the elbow is flexed at right angles, the forearm pronated, the wrists flexed, the thumb turned in, while the fingers are in the position of interosseous spasm, or the hands may be clenched over the thumb. If the former, the metacarpophalangeal joints are flexed, while the other phalanges are extended.

In the lower extremities the foot is in the position of talipes equinus or equino-varus, the plantar surfaces being hollowed out and the toes bent. The knees may be semi-flexed and the thighs adducted. The muscles of the calf are hard and rigid, feeling as if gathered up into a ball.

The contractions are evidently painful: the infants scream when they are handled or interfered with; the spasms may intermit, but usually last a considerable time. In rare cases, notably those recorded by Cheadle, the muscles of the face are thrown into spasm; in other cases the muscles of the jaw, abdomen, neck, and back have been affected. More commonly the spasm is confined to the hands and feet, or the hands only may be affected. The spasm lasts from a few minutes to many hours or even days, then disappearing, and perhaps appearing again. It never threatens life *per se*, as it only affects the muscles of external relation, though the child may die from the effects of the gastro-enteritis, of which the muscle-cramps are only symptoms. The only case which terminated fatally, which we have seen, was the case, referred to above, of a boy aged 6 years, who died in a few days from the effects of a gastro-enteritis; the principal symptoms were constant vomiting, cramps in the stomach, and tetany of both upper and lower extremities. The post mortem showed the brain and cord to be normal to the naked eye; the mucous membranes of the stomach and intestines were injected, and evidently in a state of acute catarrh. In another case, somewhat similar, Hadden could find no changes in the cord.

Tetany is apt to return from time to time after a considerable interval; this may be noticed in cases received into hospital: these mostly quickly get well and go home, but in another week or two are as bad as ever.

*Diagnosis.*—Tetany may be mistaken for cerebro-spinal meningitis, but it can only be thus mistaken when the constitutional symptoms accompanying the tetany are severe. In tetany there is an absence of cerebral symptoms,

as well as vomiting, fever, and sore throat. In tetanus the spasm of the masseters is an early symptom; it is absent in tetany, or comes on late in the attack. The position of the fingers is different in the two diseases. In girls or older boys hysterical contraction might simulate tetany, but the former affects one limb, or an arm and a leg only, while the latter is always bilateral.

*Treatment.*—The treatment must be directed in the first place to the exciting cause. A dose of calomel or grey powder should be given if there is any gastro-intestinal disturbance or undigested food lodging in the intestinal tract, and the greatest care taken to give only the blandest food. Warm baths may be given to relieve the spasm, and hot laudanum fomentations applied to the hands and feet. Bromide of potassium is likely to relieve the symptoms if given in full doses. Chloral, belladonna, digitalis, and Calabar-bean have all been used with benefit. Cheadle found the  $\frac{1}{36}$ th to  $\frac{1}{3}$ rd grain dose of Calabar-bean of use in one case.

**Nystagmus.**—Nystagmus is common during both infancy and childhood and accompanies very different conditions. It usually consists in short, rapid oscillations of the eyeballs in a lateral direction, the head sometimes moving also. In some cases the ocular movements are vertical instead of lateral. It may be present in congenital cataract, tumours of the brain, hydrocephalus and hereditary ataxia; but it is also present in children who are not suffering from any organic disease. It may be present in some forms of clonic spasm of the neck.

**Head-nodding** and **Head-shaking**, going on constantly as they sometimes do in infants and young children, are the result of a clonic reflex spasm of the sterno-mastoids, either both acting together and making a nodding movement, as in expressing assent, or acting alternately and shaking the head as if expressing dissent. The movements may be constant or occur less frequently, as ten or twelve times an hour. Nystagmus may be present. These curious spasmodic affections appear to be allied to laryngismus. Dr. Gee records a case whose brother died of laryngismus, and in one case of 'head-nodding,' mentioned by A. Baginsky, the child suffered later from convulsions and laryngismus. Head-shaking in older children Dr. Gee connects with epilepsy. The prognosis is good; like laryngismus, these affections appear to be due to some reflex irritation in the alimentary canal or to dentition.

'**Head-banging**' in children has been described by Dr. S. Gee. It consists in a peculiar habit, to which some children are liable, of turning over on to their face at night and banging their heads into the pillow. Dr. Gee records three cases: two of these were two-and-a-half years of age, and one was five years. One child used constantly, nearly all night, to bang his forehead into his pillow. No cause was found to account for this strange habit. It appeared very intractable, but one child much improved whilst living in the country.

**Pseudo-hypertrophic Paralysis.**—Very little is known about the etiology of this peculiar disease. It is apt to run in families, and, strange to say, while it affects boys far more frequently than girls, in some families it affects the boys only, and in others it affects the girls. In some cases there is a family history of the disease, and it appears it may be transmitted through the female side without the women themselves being affected

(Gowers). In one of our own cases the patient's brother was an epileptic, but it is rarely that any family tendency to nervous disease exists.

*Symptoms.*—In the majority of cases symptoms first make their appearance during the second or third year, the child being late in learning to walk, the parents attributing this to backwardness or weakness. In some cases the symptoms of weakness are noted after the child has been walking some time, perhaps as late as the sixth or seventh year. The early symptoms are those of weakness in the legs. As Gowers well puts it, 'these children usually walk late, often also walk clumsily, fall with ease, and rise with difficulty.' If placed upon the ground they either cannot get up without help, or, what is more likely in the early stages, they are obliged to use their hands in rising, pushing themselves off the ground and catching hold of chairs or table-legs to help themselves up. They walk clumsily, with a swaying gait, are quickly tired, and have to be wheeled about in a perambulator long after children of a corresponding age are running about and going walks.

In other cases the friends pay little heed to the backwardness in walking, but are struck with the size of the calves or perhaps apparent stoutness of the child. At 4 or 5 years of age, often earlier, the muscular hypertrophy is conspicuous. The muscles of the calf are strikingly enlarged, firm, and hard; as are usually also the glutei and lumbar muscles—less often the hamstrings, extensors of the knee, and dorso-flexors of the foot. Of the other muscles, the infra-spinatus is, next to the calf, the most frequently enlarged, and, as Gowers points out, this enlargement of the infra-spinatus may be of diagnostic importance. The deltoid and supra-spinatus are often enlarged, the latissimus is mostly wasted, and the rule is that the other muscles of the upper extremity are wasted rather than hypertrophied. In rare cases the masseters and muscles of the tongue are enlarged.

The muscles, whether enlarged or wasted, are weak, and it is this weakness of certain muscles which gives rise to the characteristic

movements of the child. The waddling gait is the result of weakness of the gluteus medius and extensors of the hip generally. The difficulty in rising from the floor is due to the paresis of the extensors of the knees in the

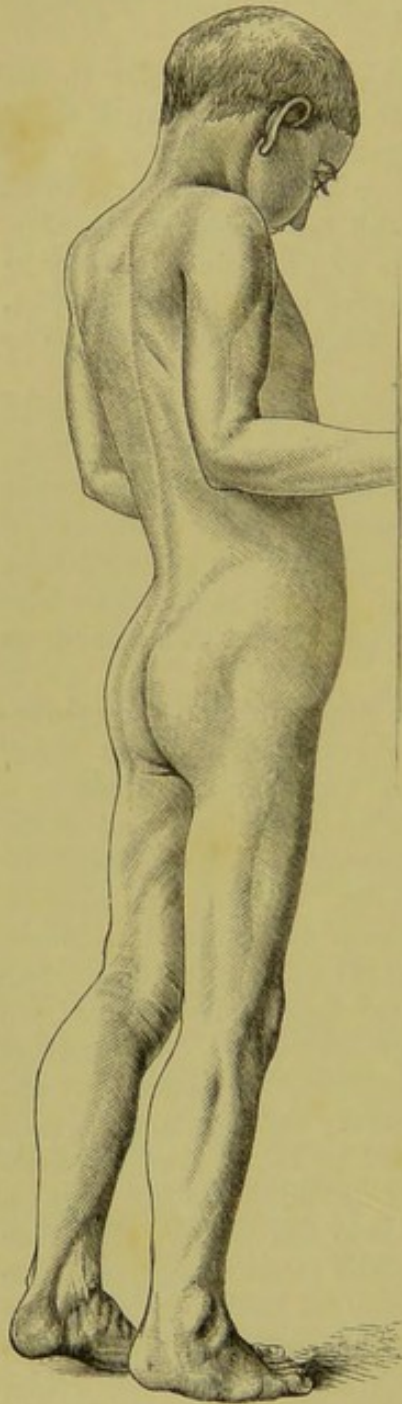


Fig. 76.—A case of Pseudo-hypertrophic Paralysis in a boy of 10 years; showing enlarged calves and slight talipes equinus.

first part of the act, and the extensors of the hips in the second, the patient assisting the extension of the hips by placing his hands on his knees, and 'climbing up himself' by grasping his thighs alternately with his hands.

Later in the disease the enlarged muscles contract, the earliest to shorten being the calf muscles, so that a talipes equinus is produced. Later on, the knee and elbow may become flexed.

The weakness of the extensors of the hip produces a certain amount of lordosis or curvature of the spine with the concavity backwards, the patient assuming this position in order to maintain his balance. (See figs. 76 and 77.)

In the last stages the patient becomes entirely bedridden and helpless, partly on account of the paresis of the muscles, partly also in consequence of the muscular contractions producing talipes equinus. In this stage the enlarged muscles mostly waste, and consequently lessen in size. The electric irritability of the muscles is unaffected both to the continuous and interrupted current at first; later, as the muscular fibre wastes, it gradually disappears. The knee-reflex, at first normal, gradually disappears for a similar reason. In children suffering from this disease the mind is usually weak.

The progress of the disease is slow, extending over many years, the patient possibly being helpless and bedridden, having almost lost the use of his legs. He is even unable to sit up on account of the wasting of the spinal muscles, but is usually able to use his hands to the last. Death is apt to take place from bronchitis; this was the case in one of our own cases, who lived to the age of 12 years, the disease having existed at least 8 years. In the majority of cases where the disease begins early death takes place soon after puberty, at any rate among the hospital patient class; under the most favourable circumstances, where great care is taken of the patient, life may be prolonged to a greater age. The course of the disease appears to be slower in girls than boys.

*Diagnosis.*—This is most difficult in young children in the early stages, and in the absence of typical enlargement of the calf muscles and infra-spinati. A fat, yet weakly, child of three or four years of age, who is late in walking and more or less rickety, may somewhat simulate a case of

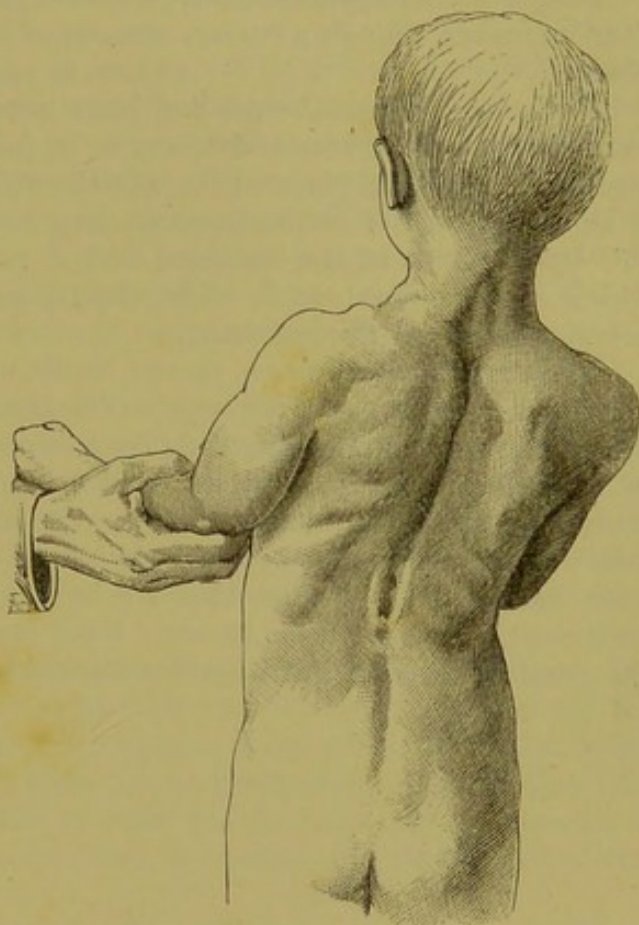


Fig. 77.—Same case as fig. 76; showing Hypertrophied Deltoid and Infra-spinati.

pseudo-hypertrophic paralysis in its gait, and in the difficulty of getting up. Usually there is sufficient enlargement and hardness about the gastrocnemii to make the diagnosis tolerably clear, especially if there is corresponding enlargement of the infra-spinatus and wasting of the latissimus dorsi. In the absence of muscular enlargement, especially if there is wasting, the disease may be confounded with idiopathic muscular atrophy; but the latter disease is rare before puberty, is apt to affect the face and hands, and to avoid the calf muscles. A fragment of muscle may be obtained, and muscular atrophy can be excluded, if there is an excess of fibroid and fatty tissue present.

*Prognosis.*—The cases slowly, but surely, get worse; the weakness year by year increases, though a certain amount of temporary improvement may take place.

*Pathology.*—The disease has been conclusively proved by the careful examinations of Gowers and others to be primarily a disease of the muscles, and if changes take place in the spinal cord they are only secondary. There is an overgrowth of connective and fatty tissue; it is the latter which forms the enlargement of the muscles, and it is the absence of muscular fibres which renders them weak. The shortening which takes place is due to the contraction of the fibrous tissue.

*Treatment.*—Medicines, except those which are likely to improve the general health, are of little use. The treatment which has proved itself of the greatest use in checking the progress of the muscular wasting is exercise of the affected muscles by well-arranged movements, which the patient is encouraged to perform, and friction, with passive movements, so as to prevent shortening of the muscles. We have certainly seen cases which have been admitted to hospital improve in no inconsiderable degree under this treatment. It is needless to say it must be systematic, and carried out with the greatest patience if it is to be successful.

## CHAPTER XXVI.

## DISEASES OF THE GENITO-URINARY SYSTEM.

**Congenital anomalies of the Kidneys.**—The principal malformations of the kidneys found *post mortem* are (1) Absence, or only a trace, of one kidney, with hypertrophy of the other. (2) 'Horse-shoe' kidney, in which the two kidneys are united by a bridge of kidney tissue, giving the organ a horse-shoe shape. The kidney is placed with its convexity downwards, the ureters passing down behind the bridge. (3) The kidneys are frequently found *lobulated*, the surface being deeply fissured, dividing them into 'lobules,' as in the foetal state. (4) The kidneys may be *displaced* or more or less *movable*.

These abnormalities, though of extreme importance in reference to operations on the kidney and the diagnosis of abdominal tumours, need not be further referred to here. Obliteration of one ureter, partial or complete, may give rise to hydronephrosis and require operation, as in a case reported by Tuckwell and Symonds of Oxford.<sup>1</sup> Incontinence of urine from an abnormal opening of the ureter just in front of the meatus urinarius has also been met with.<sup>2</sup>

**Addison's Disease. Tuberculosis of the Adrenals.**—Addison's disease occurs occasionally in boys after puberty; it is very rare before this epoch. Dr. Pye Smith has recorded a case in a boy of 14 years, and Monti has collected 11 cases in children from 3 to 14 years of age. Tubercles, both caseous and grey, are frequently present in the supra-renal capsules of children dying from general tuberculosis, without any symptoms occurring during life.

**Hæmaturia.**—Blood is present in the urine in a variety of conditions, both in general diseases as well as in local, and a difficulty may not infrequently be experienced in determining the source from which the bleeding takes place.

Hæmaturia or hæmoglobinuria occurs at times in infants a few days or weeks old, who are also jaundiced; epidemics of such cases have been described by Winckel and Bigelow as occurring in lying-in hospitals (p. 25). Two fatal cases, in which hæmoglobinuria was present in infants 5 months and 8 months old respectively, have been described by Hirschsprung.<sup>3</sup> In both cases the symptoms supervened suddenly: there was cyanosis, dark albuminous urine and feverishness; in one of the cases there was dyspnœa

<sup>1</sup> *Lancet*, vol. ii., 1882, p. 141.

<sup>2</sup> Madden, *American Obstet. Jour.*, July 1884.

<sup>3</sup> Congrès international périodique des Sciences Médicales, 1884: section de Pédiatrie.

(uræmic) and tetany of the hands and feet. The post-mortem showed that all the organs were of a dirty-brown colour, and the blood in the body had undergone a remarkable change. Similar cases have occurred from poisonous doses of chlorate of potash, but neither of these cases had been taking this salt.

Hæmaturia occurs occasionally in wasted infants and young children from thrombosis of one of the renal veins, a consequent hæmorrhagic infiltration of the kidney taking place.

A commoner cause of hæmaturia in infants and young children occurs in connection with an impoverished condition of blood—in 'infantile scurvy' or acute rickets. We have several times seen cases in which there has been hæmaturia for some time, a considerable amount of blood being lost apparently by a passive oozing of blood from the kidneys. These cases are often associated with purpura. Hæmaturia sometimes occurs in infants under a year old, which lasts for a few weeks and then disappears without any definite cause being found out except that they are somewhat anæmic and inclined to rickets. We have seen hæmaturia in older children associated with anæmia the result of 'scurvy' or tuberculosis.

Hæmaturia may be the first symptom of **hæmophilia**, and in any case where the diagnosis is doubtful the family history should be inquired into for similar cases.

Hæmaturia, often associated with purpura, may occur in acute cases of variola, diphtheria, or typhus, resulting from the rapid blood change which takes place.

Hæmaturia may be present in acute nephritis; in this case the urine is usually of a smoky tint, more the colour of porter, but in some cases the colour may be bright-red from the amount of blood which it contains. We have seen hæmorrhagic nephritis following scarlet fever, diphtheria, and pneumonia. A microscopical examination of the deposit which falls to the bottom of the glass after the urine has stood for a while will show blood and epithelial casts in cases of nephritis.

Blood in the urine also occurs in cases of renal or vesical calculus, more rarely in tubercular kidney, sarcoma of the kidney, and vascular growths in the urethra or bladder.

Poisoning by chlorate of potash, cantharides, or turpentine as a cause of hæmaturia must not be forgotten.

*Treatment.*—The treatment necessarily depends upon the cause, and the history of the case, and other symptoms apart from hæmaturia, must be carefully considered. It is important to exclude stone in the bladder as the cause of hæmaturia, and in all cases where the cause of the blood in the urine is doubtful it is wise to explore the bladder with a sound. Hæmaturia may be the only symptom of a stone present. In hæmaturia depending upon an impoverished condition of blood the most important part of the treatment consists in improving the condition of the general health. Meat juice, orange or lemon juice, with dialysed iron or the perchloride, may be given.

Styptics may also be given, though we have frequently been disappointed with their action. Of these, ex. hamamelis liq. (U.S.P.), in 5–15 minim doses, may be given every four hours, and continued for some days. Gallic acid,  $\frac{1}{2}$ –2 grains, with aromatic sulphuric acid, is sometimes efficacious where

hamamelis fails. Spirits of turpentine,  $\frac{1}{2}$ –3 minims, in mucilage or liquid extract of ergot, 2–10 minims, may be tried.

The treatment of other forms of hæmaturia must depend upon the cause.

**Intermittent Hæmoglobinuria** occurs in children; we have seen several cases of this curious condition in children, but not in infants.

**Pyuria**, or pus in the urine, occurs in infants and children in rare cases, accompanying or following a febrile condition (S. J. Gee). It is difficult to say the exact source of the pus in these cases: possibly it may be due to a temporary pyelitis or cystitis. Pus in the urine as a more chronic condition usually depends upon chronic cystitis, either idiopathic, tubercular, or due to the presence of a stone in the bladder. The source of the pus may be the kidney or its pelvis, there being a simple or tubercular pyelitis, or a stone lodged in this situation. The pus may come from the vagina, but this is not common.

**Lithæmia.**—Infants and children frequently pass uric acid in their urine, the uric acid being seen as a sandy deposit in the chamber vessel. The cause of this is mostly uncertain. Large quantities are often passed during convalescence from scarlet fever, not infrequently in cases followed by nephritis.

We have sometimes seen cases in which uric acid has been passed in large quantities; in one case coming under our notice the urine would be clear for a while, and then, especially after rough movements, as in romping or riding a pony, urine thick with uric acid crystals would be passed. Uric acid is sometimes passed more copiously with the urine voided with a stool, giving at first the impression that the uric acid has come from the bowel, when apparently the straining at stool has caused the dislodgment of uric acid deposited in the bladder or pelvis of the kidney. In lithæmia a restricted diet should be given, and citrate of potash and lithia may be prescribed.

**Tumours of the Kidneys.**—Swellings which occur in the region of one of the kidneys may be due to one of the following causes:

(1) New growth. (2) Tubercular abscess in the kidney. (3) Hydro-nephrosis. (4) Perinephritic abscess.

(1) **Renal new Growths.**—In the majority of cases a new growth involving a kidney is a round-celled sarcoma which begins outside the kidney, gradually displacing and compressing the kidney itself. It is difficult to say exactly where these growths begin: presumably in lymphatic tissue. In the minority of cases the new growth appears to begin in the kidney itself—at least no trace of the kidney can be found post mortem, but traces of kidney structure may be found scattered through the tumour on microscopical examination.

In some cases the tumour is a myo-sarcoma, or in other words it is a round-celled sarcoma with a variable quantity of striated muscular tissue and spindle-shaped cells. In rare cases the growth consists of alveoli lined with columnar epithelium, similar in structure to the cylindrical epithelial carcinomas found in the large intestine. It is difficult to say where such tumours begin when occurring primarily in the kidney: possibly in the remains of the Wolffian body.

Renal sarcomata are usually soft in consistence, resembling brain sub-

stance, and frequently contain masses of blood clot and altered blood in consequence of hæmorrhages which take place into their substance. They often attain to a great size, weighing many pounds, and by their enlargement displace the other organs of the abdominal cavity. The liver or spleen is pushed upwards, the small intestines are pushed on one side or posteriorly; the large intestine, where it crosses the tumour, is compressed against the abdominal wall. The tumour may set up a certain amount of chronic peritonitis and contract adhesions to the intestines and other visera.

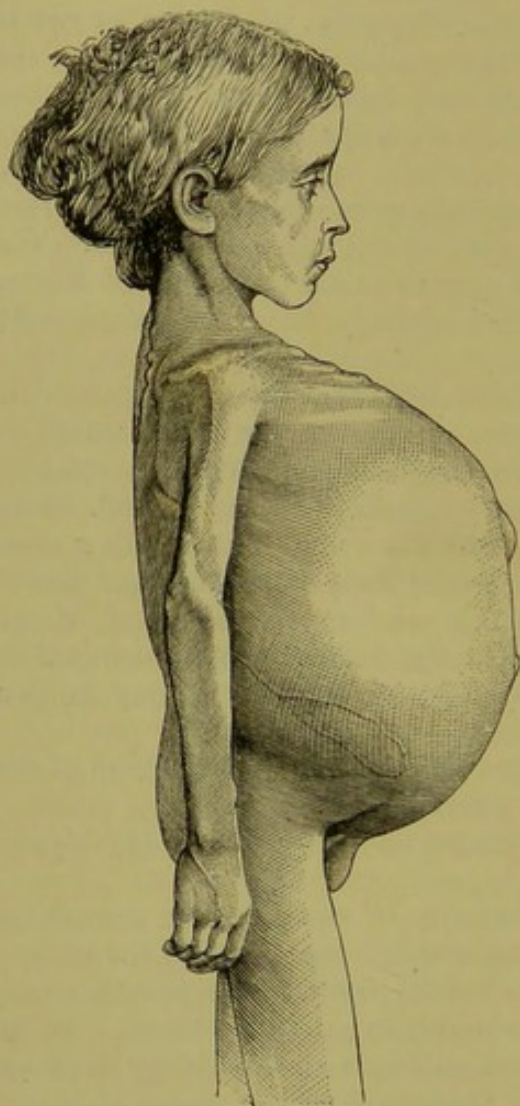


Fig. 78.—Cylinder Epithelioma of Kidney in a girl of 9 years. Dr. Hutton's case.

Renal sarcomata occur most commonly in children under six years; of 50 cases collected by Seibert, 40 occurred during the first five years of life, 12 being in infants under a year old. In a case recorded by A. Jacobi a sarcoma was present in the kidney of a fœtus born dead, and other cases (Sir William Roberts and Lloyd Roberts) have been recorded in which the tumours were present at birth.

*Symptoms and course.*—In the majority of cases enlargement of the abdomen due to the new growth encroaching on the other abdominal organs is the first symptom to call the attention of the friends to the case. In the minority of cases (one-fifth, Seibert) hæmaturia is the first symptom occurring at a variable period before the discovery of a tumour. The swelling is first noted occupying the right or left lumbar region, between the ribs and the crest of the ilium; it has a rounded outline, which can be traced downwards, but not into the pelvis, and upwards behind the liver or spleen. By palpation it can be separated from the liver or spleen. It moves less freely with respiratory movements than an hepatic or splenic tumour does. Percussion shows that the

large bowel lies across superficially to it, but if the tumour is large the colon may be compressed and no tympanitic note will then be detected. The swelling has a soft semi-fluctuating feel, and on exploration with a subcutaneous syringe pure blood is withdrawn. During the early stages the patient appears perfectly well, is well nourished, complains of no pain; there is no tenderness on handling the tumour. Exceptionally pain is complained of, in some cases it is acute and due to accompanying peritonitis. In

Seibert's collection of 50 cases hæmaturia was present in 19 at some time or other during the course. Vomiting is an occasional symptom. As the tumour increases in size it distends the abdominal walls, the skin becomes smooth and shiny, and is marked with large dilated veins. The tumour pushes up the diaphragm, passes perhaps beyond the middle line in front, and extends backward to the spine behind, sometimes, as in the case, fig. 78, forming an enormous abdominal tumour. The liver and spleen are frequently enlarged; the patient gradually emaciates and has a cachectic appearance; perhaps the lower limbs become œdematous from pressure on the vena cava, and death comes perhaps after many weeks of lingering misery. Constipation is often present from pressure on the colon.

*Diagnosis.*—A sarcomatous enlargement of the kidney may be possibly mistaken for a hydro-nephrosis, abscess of the kidney, perinephritic abscess, spinal or otherwise. It is less likely to be mistaken for a tumour of the liver or spleen. A renal tumour may be distinguished from a *hepatic* or *splenic tumour* by the fact that it moves less with respiration and the colon traverses its anterior surface, and moreover the edge of the liver and spleen may usually be felt. A *congenital hydro-nephrosis*, in which the obstruction in the ureter was complete, might cause some difficulty in diagnosis; there would be, however, in a swelling of any size, fluctuation transmitted from the abdomen to the flank in a hydro-nephrosis, and on exploratory puncture the fluid withdrawn would make the diagnosis clear. An abscess in, or scrofulous enlargement of, the kidney is rare without a history of pain and tenderness in the lumbar region, and without pus in the urine. It is however possible that these may be absent, and then the rapid growth of the sarcomatous kidney would in time decide the diagnosis. But a difficulty could rarely occur.

*Prognosis.*—This is necessarily grave; though such tumours are chronic in their course and the patient may live for many months or even a year after the discovery of the tumour.

*Treatment.*—As far as we know, no drug influences the progress of the growth. Removal of a sarcomatous kidney is usually followed so rapidly by recurrence that this, the only possible, treatment is hardly justifiable.

**Tuberculous Kidney.**—Tuberculosis of the kidney is very commonly met with in children as part of a general tuberculosis. Thus, of 110 fatal cases of tuberculosis in the Children's Hospital in the years 1881–1885 inclusive, in 46 there was evidence of tubercle in the kidneys in larger or smaller amount. Most frequently the lesions are simply scattered grey tubercles in the substance or on the cortex of the organ: this was the case in 39 instances.

Much more rarely large masses of tuberculous material are found, or occasionally extensive destruction of the papillæ and ulceration of the pelvis, and sometimes of the ureter. Occasionally calculi are found coexisting with tuberculous lesions.

It is in our experience rare to find children suffering from tuberculous kidney apart from a general tuberculosis; less than half-a-dozen such cases were admitted to the hospital in the five years above mentioned, and genito-urinary tuberculosis, i.e. lesions affecting the kidneys, bladder, testes, prostate, vesiculæ seminales and so on, is not nearly so common as in adult life, though the bladder is not rarely involved. When the tuberculous lesions of the

kidney are only part of a general tuberculosis life is usually destroyed before the kidney affection is very far advanced, but where the disease is limited to the urinary tract the whole of one kidney may be destroyed and converted into a mere sac with hardly a trace of secreting structure left. Very commonly both kidneys are affected together, but in a considerable proportion of cases one organ alone is attacked, and under such circumstances life may be prolonged, or even recovery may take place, the damaged kidney shrinking, and ceasing to cause irritation; the whole of the work then devolves upon its fellow. All stages of disease, from the presence of a few tubercles to that of cheesy masses, and on to complete disorganisation, may be found. Perinephritic abscesses develop in some cases.

*Symptoms.*—When the kidneys are the seat of miliary tuberculosis there are usually no symptoms whatever pointing to disease of those organs: thus of 39 cases of this form of disease in only one was there even albuminuria, and that to a very slight degree. When, however, tuberculous ulcers or abscesses exist, pus, mucus, and large quantities of albumen may be found; but the only instance in which hæmaturia existed in the 46 cases of tuberculous kidney we have examined was one in which calculi coexisted with the tubercle, and undoubtedly the presence of blood in the urine points to calculi rather than to renal tuberculosis.

Pain and tenderness are only prominent symptoms when there is extensive disease and the pelvis becomes distended with pus and tuberculous material, and the same statement holds good of enlargement; it is only in the later stages of the disease that any palpable enlargement of the kidney takes place.

Frequent micturition is rather a symptom of tubercular cystitis than of renal disease, and where it exists with evidence of tuberculosis of the kidney, especially if there is tenderness of the bladder and much pain on sounding or passing a catheter, it is tolerably certain that the bladder is affected as well.

The presence of tubercle bacilli in the urine would, of course, indicate urinary tuberculosis, though without other evidence it would not show whether the disease was renal or not; unfortunately in most cases of renal tuberculosis the bacilli are not to be found until the disease is far advanced.

When one kidney alone is affected and the ureter becomes blocked with caseous material or granulations, pyo-nephrosis may develop and form a large abdominal tumour in which fluctuation may be detected: in such cases more or less fever will also be present and the diagnosis will be easy. It is in the early stages that a doubt arises. If there is a tubercular history or evidence of tubercle elsewhere, if the trouble is of only a few months' duration and there is pus, but little or no blood, in the urine, and if there is a gradual failure of health, the disease is probably renal tuberculosis.

*Treatment.*—In cases of miliary tubercle nothing, of course, can be done for the renal affection. Where pyelitis exists medicine can do something: the urine should be kept unirritating by the use of diluents and boracic acid (2 or 3-grain doses in half-an-ounce of peppermint water); alkalies such as carbonate of potash or liquor potassæ, or the citrate of potash with hyoscyamus,

will also be found useful. If there is lumbar pain and tenderness, with palpable enlargement of the kidney, and the symptoms do not subside under medicinal treatment, nephrotomy by the lumbar incision should be performed and the kidney drained. If on exploration the kidney is found entirely disorganised and there is evidence from the amount and quality of the urine that the other kidney is sound and efficient, a trial should be given to simple drainage; but, should the discharge not decrease, and should the health be failing, removal of the affected kidney is called for. This, however, clearly can only be justifiable if the other organ is working well, and if the bladder or viscera are affected nephrectomy would be probably useless. If removal of the kidney is decided upon, it should be done before the health is too much broken down, and the lumbar operation should be the one selected. We have only once met with a case *in a child* calling for either nephrotomy or nephrectomy, so that we do not think suitable cases can be common.

**Hydronephrosis** is not very rarely met with in children, and may be congenital or the result of partial blocking of the ureter by a calculus or cicatrix. Complete obstruction of the ureter appears to lead usually to atrophy of the kidney rather than to hydronephrosis.

The dilated kidney forms a tumour which has characters like those of the solid renal growths, except that fluctuation may be felt in it. The history is, however, often of longer duration than is the case in solid tumours, which usually prove fatal in less than eighteen months. Occasionally the fluid of a hydronephrosis is discharged by the ureter, in which case the swelling will, of course, vary in size.

*Treatment.*—Hydronephrosis should be treated by aspiration, which is best performed in the lumbar region. The fluid drawn off has usually the characters of clear dilute urine. Should the cyst refill after one or two tapplings, the kidney should be cut down upon and drained (lumbar nephrotomy); only after failure of this treatment should nephrectomy be thought of.

**Renal Calculus.**—Stone in the kidney is, like stone in the bladder, a disease much more commonly met with in some localities than in others; it is, however, apparently relatively rare in children, and when it does occur it is seldom that the symptoms are as severe or characteristic as they are in the case of adults. It appears that the majority of calculi formed in the kidney in children pass down to the bladder without giving rise to any severe symptoms of renal colic. Should, however, a stone form in the kidney and be retained there, it may give rise to pain, local and radiating, pyuria, frequent micturition, tenderness on pressure over the kidney, with rigidity of the lumbar muscles, retraction of the testis, vomiting, and above all to hæmaturia: this last is the most characteristic symptom of calculus, and in the absence of nephritis renal hæmaturia is probably due to calculus, though occasionally intermittent hæmaturia is met with without there being any proof of the presence of a stone.

In a few cases, if the disease goes on, pyo-nephrosis may be set up, and the kidney will then form a tumour perceptible to the touch.

*Treatment.*—Should medicinal treatment, which is the same as that for tubercular nephritis, fail to give relief, the kidney should be exposed by the lumbar incision and explored by puncture with a needle; if the calculus is

struck, a director is passed along the needle, and the kidney opened along its convex surface and the calculus removed. If the needle fails to find the stone, provided the symptoms are well marked, the kidney should be carefully explored with the finger, both by palpation upon the surface and subsequently by opening the pelvis and examination with the finger and with sounds. Any calculus found should be removed and a drainage tube passed up to the surface of the kidney. The wound is then treated on ordinary principles, the tube being gradually shortened. If the kidney is healthy and the ureter patent, the wound will probably speedily close entirely; if, however, the ureter is blocked, or there is much destruction of the kidney, discharge may go on indefinitely and it may be necessary to remove the organ in order to obtain healing of the wound. Before nephrectomy is thought of, however, care must be taken to ascertain that the other kidney is capable of doing sufficient work. For further details we must refer to the works of Morris, Bruce Clarke, and Newman; also to papers by one of the present writers in the *Medical Chronicle* for 1886-7-9.

**Acute Nephritis.**—Reference has already been made to acute nephritis (p. 219) when speaking of scarlet fever, as acute nephritis occurs more frequently during convalescence from this fever than after any other disease. It is well to bear in mind, however, that nephritis may occur after some other febrile states, such as diphtheria, varicella, typhoid fever, and zymotic diarrhœa. These febrile conditions appear to leave behind an irritable kidney which is liable to take on an acute inflammatory state. While in the great majority of cases acute nephritis occurs as a sequela of scarlet fever, there are strong reasons for believing that it may occur as a primary disease, the result of taking cold, or from some other cause. It must, however, be borne in mind that nephritis may follow mild attacks of scarlet fever: the primary fever may have been overlooked by the friends, especially if the latter are unobservant or ignorant; and in any case, coming under notice for the first time, suffering from acute nephritis the history of the case should be carefully inquired into and the child's skin examined for any traces of desquamation.

Acute nephritis occurring during convalescence from scarlet fever, or as a primary disease, is usually an inflammatory lesion of the croupous pneumonia type. There is an inflammatory engorgement of the blood vessels, and as a result a choking of the tubules by the exudation of liquor sanguinis, and usually blood corpuscles, into the urinary tubules, takes place. As a consequence of this the urine is scanty and contains fibrinous casts, blood corpuscles, albumen, and much epithelial debris. In the less acute cases there is not sufficient blood present to discolour the urine. If the inflammatory condition fails to be relieved, secondary changes occur, the most important of which consist in a glomerular or periglomerular nephritis. The glomeruli become enlarged in consequence of a hyperplasia of their endothelial nuclei (Friedlander), or in other cases a fibro-cellular growth takes place between the glomerulus and the capsule of Bowman; in either case the result is the same, namely an obstruction to the flow of blood through the glomerulus. Changes in the epithelium also take place. As these changes progress the urine becomes more and more scanty, and death takes place from either cardiac failure, uræmia, or some inflammation of a serous membrane.

The symptoms and treatment have already been discussed (pp. 220 and 226), and little need be added here. It is well to bear in mind that cases of very different severity may be met with : in some cases the engorgement of the kidney is extreme and variable quantities of urine are passed, containing large quantities of blood and albumen. In other cases there may be marked anæmia, much general œdema, scanty urine, with no albumen or only a trace, and we may be left in doubt if the case is really one of nephritis, or whether the œdema is simply due to a watery state of the blood. This class of case is not uncommon in young children under three years who have recently suffered from some acute disease, such as acute diarrhœa or pneumonia ; the pallor and œdema present suggest acute nephritis, but an examination of the urine possibly gives negative results as far as albumen is concerned. In some of these cases we have failed to find any evidence of nephritis on a microscopical examination of the kidneys.

**Septic Nephritis** has been also referred to under the complications of scarlet fever (p. 219). It is well, however, to bear in mind that such cases occur after other febrile states. We have seen kidneys answering this description occurring apparently primarily, but we have always had our suspicions that some cause must have been overlooked.

**Acute Parenchymatous Nephritis.**—During many acute diseases the kidneys are apt to be affected. This is especially so in diphtheria, malignant scarlet fever, acute endocarditis, acute cases of zymotic diarrhœa and typhoid fever. At the post mortem the kidneys are pale, and a microscopical examination shows that the epithelium of the urinary tubules has undergone marked changes ; various other changes, such as minute hæmorrhage and hyaline degeneration of the small arteries, have been described. Probably the other organs, such as the liver and spleen, are similarly affected. In such cases albumen in more or less quantity is present in the urine.

**Chronic Nephritis.**—Both the 'large white' and the 'small contracted granular' kidney are found in children, usually about puberty ; the granular kidney is certainly rare. Lardaceous kidneys are not uncommon.

In chronic nephritis (large white kidney) in children the symptoms are similar to those met with in young adults. There is albuminuria, puffy face, much general œdema and anæmia, and frequently more or less dilated heart. The course is usually very chronic, improvement taking place and the child remaining well for a while, then a fresh cold is caught and all the symptoms reappear. In a considerable number of these cases recovery eventually takes place. In fatal cases the kidneys are sometimes found enormously enlarged ; in one case coming under our notice, that of a girl of 12 years, the two kidneys together weighed  $22\frac{3}{4}$  ozs., and the left measured 6 inches in length.

The granular contracted kidney is rare in children ; we have only seen two cases, and these only came under observation a few days before death. Both occurred in girls, one aged  $11\frac{1}{2}$  years and the other  $10\frac{1}{2}$  years. In the former case there was only a history of two or three weeks' illness before admission to hospital, but the history was imperfect ; she had never had scarlet fever ; when admitted there was much œdema and dyspnœa ; the urine was of sp. gr. 1015, containing half albumen—she passed 800–1000 cc. daily. At the post mortem the right kidney weighed  $2\frac{1}{2}$  oz.,

and the left  $\frac{3}{4}$  oz. The left was a mere vestige of a kidney ; the capsule of the right was adherent, the surface granular, the cortex was narrow, and, in short, the kidney was an extreme example of a granular contracted one. The ureters were dilated.

The other case (girl 10½ years) was admitted to a surgical ward for rickety deformity of the tibia. There was a history for two years before of thirst, headaches, and frequent passage of urine, especially at night. On admission there was urgent dyspnœa, for which no cause could be found ; she gradually passed into an unconscious state, and died twenty-four hours after admission. No urine was obtained, she having passed it into bed. At the post mortem the kidneys were typically granular and contracted ; they together weighed 1½ oz. only, and measured 2 in. in length ; the capsules were adherent, the surface granular, and the cortex surface wasted.

*Treatment.*—In chronic albuminuria the patient must be rigidly protected from cold, as the least chill is liable to lead to an acute attack. Bed is the best place as long as albumen is present in the urine. A simple unstimulating diet is necessary, milk forming the staple food, with arrowroot, ground rice, or other light puddings. Meat is best avoided as long as the urine is albuminous. When œdema is present, and the urine scanty, hot air or vapour baths should be given daily, while the kidneys are acted on by salines, such as tartrate of potash, or by resin of copaiba, digitalis, or squills. During convalescence tr. ferri acetatis may be given with digitalis. Vomiting is best treated by saline purgatives and peptonised milk gruel in small quantities.

## CHAPTER XXVII.

DISEASES OF THE GENITO-URINARY SYSTEM—*continued*.

**Stone in the bladder** in children is, as in adults, a much more common disease in some localities than in others. It may occur at any age, and a congenital case even has been recorded. The symptoms vary much in severity; sometimes but little pain or trouble is caused by the stone, at other times the distress is constant and severe. The causation of calculus need not be discussed: there is little evidence that any particular diet has any active share in producing it.

*Symptoms.*—There is usually pain referred to the end of the penis, or to the hypogastrium or perineum; the pain is most severe towards the end of micturition, but when there is cystitis is nearly constant. Passage of blood in the urine, usually at the end of micturition, is a very frequent though not absolutely constant sign; frequent micturition and inability to retain the urine are almost always present. The straining efforts to empty the bladder often give rise to prolapse of the rectum and hernia. An elongated, excoriated prepuce, the joint result of the irritating quality of the urine, of frequent micturition, and of pulling at the penis to relieve the irritation felt at the end of the organ, is usually seen. The urine is muddy, containing pus and phosphates in varying quantity; if no cystitis is present, it may, however, be quite clear. On sounding, the stone is usually felt at once; it is rare to find a stone in children that is not struck by the instrument as it enters the bladder, but, as this is not always so, if the other signs of stone are present repeated soundings should be made if the calculus is not found at once.<sup>1</sup>

The most common variety of calculus in children is the uric acid: next, perhaps, comes the form consisting of urates; if the stone has caused cystitis, there may of course be a phosphatic coating, or the whole calculus may be phosphatic. Ebstein believes that the uric acid infarcts of newly born children form the first stage in calculus production, and that the large quantity of uric acid present in foetal and early life explains the frequency of calculi of this substance (*Centralblatt f. Chirurg.*, No. 14, 1885).<sup>2</sup>

Calculi in children vary much in size: that is to say, that, as different

<sup>1</sup> E. Owen suggests that sometimes the stone may be lodged in the orifice of one ureter; but, though Dr. Cullingworth and others have recorded such cases in adults, we do not know of an instance of this in childhood.

<sup>2</sup> The abnormal elimination of uric acid leads to degeneration of epithelium, which forms the animal basis of the calculus.

calculi give rise to varying degrees of distress, some of them are allowed to reach a larger size before the child is brought for treatment than are others.

In shape the calculi are usually oval and flattened (uric acid), but spindle-shaped stones are often met with : such are the ones that, while small, so frequently pass into the urethra and, becoming impacted, give rise to retention of urine. Thus one of these small oat-shaped calculi some day comes to lie with one end projecting into the urethra, violent straining to pass urine takes place, and the calculus is washed along the urethra and usually becomes fixed just within the meatus at the fossa navicularis, since the meatus is the narrowest part of the urethra. In other cases the stone is arrested at the bulb or in the penile portion of the tube. The symptoms of such an occurrence are pain, œdema of the part, retention of urine, and tenesmus ; on examination the stone can usually be felt through the urethral wall, or is readily struck on passing a sound or probe into the urethra. If the case is neglected, ulceration may take place and extravasation of urine : this sometimes occurs very rapidly. We have seen fatal extravasation come on in a few hours. When this occurs the symptoms are the same as in an adult : pain, swelling of the perinæum, scrotum, and penis, constitutional disturbance, and, failing relief, rapid sloughing of the tissues. In all cases of retention of urine in a child, if phimosis will not account for the inability to empty the bladder, impacted calculus should be suspected. The secondary effects of calculus are cystitis, pyelitis, and suppurative nephritis. The ureters may become dilated and inflamed by extension of mischief from the bladder ; and obstruction to the outflow of urine, suppurative pyelitis, and subsequent extension of suppuration along the renal tubes and in the peritubular tissue may result. This is probably not always fatal, and on removal of the stone the kidney mischief may subside : nevertheless the injury so done to the kidneys may be one of the reasons why children, the subjects of stone, seldom seem to grow up, though the mortality from lithotomy is so small in childhood ; it is, as Mr. Erichsen says, very rare to see an adult who has been cut for stone in childhood.

*Diagnosis.*—One or more of the symptoms of stone may be caused by many other conditions : worms, phimosis, a contracted meatus urinarius, simple or tubercular cystitis, the so-called irritable bladder,<sup>1</sup> vesical tumours, and renal calculus, all may simulate stone in the bladder to a certain extent ; the diagnosis is only to be certainly made by sounding. Stones can often be felt by bimanual palpation, one finger being passed into the rectum and the other hand pressed down above the pubes.

*Treatment.*—Until recent times lateral lithotomy has been practically always the mode adopted for removal of a vesical calculus in boys, and its success is so great that but little attempt has until lately been made to find any other treatment. Median lithotomy is little applicable, on account of the small size of the parts. Of late the operations of litholapaxy and suprapubic lithotomy have both been employed in children. Keegan, in the *Indian Medical Gazette*, May 1884 (*vide also Lancet*, vol. ii., 1886), has collected

<sup>1</sup> Thus, for instance, hæmaturia may result from phimosis and consequent irritable bladder (Bryant), and also may be due to tubercular cystitis.

24 cases of lithotripsy in children between the ages of  $1\frac{1}{2}$  and 11 years ; among these there was one death, in six cases the stone was allowed to escape with the urine after crushing, in the rest it was evacuated ; the size of the calculi varied from five grains to four drams.

It is now well established that the urethra of a child of three or four years will readily admit a No. 8 lithotrite after slitting the meatus, and we have found no difficulty whatever, as far as this goes, in the cases in which we have tried it ; such an instrument is abundantly powerful for the vast majority of stones we find in children,<sup>1</sup> and there seems no valid reason against its performance on this ground. In our own cases there was some difficulty in seizing the stone, but this was got over in one case by passing a finger into the rectum and lifting the stone between the blades of the lithotrite. The operation, in this instance, was followed by pyæmia, and the child died ; after pyæmia had developed it was found that a second stone existed, and this, being lodged in the neck of the bladder, was removed by median lithotomy, but the pyæmia was in no way improved ; we do not, however, look upon this case as any argument against lithotripsy, though it must be remembered that the natives of India bear surgical operations far better than Europeans, provided no bone lesion is present. In our case kidneys and ureters were both diseased, and probably this condition largely contributed to the fatal result.

As to the suprapubic operation, there is much to be said both for and against it. Against it is the risk of wounding the peritoneum, the risk of urinary infiltration, and the fact of the good results following the lateral operation. In favour of it is the fact that the operation is done as it were in the open : there is no cutting in the dark, no risk of wounding important structures such as the rectum, pelvic fascia, and seminal ducts,<sup>2</sup> while injury to the peritoneum is only likely to occur with careless operating, and less likely in children than in adults, from the fact that in children the bladder is an abdominal, in adults a pelvic organ.

Suprapubic lithotomy in children has, as shown by Sir Wm. MacCormac and others, a very small mortality ; it is an easy operation, and requires no skilled assistance. In one of our cases the boy passed his urine through the urethra from the first, and recovered in about the same time that lateral lithotomy cases take.<sup>3</sup> In performing the operation no rectal bag should be used ; the bladder should be injected with from 3 to 4 oz. of boracic lotion and a gradual dissection made down to the organ, not using the knife after the peri-vesical fat is exposed.<sup>4</sup> As soon as the bladder is laid bare, two sutures

<sup>1</sup> In a later case, however, the lithotrite broke in the child's bladder, and was removed, together with the stone, by suprapubic lithotomy ; this child died of bronchitis shortly after. The death was clearly the result of the somewhat prolonged operation and exposure.

<sup>2</sup> Sir Wm. MacCormac quotes Haemstadt to the effect that of eighteen males who had been lithotomised in childhood, and had grown up and married, only one had children.—*Lancet*, March 19, 1887.

<sup>3</sup> In four other cases operated on by our colleague Mr. Collier or ourselves favourable results have followed ; but in a fifth death resulted after removal of two large vesical calculi, and both kidneys were found to be damaged.

<sup>4</sup> A staff should be kept in the bladder during the operation, and its end used as a guide upon which to open the bladder ; by pushing the bladder up gently with the staff, and opening the viscus lower down, all risk of injury to the peritoneum is entirely avoided.

are passed through it, and the organ is opened between them, the stone is extracted with forceps or the finger, and the wound either left altogether open, or the bladder stitched up, the superficial structures being left quite open. Any stitches passed through the bladder walls should not include the mucous membrane. It is well to keep the child on its side or face after the operation to allow free drainage away of any urine that may collect in the wound. In several cases (R. W. Parker and others) the wound has united by first intention, but, on the whole, we think it better to leave the rest of the wound open while the bladder wound is sutured. Our own opinion is that the operation will largely replace lateral lithotomy, but further experience is required.<sup>1</sup> Sir Wm. MacCormac has collected 33 cases, with one death.

It is unnecessary here to describe the operation of lateral lithotomy; it will be sufficient to point out that the operation in children differs from that of adults chiefly in that in childhood the field of operation is smaller, not only on account of the size of the patient, but because the genital organs are undeveloped and the prostate exists only in a very rudimentary condition. It is usually said that in children the difficulty of the operation is in getting into the bladder, in adults it is in getting the stone out. This arises partly from the small size of the parts already mentioned, partly from the fact that the bladder in children is more an abdominal than a pelvic organ, and partly because the tissues of the child are more easily lacerated than those of the adult, and very gentle manipulation is therefore required. In lateral lithotomy in a child the incision is usually carried through the whole depth of the prostate, instead of only through a part of the gland, and unless the opening into the bladder is fairly free there is a risk of pushing the bladder before the finger and stripping it up from its attachments, or even of tearing across the urethra. The only other point requiring remark is that in children it is often easy by passing a finger into the rectum to bring the stone within the grasp of the forceps or even to extrude it from the perineal opening, and this is still further facilitated in some instances by pressure with the hand on the abdomen. In one case we could easily grasp the stones (there were two) with the hand through the soft, flaccid, abdominal walls.

Vesical calculus is occasionally found in female children: in such cases the urethra should be rapidly dilated with a three-bladed dilator or a pair of dressing forceps, and the stone extracted. If the calculus is large, it should be crushed before extraction and the bladder well washed out. Rapid dilatation is not as a rule followed by incontinence, even temporarily; in a case of our own the urethra of a child three years old was dilated sufficiently to admit the little finger, and there was no incontinence even immediately after the operation.

The mortality after lithotomy in children is usually about 5 per cent. Death when it occurs is due either to exhaustion of the child by distress and pain before the operation, to kidney disease, or in some cases to peritonitis, cellulitis, septicæmia, or hæmorrhage.

**Cystitis.**—Though cystitis in children is very commonly due to stone, it is by no means rare to find other causes for it: thus retention from phimosis or a contracted meatus, or possibly a growth, may give rise to it; tuberculosis of the bladder often is a cause of severe cystitis with much pain and hæma-

<sup>1</sup> *Lancet*, March 19, 1887.

turia, while frequent micturition with phosphatic deposit often occurs in children from such causes as errors of diet, or from no obvious reason. Rectal irritation may give rise to frequent micturition and even to hæmaturia.

The so-called 'irritable rugous bladder' is a condition often described as a disease; there is no doubt that certain children are brought with symptoms pointing to stone, and on sounding them no stone is found, but the bladder feels rough and traversed by ridges. We are, however, inclined to think this is not a pathological condition in itself, but simply the result of some passing irritation such as hyperacid or phosphatic urine, since these cases seldom require prolonged treatment and usually rapidly lose their symptoms after a course of salines followed by tonics. In Mr. Holmes' view it is simply a contracted bladder resulting from some irritation. Renal calculus and phimosis sometimes are the cause of this condition.

Tumours of the bladder are rare in children; one case of prostatic tumour has been already mentioned, and Owen records a case of his own, and mentions Giraldés' and Birkett's cases. Shattock has also recorded a case of mucous polypus in the *Brit. Med. Jour.*, 1883, page 15, and several cases of sarcoma have also been met with (*vide* Southam); indeed sarcoma of the bladder occurs more frequently in childhood than any other form of growth.

Tubercular cystitis may be recognised, in the absence of stone or other obvious cause, by pain in urination, itching at the end of the penis, pain in the hypogastrium and perinæum, frequent micturition, and sometimes incontinence. The pain may be greatly lessened by passing urine as soon as the least inclination to do so is felt; the urine is alkaline, with a deposit of pus and stringy mucus and epithelium; sometimes there is hæmaturia, and the bladder usually very readily bleeds—for instance, after gentle sounding. We have found a chain of enlarged lymphatics on rectal examination in a case of this sort, and also swelling, probably glandular, in the iliac fossa. Pressure over the bladder sometimes relieves pain. We have not found tubercular cystitis in children associated with genito-urinary tuberculosis, as is so commonly the case in adults, but the disease is not common enough to speak with authority. Terrillon says the deposit is less gelatinous and more flocculent,<sup>1</sup> and the pain more constant in tubercular than in simple cystitis, while bleeding is an early symptom. Ulceration takes place after a time, and the ulcers may be single and small, or numerous and large; they are usually at the trigone.

*Treatment.*—Alkalies, citrate of potash, and boracic acid are the remedies most useful as given internally, opium and henbane being added where much pain is present. Washing out the bladder with boracic acid (gr. x. to  $\frac{3}{4}$  i.) is of much value in simple, but sometimes too painful in tubercular cystitis. Powdered iodoform washed into the bladder forms a coating upon its surface and gives much relief in some cases: this method was, we believe, first used by our colleague Mr. Whitehead in cases of malignant disease of the bladder. Rawdon suggests cystotomy in cases of tuberculosis where the symptoms are intractable.<sup>2</sup>

<sup>1</sup> Where the bladder alone is involved no casts will be found in the urine; their presence would of course point to renal mischief.

<sup>2</sup> *Med. Press and Circ.*, January 1884.

**Incontinence of urine.**—During the first few months of life the infant makes no attempt to retain urine in the bladder for more than a very short time ; after the first year, however, constant or very frequent micturition should lead to the suspicion of something abnormal. Unduly frequent micturition may be due to mere habit, to a too often recurring desire to pass urine, or to an absolute inability to retain it. In the former the apparatus is perfect, but is by some cause or other too often excited ; in the last there is either paralysis or a malformation. Nocturnal incontinence belongs to the former group, diurnal or continuous incontinence may be due to either condition. Thus a child may have a frequent desire to pass water because a larger amount is secreted, as in diabetes insipidus ; because it has a congenitally small bladder ; because it has a stone or hyperacid urine, or cystitis, or a feeling of irritation about the penis from an adherent or tight prepuce or a contracted meatus ; or because worms or other rectal irritation are present. In all these conditions, except that of too small a bladder, the urinary apparatus may be quite perfect, but it is irritated.

On the other hand there may be continuous dribbling of urine from the bladder, as a result of distention and overflow from obstruction ; or in case of entire absence of the bladder, or extroversion, or imperfect development of the neck of the bladder or of the urethral muscles ; or, again, from deficient innervation, as in paraplegia, or from imperfection of the micturition centre in the spinal cord, as seen in some cases of spina bifida. Mention must also be made of certain rare conditions, such as an abnormal communication between the bladder or ureters and the exterior. Obviously a child that can hold its water during the day can have none of these conditions ; hence, when a child is brought and said to be unable to hold its water, the first question is whether the condition is nocturnal only or constant. Dribbling from over-distention due to obstruction is nearly always the result of either an impacted urethral calculus or of phimosis, less often of a contracted meatus, though, of course, in these there is as a rule complete, or almost complete, retention rather than overflow.

Inability to retain the urine is occasionally seen associated with hypospadias and incontinence of fæces : in such cases the condition is no doubt due to actual malformation of the sphincters.

Dribbling from paraplegia will be recognised by the associated paralyses ; so too with the case of spina bifida : hence examination of the spine should be made in all cases, and the child's cerebral condition should also be inquired into. Failing these, careful examination as to the condition of the bladder and urethra should be made, to see if there is any deficiency or abnormal arrangement of these parts.

Diurnal incontinence is much less common than nocturnal, though frequent micturition without any actual inability to retain urine is common enough ; in such cases the sources of irritation already mentioned should be sought for and removed. Sometimes a child, the subject of nocturnal incontinence, passes urine frequently by day, but is able to retain it.

Ordinary nocturnal incontinence (or enuresis as it is sometimes called) is more common in boys than in girls ; it may occur at any age before puberty, but very rarely persists beyond that time ; if it does so it is usually incurable, and this rare condition is said to be most often met with in girls.

The discharge of urine may take place once or several times during the night: perhaps most often during the first sound sleep, and again in the early morning.

In cases of nocturnal incontinence those conditions which have been mentioned as giving rise to a frequent desire to pass urine during the day should be looked for, since, when the child is awake, he may be able to control the flow, or pass his urine in a suitable place; while during sleep no such power is exerted. Other causes, such as unduly deep sleep, dreams in which the child imagines that it is properly passing its water, gastric disturbance from late or unwholesome meals, temporary polyuria from free drinking of fluids at night, and perhaps masturbation, may be added to the list. We have also reason to think that mere delicacy of health, often conjoined with a somewhat unstable and easily excited mind, such as is sometimes seen in children born or brought up in hot climates, may give rise to enuresis. Possibly in some cases renal calculus or pyelitis of tubercular origin may give rise to incontinence.

*Treatment.*—Setting aside the irremediable malformations and the cases due to paraplegia, the first thing is to look for and remove any of the sources of irritation. If there is phimosis, circumcision or the breaking down of adhesions; if there is a small meatus, enlargement by incision will be required. The bladder should, of course, also be sounded in any case of doubt, or if the condition does not speedily yield to medicinal treatment. The urine should be carefully examined for over-acidity or for evidences of cystitis, and this should be corrected by the use of citrate of potash or liquor potassæ; the child should be carefully dieted and its allowance of meat curtailed, while any irritating vegetable food, such as rhubarb, should be forbidden. Late meals should not be allowed, nor should the child take any fluid for an hour or two before going to bed. Too great a weight of bed-clothes and the habit of sleeping upon the back should be avoided: in the latter, the immediate contact of the urine as it enters the bladder with the trigone is believed to excite the effort to empty the viscus.

For nocturnal incontinence alone the most successful drug is undoubtedly belladonna, or, still better in some cases, atropia. Belladonna should be given in full and increasing doses: for a child two years old it is well to begin with 5 or 10 drops of the tincture three times daily, and increase the dose by 5 drops every 12 hours till the physiological effects are produced, bearing in mind that children are not readily susceptible to the action of the drug; as soon as this point is reached the dose should be continued for several days. If the treatment is successful it should be continued for a week, and then the dose gradually diminished, increasing it again if there is any relapse. We have seen liquor atropiæ given at night in 2-minim doses, reached gradually, cure a child two years old in which belladonna had failed. This drug probably acts both by stimulating the contraction of the sphincter muscles and by acting as sedative. Bromide of potassium, alone or with belladonna, ergot, cantharides, nitrate of potash, camphor, and other drugs, have been employed. Strychnine is chiefly of use in diurnal incontinence, though sometimes it succeeds in the nocturnal form; it is said by Bouchut to be a dangerous drug for children. Such treatment as blistering, or painting over the orifice of the urethra with nitrate of silver,

or the use of a perinæal truss, is not to be recommended. The child should be made to pass water just before going to bed, and should be taken up again in an hour's time, and if possible once again during the night; he should be encouraged to try to control the inclination and to exert his will, but on no account should he be threatened or punished, except possibly in the exceptional cases where, as sometimes happens, the presence of one child with incontinence in a school induces an epidemic, as it were, among the others; in such instances probably the affection is in the acquired cases simply a trick, and may be controlled by fear of punishment. The disastrous results of frightening such children into tying strings round the penis, as well as the misery inflicted by the shame of believing that what is really a disease is a fault, are sufficient arguments against such cruelty. Cold sponging to the perinæum is sometimes useful, and we have known the use of the constant current, one pole being applied above the pubes and the other in the perinæum or over the sacrum, to succeed where other means have failed; the interrupted current also sometimes answers. The application of nitrate of silver to the neck of the bladder is advocated by Holmes. In weakly children and in cases of diurnal incontinence, where no organic cause can be found, tonics, iron, strychnine, good food, and sea air will often prove successful, and we have known sea air cure enuresis. The possible existence of chronic renal disease or diabetes must be borne in mind.

In inveterate cases in girls dilatation of the urethra and exploration of the bladder may, as pointed out by Owen, cure the affection even if no organic disease is found.

**Retention of urine.**—The causes leading to retention of urine are mentioned under their several headings, but it may be convenient here to group them together. They are congenital malformations, impacted calculus, phimosis, ruptured or strictured urethra, including stricture of the meatus, pressure on the urethra by abscess or a new growth, blocking of the orifice of the urethra by a vesical or prostatic tumour, or, lastly, the tying of a string round the penis. It must be remembered that retention of urine may be voluntary, or imaginary on the part of the friends: voluntary where the passage of the water causes pain, as is often seen after circumcision, when the urine flowing over the surface causes discomfort. We have never seen any harm other than alarm to the friends result from this voluntary retention, though it is well in such cases, if a warm bath does not relieve the retention, to pass a catheter into the bladder. Lastly, retention must not be confounded with suppression of urine from any cause. Of course, retention of urine if unrelieved will lead to extravasation, the treatment of which is free incision deeply into all the infiltrated tissues, so that a free outlet for the urine already extravasated is provided, as well as any further mischief prevented.

**Malformations of the Genito-urinary organs. Extroversion of the Bladder.**—Deficient closure of the ventral laminae, giving rise to hiatus of the abdominal wall, has already been mentioned in connection with umbilical hernia (p. 114). In certain, not rare instances, however, the lower part of the abdominal wall, from the umbilicus or its neighbourhood downwards, may fail to close, and coupled with this there may be deficiency of the anterior wall of the bladder, constituting the condition known as extroversion

or exstrophy of the bladder, ectopia vesicæ, or hiatus of the bladder.<sup>1</sup> In this condition the lower part of the abdomen presents a red rugous area covered with mucous membrane, which is usually excoriated from friction and irritation, often more or less coated with mucus and phosphates. From this surface, or rather from the orifices of the ureters exposed upon it, the urine continuously dribbles, keeping the child always wet, and leading to irritation of the neighbouring skin. This red mucous surface is the posterior wall of the bladder, which is usually flush with the abdominal wall; hence in most cases there is no bladder cavity, though occasionally there is a slight depression. More often the surface is corrugated and somewhat protuberant, and on drawing down the penis,<sup>2</sup> which is always distorted and ill-developed (*vide* Epispadias), the orifices of the ureters can be seen, and drops of urine may be watched flowing from them, and often escaping in a little jet when the child cries or strains.

On further examining such a child, it will usually be found that the symphysis pubis is deficient, the two bones failing to meet in the middle line, and being only connected by fibrous tissue. The umbilicus may be absent altogether, or may be more or less well-formed. The scrotum is always imperfectly developed, and the testes do not fully descend, usually lying in or just outside the inguinal canals. Very commonly there are inguinal herniæ developed, and these may even become strangulated. We have had occasion to operate in such a case.<sup>3</sup>

<sup>1</sup> A patent urachus or even a protrusion of the bladder-wall through such a passage may also be found; *vide* Tanner, *Diseases of Childhood*.

<sup>2</sup> The malformation is most common in males.

<sup>3</sup> According to Dr. Champneys, *St. Bartholomew's Hospital Reports*, 1877, extroversion may be associated with talipes and other deformities; the sex may be doubtful from external appearances; there may be rectal prolapse, with a long, loose, rectal mesentery. All grades of deformities, from mere separation of the symphysis pubis, with perhaps a hernial pouch, but no deficiency of the bladder, may be met with; in the second degree of deformity there may be prolapse of the bladder, though it is itself perfect: the prolapse may take place through the urethra or urachus (Vrolik, Froriep); the third degree is the ordinary form; while in the fourth and most severe degree there is extroversion and division of the bladder into two halves by the opening of the intestine between them. The condition really arises from the fact that the allantois is developed by two lateral portions which afterwards meet in the middle line, and thus the various degrees of deformity of the bladder, epispadias, &c., are explained (*vide* Baly in Müller's *Physiology*). Union between the halves of the allantois takes place at the third week of foetal life, so the deformity must exist at that time.

The condition of the umbilical vessels is inconstant: they may run separately to the placenta (Dietrich). The umbilicus is lower than usual, and the anus is generally more anterior than usual. Herniæ are inconstant. The external genitals may be deficient altogether or developed in varying degrees; the testes may be retained, or may descend into the scrotum and be well developed. The symphysis is not always ununited; when it is so it causes awkwardness of gait.

As Tenon pointed out, the malformation is not a cleft of the bladder merely, since there is a deficiency of all, excepting the trigone and neighbouring parts. The pelvis of the kidney and the ureters are usually dilated, and may open into the rectum, vagina, or urethra.

The intestine is variously malformed or deficient, and there may be imperforate or misplaced rectum.

For further details and references Dr. Champneys' able paper should be looked at; from it much of the above is taken.

This deformity, which is quite unmistakable, gives rise to much trouble, both from the constant wetting and excoriations as well as from the incapacities associated with it. It is impossible in most cases to fit any apparatus satisfactorily to receive the urine. Hence the treatment is solely operative; and even this, it must be confessed, is not always satisfactory. Attempts have been made to divert the ureters into the intestine, but not hitherto with success (T. Smith and Simon). Holmes, Ayres, Wood, Greig

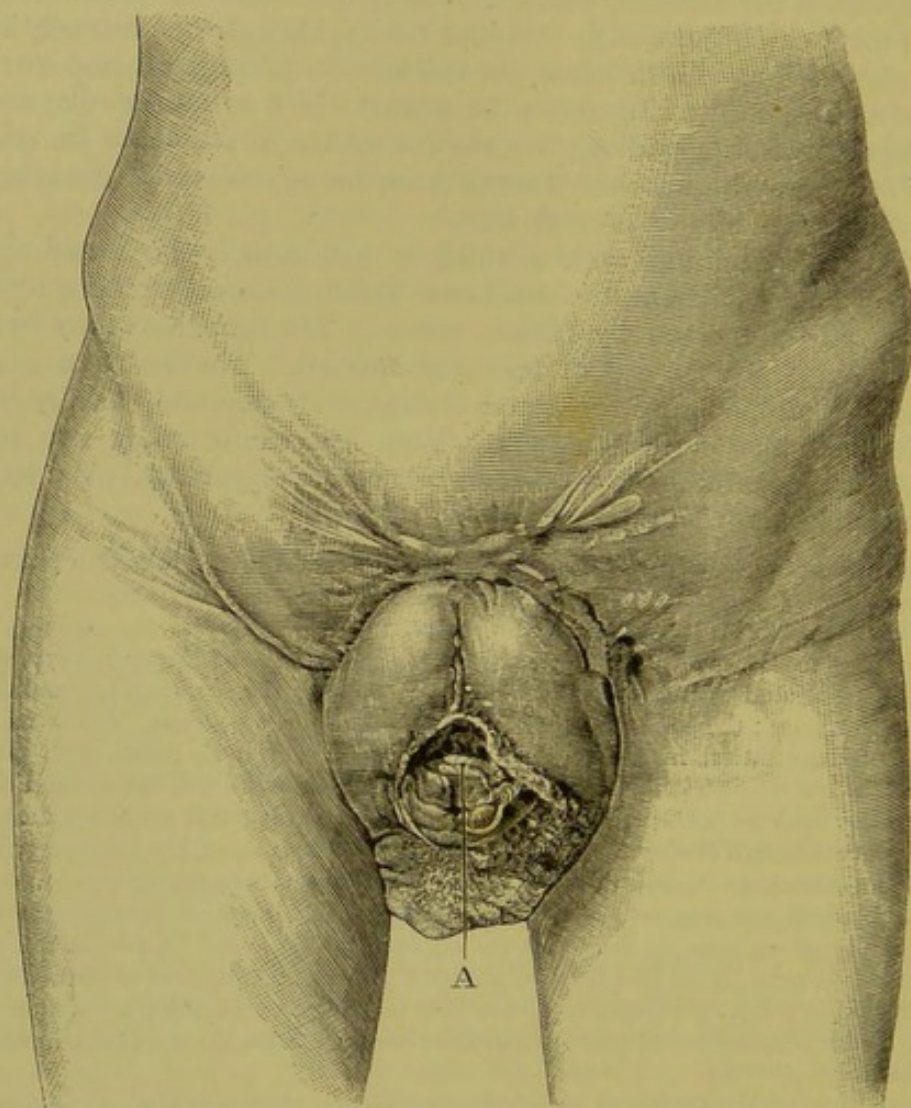


Fig. 79.—Shows the result of a plastic operation for Extroversion of the Bladder in a boy.  
A points to the glans penis.

Smith, and others have devised operations for covering in the exposed bladder; these consist of dissecting up a flap from the abdominal wall or scrotum, and turning it over the bladder surface, subsequently covering over the raw side of the flap with other super-imposed flaps from the groins. For details of the operation we must refer to works on operative surgery. Several successive attempts are often required before a good result is obtained, and there is sometimes a tendency for the flaps to retract and leave the lower part of the bladder exposed; this difficulty is met by subsequent attachment

of the flaps to the scrotum or labium below, a plan suggested by Mayo Robson,<sup>1</sup> and one we have found of value. On the whole, the result of our experience is that the operation should certainly be done in all cases where the child is in a condition to bear a somewhat severe and prolonged manipulation, and that a great improvement may be expected as a final result (fig. 79). The child should not be operated on until it is 3 or 4 years old. It has been proposed to scrape or cut away the mucous surface of the bladder except at the orifices of the ureters, and thus avoid the irritation of the mucous secretion. We have not, however, tried this method.<sup>2</sup> After operation one of the troubles is the constant formation of phosphatic deposit about the parts; careful cleansing and daily syringing with a dilute acid solution is required. Hydrochloric acid, ℥ xx, glycerine, ℥ i, water, ℥ i, we have found a useful form of wash.

In extroversion of the bladder in the male the penis is nearly always deformed, the corpora cavernosa are deficient to a greater or less degree, and the corpus spongiosum is ununited on its upper surface, so that the floor of the urethra is exposed on the dorsum of the penis. The whole organ is stunted and turned up against the abdomen; the prepuce is usually redundant below, and the glans is generally better developed than the rest of the penis.

**Epispadias.**—The condition of penis above described may occur without extroversion, constituting epispadias.<sup>3</sup> In such cases there is usually imperfect power of retention of urine from deficient muscular development at the neck of the bladder, and for sexual functions the organ is useless. In such cases an apparatus is readily applied to prevent the discomfort of constant wetting; but to improve the power of urination, and perhaps the sexual function, operations may be performed, consisting in either turning down a hood-like flap from the front of the abdominal wall over the urethral groove, or in dissecting up flaps of skin and bringing them over the dorsum—or, lastly, in taking a flap from the scrotum and turning it upwards over the penis, which is passed through a slit in the centre of the flap. Any small fistulous openings left after union of the main flaps are closed by subsequent operation or by repeated application of the actual cautery. In all such operations it is a good plan, as a preliminary step, to open the urethra or bladder through the perinæum, so as to allow the urine to drain away freely, without flowing over the wound. Our colleague, Mr. Hardie, and Mr. Howlett, of Hull, have adopted this plan with good results.

**Hypospadias.**—When the floor of the urethra, together with the corpus spongiosum, is deficient to a greater or less degree, the deformity known as hypospadias is present. In the slighter cases the deformity is merely one of the urethral orifice, which opens on the under surface of the glans penis

<sup>1</sup> *Brit. Med. Jour.*, January 31, 1885.

<sup>2</sup> Excision of the bladder, with or without transplantation of the ureters, direct suture of the vesical margins, with or without section of the sacro-iliac joints, to allow approximation of the rami of the pubes, have also been suggested; but no sufficiently encouraging results of these methods, except in one case of Wyman's, have been obtained. A good summary of the various operations will be found in *Ann. des Mal. des Organes Génito-Urinaires*, March 1888, by Pousson.

<sup>3</sup> A case of epispadias in a girl is recorded by Smith in *Brit. Med. Jour.*, September 20, 1884.

instead of upon its apex, though, even in these cases, the corpus spongiosum is always thinner and less developed than it should be. A dimple usually represents the opening of the urethra, or a groove may run on from the existing opening to the end of the glans. All degrees of malformation are met with from this to cases where the urethra opens in the perinæum, behind the scrotum. In severe cases, the corpus spongiosum being entirely deficient below, the penis is bent downwards and held down by fibrous bands representing the aborted spongy body; it is also bound down by the deficiency of the prepuce below, though a redundant, hood-like fold overlies the glans above. In the severest cases the scrotum is cleft and ill-developed, and the testes are retained or imperfectly descended, and the arrest of development may be such as to give rise to doubts as to the sex of the individual; such are the majority of the so-called hermaphrodites.<sup>1</sup>

The slighter degrees of deformity, where the urethra opens at the base of the glans, need no treatment, and do not interfere with either the urinary or sexual functions as a rule, though we have met with a case where this condition was associated with incontinence of urine and fæces, probably due to deficient development of the sphincters of both outlets. In all cases of hypospadias a probe passed into the urethra will show how thin the lower wall is, and the meatus is often contracted and insufficient. Sometimes the opening is sufficiently far forwards to serve all purposes, but the penis is tightly bound down to the front of the scrotum. In such cases the organ may be liberated by careful dissection, but unless great caution is observed the thin floor of the urethra will be cut through, and a urinary fistula result. Where the opening is further back than half the length of the penis an operation may be performed to lengthen the channel; a preliminary cystotomy or urethrotomy having been done, flaps should be dissected up from the sides of the penis and turned over one another (method of superimposed flaps). This is the most successful plan, but even it often fails from non-union, or breaking down again after partial adhesions.

**Congenital contraction of the Meatus Urinarius and Congenital Stricture** of the urethra have already been mentioned. We have met with two instances of the latter: one, seen in adult life, was remedied by catheterism in the ordinary way; in the other, an infant, there was retention of urine, with overflow. On passing a catheter two distinct obstructions were found, one at the front of the scrotum, and the other in the prostatic region; they appeared to be definite bars of thickened tissue, the latter closely simulating prostatic enlargement, which, if it existed, only affected the middle lobe.<sup>2</sup>

Congenital contraction of the meatus may become an important affection, giving rise to incontinence, to retention and consequent cystitis, and indeed to all the secondary troubles associated with obstruction to the urinary outflow. In one instance a boy 5 years old was brought to us, who was said to have had gonorrhœa for 3 years and was believed to have been tampered with; there was a distinct gleet discharge, and the meatus was very

<sup>1</sup> Sometimes the urethra is continued on to the glans, but there is a congenital urethral fistula further back, even within the rectum, and urine escapes by both orifices.

<sup>2</sup> Dr. Mudd, *St. Louis Med. and Surg. Jour.*, November 1883, mentions a case of enlargement of the middle lobe in a child of thirteen months; the swelling proved to be a myoma.

small. All the symptoms disappeared after slitting the meatus and passing a catheter a short distance down the urethra at frequent intervals for a few weeks; the child was subsequently neglected, and re-contraction took place. The following case further illustrates the evils of a narrow meatus:—

*Contracted Meatus Urinarius. Retention.*—Jas. F., age 4 years; admitted December 7, 1882. Well till five weeks before admission, when he was unable to pass urine without pain; subsequently had pain in hypogastrium and became ill in himself; never passed blood; was catheterised at the Out-Patient room twice, and once passed urine voluntarily. On admission was found to have a contracted meatus, and was catheterised, a small instrument (size not recorded) being passed; urine clear, sp. gr. 1028, faintly acid, slight sediment of mucus and phosphates on standing, no albumen; the edges of the meatus were found to become glued together, and he was unable, even by violent straining, to pass urine himself; the bladder contracted tightly round the catheter. December 11, the meatus was incised to enlarge the orifice, and a No. 8 silver catheter passed daily through the meatus, but not into the bladder. He was discharged on the 17th with all his symptoms relieved. It is usually said that retention in children is always due either to impacted calculus or extreme phimosis. Here probably some balanitis led to ulceration and cicatricial contraction of the meatus, the edges of which were probably acting as valves, which shut by the pressure of the urine.

Complete obliteration of the urethra may also be met with, as in a case recorded by Partridge and Watson.<sup>1</sup> Mr. Gay has recorded a case of double urethra, one on the dorsum and the other in the normal position, both communicating with the bladder, though not with one another.<sup>2</sup>

Prolapse of the mucous membrane of the urethra in girls may be caused by straining; it gives rise to pain, bleeding, and irritability of the bladder. Day, who describes the condition in the *Medical News*, Dec. 1883, advises astringents in mild cases, and removal by ligature of the prolapsed part in more severe instances.

We have seen one case of complete absence of the penis, the urethra opening just at the margin of the anus, outside the external sphincter; the scrotum and testes were well developed. The child was under the care of our colleague, Mr. Collier.

**Phimosis**, or the condition where a long prepuce exists which cannot without difficulty be drawn back over the glans on account either of the small size of its orifice or because of adhesions, is an affection which may be congenital or acquired. Further, it varies much in degree: the prepuce may be very long and end in a puckered, tapering point, in which there is but a pinhole orifice,<sup>3</sup> so that when urine is passed it collects between the glans and prepuce, and 'balloons' out the latter, or the prepuce may be tightly stretched over the glans and universally adherent to it.

In most children at birth the prepuce entirely covers the glans, and on withdrawing it adhesions are very often found between the two, while the coronal groove is filled up with retained smegma in round lumps; if these adhesions are not broken down and the glans kept clean, secondary inflam-

<sup>1</sup> *Path. Soc. Trans.*, vol. xiv. The ureters were enormously dilated; one kidney was atrophied, and the colon ended in the bladder; other deformities also existed. Another case, treated successfully by a sort of forced catheterism, is recorded by Forster, of Darlington, *Brit. Med. Jour.*, January 3, 1885; also Shattock, *Lancet*, February 11, 1888.

<sup>2</sup> *Path. Soc. Trans.*, vol. xiv.

<sup>3</sup> Tanner has found it absolutely imperforate.

mation is apt to occur (balanitis) and give rise to still further adhesions, with perhaps increased contraction of the prepuce. In most cases, with a little trouble, the foreskin can be drawn back, the adhesions being torn down by the finger and thumb or a probe; the adhesions are frequently non-vascular, at other times a few drops of blood escape. Daily retraction and cleanliness for a week or two gets rid of all further trouble, occasional drawing-back and washing being all that is afterwards required.

If phimosis is neglected, many ill results may follow: retention of urine from obstruction at the preputial outlet or at the meatus; as a result of such contraction extravasation of urine may occur, or incontinence of urine from irritation. Prolapse of the rectum and hernia may result from the straining required to empty the bladder or from irritation; while cystitis, balanitis, formation of subpreputial calculi, masturbation, and in later life sterility and increased liability to venereal diseases and epithelioma may result from neglected phimosis. Other troubles, such as paraphimosis if a tight prepuce is withdrawn, and, according to Mr. Barwell's view, possibly joint lesions from reflex irritation, may occur.<sup>1</sup>

If the obstacle to retraction is simply the adhesions, the breaking down of these, already mentioned, is sufficient; if, however, the preputial orifice is tight, circumcision should be performed in infancy. Dilatation of the prepuce answers in some cases, but we are strongly opposed to it, since we have seen not only rapid re-contraction but also much inflammation set up, necessitating circumcision and a long delay in healing; it is not a good plan.

In any doubtful case it is wiser to circumcise, as the operation is as harmless as any operation can be if done properly.

In every male infant the condition of the prepuce should be attended to during the first few weeks of life; much subsequent trouble may be thereby avoided.

There are many ways of circumcising, of which we will only describe the one we prefer. Slitting up the prepuce should never be done in children: it is much better to circumcise properly.

The child should be anæsthetised and a tape tied round the root of the penis; then, with a pair of dressing forceps, the prepuce should be seized just in front of the glans, but it is not to be drawn forwards so as to put it on the stretch, or too much skin will be removed. The forceps should be held vertically, and the skin in front of them shaved off with a scalpel; but at the lower part of the section the knife should be turned forwards so as to make a little triangular tongue of skin projecting from the cut edge of the prepuce; the dressing forceps are now removed and the skin retracts; the mucous membrane is next slit up along the upper surface of the glans with a pair of scissors, and clipped away all round as far as the frænum, leaving enough rim of mucous membrane to readily hold the sutures; the frænum should not be clipped close. Interrupted catgut sutures are used to stitch together skin and mucous membrane, generally one on the dorsum and one on each side are sufficient; the little tongue flap is then stitched to the frænum and made to cover in its raw surface; by this means, which was shown us by Mr. Davies Colley of Guy's some years ago, rapid healing is usually obtained

<sup>1</sup> Sayre also records cases of various contractions and deformities of the lower limbs resulting from phimosis.

and there is no raw surface to granulate. The tape is removed and the patient kept lying down for a few days. It is better to do without any dressing, simply keeping the clothes away from the part by a cradle.<sup>1</sup>

In a perfect circumcision the edge of the prepuce will just cover the corona; if too much is removed the corona is apt to remain tender and irritable for a long time. If catgut sutures are used they do not require removal. The Jewish mode of circumcision does not, we think, give such good results as that above described. Martin<sup>2</sup> alleges that circumcision may produce contraction of the meatus, as a result of exposure and friction, and various secondary reflex irritations, which he has relieved by slitting the meatus; but we doubt the occurrence of any bad result from circumcision properly performed, and think any such troubles are more likely the result of the condition for which circumcision is done.

**Balanitis** is often met with in children, and is usually the result of neglected phimosis; the prepuce may be much swollen, and large quantities of pus are sometimes discharged from within it; there is much scalding pain on micturition. Mild cases are readily cured by syringing at the cavity beneath the prepuce with warm water or lead lotion. As soon as the acute inflammation has subsided circumcision should be performed; it is sometimes necessary to circumcise at once, but in such cases the wound is apt to be slow in healing.

The trick of tying a string or tape round the penis, for mischief, or to prevent the need of passing urine, is to be thought of in cases where a child is brought with swelling and inflammation of the penis; the string may be completely buried in the soft parts, and may give rise to ulceration or even sloughing, urinary fistula, &c.

**Congenital Paraphimosis** is the condition where the glans is congenitally uncovered by prepuce; it is not a common condition, but is always found in hypospadias, even in the slighter degrees.

Acquired paraphimosis is produced by retraction of a tight prepuce, so that the glans is exposed; it is usually the result of mischievous meddling with the penis. If the prepuce is not speedily drawn forward again, the tight foreskin constricts the penis behind the corona and interferes with the venous circulation both in the prepuce and the glans; the result of this is swelling and pain, the swelling being chiefly of the prepuce, since its tissue is more lax than that of the glans. If the condition is neglected the appearance becomes somewhat alarming; there is much œdema, often redness, and some ulceration with distortion of the organ. Since the constriction is tightest on the dorsum of the penis, there is little or no risk of ulceration into the urethra, and still less of complete gangrene, as has been sometimes stated, but much trouble and no little alarm are often caused by this condition, and we have known it give rise to suspicions of erysipelas; it might also possibly be mistaken for extravasation of urine or cellulitis. The treatment of the affection consists in drawing forward the prepuce again; to do this the swollen foreskin should be punctured with a needle and all the serum squeezed out: by then drawing forward the prepuce with the fore and middle fingers of both

<sup>1</sup> If there is any troublesome oozing, a strip of lint may be wrapped round the penis, leaving the meatus exposed. Bleeding should be carefully arrested before putting in the sutures.

<sup>2</sup> Gaillard's *Med. Jour.*, April 1885.

hands, at the same time pressing back the glans with the thumbs, reduction can be accomplished, unless the constriction is very tight or of long standing. Another method consists in winding a piece of tape or narrow elastic round the penis, from the glans backwards, and so, by reducing the size of the glans, the foreskin can be brought over it. Where the paraphimosis has existed for more than a few days it may be irreducible : or, if the constriction is very tight, it may be necessary to divide the contracted prepuce behind the corona, but this is rarely required. Under such circumstances the swelling is to be reduced by puncture and a lead lotion dressing applied ; in time the parts will model down, and, though permanent paraphimosis usually results, no serious harm occurs. After reduction of a paraphimosis, if the foreskin is long and tight, circumcision should be performed, or in any case measures taken to prevent a repetition of the retraction.

**Masturbation.**—Masturbation in children is usually the result of a long prepuce, or retained secretion, or of some other source of irritation about the pelvic organs in either sex, such as worms, balanitis, vaginitis, stone, &c. The treatment obviously in such cases is to remove the source of irritation ; circumcision is in obstinate cases desirable, both as a means of removing irritation and as a deterrent, while in older children, who are able to understand the matter, and in whom the habit is a bad practice, and not the result of any obvious physical cause, judicious speaking, pointing out the uncleanness and the debasing effect of the act, is the best line of treatment. Coupled with these plans should be care in avoiding opportunities, and, if necessary, punishment should the vice be persisted in. In all cases onanism should be treated first as a disease, and only as a vice when it is clear that no cause for it exists.

**Œdema of the Scrotum** in children is sometimes met with apart from any obvious inflammatory condition : it may be part of a general œdema due to cardiac or renal disease ; in other instances it is the result of intertrigo, such as is met with in fat and dirty children ; occasionally it occurs without obvious cause, and in such cases some source of obstruction to the lymphatic or venous circulation should be looked for. Erysipelas, or diffuse cellulitis of the scrotum, penis, &c., is also occasionally seen. In all these conditions attention to the general health and the use of lead lotion are usually all that is required.

**Diseases of the external Genitals in females.**—The congenital malformations of the external genitals of female children, apart from so-called hermaphroditism, are rare, with the exception of the simple adhesion between the labia minora of the two sides, which, as Mr. Holmes has pointed out, if neglected, may produce retention of menses in later life, and probably forms the majority of the cases of so-called imperforate hymen. The treatment of adherent labia is very simple ; the adhesions are broken down readily with a probe, and a little oiled lint kept between the labia for a few days, together with ordinary cleanliness, is all that is required.

Hypertrophy of the labia or clitoris in children, though common among the natives of some hot climates, is very rare in this country. We have, however, occasionally seen it, though rarely to an extent that required treatment. In a young adult, however, we have had occasion to remove hypertrophic labia, the condition having lasted some years, but whether it was

congenital or not we cannot say. Nothing short of operation is likely to be of any service. We have recently seen a case in which the clitoris of a little child was much enlarged and caused irritation; examination showed that there was adhesion of the prepuce of the clitoris to the glans, with retained smegma, just as in the case of phimosis in the male.

Nævus of the labia is seen every now and then, and is best treated by puncture with the actual cautery.

Of acquired affections, simple **Vaginitis**, or, as it more commonly is, **vulvitis**, is frequently met with; it is usually caused by neglect and dirt, and often by the irritation of thread-worms, but is sometimes the result of inoculation with the discharges from other cases of vulvitis, or from older people by the use of dirty sponges for washing, &c.<sup>1</sup> Very rarely indeed is it the result of attempted rape, and such charges are often brought against innocent persons simply because the mothers conclude that all discharges from the genital organs in children must be venereal; and it should be remembered that some children are led to invent stories or to confirm suggestions made by ignorant or dishonest mothers.

This simple vulvitis is very contagious in many cases and readily spreads from one child to another, hence isolation, perfect cleanliness, the removal of sources of irritation, and the free use of antiseptic lotions such as perchloride of mercury or boracic acid should be employed. In some cases astringent lotions such as sulphate of zinc or alum are useful, and iodoform should be well dusted into the vulva. In one instance we found prominent masses of granulations in the vagina in a case that had long resisted ordinary treatment; in this case nitrate of silver proved the best application.

The so-called **aphthous vulvitis** is a superficial ulceration occurring not rarely about the labia in ill-nourished, neglected, and unhealthy children, especially common as a sequel or complication of one of the exanthems. It occurs also in some cases of nephritis, and may simulate the severer disease, noma, from the presence of dried blood on the surface, giving the appearance of sloughing, as in the following case:—

*Acute Nephritis. Ulceration of Labia.*—Mabel C., age two years. Admitted October 27, 1885. Two months ago an eruption appeared on the face and head, which has lasted since; for the past fortnight the labia have been swollen and sore, small spots appearing first; has had epistaxis for the last few days; is said not to have passed urine since the 24th; bowels open this morning, motion quite black. On admission, pale, pasty, bloated child; labia both much swollen and superficially ulcerated; no vaginal discharge; some superficial ulceration around the right ear; eczematous patches on the head, covered with blood-stained scabs. 28th, seems very feeble; no urine passed until this morning, and then into the bed; vulva as yesterday, some thread-worms seen about it; eyes puffy; does not take food well; found dead in bed at 9 p.m. The vulva was dressed with carbolic lotion and boracic lint, and carbonate of ammonia and bark, with strong beef tea and wine, given. Temperature, 28th, M. 98·2, E. 96·6.

*Post mortem.*—Both lungs rather congested and oedematous; no pneumonia; heart normal; kidneys swollen, weighed together 3 oz., not very congested; in one, cortex finely granular (like scarlatinal nephritis) with red points; the ulceration on the vulva and head was quite superficial; there was no sloughing; it extended all over vulva to the vaginal orifice.

<sup>1</sup> Kroner and De Amicis have found gonococci in non-specific blennorrhœa in children. *Rev. Mens. des Malad. de l'Enfance*, December 1884.

The treatment consists in cleanliness, free stimulation, and abundant nourishment, together with such measures as the disease with which it is associated demands.

According to Savarin aphthous vulvitis occurs most commonly in children of from two to five years, and usually is a sequel of measles; the patches begin as blisters and then ulcerate; they may finally become gangrenous. There is some fever and the parts around are swollen, but there is very rarely lymphatic enlargement. The labia majora are most often affected, but the process may spread to the perinæum, groin, &c. The disease has a certain resemblance to diphtheria and syphilis, but is distinguished from the former by the imperfect membrane formation, and from both by the multiplicity of the ulcers, the absence of lymphatic enlargement, and the history. The prognosis is favourable unless gangrene occurs, and the best applications are boracic acid and iodoform.<sup>1</sup> Tubercular ulceration may be met with about the vulva as in other parts.

**Noma Pudendi.**—Noma pudendi or noma vulvæ is a gangrenous affection of the external genitals, of precisely the same character as cancrum oris; it runs a similar course, occurs under the same conditions, and requires the same treatment. It is quite as fatal as cancrum oris, if not more so; it is, however, much rarer: many of the cases of so-called noma are merely aphthous vulvitis. We have very rarely seen well-marked cases. Morse has found an organism in noma that he regards as pathogenic.<sup>2</sup>

Warty and cystic growths are mentioned by Mr. Holmes and others as having been met with about the vulva and vagina in children, and would require treatment on general principles.

Hæmorrhage from the vulva or vagina is occasionally met with in infants, but is of trivial importance and requires no treatment (Holmes); *vide* chapter on Diseases incidental to Birth.

**Irritable Mamma.**—Irritable or painful mammæ are not uncommon in girls of from ten to fifteen years. There is slight enlargement of the glands, which are tender; the pain is variable: usually one breast is affected at a time and the other is attacked later. This condition is usually met with before menstruation has occurred, but is probably associated with the physiological growth of the organs. A similar condition is met with to a less marked degree in boys about puberty. Occasionally the condition is simply hysterical. Treatment seems to be of little use, but all the cases we have seen have got well. Belladonna and strapping locally, with tonics and arsenic internally, should be tried.

In infants the breasts occasionally suppurate; this is usually the result of rough handling on the part of superstitious nurses,<sup>3</sup> and may result in permanently stunted or retracted nipples.

**Abnormalities in the descent of the testicles.**—In the fully developed child the testes should be in the scrotum at birth, or rather shortly before birth;<sup>4</sup> it is not, however, rare for their descent to be delayed for varying

<sup>1</sup> *Vide* Savarin, *Rev. Mens. des Malad. de l'Enfance*, May 1884.

<sup>2</sup> *Med. Record*, January 1885.

<sup>3</sup> The breasts are pulled at to 'break the nipple strings,' with the idea of preventing retraction of the nipples in later life.

<sup>4</sup> Camper found the testes in the scrotum at birth in 63 cases out of 70.

periods—they may even pass into the scrotum as late as the time of puberty. Most commonly descent takes place between the second and tenth years (Hunter, quoted by Jacobson); if the testicle does not come down by the end of the first year, Curling says it is usually accompanied by a hernia. In some instances the organs are permanently retained within the abdomen (cryptorchism); sometimes one testicle descends, the other being retained (monorchism). When the testes have not reached their proper situation they may be found in the abdomen, at the internal ring, in the inguinal canal, in the upper part of the scrotum, in the perinæum, or even in the thigh;<sup>1</sup> and instances of descent of the testes through the femoral canal are on record. Usually the glands are movable, and, though they may generally occupy one particular position, they may often be drawn down or pushed up beyond that spot, just as their situation alters according to the contraction or relaxation of the cremaster and dartos under ordinary circumstances.

We still know so little of the descent of the testicles that the cause of failure of this process must at present remain somewhat obscure. Possibly failure in the action of the gubernaculum, possibly simply a lack of development; certainly sometimes adhesions to surrounding parts, to the funicular process, the intestine, or the mesentery, prevent the descent. Premature closure of the funicular process, contraction of the inguinal rings, or a deficient development of the scrotum in some cases, perhaps accounts for the failure; other less frequent causes, such as shortness of the vas deferens, a long mesorchium, allowing the testis to float freely in the abdomen, fusion of the two testes, or an enlarged epididymis, are mentioned by Jacobson.<sup>2</sup>

The condition of the glands when they are in an abnormal position is a question of importance: they are often imperfectly developed; in other cases, however, they are in no way defective, and cryptorchism by no means necessarily implies sterility, while monorchism is, of course, functionally still less important.

Apart from functional imperfection, various evils may attend imperfectly descended testes. From their abnormal position and diminished mobility, they are in many cases more exposed to injury, as, for instance, when they are lodged in the perinæum or in the canal. If a testis becomes inflamed from injury or other cause, the symptoms are likely to be much more serious if the gland is retained within the abdomen or in the canal, while retained testes are said to be frequently the seat of new growths.<sup>3</sup> Most important, perhaps, of all is the effect of an imperfect descent of the testicle upon the formation and persistence of hernia. By keeping the inguinal canal and rings open, the misplaced organ directly encourages the descent of a hernia. Where the gland acquires adhesions to the bowel and then descends into the canal, or even where the adhesions result from descent of a hernia after the

<sup>1</sup> Displacement of the testis into the thigh has been accounted for by the fact, that some fibres of the gubernaculum testis pass downwards into the upper part of the thigh.

<sup>2</sup> Holmes, *System of Surgery*; vide also Lockwood, *Brit. Med. Jour.*, 1887.

<sup>3</sup> Especially, according to Virchow, when they are retained in the inguinal canal; he points out that obscure abdominal tumours, in the absence of any more obvious connection, should induce examination for an undescended testis.

testis, the matter is still further complicated, and great difficulty in the management of such cases may arise.<sup>1</sup> It is quite common for a child to be brought with the statement that it is ruptured, and that it has perhaps been wearing a truss—but this is said to have been always painful, and the child screams all the while it is on. Examination shows an undescended testis lying in the canal, which has been pressed upon by the truss; and, of course, the child could not bear it. In such cases the undescended testis is often the supposed hernia, though frequently enough the two conditions coexist, and a reducible hernia is found to descend above the testicle.<sup>2</sup>

Mr. John Wood makes some valuable remarks upon this subject in his lectures published in the *British Medical Journal*, June 1885. Where a hernia and an imperfectly descended testis coexist, the gland, if wasted, may be removed; if adherent to the bowel, it may be returned within the abdomen and the ring closed, or, if possible, may be separated, drawn down into the scrotum, and fixed there, the sac and canal being closed above it. In funicular hernia a tunica vaginalis may be made by detaching part of the funicular process, and bringing it down into the scrotum; if the cord cannot be drawn out enough to let the gland come down, the epididymis may be loosened from the testis, and the latter turned down so as to reach the scrotum. All Mr. Wood's results in these operations have been good, with one exception. The diagnosis of undescended testis is not often a matter of difficulty: an examination of both sides of the scrotum will generally clear up the case. But we would suggest a word of caution not to be satisfied with too cursory an investigation: sometimes one testis may be down, and, unless both are felt for at the same time, may slip about so as to feel as if it belonged to either side; sometimes, too, an empty scrotum may be felt, but a little examination and manipulation of the canal, or the application of heat, may bring down the testicle, and the case may turn out to be merely one of retracted, not retained, testis.

Occasionally a hernia, if it contains thickened omentum or glands, may be taken for a testicle or a hydrocele of the cord, or a fibrous or fatty tumour may simulate a testis in the canal. There is considerable variation in the size and firmness of the testes of young children, and we have frequently seen mistakes made about these conditions.

The treatment of undescended testicle is an important and sometimes difficult matter. Where in an infant or child 3 or 4 years old there is an undescended or imperfectly descended testicle, with no hernia, nothing should be done except gentle attempts to bring the gland further down by pressure from above with the fingers; this manipulation should be repeated frequently during the day. In an older child, up to the age of puberty, the same line of treatment should be adopted as a rule; if, however, the testicle gives rise to pain or trouble, an attempt may be made by operation to bring it down and fix it to the bottom of the scrotum. Mr. Wood has had some successes, as already stated, but the operation is not often required; we have

<sup>1</sup> The cæcum may descend with the testis in consequence, possibly, of unusual strength or abnormal arrangement of that portion of the mesorchium called the 'plica vascularis' (*vide* Lockwood, *Med. Chir. Trans.*, 1886).

<sup>2</sup> We have met with a case in which both testis and hernia were strangulated; we removed the testis, closed the canal, and the patient made a good recovery.

performed the operation in one case only, but the ultimate result is unknown, as the boy was lost sight of. The scrotum in such cases is often small and ill-developed. The operation consists in exposing the testis as in an operation for hernia, and passing a silk or catgut stitch through its outer tunic, or between the gland and the epididymis, and then bringing the suture out at the bottom of the scrotum and fixing it there. Testis in perinæo is probably best treated by replacing it in the scrotum—by operation, if possible; if not, and its presence gives rise to trouble, it should be removed. Mr. Jacobson advises that all such operations should be postponed till after the 1st or 2nd year. It is essential to freely separate the testis from all the adhesions<sup>1</sup> which usually exist, so that it lies quite readily in its new position, even before it is stitched there. Displacement of the testicle into the perinæum is sometimes the result of dislocation, and is not congenital: under such circumstances it has been successfully replaced.<sup>2</sup>

We must strongly protest against the use of a truss for undescended testis in young children with a view of keeping it out of the way, or preventing the descent of a hernia where no rupture already exists; we cannot but consider the plan unnecessary and unscientific except in the cases where the testicle is inseparably adherent to the bowel, and, as this can only be ascertained by operation, we think it is wiser to operate in doubtful cases, separate the testis, bring it down, and close the canal above it if possible. If this cannot be done, the testicle should either be removed<sup>3</sup> or, after reducing it into the abdomen, the canal should be closed; hence it is only in such cases that any obstacle to the descent of the testicle should be interposed.

Should an undescended testis become inflamed from injury or from pressure while in the canal, the symptoms may be severe, and may simulate those of strangulated hernia—the absence of the gland from the scrotum usually clearing up the doubt; if, however, there is any uncertainty about it, or the symptoms do not speedily subside, the parts should be explored, and the inflamed or gangrenous testis is generally better removed. Fatal peritonitis has resulted from this condition.

Jacobson, in his well-known article in Holmes' *System of Surgery*, advises the use of Dover's powder, hydrarg. c. cretâ, and hot poppy fomentations in these cases in the early stage; to this article we must refer for further details on this subject: to it we are indebted for many of the points in the present chapter.

Where a hernia coexists with an undescended testis, but the two are not adherent, the best treatment is to apply a truss of special size and shape for the particular case, made so as to fit between the testis and the canal, and so, while the rupture is kept up, the testis is pressed downwards. We have employed this plan usefully, and by its means both defects may be cured. Should the truss fail to procure closure of the canal, the hernia should be dealt with by the operation described in Chapter VIII.; the funicular process

<sup>1</sup> The adhesions may be remains of that part of the gubernaculum which is attached to the tuberosity of the ischium, and this may explain the abnormal position of the testis; vide Lockwood, *Med. Chir. Trans.*, 1886.

<sup>2</sup> Victor Horsley, *Med. Times and Gazette*, December 1883.

<sup>3</sup> This should be only done, as a rule, when the testicle is small and wasted, and can be separated from the gut without risk of injury to the bowel.

being closed above the gland, the descent of the testis will be favoured, and an attempt may be made at the same time to fix it in the scrotum.

**Supernumerary testicles** probably never occur; the supposed instances have turned out to be either hydroceles of the cord, herniæ, or solid tumours. Congenital absence of the testes as distinguished from mere cryptorchism is an exceedingly rare condition and usually associated with other malformations.

Deficiency or closure of the vas deferens is occasionally met with: in such cases the testis is well developed, but, of course, functionless. Inverted testicle, where the epididymis lies in front of the gland, is sometimes a congenital, sometimes an acquired condition; it may be of importance in case of the appearance of a hydrocele or hernia.

Mr. Jacobson's table of the complications of misplaced testis, in so far as it relates to children, is here summarised from his article in Holmes' *System of Surgery*:—

1. The testis may be retained (*a*) in the abdomen, (*b*) in the iliac fossa, (*c*) in the inguinal canal, (*d*) just outside the external ring.

2. The testis may take an abnormal course into (*a*) the perinæum, (*b*) the crural canal.

3. Retained testis may become inflamed or gangrenous, may give rise to peritonitis, may simulate a strangulated hernia, or may become the seat of tubercular disease, of malignant growth, or may atrophy.

4. Misplaced testis may be complicated with hernia, (*a*) from adhesion of intestine to the undescended testicle, or (*b*) from co-existing patency of the funicular process.

5. Hydrocele may be a complication, as (*a*) an acute condition from inflammatory effusion into some unobliterated portion of the processus vaginalis, or (*b*) as a chronic effusion; in either case there may be a communication with the cavity of the peritoneum above, or extension into the scrotum below.

**Congenital displacement or Hernia of the ovary** sometimes occurs, one or both organs protruding into the inguinal or even into the femoral canals, and occasionally in later childhood a similar malposition occurs. We have seen both ovaries prolapsed into the inguinal canals in a case of tubercular ascites, the ovaries returning to the abdomen on the subsidence of the fluid. If irreducible, the ovaries may give rise to trouble in later life from their enlargement at the menstrual periods, as well as from their presence keeping the inguinal canals patent: hence, where possible, they should be returned to the abdomen and kept back by a truss; occasionally an operation as for hernia may be required.

**Diseases of the testicle in childhood.**—Simple **acute orchitis** in children occurs as a result of injury—undue pressure of a truss—or the result of an operation such as that for the radical cure of hernia or lithotomy; sometimes without assignable cause, or under circumstances mentioned in the case of hydrocele. The inflammation often results in the development of hydrocele, and there is often œdema of the scrotum; but the affection is seldom severe, and subsides readily under the use of lead lotion, rest, and elevation. We have never seen any immediate bad result, though it is possible that the subsequent growth of the gland may be interfered with. Orchitis from mumps is very rare in childhood; we have never seen it. Chronic orchitis may result from the acute form.

**Syphilitic Testitis** is, in our experience, very rare; Mr. Holmes mentions having seen hard knots in the testicle which were apparently gummatous;

they readily yield to the use of hydrarg. c. cretâ. Other cases have also been recorded, and sometimes a diffuse orchitis is found.

**Tubercular disease** of the testicle is met with in two forms: as a part merely of a general tuberculosis, and as a localised condition limited to the testis alone or the genito-urinary tract.<sup>1</sup> In the former case the tubercles may be only miliary and disseminated, and hence not recognisable during life, or they may form definite, hard, circumscribed masses in the epididymis, just as in adults. While the disease is limited to the testicle, it takes the form just described, giving often a sensation as of a 'dumb-bell' or double testicle; it is usually not painful, and often of slow growth. If nothing cuts short the child's life, the testicle usually at last breaks down, and a suppurating 'strumous testis' develops, with its characteristic adherent skin, livid colour, and intractable course; the cord is usually thickened.

Where the tubercle is generalised, no treatment of the testicular affection is, of course, of any use; when, however, no obvious lesion exists elsewhere, the usual management, medicinal and dietary, of these cases should be carried out (cod-liver oil, phosphate of iron, &c.) For the testicle itself, pressure, with occasional inunction of mercurial or iodide of lead ointment, may be used, but as soon as suppuration occurs it is probably better to remove the gland; it is in such cases most likely functionally destroyed from blockage of the efferent ducts, and is a source of general infection. The operation is sometimes advised as a precautionary measure as soon as a diagnosis can be made, but the propriety of this we think open to doubt; we have had occasion to perform the operation only once or twice, and in one case the child was seen two or three years later in good health, his brother being affected by 'general surgical tuberculosis.' In this instance the disease began at 7 weeks old, and the gland was removed at 18 months; both testicle and epididymis were involved. Our colleague, Professor Dreschfeld, has recorded a case of congenital tuberculosis of the testis in which tubercle bacilli were found.<sup>2</sup> Hernia testis occurs only in those cases where the body of the testis is involved, and when present castration is probably the wisest course.

**Tumours of the testis.**—Tumours of the testis in children may be congenital or acquired; the congenital are rare and usually 'dermoid,' consisting of cysts which contain hair, teeth, &c., as in the corresponding tumours of the ovary.<sup>3</sup> Striped and unstriped myomata have, however, also been found,<sup>4</sup> as well as congenital adeno-sarcomata,<sup>5</sup> and, according to Silcock,<sup>6</sup> carcinoma—though Butlin disbelieves in the occurrence of carcinoma testis in childhood.

Acquired tumours are usually sarcomata (round-celled), very rapidly growing, very malignant, and tending to involve the lumbar glands very

<sup>1</sup> Genito-urinary tuberculosis is much rarer in children than in adults, but it is common to find both testes tuberculous.

<sup>2</sup> *Brit. Med. Jour.*, 1884, p. 860.

<sup>3</sup> Teratomatous tumours of the testis are explained by Saint Hilaire as instances of 'fœtal inclusion'; by Owen as instances of parthenogenesis; and by Lebert as the result of 'hétérotopie plastique.'

<sup>4</sup> Rindfleisch and Rokitansky.

<sup>5</sup> R. W. Parker, *Path. Soc. Trans.*, 1885.

<sup>6</sup> *Path. Soc. Trans.*, 1885.

early. The large size, rate of growth, solidity, dilated veins, opacity, and bossy surface sometimes with cysts, make the diagnosis usually easy. These growths generally occur in the first few years of life, but according to Butlin are common from the time of birth to the tenth year.

Non-sarcomatous cystic disease may be met with; the cysts usually arise as dilatations of the seminal tubules, and may be lined by cylindrical or ciliated epithelium. Immediate removal is the only treatment to be adopted in a case of malignant disease of the testis, though recurrence within a year is to be expected in most cases; in simple cystic disease the same treatment is required, since a diagnosis between it and sarcoma is impossible. In the case of dermoid cysts it is sometimes possible to dissect away the cyst without injury to the testis.<sup>1</sup>

**Hydrocele.**—Hydrocele is a very common affection in childhood, most frequently met with in quite early infancy; it may result from simple irritation, intertrigo, &c., especially when, as is often the case in that condition, the testes hang loose and pendulous. It is sometimes caused by injury, the testis being squeezed by the child while keeping its legs crossed, or by other

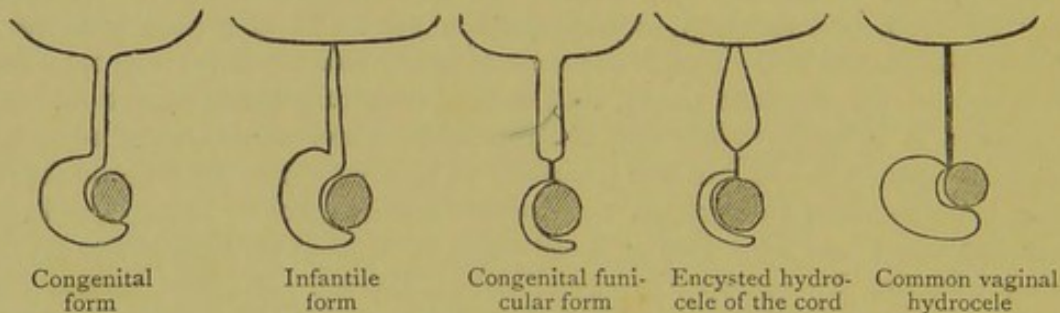


Fig. 80.—Diagram of the commoner forms of Hydrocele of the Vaginal Process. Altered from Lane.

accidents. Hydrocele may be congenital where the whole processus vaginalis remains patent; in this case, if the communication with the peritoneal cavity remains free, the fluid will flow in and out according to the position of the child. We must say this condition is not often found: either the opening is a small one and readily occluded by flexion, or this form of hydrocele is rarer than is commonly supposed.

Infantile hydrocele, so called, is the condition where the tunica vaginalis and funicular process are distended with fluid, the processus being closed at the internal ring; this is a common condition. Again the funicular part of the processus may remain open, but be shut off from the tunica vaginalis; in such case a congenital funicular hydrocele would result. Or, finally, there may be an encysted hydrocele of the cord from distention of an unclosed segment of the funicular process.

Diffused hydrocele of the cord, described as a sort of œdema of the cellular tissue of the cord, is believed to be very rare; we met with a case while operating for hydrocele of the cord, in which there was some gelatinous material lying in the tissue of the cord, superficial to the funicular process, which contained ordinary clear fluid. Hydrocele (encysted) of the testis, and epididymis from dilatation of the hydatid of Morgagni, or organ of Giraldès, may possibly

<sup>1</sup> Verneuil, *Brit. Med. Jour.*, April 4, 1885.

occur ; it is, however, usually a disease of later life, and no case appears to have been recorded in childhood. (Gosselin.)

*Diagnosis.*—The diagnosis of hydrocele in children is made by first examining the cord, and excluding the presence of a hernia by finding that there is no increased thickness of the cord above ; next, a soft, elastic, fluctuating feeling points to hydrocele ; and, finally, translucency, or the possibility of reduction gradually by pressure or elevation, without any gurgling sensation, clears up the case. It is, however, certain that herniæ in infants, when the bowel contains only flatus and is much distended, are sometimes quite translucent. Mr. Howse was, we believe, the first to point out this fact, and we have many times seen the same thing.

When there is an encysted hydrocele of the cord it is usually possible to bring it down by traction, and feel the absence of thickening above, or the tense swelling may be made to slip backwards and forwards between the fingers, quite unlike a hernia. The mode of reduction serves to distinguish a funicular hernia from a funicular hydrocele, and the absence of distinct impulse gives corroborative evidence. Hydrocele of a retained testis sometimes occurs and may give rise to difficulty ; the possibility of isolating it, its irreducibility, and its consistence, together with the absence of the testis from the scrotum, will give the clue.

Combinations of two forms of hydrocele, e.g. of vaginal hydrocele with encysted hydrocele of the cord, may be met with, and a funicular process may contain fluid at one time and a hernia at another. Or there may be infantile hernia with infantile hydrocele. A collection of fluid may form in the sac of a congenital hernia, but is usually masked by the presence of bowel.

Engel and Camper are quoted by Jacobson as having found the processus vaginalis closed at birth in about 10 per cent. only of children examined ; this supports the view that some abnormal condition of secretion in the abdominal cavity must exist to produce a congenital hydrocele, for it is certainly not as common as these figures would imply.

**Hydrocele in girls.**—The funicular process in girls (canal of Nuck) is occasionally the seat of hydrocele ; the diagnostic points and treatment are practically those of hydrocele of the cord in boys.

*Treatment.*—Many cases of hydrocele get well without treatment ; those due to local irritation subside on removal of the cause. The congenital form may disappear by spontaneous closure of the funicular process ; other cases subside under the use of evaporating lotions, lead lotion, or mild counter-irritation such as painting with tincture of iodine. The congenital and funicular varieties are usually cured by a truss, and it is seldom that hydroceles give much trouble. When, however, these plans fail, the methods of treatment we prefer are : (1) injection with solution of pure carbolic acid in glycerine (1 part in 3) without emptying the sac of its fluid, so that the injection is still further diluted ; (2) simple antiseptic incision : the sac is laid open and drained for four or five days without any stitching of the edges of the sac to the skin, as in the so-called 'schnitt-operation.' Tapping, subcutaneous puncture, letting the fluid escape into the loose scrotal tissue, setons, injection with iodine or spirit, &c., all have their advocates, and are no doubt often

successful; but the plans mentioned are in our opinion the safest,<sup>1</sup> surest, and quickest, though relapses occasionally occur, whatever method is adopted. We have seen a hydrocele develop some time after an operation for the radical cure of hernia in an infant in whom the bowel was strangulated.

Œdema of the scrotum is often met with as a result of intertrigo in children, and should be distinguished from hydrocele, anasarca, erysipelas, and extravasation of urine—also from the ‘inflammatory’ or ‘malignant œdema,’ so called.

**Varicocele** has been met with in childhood by Bryant, Pearce Gould, and Landouzy, but we have never seen a case earlier than about the tenth year.

**Ovarian Tumours** in children are nearly always sarcomata, teratomata, or dermoid cysts; <sup>2</sup> they may appear at any age: thus Chiene<sup>3</sup> has operated successfully at three months, and Roemer<sup>4</sup> of Berlin at twenty months. The only treatment is abdominal section in the ordinary way. In the case of large tumours it may be impossible to make an accurate diagnosis between ovarian and renal or other congenital tumours until the abdomen is opened. Precocious puberty has in some instances been found associated with ovarian tumours. We have seen considerable development of the external genitals, with growth of hair and discharge of blood from the vagina, in a child three years old, who was the subject of a tumour which apparently involved the liver and the right kidney. Tuberculous pyosalpinx has once been met with by Chaffey, and once by Quarry Silcock.<sup>5</sup>

<sup>1</sup> Poland has recorded a case of fatal peritonitis after tapping a congenital hydrocele of the cord.—*Lancet*, December 1884.

<sup>2</sup> Evers, *St. Louis Courier of Medicine*, August 1884, has met with a case of sarcoma in a girl of two and a half years.

<sup>3</sup> *Edinburgh Med. Jour.*, June 1884.

<sup>4</sup> *Jahrbuch f. Kinderheilk.*, Bd. xxi., H. 4. Eight out of eleven cases collected by Roemer recovered.

<sup>5</sup> *Path. Soc. Trans.*, 1885. See also *Tumours of the Ovary, &c.*, by Doran.

## CHAPTER XXVIII.

## DISEASES OF THE BONES.

**Diseases of the Bones.**—A full description of the subject of inflammation in bone would be out of place in the present work, but a few of the more important points may be summarised thus :—

The process of inflammation as occurring in bone differs from that in the soft parts only in that the inflamed tissue is more rigid and unyielding ; hence, on the one hand, the progress of inflammation may be slower, and on the other, as tension is greater, its effects may be more destructive.

As elsewhere, inflammation in bone leads to rarefaction, i.e. absorption of healthy tissue (rarefying osteitis), and this may go on slowly, and without any sufficient outpouring of material to develop pus or any obvious external signs of the changes going on. The bone slowly becomes thinner and weaker, and its tissue may entirely disappear ; such a change we see in the caries sicca, or non-suppurative caries, of the vertebræ or of the articular ends of the long bones. It is in some cases accompanied by a deposit of new periosteal bone while rarefaction is going on in the interior : such a condition occurs in some instances of chronic osteomyelitis of the shaft of the femur after excision in hip disease. It is in such cases that fractures occur almost spontaneously, or at least from very slight violence.

Again, in other instances the inflammatory material may be in sufficient quantity, and so incapable of becoming organised that pus is formed, and this may infiltrate the adjacent bone and so give rise to further extension of the process without the formation of any definite abscess ; such a condition we see in some of the cases of chronic osteomyelitis of the long bones, epiphyseitis, certain forms of necrosis of the jaw, &c. Under these circumstances necrosis usually results, or if there is more abundant pus formation an abscess in bone is found.

Where, in consequence perhaps (Cornil and Ranvier) of primary fatty degeneration of bone corpuscles, the bone tissue slowly dies, the dying part, acting as an irritant, gives rise to inflammation around, and the bone is slowly disintegrated, with more or less abundant formation of pus : such a process is seen in ordinary caries of a rib or of the pelvis, or the articular end of a bone. Where small islets of bone are marked out and, as it were, cut off from the rest by the surrounding inflammation, minute sequestra become detached (caries necrotica), while, if larger masses are so separated by a line of demarcation, common necrosis results. The last-named may, of course, be an acute or chronic process, a slow diminution in blood supply causing gradual starvation, or an immediate strangulation causing rapid gangrene of the part (acute necrosis).

So-called 'condensing osteitis' or 'sclerosis' is in its results a hypertrophy, making the bone denser and stronger; the new material has sufficient vitality to stand, and sufficient blood supply to support it as well as the original tissue: such a process we see in chronic periostitis, the results of which may be compared with the sclerosed bone of repaired rickets.

Should, however, this deposit of new bone go on beyond a certain point, the blood channels become themselves so narrowed that the surrounding bone is starved and so necrosis may result.

It should be noticed that while some of these processes of destruction and growth and repair are constantly seen going on side by side, as where chronic osteomyelitis causes central necrosis and at the same time the periosteum forms a new peripheral layer of bone, in others we do not see any repair so long as the disease is spreading: thus in caries of a flat bone or an articular surface, until the destructive process ceases, no new bone is, as a rule, laid down.

Inflammation in bone may occur primarily either as a periostitis or as an osteomyelitis, the latter, often called osteitis, attacking the endosteum and marrow in the medullary cavity or in the cancellous tissue. Compact bone can hardly be supposed ever to be the seat of a primary lesion, though constantly involved by direct extension along the Haversian canals from either periosteum or medulla, it being remembered that a thin layer of medullary tissue lies in each Haversian canal. Inflammation beginning in the epiphysial line may be considered as an osteomyelitis.

**Periostitis.**—Acute periostitis, phlegmonous periostitis, or 'acute necrosis,' is a disease essentially of childhood and youth, rare in infancy,<sup>1</sup> and, so far as we are aware, not occurring in adult life. The disease is seen in two distinct forms, corresponding to the anatomical structure of the periosteum: in the one there is an acute inflammation, with pouring out of the inflammatory products between the surface of the bone and the deep fibrous layer of the periosteum (true, deep, sub-periosteal abscess); in the other the exudation takes place superficially to the deep fibrous layer, in the looser cellular zone which connects the periosteum with the surrounding cellular tissue (parosteal abscess). The difference in texture of these two layers is of the utmost importance, and is marked by striking differences in the course and results of the inflammation. While the sub-periosteal effusion, whether serous or purulent, lifts up the periosteum from the bone, presses upon and detaches the vessels passing to the Haversian canals, and thus cuts off the blood supply to the affected part, and further, by the extreme tension under which it is pent in, gives rise to all those evil results due to pressure of confined fluid, on the other hand, the supra-periosteal exudation lies in loose tissue, interferes comparatively little with the blood supply to the bone, and is not bound down, so that there is but little tension.

Either form of acute periostitis may be met with as a result of injury, exposure to cold and wet, as a sequel of one of the exanthems,<sup>2</sup> or as a

<sup>1</sup> We have only twice seen it under two years old. Watson Cheyne mentions a case of Rosenbach's in which it occurred *in utero*, but this was considered to be an osteomyelitis (? epiphysitis).—*Brit. Med. Jour.*, March 3, 1888.

<sup>2</sup> Periostitis and necrosis after typhoid do not occur till the patient is well of his fever (Paget, *Path. Soc. Trans.*, 1884). Macnamara, however, quotes Affleck's cases of periostitis in the third week of typhoid.

pyæmic condition. It will nearly always be found that one of these causes has produced, or at least preceded, the attack; often two or more may be combined. The disease is no doubt an infective one.

The onset of acute periostitis is marked by fever with its general constitutional disturbance, rigors, pain in the affected limb, with swelling coming on rapidly, and usually involving the whole length of the affected bone, and often the adjacent joints.<sup>1</sup> The skin soon becomes swollen, red, and shining, and there is extreme tenderness. The temperature commonly, in the sub-periosteal variety, reaches  $103^{\circ}$ – $105^{\circ}$ , and there is much prostration. Soon the swelling increases, and, if proper treatment is not adopted, in a few days pus finds its way to the surface and is discharged, with much relief to the symptoms. Usually, however, fresh foci of suppuration arise, and if the child is neglected, in a large number of instances pyæmia occurs and the patient dies; in others, after much destruction of periosteum and the formation of many abscesses, the limb is left riddled with sinuses leading down to the bare dead shaft.

Sometimes, but not commonly, the neighbouring joints suppurate by direct extension from periosteum to capsule, and thence to synovial membrane; most often, however, there is merely a serous effusion, the result of interference with circulation, or a slight degree of inflammation.

Suppuration of a joint by direct extension might be expected to be most common in the case of the hip, where the epiphysal line lies within the joint, and this complication does sometimes occur; it is not, however, common in our experience.<sup>2</sup>

Usually the inflammation is limited by the attachment of the periosteum to the epiphysal line, and does not reach beyond this; sometimes it spreads in along this line and loosens the shaft from its epiphysis, or sets up an osteomyelitis. The same endosteal lesions may, of course, result from extension inwards along the Haversian canals, but we think it is not the rule to find suppuration within the medulla, either epiphysal or diaphysal, as the result of acute periostitis. Quite apart from osteomyelitis, the whole shaft may necrose, probably because not only is the blood supply from the numerous small vessels entering the bone throughout its length cut off, but also because the nutrient artery itself as well as the supply from the epiphysal zone is lost.<sup>3</sup>

Mr. Macnamara believes that all these cases really begin as an inflammation of the epiphysal line, and that the mischief spreads downwards and upwards, both beneath the periosteum and in the medulla. That such a con-

<sup>1</sup> Mr. Clinton Dent has pointed out that extension of suppuration to the joint is commoner in supra- than in sub-periosteal abscess; it certainly does, however, occur in both forms.

<sup>2</sup> Of 18 cases of acute periostitis under our care, the femur was affected alone in five instances, the tibia was attacked in six cases (in two of these there was extension upwards to the femur), the humerus alone in two cases, the humerus and ulna in one, the radius in one, the ulna alone in one, a rib in one, and a metatarsal bone in one instance was inflamed. Four of these cases were supra-periosteal (parosteal), and in them no necrosis followed. There were five deaths, all from pyæmia, and all in sub-periosteal cases; one child had non-purulent pericarditis (proved by aspiration) and recovered.

<sup>3</sup> *Vide* Dent's able paper, *Med. Chir. Trans.*, 1881. Mr. Dent believes that the medulla may disintegrate without being inflamed at all.

dition does occur his specimens prove, and we readily admit from our own experience, but that it is the common condition we cannot agree.

If left to itself, then, and the patient survives, acute periostitis results in necrosis of a part or the whole of the shaft of the long bone attacked; subsequently new bone is thrown out by the surviving periosteum and surrounding tissues, and the sequestra are enclosed in the sheath of this new bone, in which are cloacæ leading down to the dead part.<sup>1</sup>

Probably because the disease is a somewhat uncommon one it is often mistaken, when it does occur, for erysipelas or rheumatism; most of the cases of necrosis resulting from it are said to have followed one or other of these diseases. From erysipelas it is distinguished by the much greater pain in periostitis, by the absence of any defined line of redness, by the limitation of the disease and its evident relation to the shaft of a long bone, and, as soon as an incision is made, by the exposure of the bone shaft.

There is, of course, no real resemblance to rheumatism of joints, inasmuch as the joints are only involved in very minor degree, so that this is a less excusable mistake. The disease most closely resembling it, especially the supra-periosteal form, is diffuse cellulitis; this, however, is usually more superficial and more widespread, not ceasing at the joints.<sup>2</sup>

There is but one treatment of acute periostitis at all worthy of consideration, and that is free incisions down to the bone through the periosteum, as soon as the disease is diagnosed:

each incision should be about one inch to two inches in length, and made in the long axis of the bone, care being taken, where practicable, to make the incisions not all on one side of the limb, though, of course, important vessels &c. must be avoided. Several shorter incisions are better than one the whole length of the limb, as Mr. Holmes has pointed out.

Bleeding is usually very free, and it may be necessary to plug the wounds for a few hours to arrest it; the plugs should then be removed, drainage tubes inserted, and the wounds dressed every day or two, or oftener if there

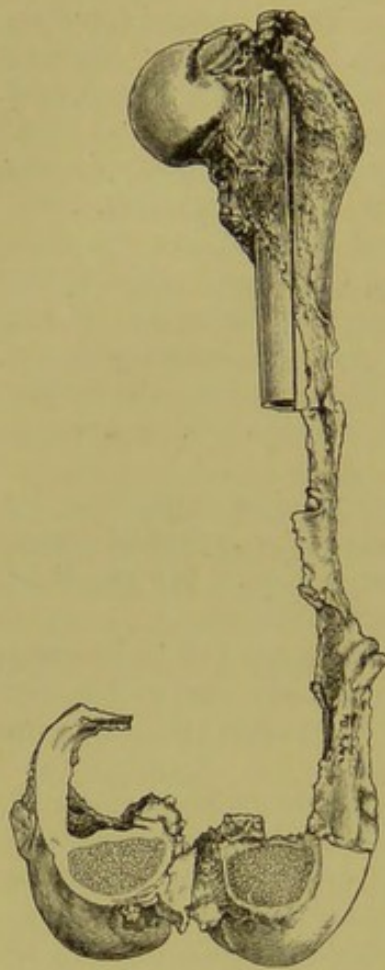


Fig. 81.—Acute Periostitis of the Femur, showing stripping off of periosteum and separation of the epiphysial junction. The lower part of the shaft has been removed post mortem.

<sup>1</sup> Dr. Macewen, in a recent paper in the *Annals of Surgery*, expresses disbelief in the existence of any bone-forming power in the periosteum, and believes that all new bone is formed from bone itself. His views are, however, not at present accepted.

<sup>2</sup> In one case which we saw with Mr. Coates, of Manchester, the mischief spread from tibia to knee, and beyond this upwards to the lower end of the femur—but this is very exceptional; there was no suppuration in the femur. We have had another very similar case, *vide* p. 490, note.

is much discharge. Should no pus be found at the time of incision, provided that it is certain that the bone has been laid bare, it may be taken as a proof that the disease is in its early stage, and the prospect is therefore better. In all cases, however, serum and flakes of lymph will be found, even if there is no pus, and there will usually be free suppuration in a short time. Too free exploration of the bone with the finger or probe, and too frequent or forcible syringing, are to be avoided, as tending to separate any still adhering periosteum, or to prevent adhesion after separation has occurred. The limb should be kept slightly raised, and stimulants, opium, and abundant nourishment given to the child. Should the fever not subside in a few hours, it is probable that some abscess has not been relieved, and a director should be passed round the bone, or a fresh incision made at any painful spot. In the tibia, for instance, where incisions can hardly be made at the back, pus may be lying beneath the periosteum at the back of the bone, bound down by muscular attachments. In spite of the authority by which it is supported (Billroth), we cannot regard applications of nitrate of silver or iodine, or anything except free incision, as good treatment.

Since such extensive necrosis and so much suppuration with liability to pyæmia usually follow in these cases, it has been proposed to resect the affected bone at the time of incision, and this has been done by various surgeons. Since the periosteum is preserved, a new bone is developed, and, it is said, without shortening in cases where a second bone exists, as in the leg and forearm.<sup>1</sup> We cannot say we see any great advantage in this method, and it is impossible in any case to be sure how much of the bare bone will die—usually it is only a very small portion compared with the part exposed; and, though we have at a later stage removed nearly the whole of the shaft of some of the long bones as sequestra, it is common to see quite small portions of dead bone as the result of most extensive stripping off of periosteum. We think, therefore, that primary resection of the diaphysis is not to be recommended<sup>2</sup> unless it is absolutely detached at each epiphysial junction and bare of periosteum throughout—a very rare condition. Neighbouring joints should not be incised unless they are pretty clearly suppurating, i.e. a slight degree of effusion does not mean suppuration. If the joint is full of fluid, and the skin over it is hot and its veins turgid, or if the swelling or fever does not subside rapidly after incision of the periosteum, the joint should be opened or, if in doubt, aspirated; if pus is found, a free incision and the insertion of a drainage tube is required.

It must be very rarely that immediate amputation is demanded, even if joints are involved; if there is no pyæmia a large proportion of the cases do well, and if pyæmia exists already amputation will not usually succeed. If after free incisions the symptoms do not subside, and especially if pus escapes from the epiphysial line, there is probably suppurative osteo-

<sup>1</sup> Much shortening has, however, followed in some cases (*vide* Neve, *Indian Med. Gaz.*, April 1884, who records a case of one-and-a-half inches shortening after removal of the upper half of the tibia; also Holmes, *Surg. Dis. of Children*).

<sup>2</sup> We believe that much harm is often done by the practice, already alluded to, of passing in the finger, sweeping it all over the bone, and then remarking that the whole bone is bare; of course it is, for the operator has just stripped off the remaining periosteal attachments.

myelitis ; the bone should then be exposed and trephined to give vent to the matter.

The time at which sequestra may be expected to be loose after the onset of the disease varies with the size of the bone and the extent of destruction : if the whole shaft dies the bone will probably be loose in a month or six weeks ; if only a part is necrosed it will vary from the time mentioned to many months, or in the case of the femur sometimes, the bone, especially if the lower end is affected, may remain for years without being detached, and yet is so far devitalised that it acts as a foreign body and keeps up suppuration. This especially applies to periostitis attacking the popliteal surface of the femur, and holds good of chronic inflammation as well as acute.

No absolute rule, then, can be laid down as to the time at which sequestra can be removed ; the sinuses should be explored with a probe from time to time, and if the dead part can be felt to be movable it should be cut down upon and taken away. If no loose bone can be felt, but the probe passes down through cloacæ in the new bone to a sequestrum, the patient should be anæsthetised, the limb rendered bloodless, the sinuses laid open, the cloacæ enlarged, and the sequestra examined : any that are loose should be taken away, and any distinctly dead but not loose bone may be cut away, but no doubtful bone should be disturbed—it may recover. The wounds are then plugged with iodoform gauze or lint, and daily dressed until they fill up or the sequestra become loose. It is very seldom that all the dead bone is removed at one operation ; usually small fragments either come away of themselves or have to be removed by later operations. In cleaning out the cavities in which sequestra lie great care should be taken not to break into joints or remove more new bone than is necessary. The delay in waiting for the separation of sequestra is not waste time, for the new bone is meanwhile consolidating and the limb getting stronger. In subsequent dressings care must be taken to keep all the cavities well drained and syringed out, otherwise retention of discharges and detritus will give trouble. Unnecessary probing of sinuses is useless and harmful : it is useless to be constantly feeling bone to see whether it is loose, for the process of separation is a slow one ; it is harmful, because broken granulations readily absorb septic material, while sound ones are proof against it—moreover, it needlessly frightens a child. Where repair is very slow, and profuse discharge is wearing out the patient, it may be necessary to sacrifice doubtful bone for the sake of rapid healing, or even in extreme cases, chiefly where there is destruction of a neighbouring joint and great prostration, amputation may be required.

CASE.—T. B., age 6½ years, was admitted April 22, 1881. Three weeks previously the boy fell down some steps and hurt his forehead and his shin, but seemed to get quite well. Two days before admission he complained of pain in the left thigh, but ran about as usual. On the following morning he could not get up, had pain in the knee, and could not move the leg ; he was delirious during the night, with profuse sweating. On admission he was pale, dull, and heavy-looking ; R. 48, T. 106, pulse 156, with low, muttering delirium. He was ordered four grains of quinine and brandy-and-egg mixture. The left thigh was swollen to nearly double its normal size from the top to the knee, and intensely painful. A short time after he came in three free incisions were made through the periosteum down to the bone ; much sanious sero-pus and lymph escaped. The bone was quite bare. After the operation the temperature was 104°, falling to 102·4°.

There was great prostration. The temperature again rose to  $106.6^{\circ}$  at 11 P.M., when he died.

*Post-mortem.*—There were recent pyæmic abscesses in the lungs, and the whole femur was bare, from the neck to the lower epiphysis. No other disease was found. *Vide* fig. 80.

Supra-periosteal abscess has the same general symptoms as the more serious condition, but it is much less severe, for the reasons already mentioned; the pain and fever are less, though the swelling is often as great. On cutting into the abscess, and passing the finger in, the bone will be found still covered with the dense fibrous layer, and is consequently not bare. Necrosis seldom follows, or if it does it is limited both in extent and depth; usually only a small scale of bone comes away. If this form of periostitis is, however, neglected, the deeper layer may slough, or the mischief spread through it, and more extensive necrosis may ensue. The diagnosis between the two conditions can generally be made by the less severity of the symptoms in the superficial variety.

The immediate and later treatment is the same as that of the sub-periosteal form, i.e. free incisions at first, and subsequent removal of sequestra, should any necrosis occur.

*CASE.*—*Supra-periosteal abscess of thigh.*—Mary Ann D., age 13 years 2 months; admitted December 24, 1882. Three weeks before admission she had pain about the lower part of the leg and walked lame; the symptoms increased latterly, and the left thigh was noticed to be swollen and shining; she had been getting thin and pale for two or three months previously; no injury. On admission a large fluctuating swelling occupied the anterior and upper half of the left thigh, large veins ramified over the surface, there was a blush of redness over it, and some tenderness and pain; an incision was made into the swelling, and a large quantity of pus escaped, which was in close contact with the bone, though the latter was doubtfully bare; considerable bleeding took place into the abscess cavity, which stopped after a free counter-opening and more perfect drainage were employed; she then steadily improved, and was discharged well on August 4. This case did not come under our care at first, and it was only at the second examination that we had an opportunity of exploring the bone; at this time it was certainly not bare, a thin layer (deeper layer of periosteum) covering the bone. The constitutional disturbance, as usually occurs in the superficial periosteal abscess, was much less than in the sub-periosteal form, and no necrosis followed.

A careful watch should be kept for the onset of pyæmia in all cases of acute periostitis; it appears sometimes exceedingly rapidly. We have just mentioned a case of acute periostitis of the femur, which died with infarcts in the lungs and ecchymoses on the pleuræ after an illness of altogether only two days, and another child died in the same way six days after an injury giving rise to periostitis of the fifth metatarsal bone.

In some instances the periostitis is multiple at the first: these cases are no doubt pyæmic, and sometimes occur after a primary joint lesion; thus we have seen acute suppuration in the ankle followed shortly by an abscess in the wrist, and a few days later by periostitis of the humerus and ulna, and by pneumonia. After death no other lesions than these were found. In another case, of an infant six months old, periostitis of the tibia followed a suppurating nævus of the scalp: the bone necrosed and gave way, a fracture resulting; the child died of pyæmia, sinking, as they so often do, quite suddenly.

The disease very rarely attacks any bones except the long bones of the limbs; the tibia, femur, humerus, and ulna we have seen most commonly

affected<sup>1</sup>—sometimes the whole shaft, in other instances only a part, being laid bare. Occasionally the short and flat bones are attacked (*vide* T. Jones, *Diseases of Bones*, p. 90).

CASE.—*Necrosis of Rib (traumatic). Empyema.*—Wm. G., age 10 years 7 months; admitted November 29, 1881. Nineteen days before admission fell with his side against the kerb-stone; two days later had much pain in the side, and swelling appeared next day; had rigors, and was feverish and vomited on November 28. On admission, pale; some dyspnoea, but not urgent; anxious expression; a soft fluctuating swelling over the lower part of the left side of the chest, rather larger than the palm of the hand; the heart's impulse was two or three inches to the right of the sternum, and the whole of the left side of the chest was dull, and the respiratory sounds were distant, though audible; a cyrtometer tracing showed distinct bulging of the left side; the abscess was opened the same day, and a small quantity of thin pus escaped; the pleural cavity was then opened and a pair of dressing forceps pushed into it between the ribs; a large quantity of slightly turbid yellowish fluid was evacuated, the abscess cavity was clearly quite distinct from the pleura, and at that time the pleuritic fluid was not purulent; the rib was bare, but not fractured; a tracheotomy tube was tied into the chest and the wound dressed antiseptically. All went well, and on December 3 a vulcanite tube was substituted for the silver tracheotomy tube. On the following day it was seen that for the first time the discharge was distinctly purulent, and it was considerable in amount; the lower half of the left chest behind was still dull and tender to percussion, though in front the resonance was good. Up to this time there was still partial orthopnoea; a week later another abscess behind and above the first opening appeared, and on incising it bare bone was felt; the dullness, &c., was clearing up. By the end of January, 1882, the discharge from the chest had lessened and the dullness nearly disappeared. On February 2nd an incision was made over the diseased rib, and about a third of it removed; there was a good deal of new bone around the sequestrum; the cavity left was plugged with a piece of sponge, which remained in place till March 6, when some of it was cut away; several bleeding points in it then appeared, due to granulations which had sprouted into it and held it firmly in position; at this time the left base was normal, except slight dullness. On March 13 antiseptics were discontinued; on the 20th more of the sponge was cut away, and at the end of the month the rest was removed; it was found that it was impeding healing and causing eversion of the edges; the sponge was filled with granulation tissue, which microscopically was seen to penetrate the unaltered sponge framework. The wound rapidly closed, and on May 5 he was discharged almost well; there was little if any retraction of the side, and the lung had apparently fully expanded. Here traumatic periostitis of the rib led to abscess externally and serous effusion into the pleural cavity; after the opening was made probably the suppuration in the chest cavity resulted from the communication with the external abscess.

Arrest of growth from destruction or synostosis at the epiphysial line may result;<sup>2</sup> or, on the other hand, there may be overgrowth from persistent hyperæmia of the limb, as the result of the subsequent irritation caused by sequestra (fig. 82). This overgrowth may, as seen in the figure, cause distortion from one bone of the limb outgrowing the other.<sup>3</sup>

Where the periosteum has extensively sloughed, or where the bone has been fractured, a short, weak limb may result from deficient development of

<sup>1</sup> A case of acute periostitis of a vertebra is mentioned by Macnamara; and *vide* note, p. 490.

<sup>2</sup> J. H. Morgan has detailed a case in the *Brit. Med. Jour.*, September 1, 1883. The humerus was the bone affected.

<sup>3</sup> Birkett has recorded a case of overgrowth of a limb after injury to the patella in a boy of eight years (*Path. Soc. Trans.*, vol. xviii.); *vide* also Edmunds, *Path. Soc. Trans.*, 1885. A case of B. Pollard's, described as hypertrophied callus, is perhaps of the same nature.

new bone ; these fractures sometimes remain ununited, and may require resection and wiring.

*CASE.*—*Non-union of Tibia after fracture as result of Necrosis.*—Female, age 4 years 5 months ; five months ago left hospital, after sequestrotomy, in a plaster bandage ; no union occurred, and limb was useless and quite movable, though not flail-like ; incision made down upon ends of bone, which were much atrophied ; surfaces refreshed and wired together by 1 silver suture, which was fixed to buttons on surface of wound ; ultimately firm union occurred, and child could bear her weight upon the leg and walk well.

As the accounts of different writers on the subject of acute bone inflammation are somewhat conflicting, and give rise to confusion, the accompanying tabular statement of how the different lesions may arise will perhaps be of service to those less familiar with bone diseases.

Acute inflammation of bone may begin as :—

A. Periostitis.

1. Sub-periosteal.
2. Supra-periosteal or Parosteal.

B. Osteomyelitis.

1. Epiphysitis, i.e. disease beginning in the cancellous tissue of the epiphysis.
2. Inflammation of the medulla of the shaft (diaphysitis).
3. Inflammation beginning in the epiphysal line, often called epiphysitis also.

Inflammation arising in any of these ways may give rise to the other forms of lesion ; e.g. sub-periosteal abscess may spread along the epiphysal line and cause suppuration in the medulla of the shaft, or inflammation of the medulla may spread outwards and cause periostitis. As a rule, however, careful clinical observation will enable an accurate opinion to be given of the primary seat of the mischief.

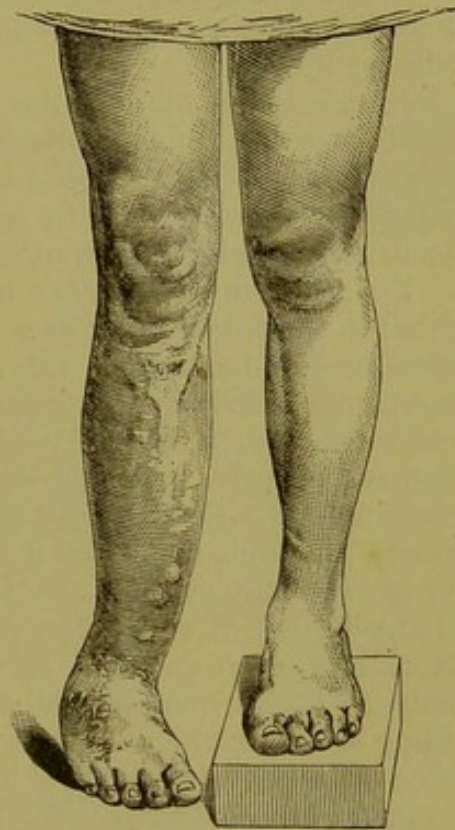


Fig. 82.—Shows Overgrowth of the Bones of the Right Leg, especially the Tibia, after Necrosis. (Dr. Massiah's case.)

**Chronic Periostitis.**—Periostitis of less severity, and less rapid in progress, is common enough, and the subacute cases are better classed with the chronic than with the acute, inasmuch as they are more like the former than the latter in their results. Subacute or chronic periostitis then occurs in children as the result of injury, as a pyæmic condition, or as the sequela of an exanthem—probably these two sets of cases are very closely allied, if not identical ; or it may be caused by syphilis or tubercle. Whichever of these is the cause in any individual case, suppuration often takes place except in traumatic and in many of the syphilitic cases. Since the process is a slow one, it is usually impossible to say whether the lesion began as a sub- or supra-periosteal inflammation ; perhaps the whole thickness of the membrane is involved at once, or else, as the bone is usually more or less deeply implicated, the lesion is sub-periosteal in origin.

The disease is characterised by local or diffused thickening of the bone in its early stages ; the swelling is tender, painful at times, but usually, unless

in subacute cases, there is no implication of the skin. Later on, the swelling, if left to itself, either subsides or softens down, and abscesses form in one or more spots; on incising these the bone is found bare and rough, with perhaps small scale-like exfoliations, or in other cases, to be described presently, more extensive lesions. The periosteum is sometimes four or five times its usual thickness and readily peels off the bone, while in old cases there is often some rough spiny deposit of new bone developed around the centre of disease. In traumatic cases in healthy subjects the thickening may subside altogether without any trouble or suppuration, or there may be sufficient new bone formation to cause swelling, lasting for months or years, without any other symptom.

In tubercular children the swelling ('strumous periosteal node') usually slowly increases, often painlessly, though by no means always so; suppuration finally occurs and matter is discharged, or in rarer instances the inflammation subsides. Generally in the tubercular cases periostitis is either the result of, or itself leads on to, osteomyelitis. (Superficial or central caries.)

Exanthematous periostitis is found usually in wasted and feeble children, either in the course of, or as a sequel to, one of the specific fevers; there is often much suppuration, with but little pain or disturbance, and a limb is found occasionally to be little more than a flabby bag of pus, without any pain and without much fever. The child lies wasted and haggard, with rough scaly skin and offensive smell, the hair harsh and often thin, and the veins showing distinctly through the thin, fatless skin. The chronic pyæmic cases so exactly resemble these that it is probable that many of the exanthematous forms are really pyæmic. A fair number of such children recover, others gradually sink of exhaustion or some intercurrent pneumonia or diarrhœa. Much less severe cases are also met with, in which chronic periostitis occurs affecting only a small part of a bone—it may be any bone—and either subsiding or giving rise to only local necrosis; the ribs are said to be specially often attacked after typhoid fever, but seldom necrose. For an excellent account of these diseases *vide* T. Jones on *Diseases of the Bones*, 1887, p. 40; *vide* chapter on Spinal Disease, *infra*, for a case of necrosis of a spinous process.

Congenital syphilitic periostitis is usually multiple, and occurs rarely during the first year or two of life, being commonest from about the 5th to the 15th year. It is, as Hutchinson has pointed out, less amenable to anti-syphilitic treatment than the periostitis of acquired syphilis, and according to him is common in the upper limbs; in our experience symmetrical periostitis of the shafts of the tibiæ ('syphilitic nodes') is far the commonest form, and in some cases it breaks down and large ulcers form on the surface. The amount of thickening may be enormous, as in fig. 83.

CASE.—*Chronic Syphilitic Periostitis of Tibia*.—Lilian G., age 12 years; admitted November 19, 1884. Mother had three miscarriages as the result of her three first pregnancies. Patient when born had an eruption about the buttocks, sores round the mouth and snuffles; improved at six months old, and has gone on well since, except for a sore eye. Duration, three years; following a slight kick; no swelling till a month later; much pain ever since; sore varies from time to time; has been under treatment (antisyphilitic) as an out-patient for some considerable time. On admission, healthy-looking girl; teeth normal; no obvious signs of syphilis; the right tibia is much thickened, and apparently bowed antero-posteriorly; no fluctuation; the most tender spot is on the front of the

lower part of the middle third; the swelling involves nearly the whole shaft; no fever. November 27, tibia trephined at its most painful spot; periosteum much thickened; the bone was much sclerosed and the medullary cavity reduced to a narrow channel; no pus and no cavity found. The reflected periosteum was stitched together with catgut and tube inserted. Operation antiseptic. All went well; she was discharged on December 17; there was no further pain, and when seen as an out-patient, February 1885, she was sound and well, and free from pain.

CASE.—*Syphilitic Periostitis of Tibia*.—John Wm. A., age 6 years. No tubercular history; one of the children died of convulsions at seven weeks—it had snuffles; three other children living; no miscarriages. Child healthy at birth, weakly since three years old; the leg has been tender for six months, but no swelling was noticed till four days ago; no pain unless touched. On admission, pale, unhealthy child; has remains of double interstitial keratitis and scars at the angle of the mouth; the upper milk incisors have gone, lower incisors small and ill-formed; there is thickening, forming a prominent swelling in the middle of both tibiae, tender, but not red. The tenderness disappeared quickly under treatment (antisyphilitic), the swelling remaining much the same. Sent home February 25.

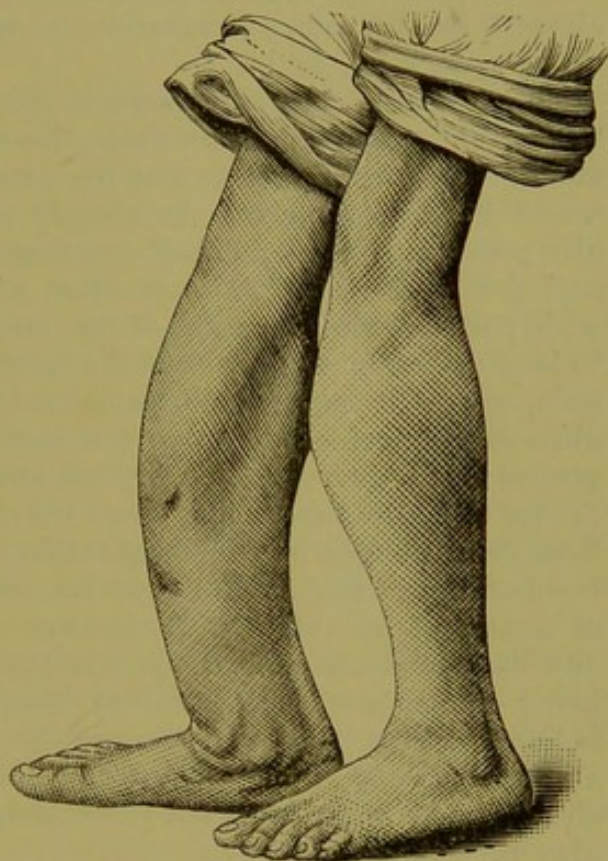


Fig. 83.—Congenital Syphilitic Disease of both Tibiæ (periosteal and endosteal). This figure, from a patient of our own, is reproduced from Mr. Jones' book.

Less frequently the upper end of the tibia is involved; in such cases there is not rarely effusion into the knee, not merely passive, but an actual serous synovitis. Other evidence of congenital syphilis is in our experience almost always to be found, though it is not always obvious. The pain is often severe, though sometimes it is almost absent.<sup>1</sup> Macnamara believes that the syphilitic telostitis of infants (*see* chapter on Congenital Syphilis) is due to interference with nutrition at the epiphysal line from pressure of new-formed periosteal deposit around, and that the telostitis is not inflammatory.<sup>2</sup> Arrest of growth may result just as in the case of older children who are attacked by syphilitic epiphysitis<sup>3</sup> (*vide* Epiphysitis). The palate and bones of the face are not rarely destroyed by congenital syphilis, but this occurs in a late stage of the disease (*vide* fig. 63); the nasal bones are, of course, early affected, and the deformity resulting gives rise to one of the characteristic features of inherited syphilis. The evidence afforded by thickening of the bone, with tenderness on deep pressure and aching pain, serve to distinguish

<sup>1</sup> Mr. Moullin has written a good paper on this subject in the *Brit. Med. Jour.*, 1884 p. 52.

<sup>2</sup> *Brit. Med. Jour.*, July 5, 1884.

<sup>3</sup> Hutchinson, *London Hospital Reports*, vol. ii.

periostitis generally from any more superficial lesion, while the onset of swelling and pain simultaneously points to the existence of periostitis rather than osteomyelitis, though either, it must be remembered, may give rise to the other. New growths are to be distinguished by their greater rarity, their greater prominence, with often bosses and a well-defined margin, and local patches of softening, as well as by their situation, which is usually at the ends of the bones; hence they are more likely to be mistaken for osteomyelitis than for periostitis.

The tubercular and syphilitic lesions are nearly always accompanied by other evidences of their respective diseases, such as tuberculous glands or ulcers, a family history of tubercle, or, on the other hand, syphilitic lesions of the eyes, teeth, &c.<sup>1</sup>

There is difficulty sometimes in distinguishing the lesions of bone due to congenital syphilis from those dependent upon tuberculosis, though we are not inclined to think that the mistake is so often made as Fournier<sup>2</sup> would have us suppose. As already mentioned, the tibia is (as Fournier also points out) the bone most commonly affected by the syphilitic lesions, and the long bones are more often attacked than the short or flat bones, with, perhaps, the exception of the skull, while the diaphysis is more liable to be attacked by syphilis than the epiphyses. New bone formation, severe pain, worse at night, little tendency to suppuration, though occasionally abscess and necrosis do occur, and evidences of syphilis from the history or presence of other syphilitic lesions, are the principal features of the one group, while the tuberculous cases are characterised by absence of any new bone formation, caries occurring rather than necrosis, by early suppuration, freedom from pain, and the other features already pointed out. The effects of treatment by iodide of potassium will give confirmatory evidence. In any case of doubt antisyphilitic treatment should be given a fair trial, it being remembered that children bear, and often require, large doses of iodide (gr. x.-xx.) to obtain good results. Nearly all the varieties of periostitis are found chiefly in the long bones, though similar lesions may be met with elsewhere, as in the jaws, &c.; *vide* chapter on Diseases of the Mouth, and also the chapter on Joints.

*Treatment.*—In early stages of the disease, if the leg is affected the child should be kept in bed with a splint on. Cod-liver oil and iron should be given in the tuberculous, hydrarg. c. cretâ or iodide of potassium in the syphilitic cases: the former in children one or two years old, and a combination of the mercury and iodide in older cases being the best treatment. Where the arm is affected, a splint should be applied and the child allowed to be up, unless any subacute mischief is going on. Simple traumatic cases require rest and the application of soothing lotions, such as lead, with or without spirit or opium, or the application of belladonna diluted with glycerine or vaseline; in some cases good is done by rubbing in mercurial ointment,

<sup>1</sup> Dr. Goodhart has met with a remarkable case of bone disease in a child a year old, which was thought to bear relation to osteitis deformans, but was probably syphilitic; there was tenderness, softening, and diffused thickening of the bone; rickets co-existed.—*Path. Soc. Trans.*, vol. xxxiv.

<sup>2</sup> *La Syphilis Héritaire Tardive*. Paris, 1886. To this work we must refer for an elaborate account of the later lesions of hereditary syphilis.

or keeping it applied over the swelling. Some surgeons have faith in the application of iodine ; a blister is sometimes undoubtedly of use in relieving pain. If after a fair trial of some weeks no good result has been obtained by these means, and pain still persists, or, of course, earlier than this if suppuration occurs, an incision should be made down upon the bone through the periosteum ; if pus is found, or any superficial necrosis, the case is to be treated on ordinary principles : if after this the pain is not relieved or returns, it may be taken for certain that osteomyelitis exists, either as a primary or secondary condition, and this should specially be borne in mind in tubercular cases in which osteomyelitis is much more commonly the primary lesion in long bones. If then there is evidence of osteomyelitis, further measures will be required (*vide* p. 504).

Occasionally in syphilitic cases no absorption takes place under mercurial or iodide treatment ; if the pain persists, the bone should be cut down upon and, if necessary, trephined or gouged, so as to open up the sclerosed bone and give vent to any pent-up material (cf. case, p. 498, *antea*). In cases of syphilitic necrosis of the bones of the face or palate a plastic operation may be required, but this should not be attempted until the destructive process has entirely ceased. Where the whole hard palate has been destroyed an obturator may be necessary. We have seen a case where, after ulceration of the palate and pharynx, the soft palate became adherent to the pharyngeal wall, and the obstruction to the nose thus produced caused so much trouble that excision of part of the soft palate became necessary.

**Acute Osteomyelitis.**—Acute diffuse or infective osteomyelitis occurs usually as a result of amputations or resections, but is of extreme rarity in this country ; it is, however, more common in hot climates : we have seen it in one instance in a case of acute traumatic gangrene in a boy. The disease is, however, more often met with as a result of extension to the medulla of inflammation beginning in the epiphysis or epiphysial line, or of acute periostitis, and occasionally occurs as a primary condition. Mr. Macnamara, and with him some of the continental surgeons as already mentioned, believe that the affection already described as acute periostitis is really acute osteomyelitis ; this, however, is, we believe, not the case as a rule, since if it were so complete recovery without extensive necrosis would not be nearly so common as it is in these cases. Moreover, in cases of acute periostitis dying of pyæmia sections of the bone have shown an entire absence of osteomyelitis in some instances.

The characteristic symptoms, in a case where acute osteomyelitis follows amputation, are swelling and subsequent suppuration of the medulla, retraction of the periosteum and soft parts, so that the bone is left bare, and diffuse swelling of the limb. Pyæmia usually rapidly ensues, and in many cases death speedily results. Amputation at the joint above has been usually said to be the only successful method of treatment, but the plan recently introduced of scraping out the entire contents of the medullary canal, as advocated by Mr. Keetley and others, is well worthy of adoption, and has proved successful in several instances ; our colleague Mr. T. Jones, among others, has had good results from this method.

Where acute diffuse osteomyelitis occurs as a sequel to epiphysitis or periostitis, or is the primary lesion, the shaft of the affected bone should be freely opened with trephine or chisel, and a similar treatment adopted. The

existence of this disease may be suspected, as already pointed out, when the severe constitutional symptoms and pain do not subside after freely incising the periosteum or opening up an epiphysial abscess; swelling and tenderness at one or more points in the shaft, or diffuse bony swelling without any collection of fluid beneath the periosteum, will indicate the presence of pus in the medulla. For an excellent account of the whole question *vide Diseases of the Bones*, by T. Jones, 1887.

**Acute Epiphysitis.**—Acute circumscribed osteomyelitis or acute epiphysitis is a more common condition; it consists in a localised inflammation attacking the cancellous tissue of an epiphysis or the immediate neighbourhood of the epiphysial line. The disease nearly always goes on to suppuration, and on examination a cavity will be found containing pus, or in some cases sequestra. Acute epiphysitis may occur in children of any age: for instance, most cases of 'acute suppurative arthritis of infants' are typical examples of this disease (*vide* p. 520); in other, though much rarer instances, older children are attacked.<sup>1</sup>

If left to itself, the pus finds its way either into the adjacent joint or along the epiphysial line to the surface,<sup>2</sup> or down the medulla of the shaft, giving rise to acute diffuse osteomyelitis. The disease may follow an injury or exposure, or one of the exanthems, or, according to Mr. Greig Smith, may arise from lymphatic infection of the bone marrow. It most commonly attacks the head of the femur, the upper end of the tibia, or the lower end of the femur, less often the extremities of other long bones. Some of the cases of acute disease of the hip, elbow, shoulder, and ankle, apart from 'acute suppurative arthritis of infants,' are really also of this nature.

The lesion is marked by early fever and much pain,<sup>3</sup> of gnawing, toothache-like character, followed, after a longer or shorter time, according to the age of the patient and the amount of resistance to the exit of the pus, by swelling of the bone coverings and effusion into the adjacent joint, which is usually kept fixed in the position of least tension.<sup>4</sup>

The pain is usually agonising, and the failure of health very rapid. Deep pressure in the earlier stages, and any touch of the limb when the pus is approaching the surface, is exceedingly painful. Local heat is usually only appreciable in the later stages; increased pulsation in the main artery of the limb may be found. In infantile arthritis (acute suppurative arthritis) the symptoms are sometimes subacute. The diagnosis is made by careful exclusion of joint lesions (by lack of marked effusion &c.) where the joint is still free, and attention to the history of the pain and swelling, so as to distinguish the case from periostitis;<sup>5</sup> pain on deep pressure in the absence of joint disease is a characteristic feature. Rheumatism and rickety pain are

<sup>1</sup> *Vide Abstracts of Cases treated at Children's Hospital, Pendlebury, 1882.*

<sup>2</sup> The epiphysis may in this way become detached from the shaft.

<sup>3</sup> In the infantile cases we have, of course, no means of knowing the kind of pain, but usually it is evidently severe.

<sup>4</sup> We have, however, seen the knee strained to its utmost degree of flexion, far beyond the point of least tension; thus showing at once that the lesion could not be intra-articular.

<sup>5</sup> Though, of course, as pointed out by Macnamara and others, and as already described, epiphysitis may give rise to sub-periosteal abscess and necrosis as well as to intra-articular abscess.

readily distinguished by the strict localisation of the suffering. In the infantile cases the joint is usually involved by the time the child is brought.

CASE.—*Abscess in the head of the Tibia.*—Wm. Hy. D., age 9 years; admitted December 30, 1881. Had pain in the leg for two months; worse for five days; no further history. On admission, he was pale, ill, and anxious. T. 103·8; there was intense pain in the right knee, which was flexed to its fullest extent; there was no effusion in the joint, and the outlines of the condyles were distinct through the tightly stretched skin. Over the head of the tibia and the upper third of the leg there was considerable swelling, most marked over the inner tuberosity of the tibia, where also the tenderness was greatest; no fluctuation; under chloroform an incision was made over the inner tuberosity, and the soft parts found infiltrated with inflammatory products, but no pus; a chink indicating the line of union of epiphysis and diaphysis was seen, and on gouging away some bone about dr. ss. of thick sanious pus escaped; no distinct cavity was found; operation antiseptic; a tube was put into the opening in the bone; one hour after, the temperature was 102·6. He had pain on several evenings subsequently, and there was but little non-purulent discharge for two days, when several drachms of pus were discharged. On January 5, as the joint was swollen, it was aspirated, and a small quantity of turbid sanious fluid withdrawn and an ice-bag applied; he had no pain afterwards, but on the 12th the joint began again to swell, and on the 15th was distended, and incisions were made into it, discharging fluid, at first flaky, but serous, and subsequently more nearly purulent. On February 9 the drainage tubes were removed and all was going on well, the wounds in the joint being superficial, though bone could be felt through the opening into the tibia; the limb had been kept fixed. On the 23rd the joint was forcibly flexed and several adhesions broken down; considerable swelling followed; the joint shortly settled down again. March 3, a small sequestrum was removed from the tibia as well as a good deal of caseous material. April 3, the limb was put up in plaster of Paris, and the boy sent out on the 5th. He attended as an out-patient subsequently; several small bits of bone came away, but the wound finally closed, and he has now, February 1883, a sound limb with a fully movable knee, though a little thickening still remains.

The treatment of acute epiphysitis consists in early and free incision down to the bone; if matter is met with, this is usually sufficient, but, should the pus not have reached the surface, an opening must be at once made into the bone and the abscess emptied, any sequestra found being removed. In any doubtful case it is far better to explore the bone than to run the risk of the abscess bursting into the adjacent joint. Should the joint be already involved, as it almost always is in the acute epiphysitis of infants, it must be freely opened and drained. For a more detailed account of infantile epiphysitis, see the chapter on Diseases of the Joints, p. 520.

Should the mischief have spread to the medulla of the shaft, the diaphysis should be exposed and trephined at one or more spots to give vent to the pus, and the whole medullary cavity should be scraped out, washed, and drained; failing this, amputation is the last resource. For some good cases illustrating this treatment, *vide* T. Jones on *Diseases of the Bones*, 1887, and *Medical Chronicle*, Dec. 1886.

A condition known as '**Growing Fever**' is sometimes met with, usually in children of from 7 to 15 years, though occasionally at both earlier and later ages. The main features are pain in the region of the epiphysial lines, rapid growth and fever sometimes, with considerable constitutional disturbance. Usually the symptoms pass off without any bad result, but in rare cases osteomyelitis may be set up, and the development of exostoses about the epiphysial lines has also been noticed after the occurrence of 'growing fever' (*vide Brit. Med. Jour.*, April 14, 1888, p. 820).

**Chronic circumscribed Osteomyelitis.**—Where chronic osteomyelitis is localised, as, for instance, sometimes in the epiphysial extremities of the long bones, an abscess may result, with or without necrosis; the symptoms are those of acute epiphysitis, already described, only less severe, and the onset of the disease is slower and more insidious. In non-tubercular cases there is often much sclerosis of bone around the abscess cavity, and the disease may go on for years without any attempt at reaching the surface. In other instances the extension of the inflammation to the surface is marked by slight and slowly increasing thickening of the periosteum, so that the diameter of the bone is somewhat increased, and the tissues over it may be slightly œdematous. The characteristic aching, gnawing pain, especially at night, is sometimes well marked, but in children more often there is comparatively little pain, and the pus soon finds its way to the surface—both these facts being due, no doubt, to the less resisting nature of the softer bones of children. Hence the more typical forms of chronic circumscribed abscess of bone are comparatively seldom seen in young children, but are most marked in young adults. Moreover, in children the distinction between circumscribed and diffuse osteomyelitis is also less defined; though sclerosis of the walls of the cavity does sometimes occur, it is less frequent in children, and the inflammation is more apt to become diffuse. The attacks of pain may be intermittent, so that for weeks or months there is little sign of anything wrong, and then all the symptoms reappear.

*CASE.—Epiphysitis of both Femora, &c.*—John W., age 6; admitted April 12, 1884. Always delicate; for eighteen months past had abscesses; twelve months ago had dropsy; eight months ago had measles; four months ago knee swelled painlessly, was poulticed and opened. On admission, delicate child; abscess scars about neck, &c. Sinus over left upper arm leading to bare bone. Just above right knee is a sinus, and two more in popliteal space, another below the knee; at lower third of leg is a large abscess; sinuses also round left knee. 18th, abscesses on leg and knee opened. 21st, sent out for a while. Re-admitted May 19. June 3, explored, and bare bone felt at back of right knee and in arm. June 11, under chloroform. Left thigh explored through incision on outer side; no bare bone felt, and posterior triangular space was healthy, but bone was enlarged, so a circular opening was made with a gouge, and deep in the centre of the bone was found a cavity containing pus and pus-infiltrated bone; on clearing out this a cavity the size of the top of the thumb was left with sclerosed walls. On the right side bare bone was felt behind and above the internal condyle; a precisely similar operation was done and just the same condition found, together with several small hard sequestra. This cavity communicated by a circuitous course with the sinus on the outer side; this was only found out by injecting lotion. A small sequestrum was also removed from the humerus. Wounds syringed out with chloride of zinc and filled with iodoform. Some cellulitis, &c., followed, but he did fairly well up to a certain point and was discharged July 31. He was subsequently readmitted with the disease in the right thigh extending, and is still under treatment 1888.

Abscess in bone is not limited to childhood, but very frequently begins before puberty, though many of these patients do not come under treatment until the disease is of long standing. Though most commonly met with in the cancellous tissue of the extremities of the long bones, abscess may also occur in the shaft, and we have twice had to trephine for circumscribed abscess in the middle of the shaft (of the femur and tibia respectively), occurring many years after an attack of acute periostitis.

*Treatment.*—As in acute periostitis, there is but one thing to be done in

these cases. A free incision should at once be made down upon the bone, and, either with a gouge or trephine, a hole made into the cancellous tissue until the abscess is reached. Before operating, the *exact spot* of greatest tenderness should be marked, and this is to be the centre of the incision. We have derived great help from this precaution in finding a small abscess in bone. Some surgeons prefer to do linear osteotomy, i.e. saw across the epiphysis with a fine saw, and thus open up the abscess; but this plan is in no way better than the other. The bone is usually found soft, red, and rarified; often only a drop or two of pus will escape, and this may be overlooked. Even if the abscess is not found, relief is almost sure to follow and pus will be discharged in a day or two; at the same time, if no abscess is found, careful exploration should be made in every direction for the matter, to diminish the risk of its opening into the joint. Should a sequestrum be found, it will be of course removed, and the cavity should be well scraped out and drained; should the adjacent joint be involved, it must be treated like any other suppurating joint.<sup>1</sup>

**Chronic diffuse Osteomyelitis.**—This disease is met with chiefly as a tubercular or as a pyæmic condition; it may result from extension from a primary periostitis, or originate in the medulla, perhaps most often beginning in the epiphysal line.<sup>2</sup>

The tubercular disease in a well-marked case is a remarkable lesion; the child has perhaps a history of some long-continued bone trouble coming on after measles or other illness, or after an injury; external examination shows thickening of a large part of a long bone, with a sinus leading down to a cavity in the shaft. At first sight it appears that the case is one in which either the periostitis is the main lesion, or a small localised central inflammation has

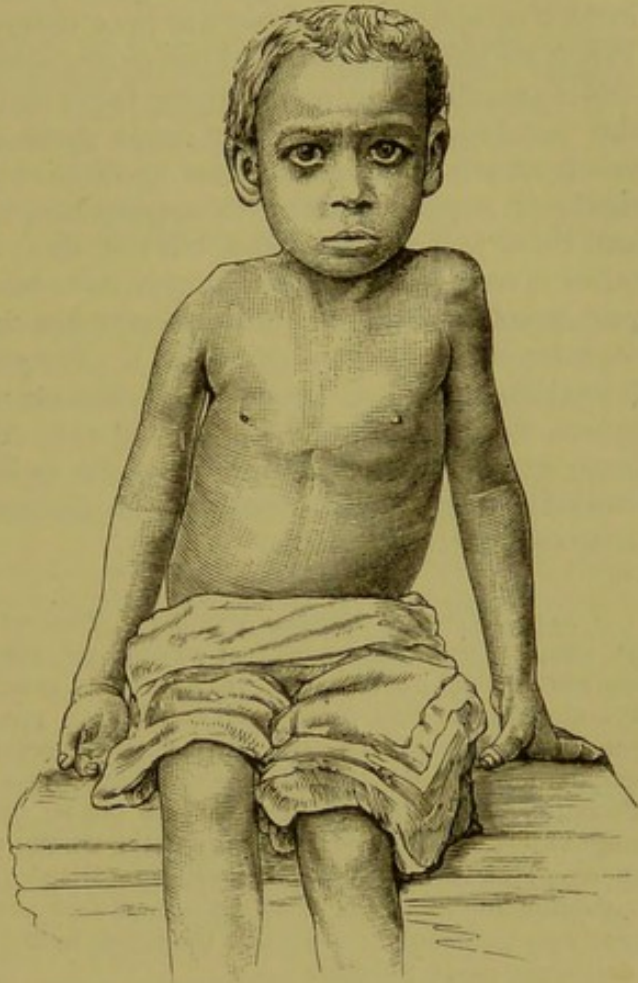


Fig. 84.—Epiphysitis of the upper end of the Right Humerus, with softening and relaxation of the ligaments of the Shoulder joint. The joint cavity was not involved.

<sup>1</sup> The subject of acute suppurative arthritis in infants (acute epiphysitis) is treated more specially under Diseases of the Joints.

<sup>2</sup> It is a matter of extreme difficulty, and sometimes impossible, to be sure whether a given lesion has begun as a local periostitis, spreading afterwards to the epiphysal line, or whether the epiphysal lesion is primary and the periostitis secondary.

reached the surface and then spread along the periosteum; but on cutting down upon the cavity, and clearing it out, a small sequestrum, infiltrated with pus, and greenish-yellow in colour, is removed. Instead, then, of finding the walls of this cavity formed of healthy, but sclerosed bone, they are soft and also infiltrated with pus, showing the same greenish colour as the sequestrum. There is no sharp line of demarcation between this green bone and the surrounding shaft, but patches of rarefied pale bone are seen in parts. On attempting to gouge away the diseased tissue it will often be found to extend throughout a great part of the shaft, and perhaps several inches of cancellous tissue are thus removed before living bone is reached. When all has been removed the cavity slowly fills up, leaving a sinus or two. Some months after, on exploring these sinuses, a similar condition is found; the purulent infiltration has again gone on spreading, and, in time, it may reach an adjacent joint and set up disease there. In such cases the compact tissue is usually healthy in appearance, though sometimes it is perforated, and there is generally some, but not always great, periosteal thickening. In other instances, where the changes have been rather more active, the diseased part becomes isolated and sequestra are thrown off ('chronic circumscribed osteomyelitis,' 'central necrosis'). Sometimes the compact tissue also dies ('total necrosis'). Though this disease most commonly affects the long bones, it may, as already pointed out, attack the jaw; here even the new bone may become infiltrated, and die as fast as it is formed; it is, however, doubtful whether this condition in the case of the jaw is tubercular (*vide* Diseases of the Alimentary Canal).

*CASE.—Alveolar Abscess, Necrosis of Jaw.*—Joseph P., age 6 years; admitted May 31, 1884. Fairly healthy till four months ago, when he had toothache; tooth extracted, but swelling did not subside. On admission, much swelling over right side of lower jaw. From socket of first lower molar, which is gone, pus and granulation tissue exude. June 4, alveolus cleared out; some small pieces of bone and a rudimentary permanent tooth removed. Discharged June 4. Readmitted June 23, with more pain, swelling, and discharge; external incision made and pus let out. June 26, swelling &c. increased; a large sequestrum removed from inside the mouth, and several more through the external opening; these sequestra were soft, foetid, and pus-infiltrated, and formed part of the horizontal and ascending rami throughout their entire thickness; the cavity left extended nearly up to the joint; some new bone had been formed and died subsequently. July 9, discharged much relieved.

The scapula, clavicle, ribs, pelvis and sternum, and facial bones are also sometimes attacked, and disease of adjacent joints may occur by extension.<sup>1</sup> The sequestra are generally soft, and in some cases the pus decomposes and they become foetid, but this is not by any means generally so in the limb bones.

A similar condition is found in the epiphyses of the long bones without the shaft being involved; sometimes a whole epiphysial nucleus will die

<sup>1</sup> Though the malar and upper jaw bones are often affected, we hardly remember having seen any of the bones of the vault of the skull attacked, except the temporal, and this has been a result of disease of the ear. The occipital we have once seen perforated by tuberculous disease, and in the same child the frontal bone was carious. The process is essentially alike in all these cases.

and shell out as a sequestrum. We have met with the same condition in the patella, leading to destruction of the knee joint.<sup>1</sup>

CASE.—*Necrosis of the Patella. Disease of Knee joint.*—John R., age 7½ years; admitted July 7, 1882. 10 weeks ago had a blow on the left knee, which became painful a week later. On July 2 it began to discharge; his health had been failing since an attack of whooping cough eighteen months ago; phthisis in family. On admission, a fluctuating swelling mapping out the left knee-joint, a little redness and venous turgidity; a half-closed sinus lay over the lig. patellæ; limb nearly straight; no pain. July 18, sinus explored; it was found to lead upwards into a cavity in the patella, from which a sequestrum, the size of a damson stone, was removed. The joint was incised on each side and a free communication found to exist between the joint and the sinus through the patella; coagulated lymph and serous fluid escaped from the joint; operation antiseptic. August 17, has done well, and line of incision was healed except at entry of drainage tube; very little discharge; general condition good; no fever since operation. August 29, discharged in a back splint; readmitted in October; wounds healed; passive movement attempted, but adhesions found to be strong and universal, not giving any hopes of a movable joint, so he was fixed in a back splint with plaster of Paris, and sent out November 15.

In this chronic osteomyelitis an epiphysial line acts only as an imperfect barrier, and, where the disease begins in it, it usually spreads both upwards towards the joint and downwards into the shaft. When the whole epiphysis is involved, the articular cartilage may be exposed on the removal of the infiltrated bone, and, as its nutrition is cut off from the side of the bone, it usually gives way, and in such cases the joint becomes involved.<sup>2</sup>

CASE.—*Osteomyelitis of Tibia.*—Annie L., age 3 years; admitted November 4, 1884. History good. In June, 1884, fell downstairs; in August first complained of pain in left leg; it then began to swell, and has been slowly increasing ever since—rapidly during the last fortnight; health failing; has pain at night, &c. On admission, tense swelling of nearly the whole tibia and the soft parts over it; skin shining, but not red; T. 98.6°. Three incisions were made over the front and outer side down to the bone, but no pus escaped. She was relieved, pain disappeared, and swelling subsided. She was discharged on November 18. Readmitted December 16, 1884. The left tibia is enlarged in nearly its whole length, and is very tender on palpation over its lower third. Some prominence of superficial veins just above the ankle, but no discolouration of skin and no fluctuation; T. normal. January 8, under spray, incision made over tibia just above the ankle; periosteum found much thickened; a small gouge was easily pushed into the centre of the bone, and some pus welled up; a quantity of soft disintegrating bone, infiltrated with pus, was gouged away until a fairly healthy surface was reached; drainage tube inserted; iodoform and wood-wool dressing. On January 19, tube removed; and on February 2 wound almost healed, but leg not diminished in size, and presents same general characters as on admission. Readmitted March 30, 1885. The wound from last operation has not healed, and is still discharging; swelling has spread up the tibia as far as knee joint; considerable thickening. April 30, no change in condition; T. occasionally 100 deg. at night. Esmarch's bandage applied, and incision afterwards made, about 2½ inches long, over lower third of tibia; periosteum detached and a new casing of bone, about ¼ in. thick, exposed; on cutting through this with a chisel, softened bone infiltrated with pus was removed, and at lower end a sequestrum about 2 in. long was extracted. A second incision was afterwards made over upper third of tibia, and the bone found in similar diseased condition;

<sup>1</sup> Vide *Lancet*, March 1883. Since then we have seen two or three similar cases.—*Children's Hospital Abstracts*, 1882.

<sup>2</sup> We have, however, seen a case where complete recovery with a movable joint occurred, although the articular cartilage was thus exposed.

the whole of the interior of the tibia was gouged and scraped out, so that a probe could be passed from the upper to the lower opening; iodoform and wood-wool dressings and back splint applied. May 26, lower wound healing; still large cavity at upper; much discharge; T. hectic, 96.4-100.4; takes food well. June 9, wounds slowly filling up; suppurating glands at angle of jaw opened; T. 98-102 deg. June 29, wounds superficial, but still much discharge. July 20, lower wound almost healed; upper filling up and contracting; less discharge; T. normal. August 11, still slight discharge from both wounds; sent home on back splint. Readmitted October 24. Leg more swollen than when last in hospital; still two sinuses over left tibia. The limb was finally amputated, as the joint became involved.

The other forms of diffuse inflammation which may attack the marrow of bones have been already mentioned: in the rarefying form the medulla may be replaced by deep red or maroon-coloured granulation tissue, and the bone may become so soft as to readily break down under the finger; such condition may, however, be recovered from. We have known a case where the femur was so affected, and recovery took place without any unusual difficulty.

In sclerosing or condensing osteomyelitis the medullary cavity may be almost entirely filled up with irregular dense masses of bone, and sometimes isolated central sequestra exist under such circumstances.<sup>1</sup>

Scattered miliary tubercles may sometimes be found in the medulla of bone as a part of a general tuberculosis; they are, however, only found post mortem, as they give rise to no symptoms during life.

The pyæmic variety of osteomyelitis is occasionally met with. In the most characteristic case that we have seen, a boy eleven years old, who was in the habit of getting wet and drying his clothes on him, complained of pain in the feet; the right foot and subsequently the knee swelled, the latter suppurated and discharged profusely a fortnight later; the left elbow, the right hip, and the left knee then were attacked. On admission, ten weeks after the onset of the illness, both hips, both knees, and the right ankle, the left elbow, and the left shoulder, were swollen; there were bedsores, and he had a systolic murmur and some evidence of pneumonia; the urine was albuminous; he was much wasted, and his skin was dry and harsh. A month after admission the left elbow was incised; at that time there was brawny thickening over the upper part of the same arm; ten days later, on exploring the humerus, there was found to be extensive but ill-defined mischief in it; a fortnight after, the disease had extended so that the whole humerus was the seat of osteomyelitis; pus discharged freely from the medulla at the upper part of the bone. The limb was amputated at the shoulder joint; in doing so a large axillary abscess was opened. The shoulder joint was healthy, the elbow disorganised; there was a sequestrum at the surgical neck of the humerus. He recovered fairly well from the operation, but subsequently fresh mischief occurred in the thigh, and he was removed by his friends, probably to die.

**Treatment of Chronic Osteomyelitis.**—The treatment of the different forms of chronic osteomyelitis has been almost sufficiently indicated in the description of the disease. The general management will be that of tuberculous children: locally, in the early stages, rest to the part by means of splints, and in some cases confinement to bed, is all that can be done. If the disease does not subside, the bone must be freely exposed—the limb

<sup>1</sup> A combination of these two conditions appears to have existed in a case recorded by Mr. Paul in the *Med. Press and Circ.*, 1884.

having been made bloodless by the elastic bandage, and the bone gouged away, all tissue that is dead or infiltrated with pus being removed; if the mischief spreads far along the medulla, a groove must be cut in the bone, and all affected cancellous tissue scraped away. Should no repair take place and the disease spreads to an adjacent joint, if the child's health is good, an attempt may yet be made to save the limb by incising the joint and draining it; in some cases, however, nothing seems to arrest the disease and amputation is required.

Washing out cavities with carbolic or mercurial lotion (1 in 4,000), and free dusting with iodoform, is perhaps the best wound treatment. In some cases it is a good plan to try the application of the actual cautery to the interior of the bone, in the hope of arresting the tubercular process. In pyæmic cases incision of abscesses, removal of sequestra, and amputation are the only local resources, and each case has to be judged on its own requirements.

**'Strumous Dactylitis.'**—The condition sometimes called 'strumous dactylitis' requires brief mention here. The disease is simply chronic tuberculous osteomyelitis, attacking usually the first phalanx of one or more fingers; sometimes the metacarpal or metatarsal bones are affected. The disease usually begins as a hard, painless swelling of that segment of the finger, though occasionally there is a good deal of pain, and always some tenderness. If no treatment is employed, the swelling increases, the soft parts become involved, abscesses appear usually at the sides of the finger, and on their bursting or being opened thick curdy pus, with, perhaps, some bony detritus, escapes. On further examination, a large cavity is found occupying the site of the old shaft, which is either entirely gone or remains in part as a cheesy sequestrum, or in some cases, if the abscess is opened early, appears to be simply bare. Around the cavity, which is filled with pus and caseous matter, is a thin layer of new bone formed by the periosteum. As successive layers of new bone have been laid down and absorbed so-called 'expansion of the bone' has occurred. After removal of all the cheesy matter and sequestra the finger may gradually shrink and get well, but is shortened, distorted, and usually weak and useless. Sometimes the destruction is so great that amputation is required. When seen in the earlier stages, constitutional treatment, with fixation of the finger on a splint and gentle pressure, will sometimes succeed in arresting the disease. It has been recommended to excise the bone sub-periosteally in the early stage, and this would no doubt cut short the disease, but the finger is not likely to be of much use. It is better treatment to wait patiently, not even being in a hurry to open abscesses,

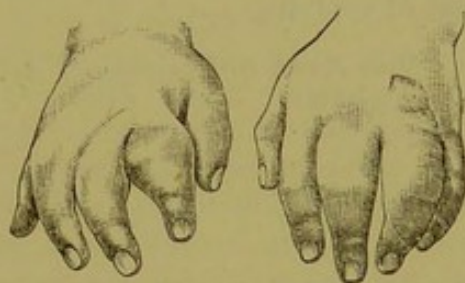


Fig. 85.—Multiple 'Tubercular Dactylitis.'

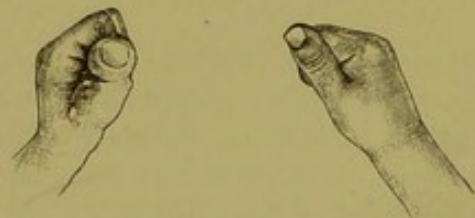


Fig. 86.—Shows Overgrowth of one Thumb, which had been long the seat of Tubercular disease. This is a rare condition, and should be compared with fig. 82 of overgrowth of the tibia.

but keeping the finger quietly fixed on a splint to try the effects of pressure and general hygiene; when sequestra are present they must, of course, be removed, and should no progress be made the cavity must be cleared out—but, as a rule, a more useful finger is obtained by expectant than by active treatment.

Often many fingers are affected, and the disease is most commonly a part of 'General Surgical Tuberculosis'; it is most frequently met with in the first few years of life. The disease is probably sometimes periosteal rather than endosteal.

'**Syphilitic Dactylitis**,' so called, is more often described than met with. The general appearance closely resembles that of 'strumous dactylitis,' and it is said that in children the disease is usually primarily an osteomyelitis, though the gummatous material may be deposited first either in the periosteum or soft tissues overlying it. The occurrence of 'dactylitis' in a child showing other signs of congenital syphilis would lead to a suspicion that the affection of the fingers was also specific. The results are usually very much the same as those of the tuberculous lesion, and the treatment is simply that of syphilis.<sup>1</sup>

<sup>1</sup> Vide *Eschle* in *Langenbeck's Archiv*, xxxvi., 1887; or an abstract in *Med. Chron.*, February 1888.

## CHAPTER XXIX.

## DISEASES OF THE JOINTS.

**Diseases of the Joints.**—There is no essential difference between the joint diseases of children and those of adults, but certain forms of disease are found most typically, or even almost entirely, in childhood. The conditions of growth as regards the relations of epiphyses to the adjacent joints and to the shaft of the bone are, however, most important factors in determining the occurrence of disease and the kind of lesion met with, and, further, the liability of children to the various exanthemata is of much importance in regard to joint affections. Ordinary acute synovitis from injury or cold is in no way peculiar to, nor even specially common in, children, and need not be discussed here; while hip disease, acute suppurative arthritis of infants, scarlatinal synovitis, and even the common tubercular pulpy disease, are instances of the modifying effects of the conditions of childhood upon forms of lesion which are also to be met with in adults.

In early life the lesions of joints are more complex than in adults, for the reason already alluded to, that not only may disease begin in the joint structures proper, but it may often reach the articulation by extension from the neighbouring epiphysis or epiphysial line. It is generally said that bone lesions are limited by the epiphysial zone and do not extend to the bone below; this, as already shown, is only partially true, and, besides this, disease spreads frequently from a starting point in the epiphysial line, or from the periosteum of the diaphysis, and extends to the capsule, and so to the synovial membrane. There is, however, often effusion into a joint adjacent to bone disease without actual continuity of disease. (For further details see chapter on Bone Diseases.)

Joint disease, then, in children may arise as a simple acute serous synovitis, which may subside, suppurate, or become chronic.<sup>1</sup> There may be a primary acute or chronic tubercular synovitis. Pyæmia or certain of the exanthems, notably scarlatina and typhoid, may give rise to an acute, sometimes suppurative, synovitis, while measles and whooping cough, as well as scarlet fever and typhoid, may result in a development of tubercular lesions. Finally, the joint disease may arise by extension from the shaft, epiphysial line, or from the epiphysis itself, and possibly from the ligaments and tendon sheaths in exceptional cases. The specific fevers are not so often, as is sometimes stated, the direct cause of joint disease: it is in most cases

<sup>1</sup> Chronic simple serous synovitis is, however, rare in children.

rather than the depressing effect of the fevers makes the child more liable to the onset of disease—thus of 125 cases of joint disease, taken consecutively from our records, including cases of disease of the hip, knee, shoulder, elbow, ankle and tarsus, and wrist joints, in only 6 cases was the joint affection a sequela of measles, in 4 of scarlet fever, in 2 of typhoid, and in 3 of hooping cough. Only those cases were reckoned in which there was no interval of health between the exanthem and the joint trouble.

In certain joints bone lesions are far most commonly primary, as in the hip, and perhaps the shoulder; in other joints, as in the knee, ankle, and wrist, bone disease when present is much more often secondary to a primary synovial inflammation, while in other joints again, as in the elbow, either starting point is common.

The hip is by far the most frequently diseased joint in children, and the knee comes next. Of 698 cases of joint disease under our care in the out-patient department of the Children's Hospital in 3 years, 369 were cases of hip disease, 160 of knee disease, and all the other joints together amounted to 169. Disease of the spine is excluded from this calculation.

For any detailed account of the pathology and symptoms of each diseased joint we must refer to the special works of Barwell, Macnamara, Howard Marsh, Hueter, and others; space will only allow of selection of the hip and knee as types of the two forms of joint disease found in childhood, with a brief reference to the other most commonly affected articulations. Hip disease stands so much by itself that its consideration will be most conveniently postponed till after that of the other joints.

Chronic disease of the knee-joint may be taken as the type of joint disease beginning in synovial membrane—pulpy disease, chronic synovitis, tubercular synovitis, white swelling, and various other titles, all implying the same condition.

Here we may say at once that we believe all the cases of chronic disease of joints marked by great thickening of synovial membrane, with little or no tendency to accumulation of fluid, but with great tendency to the formation of small multiple abscesses in the thickness of the gelatinous tissue, are truly tubercular in the most strict sense. In many instances evidence of tubercle elsewhere and a tubercular family history will be found;<sup>1</sup> in many death ultimately results from tuberculosis of other organs. The anatomical characters of tubercle are constantly to be found in the pulpy tissue, and, though not so constantly or readily, yet in a large number of instances, tubercle bacilli have been detected.

The usual history of a case of chronic tubercular synovitis of the knee-joint in a child is as follows. There is perhaps a history of phthisis or joint disease in the family; the child has been healthy, till at the age of, say, 4 years it was attacked by measles or some other exanthem. It was slow in recovery, and was never quite strong afterwards; a year later perhaps, it received some injury to the knee. Shortly after the knee swelled, but gave rise to no great pain or inconvenience, except a slight limping and feeling of tiredness; the swelling slowly increased and became somewhat more painful, especially at

<sup>1</sup> In 192 histories of chronic joint disease under our care (the spine being included), in 43 (+6 doubtful cases) there was a tubercular family history; in 61 (+1 doubtful case) the disease had followed an injury. In 19 cases out of 111 patients there was more than one lesion, i.e. there was evidence of tubercle elsewhere.

night, with night startings.<sup>1</sup> At this time the child comes under observation. The knee is found markedly larger in circumference than its fellow, its natural hollows are obliterated, it may or may not be slightly hotter than the other, there is slight flexion, and it cannot be fully extended,<sup>2</sup> any attempt to do so causing pain. There is considerable pain on pressure over the inner tuberosity of the tibia, and to a less degree over the outer side. The swelling is soft, elastic, and pseudo-fluctuating: it may exactly follow the normal outlines of the joint, or be more globular, the upper synovial pouch not being thickened; occasionally the swelling is almost limited to the upper sac. There is pretty free mobility of the joint at this stage, unless an attack of acute inflammation has supervened upon the chronic mischief. Such a case left to itself will later on become more flexed and less mobile, abscesses will form and burst at the sides or front of the joint, the swelling will increase, and the veins over the surface may become dilated and full; the tibia will become subluxated backwards and outwards, and at the same time rotated outwards upon the femur; the limb will become wasted and powerless. In many cases pain increases and the child's health suffers, until at last the pain and discharge, or the invasion of other organs by tubercle, wears him out.

The severity of the symptoms varies greatly: in some instances pain and stiffness exist throughout; in others free, though not usually full, mobility and absence of pain may be found during nearly the whole course of the disease.

If a knee joint, such as the one described, is laid open, the synovial membrane is found everywhere converted into a thick, pinkish-grey or yellowish, semi-transparent material, soft and gelatinous to the touch, but in parts tough and elastic; in parts the grey tissue is streaked with opaque fibrous bands, and here and there caseous foci will be found softening and breaking down—these are especially common towards the posterior part of each femoral condyle. These breaking-down foci do not usually communicate with the cavity of the joint itself, which is largely filled up by the thick granulation masses and contains little or no fluid.

The pulpy tissue grows over the cartilages at first in delicate vascular tendrils or films, but afterwards these become thicker and form fleshy pads replacing the cartilage at the edge and lying in pits dug out of its surface, so that finally only a small central island of healthy cartilage remains in the middle of each condyle and each articular surface of the tibia.

Often granulation sprouts spread beneath the cartilage and, detaching it from the bone, give rise to superficial rarefying osteitis, 'subchondral caries,' which causes necrosis and separation of the articular cartilages.

The semilunar cartilages are as it were embedded in the gelatinous tissue, and in some far advanced cases can hardly be distinguished; usually, however, they are readily made out. The crucial ligaments are coated over with the pulpy tissue, and are often very vascular, with bright streaks of vessels running along them; on scraping away this tissue the ligaments are found to

<sup>1</sup> We cannot too strongly insist upon the fact that tubercular disease of joints may go on for months, steadily getting worse, without any pain at all, and with but little impairment of mobility; this so frequently occurs, and yet is so frequently a cause of mistakes, that we desire to emphasise the statement here.

<sup>2</sup> This is usually, but not always, true.

have nearly their natural appearance, except that here and there a little sprout has forced its way between their fasciculi.

The cavity of the joint is often subdivided into loculi by adhesions between masses of the granulation tissue. On gouging out one of the granulation pits in the cartilage it will be found in some cases not to extend through, in others the bone beneath is reached and eroded locally.

The capsule and lateral ligaments, &c., are much thickened, and this gives rise to the deceptive sensation of bony thickening so often met with in the knee. However much it may appear that there is enlargement of the bones in a case of chronic disease of the knee, it is almost perfectly safe to say that the thickening is in the soft parts alone, and that there is no new bone formation. It is only very rarely that a layer of periosteal new bone is found beyond the limits of the capsule.<sup>1</sup>

In the great majority of cases of disease of the knee the bone is healthy, unless the disease is far advanced; when this is so, islets of soft rarefying bone and carious patches will be found, the latter in their early stages being recognised by the yellow and red mottling in the neighbourhood of the articular cartilage,<sup>2</sup> with some rarefaction. In some instances, however, sequestra of varying size are found—most commonly in the femur, less often in the tibia; usually the necrosis is at the back of one or other condyle; we have, however, found it in the middle of the intercondyloid notch. Where necrosis does occur the disease often tunnels a considerable way through the bone, or rather the disease has probably begun in the epiphysial line or epiphysis itself, and extended towards the joint.

As Mr. Howard Marsh has pointed out, a condition of 'quiet strumous disease' may exist, leading to a stiff joint without any active stage or suppuration; we have seen such joints occasionally, and they are to be distinguished by having a greater amount of solid thickening than occurs in serous synovitis, but less than in the ordinary tubercular joint.

**Tubercular disease of the Shoulder** is rare in children; there is hardly sufficient evidence to show how often the disease begins in the synovial membrane and how often in bone. The swelling forms a globular mass, most prominent in front, and stiffness of the joint is usually marked. When suppuration occurs the abscesses usually point behind or in front of the deltoid, occasionally in the posterior triangle; no information as to the primary lesion can be obtained from the position of the sinuses, since extra-articular abscesses due to epiphysitis discharge in the same spots. Disease in the epiphysial line may or may not lead to destruction of the joint. In one interesting case we removed, as a sequestrum, part of the upper end of the diaphysis, including the epiphysial line, and subsequently nearly the whole shaft of the humerus: the inflammation had spread from the periosteum to the capsule and the ligaments became so relaxed that there was a deep

<sup>1</sup> The presence of new bone about a chronic tubercular joint is usually a sign of repair and of subsidence of the disease; sometimes, however, it is associated with central bone disease (chronic osteomyelitis), never, we think, with progressive synovial disease alone.

<sup>2</sup> It is often very difficult to be certain of the condition of bone in very early stages of disease: patches of various shades of yellow and red are met with in perfectly healthy bone; where there is any rarefaction or opaque yellow deposit, disease is present.

groove below the acromion, the humerus having dropped away from the scapula ; the joint did not suppurate, and all went on well.

We have only twice found it necessary to excise the shoulder joint in children ; in all the other cases the disease has subsided.<sup>1</sup> In one instance, where there was much necrosis, a very useful limb resulted with  $\frac{3}{4}$ -inch shortening, and but little wasting, but the joint was hardly at all mobile.

*CASE.—Disease of Shoulder joint. Excision.*—Lewis H., age 4 years ; admitted July 19, 1882. Three years ago the left arm was seen to be stiff and painful ; abscesses formed about the shoulder and were opened ; no bone removed ; for last eighteen months had been discharging a little constantly, and lately the child had lost flesh ; no phthisis in family ; other children healthy. On admission, rather pale, but fairly nourished boy ; general thickening all round the left shoulder ; a patch of red thinned integument, with pus beneath, in front of the insertion of the deltoid, and a sinus at the posterior border of the muscle : the pectoral fold bulged downwards and forwards ; there was pain in movement. July 26, much discharge, especially on pressure about the axilla ; very little mobility, even under chloroform, slight power of rotation alone remaining. August 2, the upper end of the humerus was excised, together with about an inch of the shaft, by a single straight incision at the anterior border of the deltoid ; two loose sequestra were found in an abscess cavity surrounding the head of the humerus ; the joint was entirely destroyed ; the glenoid cavity and acromion were roughened ; there was some deposit of new bone around the upper part of the shaft of the humerus ; the part removed was not entirely necrosed, but there was a large cavity in it ; terebene dressings, hand slung up to chest ; some rise of temperature followed. He went on well, but slowly ; at one time some bare white bone was seen, but this vascularised subsequently, except a small part removed on August 26, and two more small pieces which came away in September. Passive movement was begun on September 23, and on the 28th more free movement was made under chloroform. He had chicken-pox in October, and was discharged with sinuses still open on November 8. Passive movement failed subsequently to give him any great amount of mobility. February, 1883, he is well and strong, and has good use of the arm, but the movement is almost entirely of the scapula ; the limb is not much wasted, and there is  $\frac{3}{4}$  inch shortening.

**Disease of the Elbow joint** arises either as a primary synovitis or about equally often as disease of bone ; in the latter case the olecranon or one of the condyles, most often the outer, is first attacked.<sup>2</sup> Swelling extends all round the joint, but usually appears first over the radio-humeral line at the back of the joint. Later the front of the joint becomes swollen : this is sometimes due to glandular enlargement, comparable to the swelling of the inguinal and iliac glands in hip disease ; in other cases the supra-condyloid gland suppurates. When the olecranon is the seat of the primary lesion the sinus is usually over it and leads directly, or nearly so, down upon it.

In old neglected cases the number of sinuses is sometimes considerable, and the soft parts are undermined and much destroyed by pulpy infiltration. The joint is kept slightly flexed, and there is usually much muscular wasting. Occasionally we think the disease begins in the olecranon bursa, which is so common a starting-point for mischief in older patients ; this bursa is sometimes chronically enlarged in children. Stiffness is an early and marked feature of disease of this complex joint, though the mobility of the fingers is good, even if there is much infiltration of the muscular attachments about the elbow.

<sup>1</sup> Or the case has been lost sight of.

<sup>2</sup> Well-marked cheesy masses are often found in one or other condyle, but any extensive disease of the radius is very rare.

CASE.—Joseph L. D., age 3 years 11 months; admitted January 27, 1882. Left elbow injured by a fall in April, 1881; had been swollen ever since. On admission, healthy-looking child; the left elbow was flexed and the hand semi-pronated; very little mobility; two sinuses at the upper and back part of the joint led down to rough bone; a little tenderness, but no pain; general swelling all round the joint. February 2, the joint was excised; disease primarily synovial; cartilage diseased, especially on head of radius; operation not antiseptic; the limb was put upon an angular splint. On the 13th passive motion was begun. On March 1 passive movement could be carried through the full range in all directions, and there was a little power of active movement; the wound was nearly healed; discharged. October 3, 1882, at out-patients'; elbow quite healed; had almost perfect range of mobility in every way, and the arm was strong; he could lift a chair with it.

**The Wrist joint** is perhaps even more rarely affected with tuberculosis than the shoulder, but in children we have on three occasions had to excise the joint; in all, the wrist joint itself, as well as the whole carpus, was disorganised, the disease having spread among the synovial sacs. In one

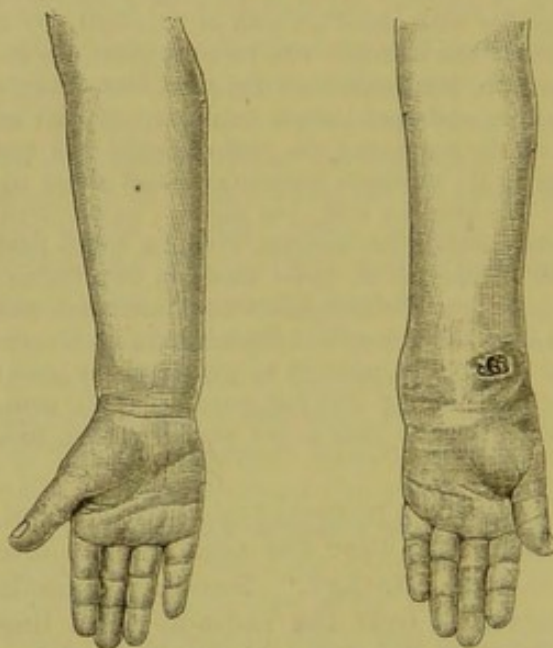


Fig. 87.—Tubercular Disease of the Wrist.

instance the mischief began in the base of the second metacarpal bone, in the others the starting-point was apparently synovial. In two of the cases an excellent result followed, the whole of the carpus, the bases of the metacarpal bones, and the lower ends of the radius and ulna having been removed by a single median dorsal incision between the tendons of the extensor communis digitorum and the extensor secundi inter-nodii pollicis; no tendon was cut through, though necessarily those attached to the parts removed were stripped back. In both of these cases a nearly perfectly mobile joint was obtained, with almost full mobility at the metacarpo-phalangeal articulation—the point of greatest difficulty in disease of the wrist.

CASE.—*Disease of Wrist joint.*—Annie E., age 6 years. Admitted March 25, 1885. History unimportant. No cause known for swelling of left wrist, which began six months before admission; much pain; poulticed for three months. On admission, a strumous-looking child; on palmar aspect of left radius at lower end is a sinus; much thickening round wrist; fluctuation in front of carpus; movements of fingers perfect; those at carpal joints absent. April 16, whole carpus except pisiform bone removed by longitudinal incision on dorsum; some bones broken down and unrecognisable; cavity scraped, and drained through palmar sinus. May 1, wound has progressed fairly and is now healing. 15th, sent home; tube still in wound; arm on splint; result very good—a strong and mobile hand (fig. 87).

One patient remains sound; the other, after keeping well for a long time, developed tubercular teno-synovitis, which will probably cause some loss of movement. In the third case the carpus alone was taken away, with an even better result. The operation mentioned is practically Langenbeck's; it

is much simpler than Lister's method, and we think much superior to it: the bones which are not already softened and destroyed shell out easily from the pulpy material in which they are embedded. The position of the sinuses in carpal disease is inconstant, but the general appearance is shown in fig. 87.

**Chronic Tubercular disease of the Ankle** is much less frequent than that of the knee; but in four years we had 43 cases of disease of the ankle or tarsus admitted as in-patients at the Children's Hospital. Of these, excluding disease of the os calcis, most of the cases were probably primarily synovial, but in the tarsus extension of disease around the small bones so interferes with their nutrition, and so readily spreads to their interior, that in late cases there is always more or less destruction of bone. We can only recollect one instance of primary necrosis of the astragalus setting up disease of the ankle joint; but it is much more common to find mischief spreading from the lower epiphysis of the tibia to the joint.

Except the posterior calcaneo-astragaloid joint, the anterior calcaneo-astragaloid and its continuation, the astragaloscaphoid joints, are, perhaps, the most commonly affected of the tarsal articulations; but the common sac or any of the tarsal joints may be attacked by disease, which then spreads from one joint to another. Calcaneo-astragaloid disease is very frequently the result of necrosis of the os calcis, and it not rarely extends upwards to the ankle joint itself.

Disease of the ankle joint is marked by swelling at the back of the joint, obliterating the hollows on each side of the tendo Achillis, and then spreading round and below each malleolus, especially the inner (fig. 88); the front of the joint also becomes swollen, and acquires a peculiar flatness or square-

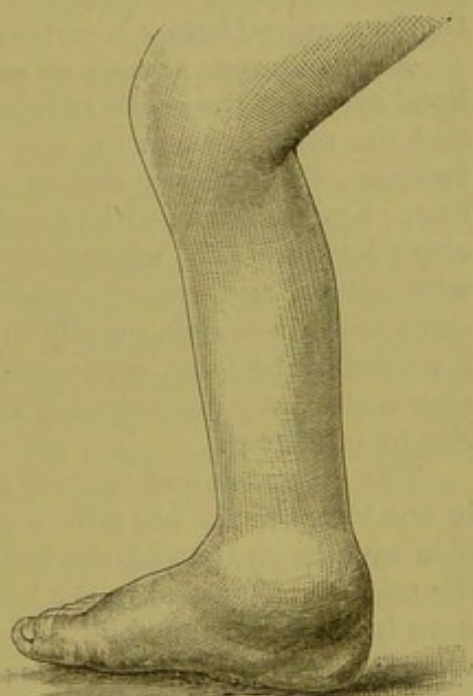


Fig. 88.—Tubercular Disease of the Ankle Joint.

ness of outline as a result of loss of salience of the extensor tendons. The foot is usually kept with the toes pointed, at other times it is dorsi-flexed; the leg rapidly wastes; later, sinuses appear, usually above or behind the malleoli. It must be remembered that disease often extends from the joint into the sheaths of the neighbouring tendons, and in such cases suppuration or swelling may track up the leg or along the foot for a considerable distance; the general conditions do not differ from those met with in the knee. In disease of the tarsal joints the foot is swollen in the position corresponding to the affected articulation, and movement of the particular joints may be painful.<sup>1</sup> When the common sac is involved the foot assumes a bulbous look, with the toes pointed and pressed closely against one another. The disease often spreads beneath the extensor or along the plantar tendons,

<sup>1</sup> This is not, however, a very trustworthy symptom in tubercular disease, though of much value in acute inflammation.

and gives rise to widespread mischief in the soft parts, so that a sinus by no means always indicates disease of the nearest joint. The arch of the foot is seldom lost, in consequence of the resistance of the rigid structures in the sole of the foot. With two exceptions, the disease is usually primarily synovial: one is that already mentioned, of caries or necrosis of the os calcis, which often extends to the calcaneo-astragaloid joints; and the other, that it is common for disease of the first metatarsal bone to extend backwards to the joint between it and the internal cuneiform.

It is sometimes difficult to be sure whether an abscess on the dorsum of the foot—the most common situation for pointing in tarsal disease—is connected with the joints or is merely peri-articular: in some cases pain on pressure or movement of individual joints, localised by pressing back towards the ankle individual toes in turn, in others swelling over some particular joint or in the sole, will indicate a deep lesion; but often exploration is required before a certain conclusion can be arrived at.

**Acute simple serous or suppurative Synovitis** is uncommon in childhood except as the result of injury or rheumatism; any joint may be affected, and the symptoms in no way differ from those seen in adults. There is swelling, which, being due to distension of the synovial sac, follows its outlines; heat and pain, with immobility and some constitutional disturbance, are also present. The inflammation commonly subsides readily by treatment with splints and ice or evaporating lotions, and leaves no ill results. In some cases, however, usually in unhealthy children, or where there has been a wound of the joint, suppuration occurs; all the symptoms are then greatly aggravated, any movement is exceedingly painful, and the temperature may rise to  $103^{\circ}$ – $104^{\circ}$ .

The acuteness and severity of the symptoms vary much in these cases: in one instance the hip joint suppurated, nearly the whole thigh was occupied by a large abscess, the head of the femur was partially destroyed, and the mischief extended to the knee joint, which also suppurated; both joints were incised, but the child sank and died. Pus was found in the knee, with superficial erosion of cartilages; the synovial membrane was thick and hyperæmic, the thigh was infiltrated with sero-purulent fluid, and the acetabulum was granulation-lined.

In other cases there is a thick 'mucous' discharge and the cartilages are not destroyed: in these cases incision generally results in recovery with a mobile joint. This form of disease most commonly occurs in children under two years of age, and is met with in the knee—less often in the shoulder, elbow, hip, or foot. Somewhat like the above-mentioned catarrhal inflammation of joints, described by Volkmann, appears to be a form of painless purulent exudation, not connected with pyæmia or epiphysitis, which has been described by Atkin, of Sheffield.<sup>1</sup>

**Pyæmic joint disease** is not rare in children, and may run an acute or chronic course. The articular lesions may be the only evidence of pyæmia, or they may occur in conjunction with bone or visceral abscesses. Both forms of disease are exceedingly dangerous, though neither by any means always fatal. We have had a case under our care of a boy aged  $3\frac{1}{2}$  years,

<sup>1</sup> *Brit. Med. Jour.*, July 11, 1885.

who had pneumonia after measles, and subsequently suppuration in one shoulder and one knee, with effusion into one of his ankles, and double empyema, together with abscesses in other parts; this child recovered perfectly, with a mobile knee, though with a somewhat stiff shoulder. Effusion into a joint in pyæmia is not always purulent, nor does the presence of pus in a joint or elsewhere always demand incision and drainage; the effusion may be absorbed, or, after aspiration, may not recur, and on examination the articular cartilage may be found quite smooth and healthy, or only somewhat yellow and opaque. In other cases, however, the cartilage becomes necrotic, or it may rapidly melt away entirely or in patches, leaving the articular lamina of bone smooth and bare; this is perhaps the most typical condition in acute pyæmia.

**Exanthematous Synovitis**, or that form of joint disease which occurs in connection with the specific fevers, has already been alluded to in discussing those affections, and scarlatinal synovitis or rheumatism has been fully described (p. 218). A second variety occurs generally, but not always, later in the course of the fever, and usually in connection with severe throat lesions. The affected joint suppurates and becomes disorganised; this is clearly a pyæmic condition.<sup>1</sup> It must also be remembered that the exanthems are sometimes a determining cause of the appearance of a tubercular lesion. Typhoid synovitis is rare, and is said to be almost limited to the hip joint; we have, however, seen the knee attacked. Synovitis, probably pyæmic, occurs as a rare complication of diphtheria. An exanthem such as scarlet fever or measles, occurring in the course of a joint disease, usually gives rise to suppuration and rapid destruction of the joint; in some cases, however, it appears that, as in the case of erysipelas, the more active inflammation does good by causing melting away or absorption of the chronic inflammatory material.

**Chronic rheumatic Arthritis** occurs occasionally in children, both in its polyarticular (nodular) and monarticular forms, as pointed out by Charcot and others, and we have once or twice seen it. It must be remembered that such cases may become tuberculous, and we have seen a joint, which had the characters of chronic rheumatic arthritis well marked, which subsequently became an ordinary pulpy knee, just as occurs in adults; the two conditions may be seen co-existing in one joint.

*CASE.—Chronic rheumatic Arthritis.*—Mary Jane E., age 13 years; admitted February 25, 1884. No rheumatic or gouty history. Duration since August, 1882, when she had pains in her shoulders, which subsided in a week. Nine months ago had pain in left hip, which lasted four months; then the left knee was attacked; both were swollen; no other joint affected; pains worse in wet weather; not increased in bed; sweats a good deal at night; urine often contains red lithates. On admission, well nourished; slight eczema of face; heart sounds normal; right knee a little swollen; no crackling or thickening; no osteophytes. Left knee, thickened synovial fringes; well-marked crackling; edges of both condyles distinctly lipped. Her condition improved with blistering and iodide of potassium, and she was sent out on March 15.

<sup>1</sup> Chains of micrococci have been found in the pus from such joints by Heubner and Bahrdt, and a similar joint affection has been caused by inoculation with cultivations from tonsillar exudation by Löffler; vide *Berlin. Klin. Woch.*, November 3, 1884, or abstract by Dr. Ashby in *Med. Chron.*, December 1884.

**Syphilitic Synovitis** is occasionally met with ; we have, however, only seen a few cases of pure synovitis in the first few months of life in congenitally syphilitic children ; the most common condition is syphilitic telostitis. A subacute recurrent syphilitic synovitis occurring in older children is met with ; it sometimes rapidly subsides under antisyphilitic treatment, as in the following instance ; but this is not always the case—it is sometimes rather intractable.

CASE.—*Syphilitic Synovitis of Knee*.—Jane B., age 8 years 3 months ; admitted October 31, 1882. A history of syphilis in the brothers and sisters, of whom there have been twelve, seven being dead ; patient herself had always been hearty ; two years ago the left knee swelled without known cause, but recovered completely in fourteen days ; the eyes had been bad since May 1882 ; the right eye was first affected, and the left was only attacked three weeks ago ; has not had much photophobia ; the left knee began to swell on October 29 ; she had a good deal of pain in it. On admission, the left knee was much distended with fluid, and was slightly hotter than the right ; she had well-marked interstitial keratitis, which was, however, subsiding ; facial aspect and teeth also characteristic ; no other signs marked. Under hyd. c. cret. and pot. iod., together with a back splint for the knee, all the swelling rapidly subsided, the eyes improved, and she was discharged, nearly well, on November 21.

Clutton has noticed the occurrence of symmetrical synovitis of the knee in congenital syphilis, and Gutterbock<sup>1</sup> other cases of asymmetrical effusion ; we have seen the same thing associated with periostitis of both tibiæ. Carrington and Lane record a case of suppurative synovitis of the hip, knee, shoulder, and both elbows in a child with congenital syphilis ; there was rickets also present, but no epiphysitis.<sup>2</sup>

The best treatment of these cases is the administration of iodide of potassium internally with hydrarg. c. cretâ, while mercury ointment should be rubbed into the part affected ; if there is much pain, blisters will sometimes give relief. Gonorrhœal rheumatism is sometimes met with in children in association with vaginitis or ophthalmia neonatorum, as pointed out by Clement Lucas and others.

**Acute suppurative Arthritis of infants**, first described by T. Smith of St. Bartholomew's,<sup>3</sup> is a remarkably well-defined affection of fairly frequent occurrence. It is limited usually to children under a year old, though we have occasionally seen it in older children, the eldest being nearly 2 years of age. Pathologically the disease is an acute epiphysitis leading to rapid destruction<sup>4</sup> of the ossifying centre of the bone it attacks, with perforation into and disorganisation of the adjacent joint. A large number of the infants so attacked die of pyæmia. The hip is the joint most frequently affected, the knee standing next. Of ten cases of our own the hip was involved in eight instances—six times alone ; in one other case the knee was involved by direct extension, and in another the wrist, shoulder, and hip were implicated. In two instances the disease followed hooping cough, in one it came on after an injury, and in one some evidence of the onset of the disease in utero was

<sup>1</sup> *Rev. Mens. des Mal. de l'Enfance*.

<sup>2</sup> *Brit. Med. Jour.*, January 1885. *Path. Soc. Trans.*, 1885.

<sup>3</sup> Marrant Baker, John Poland, and one of the present writers have also contributed to the literature of the subject.

<sup>4</sup> In one instance the epiphysial nucleus of the head of the femur was found lying loose in an abscess cavity, or rather in a sinus leading from the joint.

obtained. We have adopted Mr. Smith's view that the lesion is primarily epiphysial ; and it is so certainly in the majority of cases, but in one or two we have not found evidence of anything more than synovial disease,<sup>1</sup> and, on the other hand, we have met with several cases in which the abscess pointed outside the joint, the cavity of which was not involved. In one instance the lesions were secondary to a cervical abscess, and there was epiphysitis of one shoulder and a peri-articular abscess of the other, so that sometimes at least the presence of an abscess about a joint in an infant is not due to an epiphysitis, and sometimes it is not an arthritis. It is often difficult to make out the connection between the abscess and the joint, but with care it may be found in most cases. The severity of the disease varies considerably ; in some instances the mischief goes on for two or three months, in others it is fatal in a few days. The characteristic features are the age of the child ; the existence of great swelling round the affected joint, often involving nearly the whole limb, and not uncommonly 'flying about,' i.e. one limb becomes swollen and then subsides, then the swelling appears in one of the other limbs, and finally the disease becomes localised in one joint only, leaving the parts first attacked uninjured.<sup>2</sup> In acute cases there is much fever, but there may be little rise of temperature in the more chronic ones.

The symptoms and course of the disease point to thrombosis, extending from the vascular cancellous tissue, or to embolism, but we have not verified this condition post mortem. The size of the abscesses is sometimes remarkable ; in one case the whole thigh, from the hip to the knee, was a bag of pus, both joints being involved.

These children are generally much prostrated and often very anæmic, worn out by pain and rapid outpouring of pus.

Treatment consists in early and free incision into the abscess, opening the joint if it is swollen, and keeping it well drained. Stimulants and abundant nourishment must be given. It is not necessary to put the limb in a splint in infants, but it is a good plan to tie it up in a pillow so as to keep it steady ; there is little or no fear of a stiff joint. Probably half the acute cases die. If recovery takes place, the limb is usually shorter and weaker than the other, but there may be a practically perfect recovery, and there is generally good mobility. We have once or twice seen older children with weak limbs clearly the result of this disease in infancy. Arrest of growth is less likely to occur where the hip is involved than the knee. The two following are fairly typical cases.

CASE.—'*Acute suppurative Arthritis*' of *Hip*.—Alfred W., age 9 months ; admitted May 3, 1884. History good. Never very strong. No known cause. Swelling about hip one month ago. On admission, pale, but not thin. Abscess round right hip ; grating felt in joint. Incision, head of bone gone. 5th, takes food well ; much discharge ; temperature subnormal. Did moderately, but on 15th still looked pale and ill. Sent home on 24th with wound superficial. Subsequently, fresh suppuration occurred, but after a hard struggle the limb became sound and well, with good mobility and little shortening.

CASE.—'*Acute suppurative Arthritis*' of *Knee*.—Mary H., age 9 months. Admitted March 21, 1885. Family history good. Child first noticed to be feverish and

<sup>1</sup> These would perhaps rather correspond to Volkmann's 'catarrhal synovitis.'

<sup>2</sup> This curious feature of the disease perhaps indicates its relation to pyæmia.

restless nine days ago; the knee then swelled rapidly, and was very tender; the swelling is now less than it was a few days ago. On admission, a well-nourished child; right knee swollen, hot, tense, and shining; fluctuation felt readily; girth 10 in. as compared with  $7\frac{1}{2}$  in. on the left side; temperature  $97^{\circ}$ . Joint freely incised on outer side, and a quantity of pus escaped. 23rd, swelling gone down; a fair amount of discharge; takes food well, and sleeps well; temperature  $101^{\circ}$ . April 1, pus tracking upwards and inwards; a larger tube inserted. 13th, swelling less; doing well. May 2, all swelling gone; tube removed. 11th, wound healed; all well.

**Acute Tubercular Synovitis** is not a very common affection; it does, however, occur, and rapidly goes on to suppuration in quite young children. The most typical instance we have seen was in a baby 10 months old, in whom suppuration of the ankle occurred a week or two after a scald over the joint. On incision a few drams of curdy pus escaped. A week later the child died of pneumonia and was found to have generalised tuberculosis; the lungs, liver, kidneys, spleen, and brain were all affected. Here, from the condition of the tubercular masses in the brain, it was clear that tuberculosis existed at the time of the injury to the skin over the ankle, and the joint subsequently became tuberculous. The case serves to illustrate the fact that in the first year or two of life suppuration occurs as a result of inflammation more readily than in older children. Acute tubercular disease also sometimes follows strains or fractures in the neighbourhood of joints; thus we have seen advanced pulpy disease of the elbow, in a girl of 8 years, 9 days after an injury which loosened the epiphysis of the inner condyle and trochlea of the humerus. The following case is also noteworthy as an illustration of the occasionally acute onset of the disease.

*CASE.—Acute Pulpy Knee.*—Harry A., age 3 years 9 months. Admitted January 4, 1885. No tubercular history; had measles at two years of age, followed by whooping cough; disease of knee first noticed fourteen days ago; no cause known. On admission, stout, well-nourished boy; right knee is much enlarged, joint hollows obliterated; swelling elastic; no distinct fluctuation; movements very limited and painful; R. knee  $10\frac{3}{4}$  in., L. knee 9 in.; extension applied. 17th, knee straight; no night pain; general condition good. 21st, as some fluid was thought to be present, the knee was aspirated, and two drams of sero-pus drawn off. 25th, temperature normal; general health good, but there is still fluid in the joint. February 4, the knee was enlarged to its original size, a Thomas' splint was applied, and he was sent home. Readmitted April 29. He wore the splint up to readmission, and has been doing fairly well till lately. On admission, the swelling has increased to 11 in., and extends some distance up the thigh; the veins are full, and the skin tense and shining; the patella floats; free incisions were made into the joint: a large quantity of turbid serum escaped from the incision on the outer side, while from the inner one, which was somewhat lower down, pus flowed; operation antiseptic; drainage as usual; the wound was dressed on May 2 and 12, when there was not much discharge and the knee was quiet; temperature never above  $99\frac{1}{4}^{\circ}$ . 26th, still a good deal of swelling; some thick, cheesy pus squeezed out; the knee did not improve much, and on June 29 he was taken home by his friends. July 6, readmitted, knee as on discharge. 18th, temperature  $102^{\circ}$ ; some retention of pus on inner side of thigh above knee. 23rd, excision of joint; much thick pulpy material, cartilage eroded, but surface of tibia healthy, except a small portion at the inner margin, which was gouged away; surface of femur bare and rough, and bone soft and showed several points of pus; when gouged the bone was quite soft, yellow, and infiltrated with pus; this was removed, leaving a cavity  $\frac{1}{2}$  in. long and  $\frac{1}{4}$  in. deep in the inner condyle; the bone surface and the upper synovial cavity were cauterised with the thermo-cautery, dusted with iodoform, and the limb was put up in a Howse's splint; wood wool dressing; on section of the part of the femur removed a yellow caseous mass was found surrounded by soft bone; there was much shock for

some hours, which was treated by opium, warmth, and alcohol; did fairly well, and temperature was never above  $100^{\circ}$  till 29th, when the knee was dressed for the first time, the temperature having run up suddenly to  $104^{\circ}$  (?); wound looked well and was quite sweet; pads of wood wool uniformly soaked; temperature fell and was not above  $101^{\circ}$  after 30th. August 3, free discharge, doing well, but splint soiled; it was removed and replaced next day; union seemed firm. 8th, tubes removed; there was afterwards some trouble with the splints, which needed changing, and the wound on the 14th was no longer aseptic; the tibia became displaced somewhat backwards and some fresh suppuration followed; this was combated by making him lie on his face for half the day; he slowly improved, and on October 16 the wounds were nearly healed, and he was sent to Convalescent Hospital. April 3, 1886, one sinus, the rest of the wound well shrunk; not yet firm, but in good position; fat and well.

*The treatment* of the various joint affections can only be briefly given here; it is impossible to mention all the applications and apparatus that have been devised. In acute non-suppurative joint affections of the upper limb, in the case of the shoulder, it is sufficient to strap the arm to the side, or, if the child is very young, to bind the limb with a flannel bandage across the chest; lead lotion in infancy and an icebag in older children is the only further application required. For the elbow nothing is better than a common inside or outside angular splint, which must reach from the axilla to beyond the end of the fingers; all short splints, leaving the wrist and fingers free, are obviously insufficient. For the wrist a straight palmar or dorsal splint reaching from the elbow to beyond the finger tips should be applied.

For the hip a Bryant's or Thomas' splint should be put on, or, in their absence, a long Liston's splint does very well. For the knee and ankle the ordinary back splint with a foot-piece should be used, taking care that when the knee is the part injured the splint reaches well up to the buttock. A Thomas' knee splint answers excellently for all stages of knee joint disease, but the child must of course be kept in bed for acute affections of the joints of the lower limb.

When suppuration occurs free incisions should be made into the joint, and drainage tubes inserted; where there is no previous opening, and the wounds are aseptic, washing out of the joint should not be employed unless flakes of lymph or blood clot likely to obstruct the drainage tube are present; it is quite sufficient to drain the cavity properly, choosing a dependent position for the incisions, and avoiding the dangerous anatomical area of each joint. In subacute cases, with sero-purulent fluid or even pus in the joint, aspiration should be tried once or twice before free incisions are made; but the joint must not be allowed to become distended with fluid, since this frequently leads to subsequent ligamentous weakness.

In chronic non-purulent effusion, and in cases where a simple synovitis has left thickening behind, elastic pressure by a Martin's bandage lightly applied, or by common bandages applied over a thick layer of absorbent wool, does good service. Friction is often useful, and blisters frequently relieve pain and promote absorption. Care must be taken not to be misled by the presence of adhesions remaining after subsidence of disease into thinking that progressive mischief exists. A joint that has been acutely or subacutely inflamed, and after a week or two of treatment remains stiff, a little swollen, cold, and tender on pressure over one or two spots, with intense pain at perhaps one spot *on any movement beyond a certain point, though*

*movement may be free up to that point*, is the seat of adhesions, and requires breaking down of these bands under chloroform. In such cases enquiry should always be made to ascertain that there is no evidence of any tubercular taint before moving the joint. After breaking down adhesions the limb should be kept quiet for 24 hours and effusion prevented by pressure or cold; and then, if all is quiet, both active and passive movement should be begun. While recognising the effect of adhesions in and about joints, it is well to remember that it is much less common to meet with cases of this kind among children than among adults or adolescents; probably because the restless activity of childhood prevents the joint from being kept still after the acute and painful stage is over.

When a joint has suppurated no premature attempts at procuring mobility should be made. As soon as the joint has been soundly healed for a week or two all apparatus should be left off, and the child allowed to try for itself—left, in fact, to do as it likes, in reason—it will seldom do too much. If after a few days no progress in mobility is being made, chloroform should be given and the joint carefully examined. It is generally possible to make out whether the adhesions are few and cordlike, or general; in the latter case a permanently stiff joint will almost certainly result, in the former the adhesions should be at once broken down. Where a stiff joint is arranged for, the limb must for many months, often years, be provided with a splint to keep it in the desired position. Children's joints are very slow to ankylose.

We have no great belief in inunction with Scott's ointment or oleate of mercury, and painting with tincture of iodine, as modes of treating chronic joint lesions, while pressure and friction are invaluable when acute mischief has subsided.

In all cases of synovial tuberculosis in the early pre-suppurative stages but one form of local treatment is, we believe, of much value—absolute fixation, with or without pressure. Where there is acute pain or a subacute attack in the course of chronic disease counter-irritants in the shape of blisters or the actual cautery are useful to relieve the pain, but we do not think they do any great good otherwise. We have tried and given up injections of iodine and carbolic acid into the pulpy tissue, and we cannot say we think Scott's dressing is of any great use, except as a means of pressure. For the upper extremity the plans mentioned for acute disease, combined with elastic compression, are all that is required; for the elbow and wrist the splint may be made permanent by fixing it on with plaster of Paris, or substituting light iron strips in the plaster for the wooden splint.<sup>1</sup> The joints of the lower extremity must be considered more in detail.

**Treatment of Tuberculous disease of the Knee joint.**—In early stages, where there is no dislocation and little flexion of the knee, the limb should be fixed upon a back splint with a foot-piece, and as long as the symptoms are acute the child should be kept in bed. If there is much flexion and pain the limb should be straightened gently under chloroform, and a splint then applied with an icebag over the knee for the first 24 hours;

<sup>1</sup> It is common to see figures of appliances for disease of the elbow and wrist in which the fingers are left free and can be moved; this seems to us opposed to all principles of keeping the joints at rest, inasmuch as every movement of the fingers must necessarily disturb both elbow and wrist joints.

where there is flexion, but not much pain, an extension should be put on by a weight fixed with strapping below the knee,<sup>1</sup> or a Macintyre's splint may be used—we prefer the weight. As soon as the acute symptoms have passed off and the limb is nearly straight—it need not be quite so—a Thomas' knee splint with patten and crutches should be provided, and the child allowed to get about; if there is much thickening, elastic pressure should be employed at the same time. Where the Thomas' splint cannot be obtained, or the friends cannot be trusted to look after the splint, or the child is too young to use crutches, a plaster of Paris casing should be put on, strengthened by the iron strips, as shown in fig. 92. As Mr. Paul of Liverpool has suggested it is a good plan to cover the metal with rubber tubing. The child, if it is old enough, may get about with patten and crutches after the plaster of Paris is applied. Children under 4 years of age cannot usually be trusted to use crutches, and must be kept off their feet and taken out of doors in a perambulator or carriage. Cod-liver oil and iron, careful dieting, and fresh, above all sea air—the great medicine for tuberculous bones and joints—should be the general treatment where possible. As long as there is no suppuration a fair trial should be given to the plan described; it is simple, and we know nothing better. There must be no taking off splints for washing or to see how the joint is getting on—one movement of a joint may undo weeks of rest; leather and lace-up splints are for this reason not so good for hospital patients as plaster of Paris. Where the nurse can be trusted not to play pranks with the joint, such as allowing the child to bend it, or stand upon the limb, washing is a luxury that may be occasionally indulged in, but fixation comes first. If in spite of this treatment the joint gets worse, operation is necessary; but in the case of the knee a very large proportion of patients will get better, and this because the disease is mainly synovial.

When a joint such as the knee, in spite of efficient treatment for 2 or 3 months, steadily gets worse, pain and swelling increase, and the child's health begins to suffer, more active means must be taken, and these will become necessary much sooner in acute than in chronic cases. If the pulpy material is rapidly breaking down and suppurating, and yet the child's health is keeping good, success is sometimes obtained by fixing the limb on an interrupted splint, or better in plaster of Paris, and then opening and carefully draining the abscesses, taking care, if the whole joint cavity is suppurating, to drain at the back of the joint or at the lowest point of the abscess sac if the suppuration is localised. By this means a certain number of these children will do well and acquire sound, straight, and in some instances movable limbs. The plan is, however, only exceptionally applicable. If there is no suppuration, but the pulpy swelling increases, the best mode of treatment is Erasion.

**Erasion**, or, as it is now sometimes called, arthrectomy, consists in the case of the knee in opening the joint freely by a semilunar incision, just as in the ordinary mode of excising the knee; the skin is reflected and the capsule removed on each side of the patella and patellar ligament, or, better, the patella is sawn across and the fragments turned upwards and downwards; if necessary, free vertical incisions must be

<sup>1</sup> One pound of weight for each year of the child's age up to six is a good general rule.

made to reach as high as the upper limit of the synovial pouches. Next, every particle of pulpy granulation tissue is carefully cut away with scalpel or scissors; all the infiltrated capsule and the semilunar cartilages are removed, and the articular cartilage scraped quite clean, any granulation tissue being carefully picked out from pits in the cartilage, and, if necessary, any foci of disease in the bone gouged away. This process must be most thorough, and extreme flexion of the limb is required to fully expose and clean the back part of the joint; the crucial ligaments are scraped, but carefully preserved, the lateral ligaments usually divided. The upper synovial sac must be thoroughly cleaned. The most difficult part of the operation is getting away the posterior part of the semilunar cartilages and the synovial membrane at the back of the joint. After thoroughly removing all pulpy tissue it is a good plan to apply the actual cautery to any doubtful spots. The process is a tedious one, often lasting one and a half or two hours, including the subsequent putting up in a splint. As soon as all bleeding has been stopped the limb is fixed on an excision splint and dressed in the usual method, antiseptically. Drainage should be at the back of the joint on each side, as after excision, the tubes being carried through openings made behind the joint. We prefer to Esmarch the limb before beginning the operation. For a series of cases vide *Med. Chron.*, vol. ii., 1885. We introduced the operation in its complete form in January, 1881, and the first case was that recorded and figured below.

CASE.—Lizzie N., age 13 years 9 months; old pulpy disease; joint erased, all synovial membrane, much of capsule, semilunar cartilages, and a largish patch of carious bone removed, as well as a good deal of articular cartilage scraped away; result, a perfectly

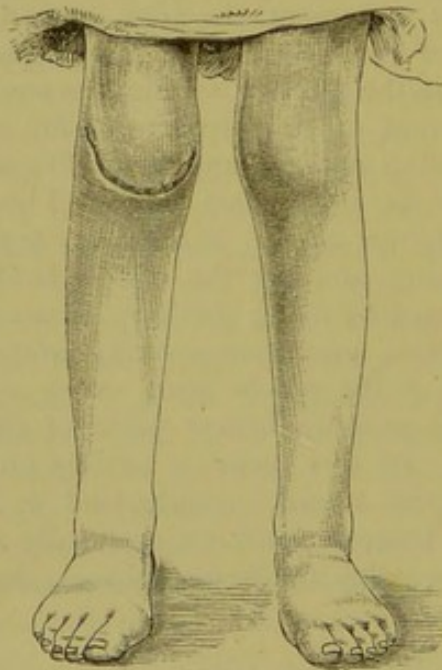


Fig. 89.

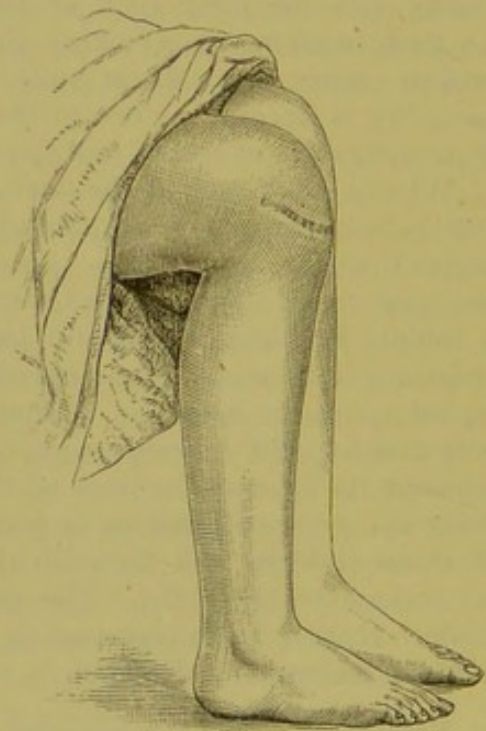


Fig. 90.

Show the condition of Lizzie N. after operation, and the free mobility of the joint.

movable, sound, painless joint, used as freely as the other; ligamentum patellæ not divided. She was under observation for nearly four years after the operation, and, except that she was liable to occasional serous effusion into both knees as a result of overwork, she remained well. The knee operated on differs little from the other except for the presence of the scar across it.

Erasion, we think, is applicable to cases of fairly early disease which have resisted efficient treatment by splints, &c. Though in the case recorded we obtained a freely movable joint, we have never had such a perfect result since, nor do we think it wise to try for mobility, except in a few instances where the wound heals at once and the adhesions are few. Erasion, if it fails, leaves the limb still fit for excision; where it succeeds, the limb is as sound as after excision, but without shortening.

Ollier and Volkmann are opponents of excision of the knee in young children, and the former prefers free incisions with application of the actual cautery, scraping, and, if necessary, 'tunnelling' of the bones, and adequate drainage, planned according to the requirements of each joint. We prefer erasion, as above described, for the knee, but the general rules of treatment must, of course, vary with the particular joints, stability and absence of shortening being the cardinal points for the lower limb, mobility for the upper. Mere scraping through sinuses is of but little use, though if fistulæ exist they should be well cleared out.<sup>1</sup> Since the case above reported was operated on, many other 'arthrectomies' have been performed, and, on the whole, with very good results.

Should the case have suppurated and failed to get well after incision, or should it be too far advanced for erasion, **excision** of the joint should be performed. Of several plans that we have tried we now employ most commonly the transpatellar operation.<sup>2</sup>

A short anterior flap of skin is turned upwards by a curved incision running with its convexity downwards from one condyle across the apex of the patella to the other condyle; the patella is then cut through with scalpel or saw, according to the degree of ossification present; the lateral attachments are divided and the fragments turned upwards and downwards. The lateral ligaments and capsule are freely divided, the bone surfaces cleared, and a thin section taken from the tibia with a Butcher's or amputating saw, care being taken only just to open up the cancellous tissue and not to trench upon the epiphysial line. A section is then made through the condyles of the femur, exactly at right angles with the long axis of the limb, so that when femur and tibia are brought together the limb is straight. It is important to remember that in the femur the epiphysial line is usually said to correspond with the upper border of the articular cartilage, or with the level of the adductor tubercle; it may, however, as we have found, be below this, and it is not necessary in cases suitable for excision to take away so much bone as to approach this line. Where there is necrosis or caries deeply involving the epiphysis a thin section only should be removed, and the diseased part then gouged away, leaving all the sound bone. We have excised with a perfectly successful result, removing a sequestrum from the lower end of the femur so large that it reached above the epiphysial line. It is by no means necessary for success in excision of the knee to take away healthy bone up to the end of a carious or necrotic cavity. We usually make the femoral section with a Butcher's saw from behind forwards, but there is no special importance in the method of doing it. All the pulpy tissue should be cut away, and all abscess cavities carefully scraped out; if there have been sinuses the wound should be well washed with chloride of zinc

<sup>1</sup> Vide *Rev. de Chir.*, March 1885.

<sup>2</sup> This operation was first employed by Volkmann, but was introduced to this country by Golding Bird; it is an admirable method, and, we think, far the best that has been devised.

(20 grains to the ounce). The two halves of the patella are then stitched together with stout catgut<sup>1</sup> or wire. As to wiring the femur and tibia together, or pegging them with steel or ivory pegs, or morticing the ends of the bones, good as the plans are in adolescents and adults, in children they are unnecessary, as their limbs are small and light, and there is but little leverage; further, the bones are so soft that wires readily cut through and give but little extra security, hence, though we sometimes employ these plans, we do not consider them by any means essential. When all bleeding has been stopped, and the wound well powdered with iodoform<sup>2</sup> and dressed with wood wool, the limb is fixed on a splint. As to the choice of splint it is a much simpler matter in children than in older patients, since the limb is short and light, and displacement is much less likely to occur. We now generally use a simple interrupted wooden splint for the first day or two, and at the first or second dressing give chloroform and fix up the limb in plaster of Paris strengthened with iron strips. Howse's excision splint, padded with wood wool and fixed on with plaster of Paris or bees'-wax and paraffin, is a very good apparatus, but somewhat more troublesome to use. We sometimes mould the iron strips along the sides of the limb instead of the back and front: there is thus less interference with drainage, and less difficulty in keeping the splint clean. Drainage of the excision wound should always be through openings at the back of the joint: a director or raspator is thrust through from within at each side of the popliteal space, and then cut down upon from outside; the whole of the excision wound is then able to be stitched up.

As soon as the anæsthetic has passed off, opium should be freely given.<sup>3</sup> As soon as the wound is healed, or in less favourable cases as soon as only sinuses remain open, the limb should be fixed afresh in a plaster splint or put upon a Thomas' splint, and the child allowed to get about with a patten and crutches; but the case is by no means done with, since nearly every case of excision of the knee in children, unless thoroughly well looked after and a stiff apparatus kept constantly on for from 2 to 4 years, according to the child's age, will become crooked.<sup>4</sup> Flexion, with dislocation backwards and outwards, is the common deformity, but we have seen a general curve of the limb develop, or distortion at the epiphysial line of the tibia. This deformity is the great difficulty and drawback in excision of the knee; the operation itself is not a very dangerous one: we have done some 25 cases without a death, though some required subsequent amputation—this was the end of 4 of our first 23 cases.

The amount of shortening resulting varies much: in 3 cases, after an interval of about 3 years, it averaged  $1\frac{1}{2}$  inch. Though the results after excision of the knee are necessarily imperfect, it must be remembered that they are to

<sup>1</sup> A simple plan is to pass the catgut round the bone, i.e. through the quadriceps and the ligamentum patellæ, but in young children a needle will readily penetrate the soft bone or cartilage. The patellar ligament at the end of the operation often seems lax and redundant: to avoid this some surgeons remove part of the patella; this is, however, unnecessary, as the parts soon adjust themselves.

<sup>2</sup> We prefer a mixture of equal parts of iodoform and boracic acid powder to iodoform alone.

<sup>3</sup>  $\text{m i}$  for each year of the child's age is the usual dose, and this should be repeated in an hour or more if required.

Occasionally, after excision of the knee, a more or less movable joint has resulted, but we do not look upon this as an object to be aimed at, but rather as a failure of the operation, inasmuch as flexion and dislocation are likely to result where no bony union is obtained.

be compared with prolonged suffering, danger to life, and amputation as the alternatives.

In neglected cases of disease of the knee, even though the disease may have to a great extent subsided, the joint often remains flexed and subluxated to such a degree that the limb is nearly or quite useless. If there is well-marked dislocation backwards, little can be hoped for in the way of reduction; all the tendons and ligaments become so shortened and contracted that, except in a recent case, little good can be done by extension or attempts at straightening—indeed in some cases these attempts only make matters worse. Where there is flexion, but no, or only slight, displacement, extension by weights should be patiently used for some weeks; if no result follows, chloroform should be given and an attempt made to straighten the limb by forcible, though not violent, manipulations, frequent extension and flexion movements being employed to break down any adhesions in or around the joint. Should it be clear that muscular contracture is an important factor in the resistance, the tight hamstrings should be divided, but we would dissuade from any violent efforts, especially if there has been much suppuration in the popliteal space: in such cases there is much risk of laceration of vessels. Should the attempt succeed, the limb is brought straight, fixed upon a back splint for a day or two, and then an immovable apparatus or Thomas' splint applied.<sup>1</sup>

Should it be found impossible to straighten the limb by these means, the choice lies between excision of the joint and osteotomy. We have employed both with good results, but they are applicable to somewhat different conditions. Suppose the joint allows considerable movement although it cannot be straightened sufficiently to be of use, osteotomy is likely to leave an unsteady limb; on the other hand, an acutely flexed limb requires removal of a very large amount of bone in excision before the leg and thigh can be brought into a straight line. We think, then, that osteotomy is best for cases of stiff joint with great flexion, excision for those where there is more mobility, less flexion, and more displacement.<sup>2</sup>

<sup>1</sup> Joints will often straighten when somewhat flexed, and even when slightly subluxated, merely by prolonged wearing of a Thomas' splint.

<sup>2</sup> M. Beck and B. Pollard advocate division of the crucial ligaments with subsequent reduction in cases of subluxation, and have recorded a few cases; we think the application of the method likely to be limited, since division of these ligaments certainly does not allow of reduction in all cases.

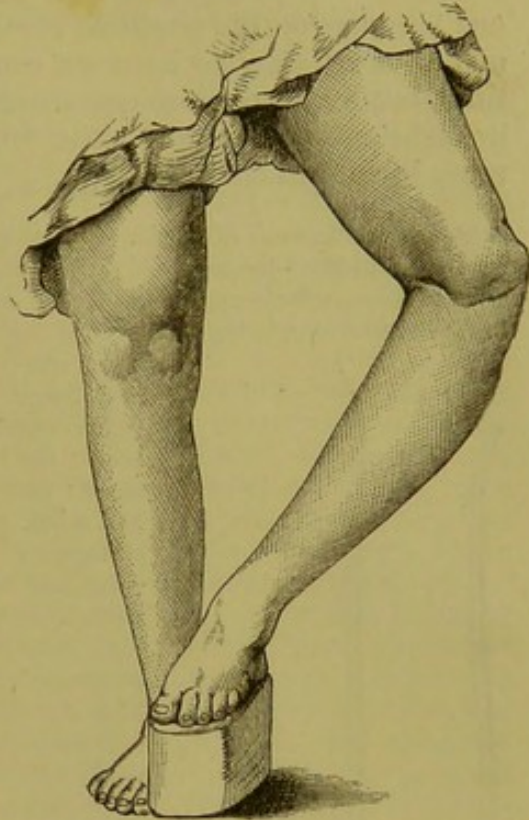


Fig. 91.—Shows the result of premature use of the limb after excision. The operation had been done at another hospital, and the patient was subsequently admitted under the care of our colleague Mr. T. Jones. There was Bony Anchylosis in the position seen in the figure.

Osteotomy in such cases is not a difficult operation; a longitudinal incision is made about three to four inches in length on the front of the thigh from the patella upwards, the femur is exposed, and a sufficient wedge of bone removed from its anterior surface to allow the limb to be brought straight. We prefer this plan to simple section, which may cause dangerous pressure on the popliteal vessels, and be followed by gangrene. In one of our cases after excision we could not nearly straighten the limb at the time, but by keeping up extension after the excision the limb was gradually brought almost straight. The following case illustrates the value of osteotomy in certain circumstances.

**CASE.**—*Necrosis of Tibia. Angular Flexion of Knee. Osteotomy.*—Ralph H., age 13 years. Admitted January 12, 1885. History good; well till two years ago; complained of pain in knee, which soon swelled; no cause known; twelve months later had some dead bone taken from the leg; discharge has continued till now. On admission, well-nourished

boy; was sent in for amputation; the left tibia is enlarged and longer than the right; on the inner side are scars of former operations, and a large sinus over the upper end of the bone; the leg is flexed nearly to a right angle; hamstrings tense; toes pointed; foot cannot be straightened. 24th, has had 6 lbs. extension on since admission, but the knee is no straighter. February 12, has had on a Thomas' knee splint since last note, and has been getting up; no improvement. 13th, under chloroform an attempt was made to straighten the limb forcibly: a few adhesions gave way, but no sensible improvement followed; back splint. 20th, an incision 3 inches long was made in the axis of the femur above the knee, the periosteum was peeled back, and a large wedge of bone removed with an osteotome; the limb could then be nearly straightened; operation antiseptic. 24th, tube removed. March 11, limb put up in back splint with movable foot-piece; wound healed and limb straight. 20th, fair union of shaft; leg straight; foot in good position; gets up with the Thomas' splint. Sent home on 24th. January 30, 1886, leg straight, walks without splint, sound and well; toes still somewhat pointed.

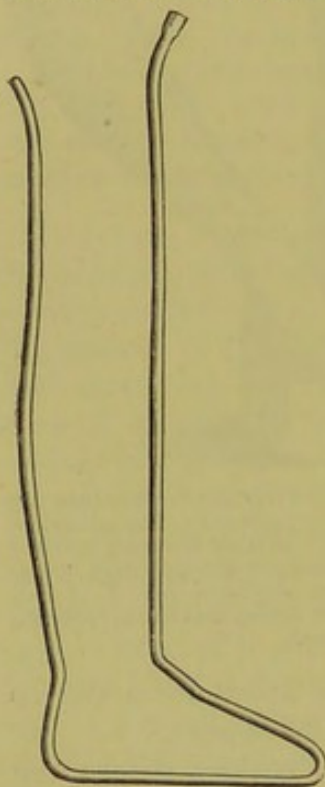


Fig. 92.—Splint for Disease of the Ankle and Tarsus. It is made of iron, covered with india-rubber tubing, as suggested by Mr. Paul. The splint is fixed to the limb with plaster of Paris bandages.

In another recent case the joint was much flexed, but mobile through a certain range; on excising the joint it was found impossible to straighten the limb without greatly shortening it, so an osteotomy was done at the junction of the lower and middle thirds of the femur, and the limb was then brought into good position.

**Treatment of Pulp Disease of the Ankle joint.**—The same general rules apply to the treat-

ment of tubercular disease of the ankle as to that of the knee in the earlier stages of the disease, and many good results will be obtained by simple pressure and fixation. To carry out this plan the best means are to use either the apparatus shown in fig. 92, or a short metal back splint with a foot-piece, the child being allowed to get about with a Thomas' knee splint. Should suppuration occur, and the joint not recover by the means described, the prospect is a very poor one: erosion and resection of the ankle for tubercular disease are very seldom satisfactory operations; the disease usually spreads,

and amputation is required. A patient trial of fixation, pressure, and drainage should be as a rule given, even after suppuration occurs, provided the child's health is maintained and the disease not actively progressing; but the prospects of such cases in disease of the ankle are not nearly so good as in the knee. We have had one good result from erosion of the ankle in the following case.

CASE.—Peter H., age 8 years 8 months; admitted January 30, 1882. Ten weeks ago the right ankle became swollen; no cause known; had been treated with cold water, strapping, &c.; never had much pain in it. On admission, fairly nourished but muddy-complexioned boy; there was much swelling round the right ankle joint on all sides, with increased heat and redness on the outer side, but little or no tenderness to pressure, though movement of the joint was painful; the circumference was an inch and three-quarters greater than the opposite side; the position was semi-extended and rotated slightly inwards. On February 9 the joint was opened by a transverse incision (Mr. Holmes' plan) across the front of the joint, dividing all the extensor tendons, &c.; much pulpy synovitis existed with 'sub-chondral caries'; all the pulpy tissue, as well as the loosened cartilages, was removed as far as possible, and a drainage tube passed across the joint, a groove being cut in the upper surface of the astragalus to prevent the tube from being nipped; the tendons were then stitched together with catgut and the wound closed; no attempt was made to unite nerves, and the anterior tibial artery was twisted; sponge pressure was applied around the joint, and the operation was antiseptic; finally the limb was fixed on a back splint with a foot-piece; a little oozing followed at the first dressing; on the following day the appearance of the foot was natural below the line of incision; a little superficial ulceration occurred at the outer aspect of the front of the foot, and union of the edges was slow, but by March 13 the incision had healed except at the drainage-tube openings; no pus had been discharged up to this date. On April 20 some sensation was perceived on the dorsum of the foot. There was no discharge, and on May 28 he was sent out with plaster of Paris over an Esmarch's splint and a sponge dressing still applied; after this progress was very slow, some thickening remaining about the ankle, and occasionally a small part of the cicatrix would ulcerate and break down. February, 1885, foot sound and well, but toes are somewhat pointed, and he 'throws' the foot in walking. He gets about well with a boot and without any support. A good deal of new bone formation about line of incision, but some mobility.

We have also had an excellent result after excision of the ankle.

CASE.—*Disease of right Ankle, Necrosis of Astragalus.*—Richard T., age 4 years 5 months; admitted September 18, 1882. Family history good. History: Well till six months ago, when the ankle began to swell and has gradually got worse; no pain; no injury; can walk. On admission, fairly healthy child; somewhat rickety; right ankle swollen; bulging on each side of extensor tendons and round each malleolus, especially on inner side and in front of tendo Achillis. September 30, ankle joint aspirated; a little serum drawn off, and some tr. iodi injected. October 20, no improvement; an incision behind the inner malleolus gave exit to two teaspoonsful of gelatinous and almost melon seed-like material. October 28, wound healed; joint refilled. November 16, temperature rose;  $104.2^{\circ}$  on 18th. November 23, joint opened; a large, loose sequestrum of the astragalus was found and removed; the whole astragalus was then taken away, and the lower end of the tibia and fibula resected, as well as the upper surface of the os calcis and the inferior tibio-fibular joint. The joint was opened by a transverse incision across the front; the tibial and extensor tendons were stitched together afterwards. Operation antiseptic; sponge pressure, and subsequently salicylic silk. January 13, antiseptics left off; had been doing fairly, but slowly; still some swelling. February 11, sent out in plaster of Paris over an iron splint round foot; wound not healed. He finally got a good sound foot.

But as a rule, where in spite of rest and general treatment the disease progresses, we prefer to amputate by Pirogoff's method where possible, but, failing this, by Syme's plan. We have had some very satisfactory stumps

after Pirogoff's operation, and watched them for years ; and, although it occasionally fails, where it is successful it gives a much better stump than Syme's amputation. If removal of the foot is too long postponed, disease is apt to spread up into the tibia and along the sheaths of the tendons, and then amputation higher up the limb will be called for.

**Treatment of Tarsal disease.**—It has already been pointed out that, except in the case of the os calcis, disease of the tarsus is usually synovial in origin, hence it should be treated on the general principles of such lesions—absolute fixation of the foot, with entire rest from any strain—and the usual hygienic means should be employed in addition. The apparatus already referred to for disease of the ankle is the best means with which we are acquainted of carrying out this plan, and to it a patient trial should be given. Should, however, this treatment fail, two courses are open : one that of complete removal of the disease by amputation, the other that of removal of the diseased parts alone. It is impossible here to fully discuss

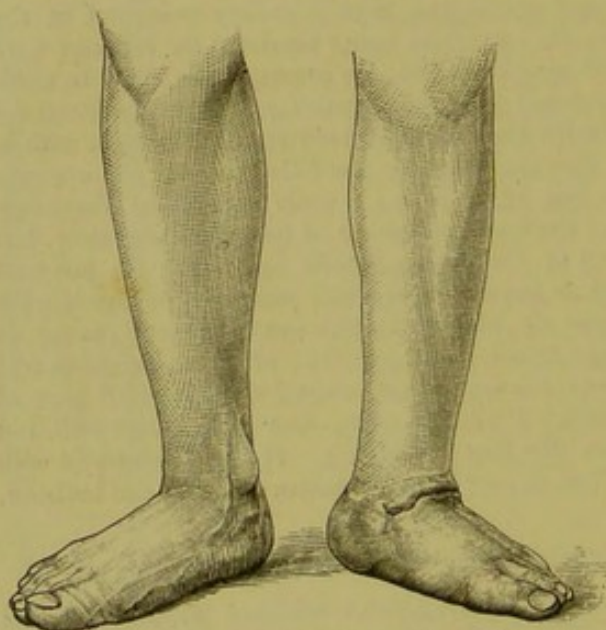


Fig. 93.—Shows a foot after resection of the whole tarsus on the left side except the back of the os calcis. Annie E. Both feet are flat.

the question, but the conclusions to which our experience has led us are these. If there are definite sequestra of one or more tarsal bones, these should be removed, and an attempt made to save the foot ; the fact of there being necrosis often means that there is a line of demarcation formed and recovery may follow.<sup>1</sup> If there is general synovial disease with caries, it may be worth while to freely expose the affected parts by turning up a dorsal flap of the soft structures and removing the diseased tissues, but so long as any affected synovial membrane or carious bone remains recurrence is to be expected. In such cases the best plan is total

resection of the tarsus, i.e. removal of all the tarsal bones, with or without the exception of the back part of the os calcis, which if sound may be left to form a support for the heel.

The simple transverse dorsal incision turning up a dorsal flap is, we think, the best method ; it fully exposes the parts, the divided tendons can be stitched together afterwards, and the use of the foot is wonderfully little impaired. After the operation the foot may be at first kept merely upon a back splint with a foot-piece, but as the cavity begins to fill up and the parts consolidate the iron splint (Paul's splint) with plaster of Paris forms the best appliance.

By this method excellent results, far superior to those obtained by a Pirogoff's or Syme's amputation, will be obtained (fig. 93).

<sup>1</sup> It cannot be stated absolutely, because, as already pointed out in the case of the leg, even where sequestra exist tuberculous infiltration of surrounding bone may be present.

CASE.—Annie E., age 17, sprained her foot in the winter of 1883-84, and came under our care in the Royal Infirmary in November 1884. She was then a fairly healthy-looking girl, with disease of the anterior calcaneo-astragaloid and astragalo-scaphoid joints, as well as swelling of nearly the whole foot; there was a sore below the inner malleolus. After treatment by rest and fixation part of the astragalus and scaphoid were removed in January, 1885. In May the disease was still progressing, and the whole of the tarsus, with the exception of the posterior part of the os calcis, was taken away, the bases of the metatarsal bones and the malleoli being also removed; some of the tendons were stitched together, otherwise no attempt at adjustment of the deeper structures was made. In the spring of 1886 the foot was as seen in fig. 93; she could 'spring' upon it to a certain extent; there was fair mobility and power; and she did her house-work with no other support than a Martin's bandage.—*Vide Med. Chron.*, September 1886.

Should the disease recur, amputation should of course be done, but this is far less likely to be required than after mere gouging or scraping operations. Partial resection of the tarsus, *except for necrosis*, is rarely successful, i.e. where there is mischief spreading about among the tarsal joints it is of little use to remove merely an individual bone or two bones. Unless a clean sweep is made of the disease it will probably recur. The exception to this rule is the os calcis, but, as in this bone the disease is usually central, it stands by itself; removal of the entire os calcis without any other bone is a highly successful and very valuable operation, and is often called for.

CASE.—*Disease of Calcaneo-astragaloid joint; Caries of Os Calcis; Excision.*—Norman G., age 2 years 4 months; admitted June 11, 1883. Family history: phthisical. History: measles ten months ago; swelling of foot followed; has been under treatment for it. On admission, sinus in sole of right foot over calcaneo-cuboid joint, another below outer malleolus; much thickening about os calcis, movement of ankle free. June 14, explored; sinus led into os calcis, and probably to calcaneo-astragaloid joint; drainage.

July 7, put up in plaster of Paris with ankle splint and discharged; splint had to be removed in a few days on account of swelling; back splint put on; had varicella July 11. Readmitted July 24, foot worse; discharge increased. August 1, flap turned forwards from heel, and os calcis excised; found carious, with a large cavity; operation subperiosteal; did well; discharged August 25. February, 1884, the foot healed and became sound and useful; a small fresh collection of pus has, however, just reformed; the os calcis has been largely reproduced, and the foot is fairly well shaped. May, 1884, sound and well; walks excellently.

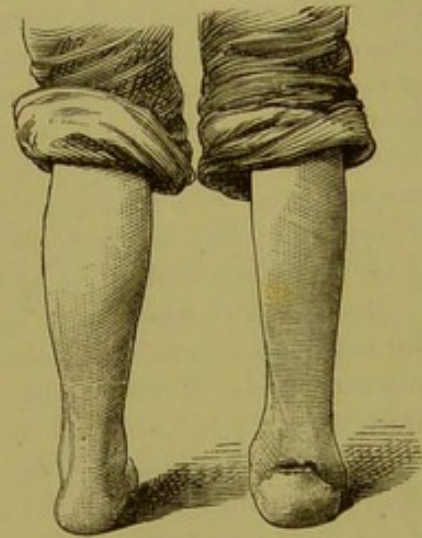


Fig. 94.—Shows the result of excision of the Os Calcis. There is nearly complete restoration of the bone.

The treatment of tarsal disease, then, is rest and pressure first; failing this—and it should have full trial—removal of sequestra if there are any; if not, resection of the whole tarsus, or at least of such part of it as shall include all the joints communicating with the seat of disease. If disease still goes on, Pirogoff's or Syme's, or, of course rarely, Chopart's operation, as the disease may demand; for disease of the os calcis removal of it alone is the better plan, and when done subperiosteally there is usually a most perfect reformation of bone (fig. 94).

After total resection of the tarsus we much prefer to keep the foot in its natural position and allow the parts to adjust themselves, rather than artificially produce a sort of equinus foot as proposed by Wladimiroff.

Conner, in a paper in the *American Journ. of Med. Sci.*, Oct., 1883, relates 108 cases of resection of the tarsus in which two or more bones were removed, including two cases of his own in which the entire tarsus was taken away through an incision along the outer side of the foot. He concludes that the mortality is not much, if at all greater, than that of amputation at the ankle joint; that it can be followed by amputation if necessary, and in 68 of the 108 cases the result was good. A paper by one of the present writers in the *Medical Chronicle*, 1886, may also be referred to.

Disease of the phalanges and metatarsal bones of the toes differs in no way from the corresponding disease of the fingers, and requires the same management except that amputation may be resorted to in the foot earlier than in the hand, since the loss of a toe is of less consequence than that of a finger.

Disease of the first metatarsal bone and of the metatarso-phalangeal joint of the great toe is common, and of importance, since it is liable to be followed by considerable lameness. Failing rest and general measures, the question of amputation or resection remains; either is followed by a certain amount of crippling, but resection of the first metatarsal bone is so frequently unsuccessful that the most speedily satisfactory result is probably that of amputation. We usually resect the bone as a first resort, and only amputate failing this; but we must confess that even when resection succeeds the toe is so shrunk and short as to be of little use.

**Sacro-iliac disease** is not very rare in children; it is usually, we think, the result of extension of chronic tubercular disease from the adjacent bone, most often the ilium—at any rate, necrosis is common, and we have removed sequestra which included the articular surface of the ilium. The disease usually runs a chronic course, and gives rise to comparatively little pain; often attention is first called to it by the presence of an abscess over the back of the joint; sometimes, however, the matter forms at the intrapelvic surface and may point in the groin or track down behind the rectum: under such circumstances there may be pain down the leg from pressure upon the sacral nerves. Pain is sometimes felt in walking from the weight of the body bearing upon the diseased joint, and pressure directly upon the joint or upon the iliac crests, or, again, traction upon the iliac crests, tending to draw them backwards, gives rise to pain. It is occasionally possible to make out mobility of the ilium upon the sacrum, and we have seen displacement of the bones as a result of disease. Caries of the spine may cause sacro-iliac disease from the burrowing of pus into the joint, and in most of the cases we have seen there has been disease of bone or joints elsewhere.

Sacro-iliac disease is best treated by rest in bed on a firm mattress, no sitting up being allowed. Should an abscess form and increase in size, in spite of treatment, it should be opened and any diseased bone removed; as soon as the acute symptoms, if any are present, have passed off, the child should have a double Thomas' hip splint applied, the splint being fixed on with plaster of Paris round the limbs and above the joint: he may then be moved out of doors on a couch with safety. If the position of the abscess prevents the application of the splint in the ordinary way, the apparatus may

be so arranged that on the affected side the splint is applied to the outer side instead of to the back of the limb. If the child recovers, there will probably be some arrest of growth of the pelvis on that side, and a lateral curvature of the spine.

We have not seen a case of acute non-tubercular sacro-iliac disease, and the strength of the articulation is such that any acute traumatic mischief is unlikely to be met with.

**Disease of the Temporo-maxillary joint** occasionally occurs in children as the result of scarlet fever, injury, or necrosis of the jaw or of the temporal or malar bones, or arises by extension from the ear, and gives rise to stiffness and inability to open the mouth, and later to distortion of the face from arrest of growth. Pain in movements of the jaw and swelling over the joint are the usual symptoms; when suppuration occurs it usually points over the articulation. We have seen the joint suppurate in a case of pyæmia which was associated with acute suppurative arthritis in an infant.

The treatment consists in opening the abscess, should one form, and the child should be fed on soft food; unnecessary disturbance of the joint is to be avoided. Should the jaw become stiff, attempts should be made to overcome the stiffness by means of a Maunder's screw, used several times daily after forcible opening of the mouth under an anæsthetic, just as in periarticular adhesions from suppuration in the neighbourhood of the joint.

CASE.—*Spurious Ankylosis of Jaw, with atrophy of the bone.*—Thomas C., age 8 years 4 months; admitted June 21, 1882. Had 'low fever and inflammation of the lungs' at 2 years old, and since then his jaw has been stiff, so that he lives on liquids and sop; was thought to have hydrocephalus; soon after he became ill he had otorrhœa, which continued until the time of admission with intervals. On admission was only able to open his mouth about a quarter of an inch; nearly all his teeth were carious; he spoke fairly well and seemed to be in good health; the jaw was much atrophied, so that the upper teeth far overhung the lower; the jaw was forcibly prised open under chloroform, and subsequently Maunder's screw was used, with the result of increasing his gape to more than an inch, and enabling him to masticate fairly well; the use of the screw has been continued up to present date, Feb., 1883.

Failing this plan, one of the forms of operation for the establishment of a false joint should be performed; probably the most satisfactory in permanent results is resection of the head of the bone by an incision parallel to and below the zygoma, taking care to avoid injury to the facial nerve, but we have not met with a case requiring the operation.<sup>1</sup>

**Disease of the Acromio-clavicular and Sterno-clavicular joints** is occasionally met with; it should be treated by fixation of the arm to the side. If suppuration occurs the joints should be freely opened and the tuberculous material removed. We have found sequestra in the acromio-clavicular joint (*vide* General Surgical Tuberculosis). A certain amount of disability in use of the limb may result.

<sup>1</sup> Or Mr. Spanton's plan of dividing subcutaneously the resisting structures in and around the joint (*vide* Mr. C. Heath's lectures, *Brit. Med. Jour.*, July 9, 1887).

## CHAPTER XXX.

## HIP DISEASE.

**Hip disease**<sup>1</sup> in the ordinary sense of the term, i.e. tuberculous disease of the hip joint, is almost entirely an affection of childhood; thus only 73 patients, the subjects of this disease, were over 20 years of age out of a total of 619 cases collected by ourselves, and probably in most of these the disease had begun at an earlier age. It is somewhat more commonly met with in boys than girls, and is much more frequent among the poorer than in the well-to-do classes. Mention has already been made in general terms of the pathology and causation of the disease: that the hip may be taken as the joint in which primary tuberculosis of the bones forming the articulation is

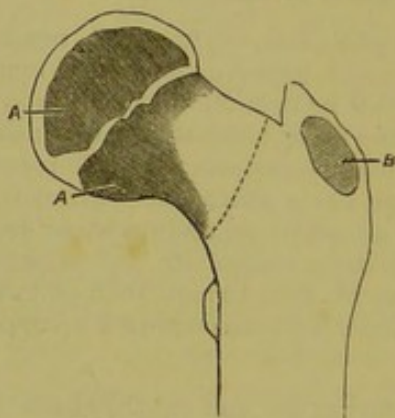


Fig. 95.—Diagram showing at A, A (in vertical shading) the parts most commonly affected in Hip Disease. B is the trochanteric epiphysis. The lower A points to the 'calcar.' (Altered from Barwell.)

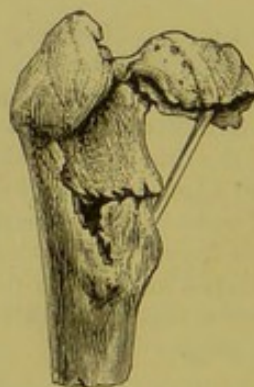


Fig. 96.—There is a large sequestrum in the neck. The head, which is still cartilage-covered, but is almost detached, is propped up by a quill. Vascular perforations are seen in the marginal cartilage. Removed post mortem.

most frequent. Indeed, our own belief, based mainly upon examination of considerably more than 100 cases of excision of our own, is that in true chronic morbus coxæ, such as we ordinarily see, and also in the acute and rapidly destructive cases, the disease begins almost invariably in the bone. In older patients a primary synovitis is more frequent, but in children an acute, sub-acute, or chronic inflammation of the upper epiphysis of the femur or its neighbourhood is by far the most common condition. In some cases the disease begins in the neck of the femur, and when this is so it is generally the under surface that is attacked, and this is the part on which the greatest strain

<sup>1</sup> For a more detailed account of Hip Disease in Childhood than space allows here the reader is referred to the monograph by one of the present writers: *Hip Disease in Childhood*, by G. A. Wright (Longmans & Co., 1887).

comes in injuries applied direct to the trochanter, and also the part least abundantly supplied with vessels (figs. 95 and 96).

In some cases the disease is primarily acetabular, but much more frequently the initial lesion is femoral, though rapid destruction of the acetabulum may occur secondarily. In 100 cases of our own the acetabulum was necrosed or perforated in 27, but in many of these the disease was probably primarily femoral. The part of the epiphysis usually first involved is the immediate neighbourhood of the epiphysial line. The occurrence of synovitis of the hip joint is not, of course, denied by us, but we believe that two entirely different classes of cases come under observation: the one is a simple synovitis, usually traumatic, a lesion that occurs in the healthy and unhealthy alike, and is as amenable to treatment in the hip as elsewhere. The other class is one composed of tuberculous patients; from some injury, or even slight overstrain only, of the part, the cancellous tissue of the bone has its normal circulation slightly interfered with; inflammation follows, and inflammation in a tuberculous subject is only too prone to follow the usual course of a tuberculous lesion, and the special anatomical features of the hip joint make it especially liable to serious and progressive disease. Necrosis of the pelvis or femur is common in the course of this disease; thus in our first 100 cases of excision there were 17 instances in which sequestra were found, either in or detached from the femur, and the acetabulum contained sequestra in 22 cases.

The naked-eye characters of a typical specimen from hip disease in an advanced stage are the following:—The cartilage is all gone or hanging in tags or worm-eaten plates, or it may be merely loosened and thinned with a layer of granulations underlying it (fig. 97); the synovial membrane is red and vascular, somewhat thickened, but rarely to anything like the degree already described in the case of the knee joint. The bone as seen in section varies somewhat, but certain characters are very constant. Sometimes the whole upper epiphysis is detached and forms a hard, loose, marble-like sequestrum; in a larger number the upper epiphysis is destroyed to a greater or less extent: sometimes only a small part of it is actually gone, but in all it is of a dull yellowish-white colour. In some late cases the colour is opaque, and the bone is putty-like, with or without obvious rarefaction; in earlier cases there is a mottled appearance, patches of dark red hyperæmic bone alternating with dull yellow areas, and here and there a soft patch of granulation tissue. Sequestra may be present, and the epiphysial cartilage may be little altered, perforated, or entirely destroyed.

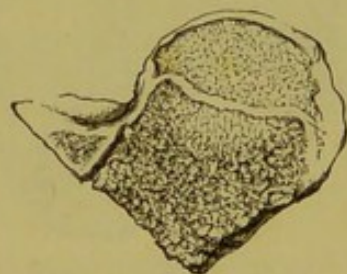


Fig. 97.—There is disease on both sides of the epiphysial line. On the under surface of the neck is the rough depression caused by pressure against the rim of the acetabulum. There was pathological dislocation.

Occasionally the disease spreads far down the shaft; more commonly the bone below the level of the great trochanter is congested, with more or less rarefaction, but no extensive disease. Corresponding lesions are found in the acetabulum, which is often rough and eroded, and its walls absorbed, so that the cavity is wider and shallower than in health. Occasionally there is very extensive caries or necrosis of the pelvis, and, indeed, nearly the whole innominate bone may be diseased. It must be remembered that even

when the pelvis is perforated there is a thick wall of dense fibrous material intervening between the pelvic organs and the joint cavity, so that, although the bone is bare on both aspects, and much of it requires removal, there is no danger of injury to the viscera. The joint itself usually contains pus and false membrane, with broken-down caseous granulations and detritus. The conditions commonly found in the acetabulum have been already mentioned; it should, however, be stated that in the later stages of the disease what is called 'travelling acetabulum' may be produced where repair to some extent is going on; the rim of the acetabulum is destroyed by what looks like a sort of ploughing-up process, and when repair begins new bone is formed higher up on the dorsum of the ilium to form a socket for the end of the femur. In some instances the innominate may be separated into its component bones, as in two specimens in our collection.

In other cases suppuration may occur within the pelvis, either as a result of perforation of the acetabulum or of extension of inflammation through the thickness of the bone, or of pus, as it not unfrequently does, tracking over the brim of the pelvis and then gravitating downward. We have seen several cases where pus has burrowed up the sheath of the psoas and so got within the pelvic cavity.

The remains of the head of the femur may lie in the little-altered acetabulum, or be drawn upward upon the dorsum, or even project through the acetabulum into the pelvis; it has even been found fixed to the acetabulum, though quite detached from the femur, or, rarely, firmly impacted, as we have seen it. The amount of acetabular disease depends, apart from the possibility of the origin of the affection there, upon the fact that when once the joint cavity is involved a large surface, i.e. the whole acetabulum, is at once exposed to irritation, and so the process in it is more rapid; it also depends upon how much the head of the femur has been allowed to press upon the pelvis.

It is very rare to find any attempt at a new formation of bone while the disease is progressing, while, after removal of the upper end of the femur, new bone may be rapidly formed; in this, of course, the hip resembles other joints. This rapid formation of new bone after excision is a strong indication for that operation, in that it shows that nature is unable to begin repair until the disease is removed.

The etiology and pathology of morbus coxæ, then, may be summed up as follows:—

1. Hip disease is dependent upon that deficient power of recovery and tendency to caseous degeneration which may be called strumous or scrofu-

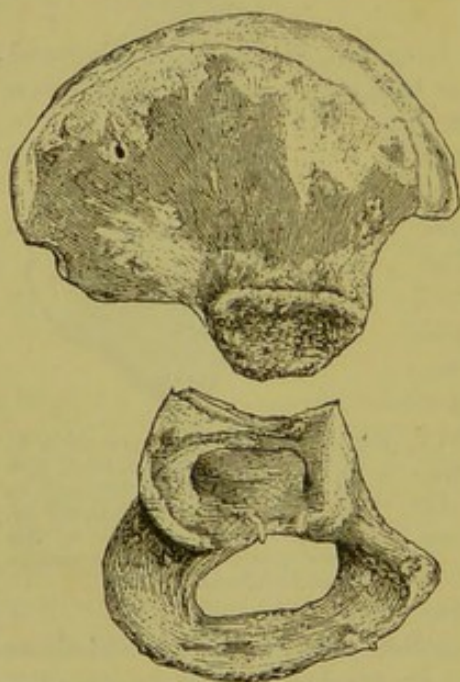


Fig. 98.—Shows extensive Acetabular disease. The ilium is completely detached from the other two bones, and is largely necrosed; white scale-like patches of new bone are seen on the surface. The disease was acute.

lous disease, or, better, tuberculosis, and this constitutes the predisposing cause. It is in fact a local tuberculosis.

2. Any slight or severe injury, over-use, &c., or the onset of a specific fever, may, in such a constitution, prove an exciting cause.

3. Injury in a healthy child may produce synovitis, or even acute inflammation of bone about the hip, as elsewhere, but this does not, except very rarely, lead to chronic hip disease.

4. In the vast majority of the cases of 'morbus coxæ' the disease begins as an osteomyelitis of the upper epiphysis of the femur, or of the immediate neighbourhood of the epiphysal line.

5. This particular osteomyelitis tends to destruction, and usually runs a chronic course with caseation of the inflammatory material, and resolution can rarely, if ever, be expected when the disease is well established.

6. The occurrence of the disease in childhood is explained by the physiological and anatomical peculiarities existing before puberty.

Besides the common chronic hip disease, there is a form of **acute hip disease** which may run its course in a few weeks, or even days, and produce as much or more destruction of parts than months or years have in the chronic cases. Instances of this condition are not very rare; every hospital surgeon sees them occasionally. Some of these cases are probably pyæmic, others belong to the class of 'acute suppurative arthritis of infants' (*vide* p. 519); others again are acute traumatic inflammation, synovial or osteomyelitic; possibly in some partial separation of the upper epiphysis may occur with rapid necrosis; others again are probably cases of acute periostitis of a nature similar to that occurring in the shaft of the femur, tibia, &c. These last may result in widespread suppuration and necrosis of the pelvis and femur. An acutely destructive condition may come on in the course of chronic disease.

Lastly, acute tuberculosis sometimes leads to rapid suppuration.

*Symptoms.*—In describing the symptoms of hip disease it will be convenient to take them one by one, and discuss the views and explanations of each symptom before passing on to the next, and finally to group them together in a type case.

*Pain.*—Pain is a prominent feature of most cases of hip disease from the beginning; at least, until complete disorganisation of the joint and displacement or destruction of the head, or recovery.

The seat and degree of pain are, however, alike very variable. Thus pain may be referred to the hip itself, the buttock, the back or front of the thigh, the knee in front or behind, or any part of the leg or foot. It may be localised or diffused so that the patient strokes the whole thigh down in some cases when asked where his pain is, and but rarely points to any one spot. There is no consistent relation to be made out between the seat of pain and the position or extent of disease. Probably the front and inner side of the knee is the most frequent seat of pain. Tenderness, however, is often much more localised to the position of the joint, but even that is very variable. Pain is, undoubtedly, often remittent: sometimes an interval of some weeks intervenes, even without treatment, between the attacks. We have seen cases where the child had been walking about with a shortened, distorted limb, who never had any pain from beginning to end; and others, with large abscesses, who have also been throughout free from

pain ; while the agonising pain of those who have to endure 'night startings' is only too familiar to all who have been residents in hospitals.

In considering the question of pain, it is well to bear in mind the number of different sources of nerve supply to the joint.

It is not practicable, nor very important, to distinguish by a knowledge of the nerve distribution the exact patch of synovial membrane or ligament that is locally inflamed : its only value, if it were possible, would be from a prognostic point of view ; but here history, duration, and other symptoms are more trustworthy. There is, however, no doubt that 'night pains' give us evidence of extension of the disease to the articular surface.

It is, then, clear that pain in cases of hip disease is variable in its seat, or rather that it may occur in a great many different places ; of these special attention has always been paid to pain in the knee, and several explanations are given of this pain. In the majority of cases it is probably due to 'transferred sensation' from one of three sources, the anterior crural, the sciatic, or the obturator, branches of which are distributed to the front and back of the joint. In our experience, the pain in the knee is generally rather vaguely referred to the front of the knee, the child passing its outstretched hand over the whole of the front of the joint. The pain, in fact, is referred rather to the distribution of the anterior crural than of the obturator.

Pain in the hip is not usually a marked sign in the sense of there being any constant pain ; tenderness on pressure over the front or back of the capsule, and pain in pressing the trochanter inward or the head of the bone upward, is, of course, present in all acute cases, and a large proportion of the chronic ones.

*Night startings* or pains are a prominent and important feature in acute and subacute cases ; they may be altogether absent in chronic disease—except where acute mischief has supervened upon chronic—and they may be absent throughout the whole course of a case. When they do occur, they indicate that inflammation has extended to the joint surfaces ; and further, that our means, whatever they may have been, of treating the lesion, have been inefficient so long as these startings continue. Their cause is too well recognised to need discussing. The rigid muscles, acting under the influence of 'joint sense' (Barwell), contract spasmodically to fix and immobilise the joint surfaces ; as sleep comes on, with its accompanying muscular relaxation, some friction or pressure of the tender surfaces together takes place, causes acute pain, a sudden awakening with a cry, and a violent spasm of the muscles to again fix the joint. This may be repeated many times in a night, and is a strong indication for treatment. These night pains are very uncommon after excision ; where they do occur they mean that disease is extending in the pelvis, and probably the femur is not kept sufficiently far away from the acetabulum to prevent pressure upon it ; in such cases, then, it is well to increase the extending force, though in some cases too great extension may increase pain. Tenderness or pain on pressure has been already alluded to. When superficial tenderness really exists, the fears of the child, if he has already been ungently handled, being taken into account, it means that suppuration has occurred in the soft parts and is becoming superficial, or, in very acute cases, it seems that really all

the parts in the neighbourhood of the joint are hyperæsthetic ; it is certainly the case that in no joint does inflammation extend so widely among the soft tissues as in hip disease.

When, however, no pain is produced, except on deep pressure applied over the head of the bone, it is probable that the disease is limited to the bone, and has not yet set up mischief of any serious nature within the joint, or, at least, that any such change is a very chronic one. It is well to bear in mind that pressure on an inflamed ligament is very painful indeed—a fact easily verified in chronic synovitis of the knee, and it is possible that the pain in these cases may be due to extension of the disease to the capsule rather than to the inflammation in the bone itself.

Certain movements of the joint are more painful in case of inflammation than others, and it is true that a patient may have quite or almost painless power of flexion of the joint, and yet be quite unable to bear rotation or abduction.

Night startings may exist and be due to hip disease without any recollection of pain on awaking ; but Howard Marsh cautions us against mistaking the cries of nightmare for those of night starting.

It is well to remember that inflamed inguinal glands may cause pain and tenderness, which must be distinguished from that of the joint itself.

*Lameness.*—Limping or lameness is the symptom usually first noticed by the parents in the case of children with chronic hip disease. Even this, however, may be preceded by a feeling of tiredness or ill-defined aching about the limb after exercise, the aching passing off after rest, but recurring again after less and less exertion. The limping may be quite painless at first, and differs in appearance from the well-marked 'drop' seen in later stages, when there is shortening of the limb. At this time the child generally shows a tendency to rest the affected leg, and throw the weight upon the sound limb at every opportunity. Later, well-marked lameness comes on and is accompanied by pain. It is at this time that the mistakes in diagnosis are so often made ; the obvious symptoms are lameness, and often pain in the knee or thigh ; there is no other marked sign, and the condition is supposed to be disease of the knee or 'weakness' with 'growing pains,' and so on. This stage requires careful and exact investigation to discover it, and at the same time is the period at which treatment is most effectual. Later in the disease lameness is due either to actual shortening, or to tilting of the pelvis to take the strain off the tender limb, or to flexion.

*Heat.*—Increased temperature in the joint is, of course, only apparent where the inflammation is acute, and from the thickness of the parts covering the joint is not readily ascertained ; it is not, therefore, a symptom of much value, except in the third stage, where superficial swelling combined with heat indicates the presence of suppuration outside the joint. In some cases of acute synovitis, pure and simple, a local rise of temperature may be made out, and is a valuable indication of acute inflammation of the soft tissues.

*Swelling.*—Swelling is one of the most important symptoms. In the first place, local swelling over the front and back of the joint—i.e. just external to the femoral vessels or pushing them forward, and just behind the trochanter, obliterating the normal hollow—indicates effusion into the synovial sac, and, with a recent history of injury, indicates an acute synovitis.

With a longer history such swelling is due to the secondary inflammation of the joint by extension from osteomyelitis.

Swelling of the great trochanter indicates suppuration within the joint, and we believe may be relied upon as pathognomonic of it; it is true that this thickening may disappear under treatment, but none the less has there been pus there which has been absorbed as far as its fluid portion goes, and if once that thickening has occurred we do not think any case is free from danger of relapse.<sup>1</sup>

Periarticular or 'adjacent' abscess certainly does occur, but not so commonly, we think, as some writers describe. Swelling of the inguinal glands is considered by Mr. Barwell to indicate osteitis. We would go even farther, and say that when considerable it often indicates disease of the pelvis rather than of the femur.<sup>2</sup>

*Muscular spasm.*—Spasm of the muscles around the hip is, as in the case of other joints, an almost universal condition—quite universal, if we except those cases of osteomyelitis where the inflammation is as yet limited to the bone, and the few cases where the joint is slowly and painlessly disorganised—cases already alluded to under the section of Pain.

The spasm is due, as is well known, to two causes: reflex spasm from irritation of the terminal nerve filaments supplying the articulation, the stimulus being reflected in accordance with Hilton's laws to the muscles moving that joint—Barwell's 'joint sense'; and secondly, a voluntary contraction of the muscles to prevent movement of the painful surfaces the one upon the other.

It is well known to what the particular position of the joint in disease is due; flexion and abduction, as long as it remains a closed cavity, is the position of least tension and therefore of least pain; the aggregate mass of flexors, too, is stronger than the extensors here as elsewhere, so that flexion is the position of rest.

The rigidity of the spasm is very great indeed, so much so that in many cases, without painful manipulation, it is impossible to say from mere physical examination that the joint is not ankylosed. In most cases, however, there is a certain limited range of movement allowed through, perhaps, 10° in the middle of flexion, and in many cases a considerably larger range, while in some it is only in extreme flexion and extension that spasm exists.

Nocturnal spasm has already been alluded to under the section of Pain.

*Fixation or rigidity.*—Fixation of the joint, apart from muscular spasm, may depend upon any one of three causes, but can only exist in the second or third stages of the disease, or as a result of quiescent or cured disease. The causes are adhesions within or around the joint, matting together of muscles so that their power is lost, or bony ankylosis. Chloroform at once reveals the nature of the rigidity, whether it is due to mere muscle spasm,

<sup>1</sup> This thickening results from extension of the disease from the interior of the bone to the surface, and, as soon as the cavity of the joint is involved, suppuration almost invariably occurs, though of course not necessarily outside the joint.

<sup>2</sup> It is common to find some enlargement of inguinal glands in tuberculous children, but we think they seldom suppurate unless the pelvis is diseased. The condition of the iliac glands will be noticed again.

when, of course, it will disappear ; or to adhesion or permanent muscular contracture, when it can generally be sufficiently overcome to show that there is no bony union of the parts.

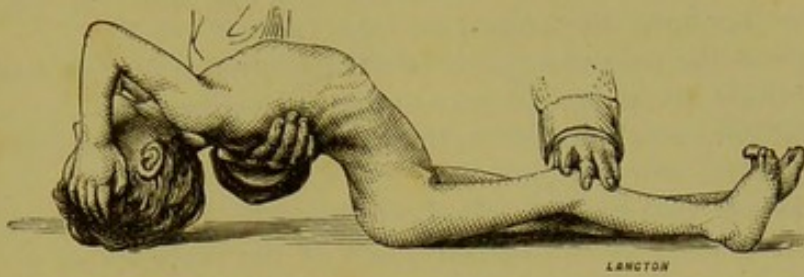


Fig. 99.—Showing the extreme Lordosis produced by partial correction of the deformity in a case where rectangular flexion existed.

*Grating or crepitation.*—Grating felt on movement of the hip joint can be due to one cause only, the presence of exposed bone. This may be either due to erosion of cartilage allowing the bare head of the femur to grate against bare acetabulum, or to sequestra grating against one another, or to the upper end of the femur rubbing against its own bare and detached head. It is, therefore, where it can be felt, an absolute and pathognomonic indication of the presence of dead or carious bone. But it must be remembered that it can usually only be obtained under an anæsthetic, when free movement without pain can be procured.

*Abscess.*—The vast majority of cases of hip disease go on to suppuration. A certain number of cases get well by the process of removal of the inflamed end of the bone without suppuration—a *caries sicca* ; but the greater number by far go on to the formation of pus. Yet of this number by no means all develop abscesses which open and discharge externally. Suppuration within the cavity of the joint takes place and even bursts the capsule, and yet by absorption of the fluid and caseation, or removal more slowly of the solid elements, the swelling caused by the abscess may disappear and the case recover. Still we are convinced that nearly every case of chronic disease of the hip, if the joint was examined, would at a certain period of its course be found to contain pus.

When the joint cavity suppurates the pus may take very various courses after it has burst from the joint, but usually it issues at the posterior part, sometimes on the inner, sometimes on the outer side. It may then pass forward beneath the rectus femoris and point at the anterior border of the tensor vaginæ femoris ; it may travel down the thigh and point at a lower part of the edge of this muscle ; it may gravitate backward and open at the upper or posterior border of the great trochanter, or, farther still, at the lower border of the gluteus maximus ; it may reach to the perinæum, extend along the adductor tendons, and come to the surface at the inner side of the thigh ; or, again, it may pierce the skin just at the inner angle of the fold of the groin between the scrotum or labium and the thigh. It may travel up the sheath of the psoas and point above Poupart's ligament, or, travelling over the brim of the pelvis, may then gravitate downwards and burst into the rectum or the ischio-rectal fossa, or escape through the sciatic notch. We have records of two cases where pus discharged through the rectum, and

we are inclined to think it is commoner than is supposed, and that the disappearance of abscesses about the joint is sometimes to be thus accounted for. A bad result does not necessarily follow, and some cases are probably glandular abscesses not directly connected with the joint; in other instances faecal matter has been discharged into the joint.

Abscesses in the neighbourhood of the hip not due to disease of that joint must be carefully distinguished from those which either directly communicate with the joint cavity or result from the breaking down of tubercular matter in the walls of the articulation.

From the cases we have watched we think the conclusion may be drawn that when an abscess points on the front of the limb, above a line drawn through the upper border of the great trochanter, there is disease of the pelvis, and this is the more certain, the higher and the more internal the opening. Abscess pointing between the scrotum or labium and the thigh we always look upon as of serious import, indicating pelvic caries. The peculiar conical projection to be felt on pressure above Poupart's ligament, as pointed out by Barwell, is rather due, in our opinion, to enlargement of the iliac glands than to periosteal pelvic thickening in the great majority of cases; like thickening to be felt by rectal examination at the site of the acetabulum on the inner wall of the pelvis, it is to be looked upon as a grave sign and one pointing to marked pelvic disease.

*Wasting of limb.*—Muscular wasting of the affected limb is an early and prominent condition in hip disease: so early and so rapid that it is, and with good reason, ascribed to the result of trophic nerve changes rather than to mere disuse. The limb in later stages assumes a peculiar bulbous look, the thigh and leg are small, thin, and weak, while the hip itself is rounded, swollen, and distended as compared with the opposite side, and coldness and venous congestion are commonly present, often with œdema of the foot from venous or lymphatic obstruction. The bone, too, undergoes a great amount of atrophy, the denser layer is thinned, and the spaces of the cancellous tissue enlarged, so that the bone becomes diminished both in diameter and strength. Such is the condition which has in several cases led to fracture of the bone in attempts at thrusting the upper extremity out of the wound in the operation of excision, and is a fact to be remembered in the forcible straightening of the limb.

Arrest of growth under such circumstances is to be expected and does occur, but to a much less extent than would be imagined, as will be seen in the section on Results of Excision.

*Outline of region of hip.*—Two points are always described in connexion with disease of the hip as being characteristic of it—loss of the fold of the groin, and flattening and widening of the buttock with lowering and partial obliteration of its fold. These conditions are worth noting, although they are not always present, nor always characteristic of hip disease when they are present. The fold of the groin is most completely obliterated when the limb is abducted and rotated out, especially if there is also swelling of the front of the joint or glandular enlargement. On the other hand, the fold is exaggerated in adduction and rotation inwards; in this position in girls the labium will be compressed, flattened, and partially or entirely hidden.

The *rima natium* is inclined upwards and towards the diseased side,

which is simply the appearance produced by lowering of the buttock in the second stage ; in the third it of course takes the opposite direction.

*Dislocation and shortening.*—The older writers on hip disease spoke of dislocation as one of the common results of the destruction of the joint. Probably they were misled, in the absence of actual dissection, by the shortening, adduction, and inversion of the limb which occurs in the third stage.

As a matter of fact it is probable that without injury true dislocation of the head of the femur out of the acetabulum very rarely occurs. Several conditions may exist and give rise to the appearance of dislocation, the most common being destruction of the head of the femur ; the truncated



Fig. 100.—Shows the position assumed in the second stage of hip disease. Flexion, abduction, rotation outwards, apparent lengthening. Right hip disease.

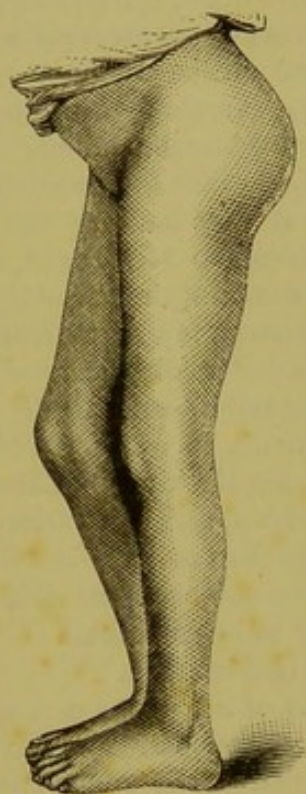


Fig. 101.—A side view of fig. 100.

upper end of the bone is then drawn upwards by the muscles attached to the trochanters, so that the upper border of the great trochanter rises above Nélaton's line ; here, as the head of the bone no longer exists, true dislocation can hardly be said to have occurred. Occasionally, however, true dislocation of the head of the femur on to the dorsum does occur—we have met with several instances of it.

Apparent lengthening of the limb is due to a lowering and throwing forward of the pelvis on the affected side ; apparent shortening, on the other hand, to the pelvis being raised and thrown behind the sound side. Or, to take the same fact in another way, the apparently lengthened limb is flexed and abducted, the apparently shortened limb is flexed and adducted, the

two conditions being usually, but not always, associated with rotation outward and inward, respectively.

Taking the usual classification of the course of the disease into three stages, the position assumed successively by the limb will be—in the first stage, flexion to a variable degree, with or without slight abduction, and possibly rotation outward; in the second stage, flexion, usually well marked, with abduction usually, and rotation outward, producing apparent lengthening—sometimes, however, there is adduction, and sometimes mere flexion, with no rotation, or with rotation inward; in the third stage there is always flexion, and most commonly adduction and rotation inward, with apparent or real shortening, but there may be abduction and rotation outward. Thus position, though a valuable, is not an absolute guide, and requires to be checked by the other symptoms present.

**Scissor-legged deformity after Hip disease.**—Mr. Lucas,<sup>1</sup> Dr. Tyson of Folkestone, and others have recorded cases where, as a result of double hip disease, a peculiar 'cross-legged or scissor-legged deformity' occurs; both legs are adducted, the one in front of the other, and progression takes place entirely by movement at the knee joint. It is easy to understand the condition by simply walking with the knees crossed over one another. It occurs, according to Mr. Lucas, in cases where disease has taken place first in one joint, resulting in adduction, and then subsequently in the other joint. Other deformities may result from the same condition.

**Diagnosis.**—The diagnosis of disease of the hip is as difficult in some cases as it is easy in others. In well-marked cases where the disease is advanced it usually is quite readily diagnosed, while, on the other hand, few diseases are so closely simulated by a large number of other affections as disease of the hip, and the variety of symptoms that it presents is in itself a fruitful source of mistake. It will, perhaps, most conduce to a clear understanding of the subject if we first tabulate the diseases for which hip disease is most likely to be mistaken.

1. Acute rheumatism.
2. Bursitis of the psoas or one of the gluteal bursæ.
3. Ostitis or periostitis of the great trochanter.
4. Periostitis of the upper end of the femur.
5. Sacro-iliac disease.
6. Psoas abscess.
7. Iliac abscess.
8. Gluteal abscess, traumatic or spinal.
9. Abscess connected with disease of the pelvis.
10. Perityphlitic abscess, suppuration around the sigmoid flexure of the colon, pelvic glandular abscess, or chronic adenitis, or possibly renal disease.
11. Superficial abscess, glandular or other, and deep abscess around the joint.
12. Infantile paralysis.
13. Syphilitic synovitis or telostitis.
14. Hysteria.
15. 'Congenital dislocation' of the hip, or other congenital conditions.

<sup>1</sup> *Clin. Soc. Trans.*, 1881.

16. Rickets.

17. Disease of the knee.

Of these diseases only a few of the more important need be selected here. Inflammation of the gluteal bursæ, of which that between the gluteus maximus and the great trochanter is the most commonly affected, may simulate hip disease. In this case a large gluteal abscess may be mistaken for abscess connected with the joint, or if the abscess has burst the long track left may lead upwards, and be indistinguishable from one communicating with the joint; the absence of shortening, of adduction, or of grating on movement of the joint, which will also move freely through a certain range, absence of pain on jarring or pressure, and of fulness in front of and behind the joint, are the diagnostic points.

Disease of the great trochanter is more difficult to distinguish, and it must be remembered that inflammation may extend from the shaft to the joint; but, although in trochanteric disease sinuses may exist in the same positions as those in which they are found in morbus coxæ, the smoothness and freedom from grating, as well as the wide range of mobility of the joint, will serve to distinguish between the two; other abscesses in the neighbourhood of the joint are recognised by their history, which is usually too short for chronic hip disease, and not acute enough or sufficiently severe for acute joint inflammation. They are also recognisable by the freedom and smoothness of the movements of the joint through a certain range, even though that range may be a limited one. Absence of pain and tenderness in some part of the joint circumference will be contributory evidence.

Infantile paralysis simulates hip disease in the lameness to which it gives rise, but is distinguished from it by the absence of pain and swelling, and especially by *freedom of mobility*, and by an amount of wasting and coldness of the limb disproportionate to the other symptoms, as well as by the history of the disease; it is, however, worth noting that in the *British Medical Journal* for 1877 Mr. Savory records a case of acute hip disease in a leg affected by infantile paralysis.

Syphilitic disease is distinguished by other evidences of syphilis, by the slight tendency there is to suppuration, and by its amenability to mercurial or iodide treatment. We have, however, seen chronic hip disease in a congenitally syphilitic child (*vide* also p. 130).

Sacro-iliac disease and psoas abscess may both simulate hip disease in regard to the position in which they give rise to pain, and as to flexion of the joint; it is, however, only necessary to examine the spine and sacro-iliac articulations to find in most cases symptoms incompatible with disease of the hip alone, while in simple psoitis flexion and inward rotation are free.

It must be remembered, at the same time, that the abscess within the psoas sheath, resulting from either of these diseases, may open into the hip joint, and so a secondary hip disease may be developed. It is not, we believe, very rare for psoas abscess to do so; and, although we have only had one opportunity of verifying the fact post mortem, we have in several instances believed such to be the case. Spinal caries and hip disease may, of course, coexist independently of each other, and this is not rare. It is sometimes impossible to be sure that disease of the hip does not exist where an iliac or psoas abscess has burrowed down and surrounds the hip joint on all

sides; the symptoms are then often identical, and only the discovery of the spinal or iliac disease can clear up the case. In other instances free mobility of the joint through a certain range in all directions excludes hip disease. Rectal examination enables us to distinguish between hip disease and spinal gluteal abscess, since in the latter the abscess can be felt to extend upwards over the brim of the pelvis.

Abscess connected with the cæcum, or sigmoid flexure, is not uncommonly mistaken for hip disease. Such cases closely resemble iliac abscesses from other causes, with the addition of symptoms indicating connection with or proximity to the large bowel.<sup>1</sup>

Congenital atrophy of the femur is not likely to be mistaken for recent disease, but may, perhaps, be a result of intra-uterine affection of the joint.

One of the commoner sources of error is enlargement of the iliac or of the inguinal glands; pain, lameness, flexion, and some rigidity of the joint are found; on examination by deep pressure above Poupart's ligament the enlarged glands may be felt and palpation is painful; careful search, however, will show rigidity only in extension or slightly in abduction as well, while flexion, adduction, and rotation are free; there is no trochanteric thickening and no evidence of effusion into the joint. It must be remembered that the glandular enlargement may be due to hip disease itself.

It is always well to use the 'method of exclusion' in doubtful cases, and to bear in mind that there is no one symptom pathognomonic of hip disease, but that, as in other morbid conditions, several factors have to be taken into account in forming a diagnosis. *Free, smooth, painless mobility is perhaps the most satisfactory evidence of the absence of hip disease.*

To sum up the diagnostic points of hip disease. A patient who is a child, who walks lame, especially after a little exercise, who has thickening of the trochanter, some tenderness on pressure over the hip joint, and pain together with slight flexion and some immobility of the joint, without evidence of spinal or sacro-iliac disease or pain in any part higher than the hip, and in whom pain is increased by abduction or rotation inwards, has got disease of the hip. We would here lay stress upon the fact that there is not the smallest necessity for hurting a child in an examination for hip disease. It is true that pressure upon the trochanter or heel, what is expressively called by American surgeons 'crowding the joint surfaces together,' gives rise to pain in disease of the joint, but it is neither a necessary nor a pathognomonic sign. Night starting is a valuable, but not a constant nor always trustworthy, symptom. Later in the disease the problem is usually easily solved, but not always, for, as indicated above, disease of the trochanter or abscess around the joint, as well as bursitis, may resemble hip disease very closely; in such cases the position and swelling of hip disease, as well as its rigidity, are very closely simulated, and we must rely on other points. Such conditions can, however, only be mistaken for the later stages of the disease, in which there will be shortening of the limb, raising of the trochanter, and probably grating in the joint if examination is made under chloroform. It is only occasionally that we see a child in quite the first stage before the mischief has reached the surface of the bone; in such case

<sup>1</sup> Vide paper 'On some Forms of Abdominal Abscess occurring in Children,' by G. A. Wright, in *Arch. of Pædiatrics*, 1884.

pain, lameness, slight flexion and slight rigidity, are the principal signs. Usually the patient is brought in the early second stage, when trochanteric blurring is found.

Believing, as we do, that chronic hip disease begins invariably, or nearly so, as an osteomyelitis, we cannot follow Barwell's distinctions in the diagnosis of this condition from synovitis. We do, however, think that *acute* synovitis can be distinguished from the early stages of true hip disease by the greater pain on movement of the joint, with absence of trochanteric thickening, and under chloroform free and perfect mobility in the former; there may be also swelling in front of the joint, but this depends upon the amount of the effusion. In simple traumatic synovitis the mischief immediately follows the injury, while in the bone lesion there is usually an interval of two or three weeks, or often months, between the accident and the onset of symptoms; thus the child falls, cries for a few minutes, but is then well again, and in a month's time begins to limp. This evidence of the history is most important. Careful enquiry should always be made in every case for any previous trouble about the hip, since the acute symptoms may be grafted upon old latent disease.

Acute osteomyelitis is readily diagnosed; great constitutional disturbance, fever and prostration, great pain, amounting to agony on the least movement, *helplessness of the limb*, rapid and extensive swelling, with venous turgidity, make the diagnosis easy.

Mr. Howard Marsh, in his valuable paper in the *British Medical Journal* for 1877, gives us most useful information on the diagnosis of hip disease. Thus he points out that, though flexion may be free in some cases, the flexed limb is carried into abduction, and not straight up towards the abdomen; again, flexion may be limited in cases of gluteal, or extension in cases of psoas abscess, but in hip disease both are limited in their more extreme degrees, even if free in part of the range of mobility. His caution as to the dangers of frightening the muscles into spasm is also well worth remembering. In examining children it is always wise to manipulate the sound limb first, as this gives the child confidence that he is not going to be hurt, and he is less likely to voluntarily hold the joint stiff. Rectal examination for thickening of the inner wall of the acetabulum we have occasionally found of value in doubtful cases, and it certainly should be employed if there is any suspicion of primary acetabular disease; under such circumstances it may be the only way to clear up the doubt. An excellent account of it is given in Dhourdin's work, '*De la Coxalgie Cotyloïdienne*.'

In examining a child for suspected hip disease in an early stage the course of procedure should be as follows. First, the child's confidence should be gained, so that it will not be afraid; next, all clothing should be removed and a blanket wrapped round the patient, who should be allowed to walk to a flat, hard, couch or table covered with a rug. The position of the limb and the child's gait should be carefully watched. Then, with the child lying straight and flat upon its back, any abduction of the limb should be looked for, an imaginary test line passing downwards from the middle of the sternum through the umbilicus and pubes being taken as the guide. The length of the two limbs, taking into account the pelvic tilting, is now to be compared. The next point is to notice whether the affected limb is put

down flat upon the table, i.e. whether the thigh and knee are flexed or the back arched (lordosis); also whether there is any wasting of the limb. The surgeon should then take the *sound* limb gently in the hand and fully flex it, looking for any movement of the pelvis; as soon as the full degree of flexion has been ascertained the affected limb should be very gently raised and its range of mobility compared with that of the sound side, a finger being kept on the anterior superior spine of the ilium to feel for any tilting of the pelvis. Should there be any lordosis due to fixed flexion of the hip, this will disappear as the limb is raised and be increased by extending the leg. The finger, or better the thumb, should then be gently pressed into each iliac fossa to feel for swelling there, due to enlarged glands or the presence of an abscess; fulness below Poupart's ligament should also be looked for. If no restriction of movement has been found, abduction, adduction, and rotation should be tested and the two sides compared.

The child should next turn over and lie on its face—it is generally better to allow it to turn in its own way; the shape of the buttock, the thickness of the trochanters, the gluteal fold, and rima narium are now inspected and the range of extension further investigated. The spine and sacro-iliac joints should be examined at this stage, swelling of the knee joint and thickening of the shaft of the femur having been previously searched for. If there is still a doubt, a finger should be passed into the rectum, and the inner wall of the pelvis examined for thickening, or abscess, or enlarged glands; for this proceeding it is often necessary to give an anæsthetic.

No one symptom alone is sufficient for a diagnosis in early stages, but limitation of movement to some extent, and trochanteric thickening, are perhaps the two most valuable signs of joint disease.

We would here deprecate the use of any of the means of diagnosis which necessitate giving pain to the patient. The presence of disease is recognisable by the painless mode of examination in all cases where it can be made out at all.

In all cases examination for hip disease should be made with the child completely stripped, and lying on a *flat hard* couch or table.

*Prognosis.*—As regards the prognosis and the results of affections of the hip joint when treated by means other than operation, it is necessary to distinguish clearly between the two morbid conditions of acute synovitis and osteomyelitis, acute or chronic: the former recover perfectly with freely movable joints under proper treatment, and show no after ill-effects, though the treatment required is usually longer than that for other joints. On the other hand, cases of true hip disease, *unless effectually treated in the early stage*, very rarely recover without entire destruction of the upper epiphysis of the femur, usually accompanied by abscess, and always result in shortening with more or less deformity, and a very large majority die before reaching adult life.

Even when tuberculous disease of the hip seems to have subsided relapses are exceedingly common after some slight injury or intercurrent illness. It is important, however, to distinguish between relapses due to a fresh lighting up of disease and the presence of an abscess the result of irritation of some quiescent local product of former inflammation—the residual abscess of Paget.

As to the usefulness of the limb after recovery from hip disease without operation, more or less shortening is to be expected in all cases, either as a result of malposition, retraction of the femur upon the dorsum ilii, actual destruction of bone, or arrest of growth of the femur; the last is the least important factor, since increase of length in the femur takes place almost entirely at the lower end, and what shortening there is is due rather to general arrest of growth of the limb than to shortening from destruction of the upper growing line.

In private practice, where hip disease is seen early and treated more effectually than it can be in hospital practice, the prospect of recovery is much better, though even here a perfect result is rare; it will, however, be obtained under exceptionally favourable conditions. A movable joint may be obtained where the disease comes under treatment in its early stage, or even after destruction of the joint there may be a certain amount of mobility, though this is less frequent than it is after excision.

In fatal cases of hip disease death is generally due to tuberculosis or exhaustion, with hectic or lardaceous disease; sometimes an intercurrent exanthem proves fatal. Hence it is seen the prognosis depends very largely upon whether early and efficient treatment, of which that by

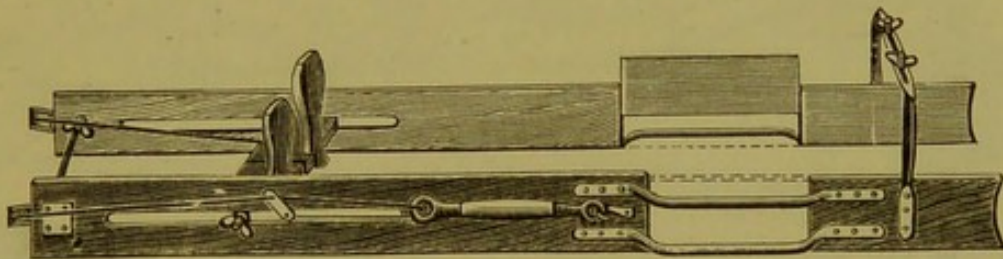


Fig. 102.—Bryant's Splint. We have had sliding pieces made to fill up the interruptions when required; this is seen in the figure.

Thomas' splint is undoubtedly the best, can be obtained. The cases least likely to do well without operation are those in which there is a great amount of thickening, and those in which, in spite of fixation, pain continues, while under any circumstances the prognosis is bad if there is extensive pelvic caries (not necrosis).

*Treatment.*—First, the ideal treatment consists in seeing the case early, keeping the child in bed until by simple extension or a Bryant's splint the limb is straightened; then a Thomas' splint should be applied,<sup>1</sup> and the child allowed to get up and about, out of doors, by the seaside. Good food, cod-liver oil and iron, with occasional administrations of rhubarb and soda if any dyspeptic troubles appear, comprise the rest of the management. Two years should be the time given for rigid treatment; after this the splint may be gradually laid aside, and the child allowed to go about with a patten and crutches for a few weeks; if still there is no sign of disease, walking upon the affected limb may be gradually permitted. During the time of treatment the greatest care must be taken not to allow the foot of the affected side to touch the ground, and to avoid all falls or strains of the joint.

<sup>1</sup> Or the limb may be straightened by means of the Thomas' splint.

In hospital practice the nearest approach to the above lines of treatment should of course be carried out, but if there is progressive disease, and the management is unsatisfactory, excision should be performed at the first sign of external abscess, or before if the symptoms are acute. In either case the presence of progressive disease in spite of treatment, with an abscess other than a residual one, or sinuses, or great thickening, indicates immediate excision. If sinuses exist with receding disease, diminishing discharge, and puckering in of cicatrices, or if with an abscess the mischief is quite quiescent or receding, non-operative treatment should be adopted for a time, if it can be thoroughly carried out; if not, or if no progress is made in a few weeks, the diseased part should be removed.

In applying extension by weight it should be made an invariable rule to make traction from the condyles of the femur, and not from below the knee. A case is on record in which prolonged extension applied below the knee resulted in separation of the upper epiphysis of the tibia. It is also objectionable in that it throws strain upon the knee joint, and is more apt to

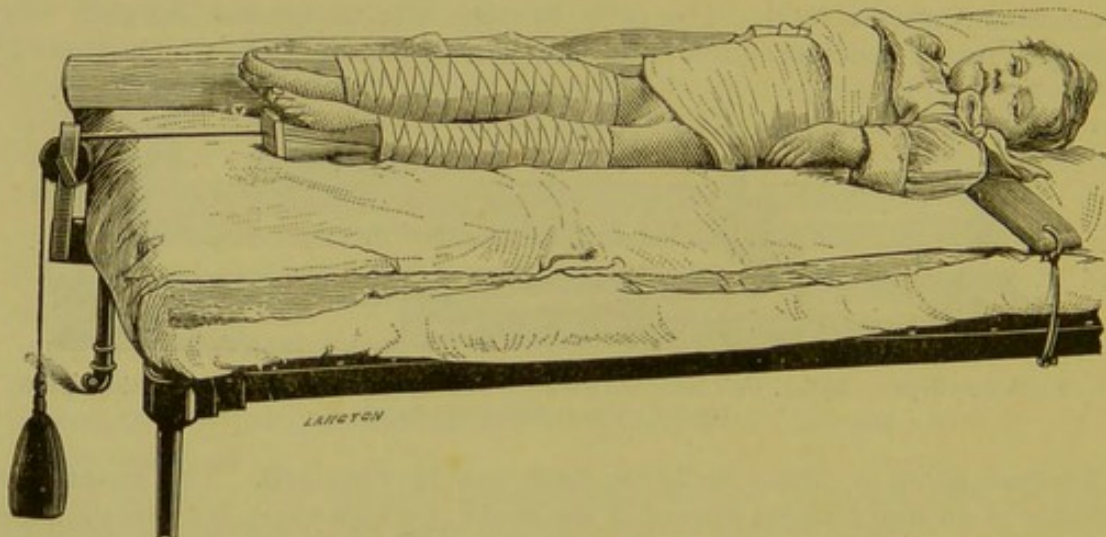


Fig. 103.—Shows extension by a weight applied above the knee, with a long splint on the sound side. Also the simple plan of keeping the child from sitting up by means of the board running behind the shoulders and fastened to the side of the bed. The shoulders are fastened to this board, and the arms are left free below the elbow. The bed on which the child lies is somewhat too soft.

slip off. The strapping should always, if possible, be applied for some hours before the weight is attached, in order that the plaster may get set, and not be dragged off by the weight. The strapping (of which Leslie's brown holland is the best) should be kept from the skin by a strip of lint or flannel bandage, or part of a stocking, to protect the sharp edge of the tibia and the prominences of the joint from pressure (fig. 103).

We have found that too great extension may be a cause of painful spasms, and it is well to bear this in mind, that too little or too great extending force are alike inefficient. In cases where treatment without operation is carried out, as for instance where adhesions, the result of old inflammation, exist, or muscular contracture has taken place, the deformity may be remedied in many instances by the ordinary extension apparatus by a weight, or by Bryant's splint. In other cases, where simple extension is

inefficient, or too tedious, it may be necessary to forcibly straighten the limb under chloroform, and then fix it by splints in its new position. The advisability of forcible straightening is a somewhat disputed point, and is not in all cases free from risk, not only of laceration of important structures, but of setting up fresh inflammation in the joint, or what remains of it.

Mr. Howard Marsh<sup>1</sup> and, in 1836, Sir Benjamin Brodie, advised that the extension should be made in the axis of the misplaced limb, and that the direction should be altered as the limb regains its normal position. We do not think this is a matter of great importance.<sup>2</sup>

It is sometimes a matter of difficulty to remedy the malposition of the

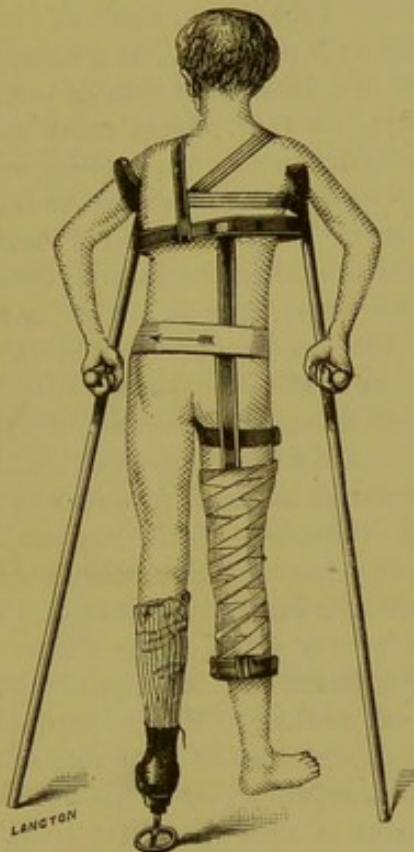


Fig. 104.—Thomas' Hip Splint, applied. Slightly altered from Mr. Thomas' work on the 'Hip, Knee, and Ankle.'



Fig. 105.—Thomas' Hip Splint, adjusted for a case with no deformity.

limb in cases of fixation in combined flexion and adduction or abduction. Here, where possible, gradual reduction by a Bryant's splint is the best treatment (fig. 102); failing this, and it cannot be always used, a long splint on one side, with a weight to the mal-placed side, should be tried<sup>3</sup> (fig. 103); and, failing this, careful straightening under chloroform. These methods are, we think, better than remedying the deformity by weights applied laterally. In more acute cases, where the deformity is mainly due to spasm,

<sup>1</sup> *Brit. Med. Jour.*, July 1876.

<sup>2</sup> If it is desired to carry out this plan, probably Hodgen's splint for fracture of the thigh would be the most efficient apparatus.

<sup>3</sup> Where there is much abduction Volkmann applies a weight to each leg, the heavier one being attached to the sound side. (A. H. Tubby.)

gradual extension is best, but by some means the limb must be got as quickly as possible into good position.

Thomas' apparatus is a very valuable appliance, and is undoubtedly the best splint we have for patients able to be up (figs. 104 and 105). The splint requires careful attention to detail, both in fitting it and in management; it is of use, first, in the early stages of disease, where it is possible to give the child the chance of long-continued and perfect rest, with general hygienic measures; and, secondly, after excision, to keep the limb quiet for a time until the parts are sufficiently consolidated to allow of movement being begun. We have habitually used it for several years.

The question of when to excise a hip joint is no doubt a difficult one, but the conclusion we have come to is this. Treatment, short of excision, when once suppuration occurs, is useful only as a palliative, or a means of temporising. Our opinion, bearing in mind Mr. Holmes' valuable remarks on the social circumstances of these patients,<sup>1</sup> is that where there is an abscess outside the joint, or, without this, great trochanteric thickening, or much pain that does not yield to treatment by rest, excision ought to be performed. While fully aware that abscesses disappear and tuberculous lesions cicatrise under favourable circumstances, we think that in the case of the hip delay is unwise among the hospital class, with whom it is as yet impossible to deal on the same lines as with the well-to-do. In almost every instance we have found much more extensive disease than might be expected from the external evidence, unless the pathology of the affection is borne in mind, and we believe that, once this chronic osteomyelitis is established, nothing short of excision can, *in hospital cases*, prevent the ultimate progress of the disease to abscess, and too often to gradual exhaustion of the patient by pain and discharge. Nature, of course, in many cases will, unaided, get rid of the dead bone by slow and tedious processes, but the number of children who can survive the process of elimination is very small, while the mortality after early excision is not great, and the failures are mainly in those instances where the operation has been put off till too late. Where actual necrosis, or caries of the head of the femur, with destruction of bone and cartilage, and often sequestra of varying size in the acetabulum, or at least caries of it, are known to exist, we think few advocates of non-operative treatment will be found. It is then, as Mr. Bryant points out, to be looked upon rather as an ordinary operation for necrosed bone than anything more formidable, and that this is the state of the joint even in cases often spoken of as those of early disease is the fact upon which we should like to lay stress.

While incision and drainage are sufficient for many joints, in the hip the extent of bone disease and the difficulty of obtaining thorough drainage make such treatment inadequate. Even if it is only to procure free vent for the products of inflammation, we must remove the head of the bone, just as we trephine for circumscribed abscess or for intra-cranial suppuration.

As soon, then, as there is any evidence of external abscess, excision should certainly be performed, and still better results will, we believe, be obtained by operating even before the pus has escaped from the articulation.

<sup>1</sup> In private practice cases are usually seen in the first or early second stage, and it is possible to ensure that the Thomas' splint shall be kept on and no strain thrown upon the joint: hence recovery without operation is the rule.

The operation is discredited because it is put off until disease is so far advanced that no mode of treatment can have more than a small proportion of good results ; while timely excision cuts short the disease, saves pain, lessens the time of treatment, and gives a better limb.

*Modes of excision.*—Various incisions for removal of the upper end of the femur have been advocated. Of these the incision over the middle of the trochanter and slightly concave forward is the one we usually adopt. We see no advantage in any of the others over the one extending downwards for about three inches, more or less according to age and the extent of the disease, along the middle of the trochanter. Where it is proposed to remove a large part of the pelvic wall, a T-shaped or flap operation may be desirable, but we have rarely had occasion to employ it.

Next, the soft parts should be divided vertically above the trochanter and the capsule opened freely, if this has not been done by the first incision. The joint should then be explored with the finger.

The next step is to separate the soft tissues from the bone on the inner side, stripping back the periosteum as far as it exists as such. The finger should then be used to pass round the bone and feel that the upper end is free ; next, still using the finger as a guard at the inner side of the bone, the femur should be sawn through just below the trochanteric margin with a key-hole or finger saw. Some part of the trochanteric epiphysis is usually left behind. The upper extremity of the bone is then readily prised out with the finger or raspator. The acetabulum should be then examined and any sequestra removed. If there is a large carious surface it may be gouged or scraped with a Volkmann's spoon or left alone. It is well to remove any rough or semi-necrosed bone, but we doubt the possibility of being able to remove all the disease without greatly adding to the severity of the operation where there is extensive inflammation without necrosis, nor is such treatment desirable.

The upper end of the femur should be examined to see if the whole disease has been removed ; if not, a further section should be made, and this may be carried a considerable distance down the shaft ; six inches have been removed with a good result, and but little shortening, by an American surgeon.

Here it is well to point out the danger of the practice of thrusting the head of the femur forcibly out of the wound before sawing it through, instead of dividing it *in situ*. Several cases of fracture of the shaft of the atrophied fatty bone have occurred. An additional objection to this practice is the ease with which the periosteum may be thus stripped off the inner aspect of the shaft and so necrosis may occur.

The operation is much more easily and safely done in the way described, and involves less violence to and less division of the soft parts. The finger is quite as good a guide as the eye to the condition of the bone.

Usually no vessels require ligatures, though there is sometimes free oozing of blood. A suture may or may not be put through the edges of the wound to partly close it, but this is not a matter of great importance ; if the case is one with old standing sinuses, we prefer to leave it quite open, and in any case a large drainage tube should be passed deep into the cavity of the joint. Any sinuses or abscess cavities should then be scraped out and well

drained before applying the dressing. It will often be found that a distinct membranous layer of lymph lines the cavity of the articulation, but there is rarely anything like the thickness of granulation tissue so often seen in the knee and other joints. It is well to remove any masses of pulpy granulations should they exist, but anything like the elaborate dissection required in erosion of the knee is impracticable.

There is not, we think, any advantage in removing only the head of the bone and leaving the trochanter.<sup>1</sup> In many cases the head of the femur is so far destroyed that it would be impossible to do less than take away the trochanter, while the trochanter if left tends to block up the orifice of the wound and prevents the free escape of discharge and débris of bone, and thus interferes with one of the main objects of the operation. The Clinical Society's Committee, however, advised that the trochanter should be left unless diseased, or unless there is extensive pelvic disease, and some of those surgeons who operate early in the disease advocate this plan.

Where intrapelvic abscess exists the acetabulum should be perforated. Examination per rectum enables the diagnosis to be made if this condition is suspected.

As regards the use of antiseptics, they should, of course, be used in cases where there is no external wound. The most convenient form of dressing afterwards is a thick pad of wood-wool, or wood-wool wadding, over a thin layer of wet gauze. Iodoform should be freely dusted into the wound before applying the dressings.

Following Mr. Howse, we prefer to have the extension put on before the operation, so that the weights, or, better, Bryant's splint, can be applied at once before the patient is put to bed. The shock of the operation is often somewhat severe, but usually soon passes off under the use of opium and stimulants. Rarely, however, much more severe and prolonged shock occurs.

The subsequent management of the case requires some special remarks. It is exceedingly difficult always to keep the wound aseptic; still, as comparatively few cases can be treated in hospital till the wounds completely close, they are under somewhat different conditions to other patients. It is, however, a great gain if the wounds can be kept sweet even for a time.

The after-treatment of cases of excision simply consists in dressing and in keeping the limb quiet and in good position. This may be done by various means, of which the best ones are simple extension by a weight (the weight may usually be reckoned at one pound for each year of the child's age from two to six; six pounds is generally enough up to twelve years of age, after which more may be added) with or without a long splint on the opposite side, and a Bryant's double splint, which has many advantages in securing 'parallelism of the two limbs,' and in the ease and comfort with which the patient can be moved. It is an invaluable apparatus, and we now almost invariably use it.

The sooner excision cases are got up and about, the better: some cases may leave their beds in three weeks; others, of course, are much longer in getting up, the difference depending mainly upon the state of the disease at the time of operation.

<sup>1</sup> A section through the neck will often leave unhealthy bone behind.

The period of convalescence after excision varies from the time mentioned to two years, while in some cases sinuses may remain open much longer if pelvic disease exists. We keep our patients usually in a Thomas' splint for from at least three to six months after excision; after this the child, if old enough, should get about with a patten and crutches, allowing the limb to swing, and only after a year or more should he be allowed to gradually bear weight upon the leg. If, however, excision is done early, the limb is fit for walking sooner, sometimes in five or six months. If the affected leg is allowed to touch the ground too soon, it becomes pushed up upon the *dorsum ilii*, and much shortening results. On the other hand, if the limb is fixed too long, it becomes stiff. A very large proportion of cases of excision in the later stages of the disease remain with sinuses, but often these produce no ill result except the trouble of dressing them: a certain number may be got to close by scraping, cautery, &c.; others are very intractable. In a certain number of cases the wound re-opens after having healed; this is undoubtedly common, but is due to over-use, neglect, or violence, and with ordinary care and treatment the wounds usually again close.

It is interesting and important to note that in measuring the amount of shortening after excision the real shortening—as measured from the upper end of the femur to the malleolus on each side—is often trifling, and sometimes there is none, while the practical shortening as measured from the pelvis to the malleolus is considerable. Though some shortening will necessarily result, any large amount is due to weight being borne upon the limb prematurely. It has already been pointed out that growth in length of the femur takes place almost entirely at its lower epiphysial line, hence the loss of length or true shortening is only the distance from the line of section to the top of the head, coupled with such arrest of growth as may result from impaired nutrition, this last being, of course, a very inconstant quantity. Ollier estimates that during the first four years of life growth takes place about equally at each end of the femur; after that time the lower end grows more rapidly.

The primary objects of the operation of excision of the hip are to save life and relieve pain; the next most important question is that of the usefulness of the limb and of the condition of the 'joint' after the operation. One of two results must occur after excision: either a freely movable limb, or one with varying degrees of stiffness, from some mobility to bony ankylosis. Bony ankylosis after excision is very rare. Close fibrous union so that but little mobility remains is very common; movement through from  $30^{\circ}$  to  $50^{\circ}$  is perhaps the commonest result, and a smaller number have complete mobility.

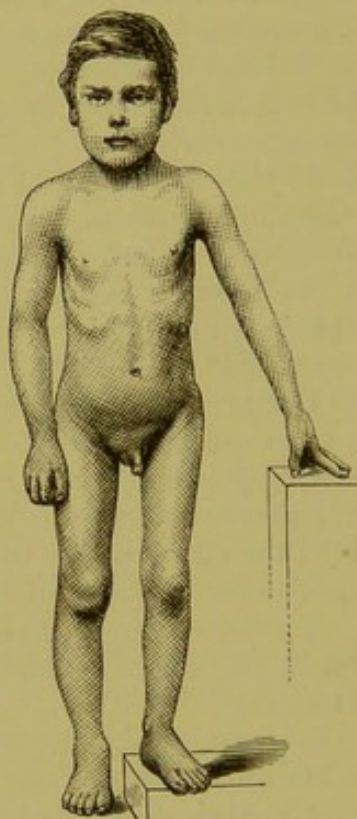


Fig. 106.—From a photograph showing a good average result after excision, when the leg has been walked upon, and the stump of the femur is thrust up upon the *dorsum ilii*.

It is not possible to estimate in figures the results to be expected from excision ; for details we must refer to the monograph mentioned at the beginning of the chapter.

Whether, then, we consider the pathology of the disease, the actual local condition, the relief of pain, the preservation of life, the duration of illness, the condition of the limb and its usefulness, or the dangers of secondary disease, on every ground, in our opinion, excision is the best course under the circumstances already stated.

*Conclusions.*—1. The hip joint in childhood is commonly subject to two affections : (a) simple synovitis ; (b) tubercular disease.

2. Simple synovitis is usually traumatic, very rarely suppurates, is amenable to ordinary treatment, and as a rule leaves behind no bad results.

3. Tubercular disease, or common 'hip disease,' affects primarily the upper end of the femur, or occasionally the acetabulum, and produces necrosis or extensive caries.

4. In the early stage of hip disease, before caseation of bone or suppuration has taken place, proper treatment will, in a fair proportion of cases, result in recovery with a nearly perfect limb.

5. As soon as suppuration occurs, it is certain that recovery will not take place without destruction of the upper epiphysis of the femur more or less completely.

6. The process of removal of the diseased bone without operation is so slow, so exhausting, and so uncertain that it should be reserved for those cases where time and care can be fully devoted to it.

7. Unless absolute rest and treatment for two years can be ensured, excision of the upper end of the femur should be performed as soon as suppuration or other evidence of necrosis is present.

8. A case of hip disease, seen before suppuration has occurred, is best treated by the use of a Thomas' splint with or without previous straightening by extension.

9. Excision of the hip cuts short the disease, relieves pain, and gives a better limb than the average result obtained without operation.

10. Excision should be looked upon as an ordinary operation for necrosis, and the operation itself is not necessarily attended by a higher mortality than sequestrotomy elsewhere.

11. Excision in old pelvic disease, or where the health is broken down, or the patient is over fifteen years of age, should be rejected in favour of amputation.

12. The presence of a sinus after operation, unless there is much discharge or evidence of extensive pelvic disease, does not imply failure of the operation.

13. The presence of an abscess after a long period of quiescence (residual abscess), without other evidence of relapse, is not to be looked upon as of serious import.

Since these pages were written Messrs. Barker and Pollard have (December 1888) brought before the Medico-Chirurgical Society of London a new method of managing the operation of excision of the hip. The method consists in clearing away all disease of the soft parts by scraping or excision ; scraping out abscess cavities, and by means of thorough and careful

asepticism getting the wound clean. The novelty is in their mode of carefully drying out the wound and closing it entirely after removal of all tuberculous material as far as possible, so that primary union is obtained. Messrs. Barker and Pollard showed cases in which this result had been obtained, and we have since then followed their plan in its main features with success. It is too soon yet to fully estimate the value of the proceeding, but as far as our present evidence goes it is a most valuable and splendid improvement. For further details we must refer to the *Medico-Chir. Transactions*, 1888; but we may reprint here Mr. Pollard's abstract of the essentials of the method:—

1. The whole of the tubercular growth must be removed.
2. Perfect asepsis must be assured.
3. Bleeding must be checked and the wound made as dry as possible.
4. Oozing must be checked by the even, elastic support of a wool dressing and a moderately tight bandage.
5. Absolute rest of the part must be maintained during the process of healing.

*Amputation.*—The question of amputation at the hip joint for disease is one of the highest importance. We must consider not only the unavoidable mortality and crippling caused by the disease, but also the interference with pleasure and education entailed by long confinement indoors. Where there is no reasonable prospect of recovery with a useful limb, amputation must not be too summarily set aside.

There is little doubt that, in cases of extensive disease where the femur is necrosed for a long distance and the powers of the patient are inadequate to repair it, in cases where descending osteomyelitis occurs, and in cases where profuse discharge and amyloid disease come on, amputation should be performed.

In cases of more advanced amyloid disease, unless the powers of the child are so enfeebled that the operation will prove fatal by shock, it ought also undoubtedly to be done.

In another class of cases the question is more difficult. Where there is disease of the pelvis, is amputation contra-indicated if other conditions require it? We would answer yes, if the pelvic disease extends so widely that there is no hope of removing it at all, and the condition is one of caries and not necrosis. Where there is caries limited to the neighbourhood of the acetabulum, where there is necrosis, or where there is reason to think that the disease in the limb is preventing repair in the pelvis, amputation should be performed.

As to the question of saving life, amputation at the hip performed with due precautions as to hæmorrhage and shock, and special care during the first twenty-four hours, is not a very fatal operation in children.

We have amputated in seven or eight cases. In six excision had been previously performed. All of these recovered well from the operation except one who died of hæmorrhage.

The best plan is the oval incision of Furneaux Jordan; the excision wound should be utilised, and the line of section brought as far as possible from the anus and vulva.

Neither the various methods of operation nor the best means of con-

trolling bleeding are questions suited for discussion here. Elevating the limb before operation, and digital pressure with the help of an elastic tourniquet in the early stages of the operation, are as efficient means of controlling the hæmorrhage as any ; in several cases we have ligatured the femoral or external iliac as a preliminary, and think well of this plan.

If possible, it is, as pointed out by Mr. Shuter, well to preserve as much periosteum as possible, and it will be found that after excision the bone usually very readily separates from the periosteal sheath ; a longer, firmer, and more or less mobile stump may be thus obtained.

## CHAPTER XXXI.

## SPINAL DISEASE.

**Caries of the Spine, Angular Curvature, or Pott's Disease,** are terms which, as commonly used, include conditions of very varying severity, affecting several different structures. This is so, since the spinal column is in each segment provided with several different articulations, and any of these, as well as the bone itself, may become the seat of disease. Thus the mischief may begin at the junction of a vertebral body and intervertebral disc, at the junction of a vertebral body with its epiphyses, in the centre of a body, or on its anterior, posterior, or lateral surfaces; or, again, the articular processes, or their joints, the transverse and spinous processes, may any of them be separately diseased. Again, the mode of connection between the skull and atlas, the atlas and axis, and the sacral joints imply necessarily varying conditions from those found in disease of the rest of the column.

Obviously, the names given to disease of the spine are not equally applicable to all these affections; disease of a spinous or an articular process does not give rise to angular curvature. It is, however, quite the exception to find in children disease of the spine affecting any part except the bodies and intervertebral discs; we can only call to mind two cases of disease of a spinous process alone, one of which was the following:—

*CASE.—Necrosis of the Cervical Spinous Processes.*—Edward H., age 4 years 5 months; admitted July 21, 1882. Six weeks ago a hard lump was noticed at the back of the neck, he having, a fortnight before, fallen on the back of his head; the swelling had gradually increased, but he had had neither pain nor tenderness. On admission he was well nourished; there was a large fluctuating swelling in the middle of the back of the neck; it was opened antiseptically, and about dr. iij of healthy pus escaped; the tips of one or more spines were bare; the dressing slipped the next day; the abscess continued to discharge, and he was sent out on August 25 with a juremast on and a still unhealed sinus. In January, 1883, at Out-Patients, he was nearly well: the movements of the neck were perfect and the thickening nearly gone, but there was still a small sinus. Subsequently a sequestrum consisting of the spinous process was removed, and he quite recovered.

We have never verified a case of disease of a joint between the articular processes, and disease of the transverse processes is rare. The atlanto-axial and occipito-atlantoid joints are also very rarely affected in children in comparison with caries of the bodies.

The ordinary form of caries of the spine affecting the bodies or intervertebral discs or both structures is met with in all parts of the spinal column from the axis to the sacrum. In 100 cases taken at random from our Out-Patient papers we found 18 cases of cervical disease, 41 cases where the

cervico-dorsal, upper, or mid-dorsal regions were involved, 33 instances of lower dorsal or dorso-lumbar disease, 6 of lumbar caries, and 2 of disease of the sacrum. R. W. Parker, as quoted by Erichsen, gives the following figures: Cervical 9, dorsal 82, dorso-lumbar 21, lumbar or lumbo-sacral 37, out of 149 cases. These figures are of some importance, for, in the first place, no attempt at removal of diseased bone can be made in the dorsal region, and only exceptionally in the cervical part of the spine, while the treatment of the disease by apparatus becomes more troublesome as we ascend from the mid-dorsal region. Pus is more likely to point externally as lumbar or

psoas abscess when the lower dorsal or lumbar vertebræ are attacked, though it is not rare for dorsal abscesses to track down the spine. Cervical abscesses point in the pharynx or side of the neck. Lastly, occasionally two foci of disease exist, as in fig. 107.

*Pathology.*—It is probable that caries of the spine begins nearly always in the body of the vertebra, and not in the intervertebral disc itself; but it is difficult to be sure of the relative frequency of these sites, for the mischief soon spreads beyond the limits of a vertebra in most instances. Erichsen considers the epiphyseal lines, the front of the bodies, and the centre of the bodies to be in this order the most frequent primary seats of disease. Wilks and Moxon apparently incline to the belief that the bones are the primary seat of 'scrofulous' disease in children, while disease beginning in the discs is a separate type of lesion—at all events in some cases the result simply of injury; probably the seat of disease varies. In most cases the lesion is an ordinary tuberculous disease of

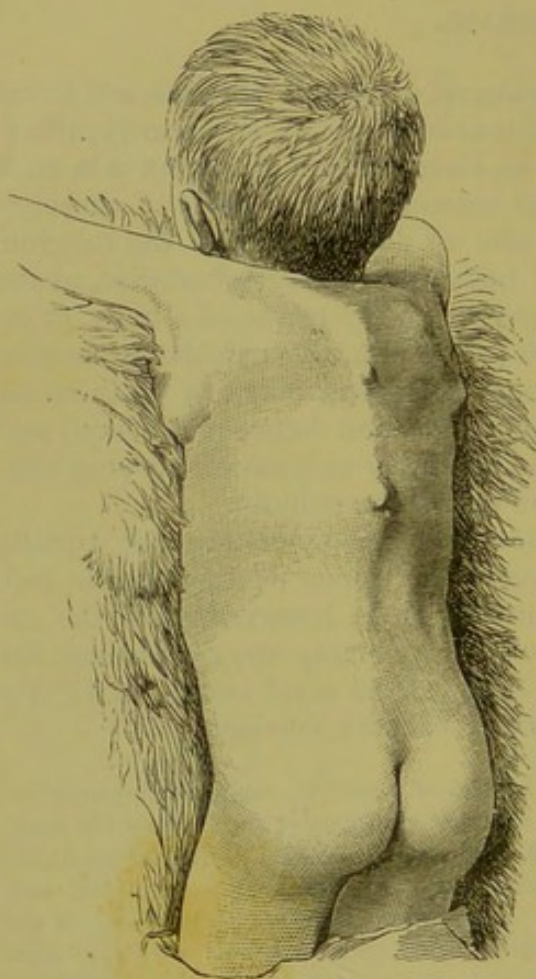


Fig. 107.—Caries of the Spine, showing two foci of disease.

bone, rarefying osteitis being found in some parts, while in others caries necrotica or more extensive necrosis exists. Although a large number of patients, the subject of caries of the spine, never develop external abscesses, it by no means follows that no suppuration takes place; large collections of pus may form beneath the anterior common ligament in the dorsal region without ever discharging, and may, like abscesses elsewhere, dry up and remain as cheesy or calcareous masses. More rarely the abscess may empty itself into the lung or intestine: the latter result we have seen in a case of lumbar caries and in sacral disease, and it is probably more common than is supposed, the pus in the motions being overlooked or put down to enteritis.

In other instances caries of the spine, like caries elsewhere, may be throughout unattended with any pus formation (*caries sicca*).

There is often a discharge of small sequestra from spinal abscesses, and sometimes fair-sized pieces of dead bone come away or are extracted, but this is not common.<sup>1</sup>

Pus from a lesion in one part of the spine may track downwards and give rise to a second focus of disease lower down, but sometimes, as in fig. 107, the two foci are quite independent and isolated from one another; in the case from which the figure was taken the lower patch of disease developed first.

In some instances disease may begin as a simple non-tuberculous inflammation, the result of injury as already mentioned; this is not, however, common in children in our experience, since in them the disease usually runs the course of tuberculous lesions generally. Cases of spinal curvature, due to the lesions of congenital syphilis, are also described.

**Abscess.**—Pus in connection with spinal caries usually burrows along certain definite lines determined by muscular and fascial barriers; thus in the neck, abscesses are either *prævertebral*, bulging forwards into the pharynx, as in atlanto-axial disease, or point at the side in the posterior triangle, just behind the sterno-mastoid, sometimes on both sides.

In the lower cervical and upper dorsal regions the abscesses, if they exist, rarely point externally, but if they do so either track down the spine and appear as lumbar or psoas abscesses, or perforate an intercostal or intertransverse space and appear in the back. Abscess in upper dorsal caries comparatively rarely points externally. Dorsal and lumbar caries commonly gives rise to psoas abscess, the pus getting into the sheath of the muscle at its upper attachment and burrowing down within it, often entirely destroying the muscle itself; it then may either pass outwards into the iliac fossa, beneath the iliac fascia, and form a swelling there (*iliac abscess*), or, travelling on beneath Poupart's ligament, bulge in the thigh on the outer side of the femoral sheath as a psoas abscess. Often, however, though forming a collection in front, the matter does not point there, but, passing on behind the vessels towards the lesser trochanter, appears at the back of the thigh as a *gluteal abscess*. In other instances the pus finds its way round the edge of the quadratus lumborum and through the transversalis aponeurosis, perhaps in the course of a branch of a lumbar artery, and points in the back (*lumbar abscess*). Again, the pus may gravitate backwards into the pelvis and escape through the sciatic notch, appearing as another form of gluteal abscess. We have seen an abscess bulging at both sciatic foramina, so that fluctuation could be felt across the cavity of the pelvis. Less often the abscess descends over the iliac crest on its outer aspect, or burrows forwards between the layers of the abdominal wall. Once it has reached the thigh, matter may track down it for an indefinite distance.

**Deformity.**—In most cases caries of the spine sooner or later gives rise to angular deformity (*kyphosis*). This is, of course, due to destruction of the bodies of one or more vertebræ, and consequent collapse of the column; or possibly, to a certain extent, is caused by muscular contraction drawing together the adjacent bodies, the spines being thereby made to project

<sup>1</sup> As in the well-known instances of the odontoid process coming away entire through the pharynx.

posteriorly. The amount of deformity in such cases varies from a mere faint prominence of one vertebral spine, only to be recognised by careful observation, to a great prominent 'knuckle' involving six or eight vertebræ. When the disease is in the dorsal region, the falling together of the vertebral bodies produces a corresponding chest deformity; the ribs are brought close together, the shoulders are raised and the head looks sunken between them, the antero-posterior diameter of the chest being increased at the expense of the vertical.

In the cervical region the deformity is usually much less marked; sometimes, however, there is a prominent angular curvature, and the head is drooped forwards with the chin upon the sternum; or the head and upper cervical vertebræ are poked forwards with a projection backwards at the root of the neck.

It must be remembered, however, that these deformities only occur in an advanced stage of destruction, and only when the whole breadth of a vertebra is eaten away; thus disease of one side or the posterior part of a body may exist without any angular deformity, and in some instances the spine is recurved so that the convexity is forwards instead of backwards; this is most commonly seen in the cervical region: we have, however, seen it in the lumbar vertebræ too. In such cases the bending is never sharply angular, but is due to spasm of the posterior spinal muscles; it can rarely, if ever, be due to destruction of bone, for to produce such result not only the bodies but the arches of the vertebræ would have to be destroyed: the condition is generally merely an exaggeration of the normal curves.

Since there is a physiological curve with its convexity forwards in the cervical and lumbar regions, a certain amount of destruction of the vertebral bodies has the effect of merely straightening these curves, and it is only when considerable erosion has taken place that a curve with its convexity backwards is produced.

Extensive disease of the posterior parts of the bodies may, of course, exist without any curvature, and in such cases the inflammatory material poured out may produce pressure on the cord or nerves, or inflammation by extension; hence the old saying, 'the less the deformity, the more the paralysis.'<sup>1</sup> Paralysis in such cases is probably hardly ever due to bony pressure, since the spinal canal is not encroached upon; this is only likely to occur where a sequestrum is pushed into the canal.<sup>2</sup> Lateral curvature sometimes results from destruction of the sides of the bodies and consequent collapse; more often, however, any lateral curvature that does exist is a result of ligamentous and muscular weakness, and as such is a true lateral curvature.

Before there is any permanent deformity from loss of material, certain characteristic attitudes are assumed by the subjects of spinal disease. In caries of the cervical spine the child often supports his head with his hands, to lighten the pressure upon the diseased spot and prevent any sudden jar, and is slow and careful in turning round and stooping. Where the dorsal or

<sup>1</sup> It is also a matter of frequent observation that paraplegia and abscess are rarely associated.

<sup>2</sup> Paraplegia is commoner in cervical and upper dorsal caries than in disease lower down.

lumbar regions are involved, instead of bending the spine to reach any object upon the floor, the child bends the knees and hips, and so brings down the hands, and at every opportunity assumes the resting position shown in fig. 108.

It is most important to distinguish angular curvature from lateral curvature and from rickety spine. It is only in the very early and very late stages of disease that there is likely to be any doubt whether a case is one of lateral or angular curvature; in ordinary well-marked cases the distinction is clear enough. In some old cases of lateral curvature very sharp bends in the spine are much like angular deformity; and again, we have more than once seen cases where there was an early lateral curve and no symptoms pointing to caries, yet in a few months undoubted caries appeared. Careful and repeated observations are, therefore, necessary if there is any possibility of doubt, and it must be remembered that the two affections may co-exist. Ordinarily a diagnosis is readily made by the presence in the one of a lateral curve and of rotation, and by the fact that the curve in caries is abrupt, in lateral curvature gradual, as well as by the presence or absence of the other symptoms of caries mentioned.

The rickety spine is distinguished by its being a general rounded curve, by the absence of rigidity, by the disappearance of the curve when the child is held so that no weight comes upon the spine, by the evidences of rickets elsewhere, and the absence of the characteristics of caries. Caries also is very rare in the first two years of life, rickety spine much most common during that period.

With these exceptions and the possible ones of an old fracture or dislocation, or congenital undue prominence of certain spines, or the development of bursæ over the spines, the result of friction or pressure, angular deformity may be taken as pathognomonic of caries either present or pre-existing.

*Abscess* is not by itself a certain indication, since it may be due to many other causes than spinal caries; still, the presence of a lumbar, gluteal, iliac, psoas, post-pharyngeal or cervical abscess should always lead to a careful examination of the spine. It must be remembered that pelvic disease, glandular, perityphlitic, perisigmoid, and perinephritic abscesses, empyema, carious ribs, sacro-iliac and hip disease, &c., may give rise to suppuration, which may point in positions identical with those in which spinal abscesses may find outlet.



Fig. 108.—Caries of the Spine, showing a characteristic resting attitude, which should be contrasted with the rickety spine seen in fig. 55.

*Rigidity* is a most important sign of spinal disease; important all the more because it is an early one; the stiffness is due to spasm of the spinal muscles, just as in disease of any other joint. Rigidity is best tested by stripping the child and putting some object upon the floor for him to pick up; by watching carefully it will be seen whether the whole spine bends as in health, or whether it is held stiff and immovable in any part.<sup>1</sup> Absence of flexibility is, taken alone, the most valuable sign of caries except deformity.

In the cervical region muscular spasm may give rise to wry neck, inability to nod or to turn the head round, according to the part involved.

Besides contraction of the posterior spinal muscles, there may be rigidity of the ilio-psoas, causing flexion of, and inability to straighten, one or both legs; this usually means that a psoas abscess is beginning to form, and the muscles are rigid in consequence of irritation, or kept voluntarily contracted to prevent pressure upon the abscess. Local rigidity of the lumbar muscles or of certain of the posterior spinal muscles will sometimes be found, thus the erector spinæ may be seen tightly contracted and standing out prominently just above the sacrum.

The test of bending the body backwards is more applicable to adults than to children, in whom it is difficult to estimate amounts of pain; it should, however, always be employed.

*Muscular wasting* occurs in spinal as in other joint diseases, but is rarely well marked, except when the disease is far advanced, and hence is not of great value alone as a symptom.

*Dysphagia* may result from pressure by an abscess upon the pharynx or œsophagus, or dyspnœa from pressure upon the trachea or lungs or upon the recurrent laryngeal nerves in disease lower down; so too, possibly, extensive abscess in the chest may give rise to physical signs, dulness, &c.<sup>2</sup>

Large abdominal abscesses may produce pressure effects upon vessels and viscera, but these are rare results. Abdominal distention from flatulence may be due either to pressure upon nerves, or to failure of the digestive powers in later stages, or to coincident tubercular disease of the intestines, mesenteric glands, &c.

The *subjective symptoms* of spinal caries are pain and loss of sensation. Pain may be acute or nothing more than a feeling of tiredness or aching; it is usually an early and prominent symptom; it may, however, be entirely absent, just as in some instances of chronic joint disease elsewhere. Usually there is pain over the affected spot, increased by pressure or jarring of the spine, such as may occur in jumping, or suddenly stepping down from a height; in caries of the cervical spine, pressure upon the top of the head often causes suffering, and in any part of the column flexion or rotation movements may be painful.

Further, there is usually pain in the course of the nerves passing out from the diseased area; thus in dorsal caries there is pain at the sternum or in the side; in dorso-lumbar disease there is abdominal pain ('girdle pain' so called, 'dry belly-ache'). Pains in the limbs, shooting down the

<sup>1</sup> Healthy children freely bend their spines, but in order to fully test the mobility of the column the child should be told to keep its knees straight.

<sup>2</sup> This is, however, more likely to be due to enlarged mediastinal glands.

legs over the distribution of the sacral and lumbar plexuses, and similarly in the arms, may be met with. Any obscure pain should always be carefully traced to its source by searching along the whole course of the affected nerve up to its origin. Thus, pain in the back of the head, so-called 'headache,' may be due to pressure upon the occipital nerves, and so on.<sup>1</sup>

The anæsthesia and paræsthesia due to spinal caries are either the result of pressure upon the theca or nerves or of inflammation spreading from the bone to the meninges or cord, and will be found described in Chapter XXV.

Pain in the spine is sometimes increased by the application of warmth, e.g. a hot sponge applied over the diseased part, but the symptom is not constant nor of any great value. In a few instances we have found herpes zoster occurring in connection with caries of the spine, and it is worth while to examine the spine in cases of shingles, since they may be a result of lesions starting in the spinal column.

The conditions most likely to be confounded with spinal disease are, in the neck, sprains or stiff neck from cold, reflex irritation, &c., glandular inflammation, and cervical cellulitis. The 'vertebra prominens' should be remembered, and the ease with which the cervical transverse processes can be felt; there is often a deceptive feeling of thickening about the cervical vertebræ which is apt to mislead unless comparison is made with a healthy neck. In caries thickening will be felt. In glandular abscess the glands themselves can usually be felt to be enlarged, and generally the pain is most marked or only exists on one side, whereas in caries there is usually tenderness on pressure on both sides. This, with the other symptoms already mentioned, will serve to distinguish between the two conditions. Prævertebral abscess, though often due to spinal disease, may be the result of several other lesions; *vide* page 57.

Caries of the dorsal and lumbar spine has already had its distinguishing features pointed out; it is only necessary to add that in all cases search should be made for evidence of abscess deep in the abdomen, since large collections of matter sometimes form very insidiously.

*Complications.*—In addition to the troubles arising directly from the spinal lesion other complications may arise; thus the vertebral disease may be only a part of a general tuberculosis in which viscera or bones and joints other than the spine may be involved. Sometimes a psoas abscess in tracking down gives rise to disease of the sacro-iliac or hip joints (*vide* Hip Disease). As a result of pressure upon or inflammation of the spinal cord and its membranes cystitis or paralysis of the bladder may result; bedsores may form both as a consequence of pressure and from the nerve lesions. Exhaustion, hectic, lardaceous disease, and general tuberculosis are the most common causes of death, though it must not be forgotten that sudden death may occur from displacement, the result of softened ligaments, in the upper cervical spine, or from bursting of an abscess into the air passages, or ulceration into a large vessel. In other instances pyæmia or some intercurrent disease cuts life short.

Paraplegia may occur in the course of spinal disease as a result of pressure from inflammatory exudation poured out into the spinal canal, from

<sup>1</sup> For illustrations of these peripheral pains the reader is referred to Mr. Hilton's admirable book, *Rest and Pain*, edited by Mr. Jacobson.

effusion pressing upon the nerve roots, an occurrence met with in the cervical region ('cervical paraplegia' of Gull), from necrosis and projection of a sequestrum into the canal, or rarely from the angular bending of the spinal column. Paraplegia occurs most frequently in cases of caries of some part above the lower dorsal spine, more rarely in lumbar disease. The degree of paralysis varies from mere weakness with paræsthesia to complete paralysis of the lower limbs, the bladder, and rectum, or in rare cases the paraplegia may be complete below the lower cervical region. There is loss of power, diminished sensibility, exaggeration of the reflexes, more or less contraction of the limbs, and in cases where the cervical or lumbar enlargement of the cord is involved actual muscular degeneration. Pain may or may not be present. For details *vide* Chapter on Nervous Diseases; Paraplegia, p. 437.

*Mode of repair.*—Repair in the spine takes place just as in other joints; the carious or necrotic process ceases, and the tissue injured beyond recovery is either thrown off and comes away in the discharge, or is encysted and remains quiescent, giving rise to no more irritation. The granulation tissue either develops into fibrous tissue or ossifies, and the adjacent bone surfaces are welded together; in addition to this bony splints and buttresses are developed around the diseased spot and further strengthen it.

It is possible in very early stages for the inflammation to subside, and the parts to return to their original healthy condition; but once there is loss of substance the curvature is never lost, though the spine may appear straighter from development of compensatory curves, or from straightening out of other mere transitory yieldings due to muscular and ligamentous weakness.

*Treatment.*—Disease of the spine requires treatment on exactly the same principles as disease of other joints, viz. rest and general hygienic measures, with such management of abscesses as each case may demand.

The general treatment need not be specified here further than to say that nutritious and careful diet, iron, and cod-liver oil, together with good and, if possible, sea air, are the desiderata. The difficulties arise in obtaining rest and in the treatment of abscesses. Rest implies absolute fixation of the diseased part: this requires different arrangements in caries of the upper and lower parts of the spine. In cervical caries the best plan of treatment is to put the child on a hard mattress, with a small pillow<sup>1</sup> to fit in between the shoulders and occiput so as just to support the spine without straining it; sandbags not too tightly filled are then laid along each side of the neck, packed well in, and secured by one placed across above the top of the head; a folded handkerchief should be carried across the forehead and fastened to the sandbags at the side to prevent any possible lifting of the head. Arrangements should be made for defæcation, &c., without disturbing the child by providing a hole in the mattress or a separate part in the middle that can be slid out. We know no better plan than this<sup>2</sup> where it can be carried out rigidly, but it is difficult to manage for a sufficient time. As soon as repair has fairly advanced, as evidenced by absence of pain for some weeks previously, loss of tenderness, and diminution of thickening, with drying up of any abscesses that may have formed, the child

<sup>1</sup> A ring air or water cushion for the head answers very well.

<sup>2</sup> As advised by Mr. Hilton.

should have on a stiff leather or poroplastic collar moulded carefully to the neck and occiput, and shaped to the shoulders below; he may then begin gently and carefully to get about for a short time daily, but on the least sign of pain or swelling the original plan must be reverted to.

Or a jurymast may be applied with a plaster or felt jacket, either in the original form devised by Sayre, or of a shape we prefer as less troublesome, and we think more efficient, as shown in fig. 109; this form has the advantage of providing elastic support, of not requiring to be made of steel, and of not tending to press upon the vertex. The jurymast must be carefully modelled to the particular case, and never removed, but the straps kept just taut. Failing the treatment in bed, the jurymast is, we think, as good a plan as any, though it is troublesome to manage. Various other methods, such as inflatable rubber collars, sawdust collars, &c., are used with advantage in suitable cases, i.e. when the disease is subsiding. Extension of the head by weights, the trunk being fixed, is sometimes usefully employed, but requires care not to overstretch the softened ligaments.

Caries in the upper and mid-dorsal regions requires as absolute recumbency as cervical disease, but it may be either in the prone or supine position, and sandbags are not required; the child should be fastened down by the simple plan shown in fig. 103 if he cannot be trusted to lie still. The jurymast plan is applicable, of course, to these cases as well, and must be used in any case where the ordinary jacket cannot be so applied as to carry the weight of the upper part of the body.

The ordinary plaster of Paris Sayre's jacket is in our opinion the best appliance for spinal caries in the lower dorsal and lumbar regions. In acute and rapidly progressing cases a period of recumbency should be insisted on, either with or without the jacket. Certain points are essential in the use of this appliance. 1. Any sharply projecting spines must be protected by padding round them, and by careful moulding of the plaster to avoid pressure. 2. The jacket must reach well up to the root of the neck in front and behind, being shaped out in the axillæ; this may be done by carrying the bandages crosswise over the shoulders and cutting out the cervical part afterwards, or by careful adjustment of the turns without crossing the shoulders. 3. The lower border of the jacket must come down well over the crest of the ilium, so as to distribute the pressure and prevent the formation of sores on the crest and iliac spines. In fact, the jacket must be closely fitting and envelope the whole spine from neck to pelvis, and not be, as it too often is, a mere wisp round the waist. We generally apply these jackets in the out-patients' room, with the child lying on its face across two chairs with a gap between them; the tripod may, of course, be used, but with the greatest caution, to



Fig. 109.—A Jurymast for Cervical or Upper Dorsal Caries. The altered shape of the upright makes it easier to fit, and it is not necessary to have it of steel; it also prevents falling forward of the head without making absolutely vertical traction. The spring of the steel is replaced by elastic cords in the straps, which have been omitted from the figure for the sake of clearness.

prevent any stretching, and it must be remembered that the point in applying a jacket is to fix the spine and prevent any further pressure, not to pull the surfaces apart—it would be as rational to put on powerful extension and counter-extension after excision of the knee, dragging the bones away from one another, as to try to extend a carious spine. Of the various modifica-

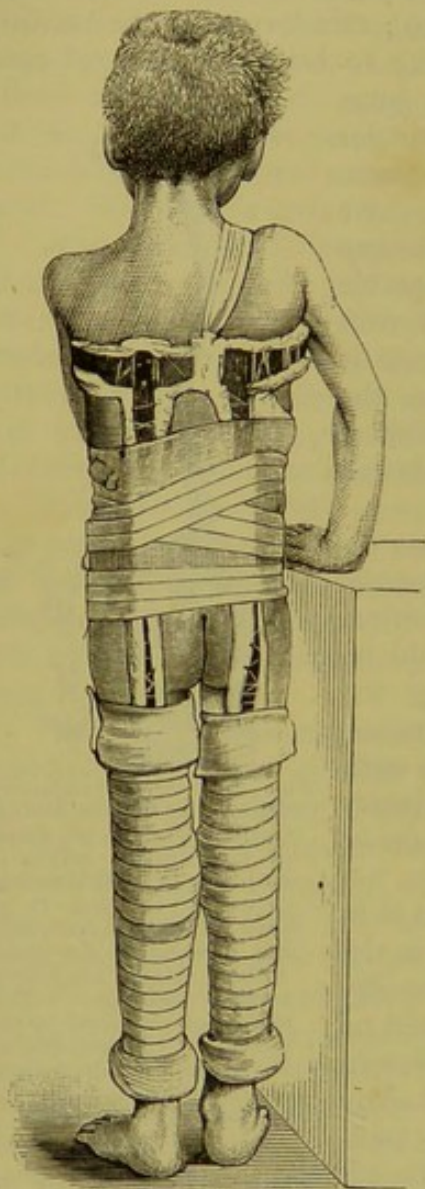


Fig. 110. — Caries of the Spine, with double ilio-lumbar abscess, treated by the application of a double Thomas' splint.

tions of the jacket we have no experience, as we are quite satisfied with the results of the 100 jackets a year we use. With careful management a jacket will last from 9 months to a year if the child does not grow out of it, but usually hospital patients require new ones every 2 or 3 months. The plan of putting on two jerseys and changing the inner one by tacking a new one to its lower edge, and then drawing it upwards beneath the jacket by pulling the old one over the head, is ingenious and saves frequent changing in some cases. Pain, after a jacket is put on, usually means pressure at some point, and should lead to careful examination: if at the hips or axillæ, it may be relieved by judicious packing or cutting out; if in the back, the jacket must be removed, or it will cause sores. Free dusting between the jersey and the skin with powdered boracic acid, or, in dirty people, with pulv. hyd. ammon., is useful. From 6 to 8 bandages are usually required for a jacket in a child; they should be applied in spirals so as to cross and strengthen one another, and care must be taken not to allow the edges to be thin and weak. 'Dinner pads' are not necessary if the bandages are put on judiciously; a soft patch in the jacket over the abdomen does not demand a re-application so long as the rest of the jacket is firm. In some cases, where, from the presence of abscesses in the back, or co-existent hip disease, or flexion of the legs from psoas abscess, a jacket is inapplicable, we use a double Thomas' hip splint and find it very useful; it ensures recumbency, keeps the spine at rest, extends the legs

and does not interfere with dressings nor require removal.<sup>1</sup>

Poroplastic and other jackets have only doubtful advantages over the original Sayre's, and have many drawbacks; they are rather applicable as protections after consolidation has taken place than as a mode of treatment for active disease. Of the various special apparatus we can only speak

<sup>1</sup> Should the child be fit to be on its legs, it can get about, with crutches, in a double Thomas'.

in the same terms, but not from actual experience of them ; we have never been tempted to try them.

If it were possible to reach and remove the source of suppuration in all cases, the management of spinal abscess would be that of all other abscesses in connection with bone disease, but the question is not a simple one, and each case has to be judged for itself. In cervical disease, as a rule, all abscesses should be opened as soon as they develop, for they are apt to track widely down the neck or, pointing in the pharynx, to become septic or a source of danger from pressure. Hence antiseptic incision, by dissection at the posterior border of the sternomastoid, is the best treatment. In one case, where the disease was of the spinous process alone, we opened the abscess, and later removed the necrosed spine ; and this, perhaps, might sometimes be done in necrosis of the bodies as proposed by Mr. Treves, more especially for lumbar necrosis. Opening the abscess in the pharynx is not a good plan, and should only be done in an emergency where the pressure is threatening suffocation ; even then we should prefer to do tracheotomy, and then open the abscess in the neck at leisure, allowing the tracheotomy wound to close.

Abscess in the dorsal region is not very common, and should be opened only if it is pointing or painful ; if due to disease of a spinous, transverse, or articular process, the seat of disease may be reached ; if of a body, this is hardly practicable without possibly resection of a rib, and is probably not desirable. Abscess pointing in the lumbar, iliac, or psoas areas is the one most commonly met with ; as to its treatment, our opinion is that if the abscess is on the point of bursting, or gives rise to much pain, or is rapidly increasing, it should be opened at once with full antiseptic precautions—the opening being made in the loin if there is any cavity there of sufficient size or, if not, in some cases it is a good plan to pass a long probe from the lower opening, iliac, psoas, or gluteal, as the case may be, and cut down upon it in the loin. Where the abscess is chronic, stationary, or only slowly increasing, where no adequate treatment has been hitherto adopted, and there is not much pain, it is wiser, in our opinion, to wait. The pus may be absorbed, there may be no sequestra to keep up irritation, and the caries may subside with rest, while we cannot remove the disease if it does not subside. When once opened there is always the possibility of dressings slipping and the wound getting foul, with the usual result of slowly progressive or acute septic poisoning. As long as the child is not going downhill, it is, we think, wiser to leave well alone. As to lumbar exploration and removal of sequestra, the plan introduced by Mr. Treves, we confess we rather agree with Mr. Owen that, while opening the abscess as near the seat of disease as possible is of course good, it is but rarely that we can hope to make out the exact condition of parts or find the sequestra, and the method is, as already pointed out, only applicable to lumbar disease.

All openings made should be free, and large drainage tubes should be used. At the time of opening the abscess it is well to explore with the finger and remove any sequestra and scrape or sponge out any caseous lymph lying loose in the abscess cavity ; this is, of course, quite a different matter from cutting down upon the vertebral bodies.

Where paraplegia occurs strict recumbency in bed should be the treat-

ment, with very careful general management and the utmost watchfulness to avoid bedsores. All discharges must be carefully cleaned away and the parts kept dry and powdered with boracic acid. Occasional washings with strong spirit tend to harden the skin and prevent pressure sores. Any contractures of the limbs should be prevented as far as possible by suitable appliances. The internal administration of large doses of iodide of potassium is highly recommended by our friend Dr. Gibney of New York, but it has failed in our own hands. Mercury may also be tried with advantage in some cases. Counter-irritation in the form of blisters or the actual cautery is sometimes of service. Where the paraplegia resists all treatment for a long time, the question of trephining the spine and removing the source of pressure is to be considered. In one case in which we operated recently we removed a thick layer of lymph from within the spinal canal, and a paraplegia of six months' standing, which had resisted all other modes of treatment, at once began to improve, but the benefit was only temporary. Dr. Macewen has recorded some successful cases (*vide* Address, *Brit. Med. Jour.*, Aug. 11, 1888).

Disease of the sacrum, with abscess pointing into the rectum, is a desperate condition. The abscess is certain to be septic, and can only be reached through the rectum until it has burrowed down to the sciatic notch, or unless it points at the back, as it may do. In one case we tried to remove the disease, but in consequence of an abnormal patency of the theca below its normal point it was wounded, and the child died of meningitis; the post-mortem showed that any such operation would have been exceedingly difficult, and probably impracticable.

The prognosis in spinal disease depends upon the stage to which the mischief has advanced, the presence of other tubercular lesions, and the amount of care that can be bestowed upon the case. It is not necessarily bad, and under favourable circumstances is decidedly good; but from one to three years' treatment or even more is required.

Atlanto-axial disease is, as already remarked, rare in children; it is essentially the same disease as tuberculosis of any other joint, but its importance depends upon the effects liable to follow softening of the ligaments and sudden displacement of the odontoid process, viz. sudden death from pressure upon the upper cervical cord. Occipital pain, rigidity and thickening of the neck, with perhaps paraplegia, are the general symptoms; there may be special difficulty in rotating the head. The general rules for cervical caries apply in other respects to this locality.

Disease of the **costo-vertebral** articulations sometimes occurs, either alone, or as a result of extension from disease of the spine or a rib. Pain, which may be radiating, and formation of abscess, are usually the only symptoms by which the disease can be recognised. The abscess may point either in the back or lumbar region; possibly some cases of psoas abscess depend upon this lesion. It is likely to be mistaken for spinal caries, but the absence of curvature, the slight, if any, rigidity, and the unilateral pain and suppuration, as well as the results of exploration, will probably enable the difficulty to be cleared up. Fixation in a plaster jacket, with, if necessary, a window for discharge, is the best treatment if the disease is intractable.

## CHAPTER XXXII.

## CLUB-FOOT, DEFORMITIES OF LIMBS, ETC.

THE deformity known as club-foot or talipes may be congenital or acquired. The varieties of the congenital affection are named as follows :—

Talipes varus	}	the simple forms.
„ valgus		
„ equinus		
„ calcaneus		
Talipes equino-varus	}	the compound forms.
„ calcaneo-valgus		

Talipes cavus may be simple or associated with equino-varus or equinus.

The only common form of club-foot is equino-varus ; this deformity is sometimes called simply varus, but, inasmuch as the distortion is a compound one in almost all cases, we shall consider it under the more accurate title—and this is the more necessary, since its successful treatment largely depends upon recognition of this complexity. Calcaneo-valgus is the next most common form ; the others are only occasionally met with, and as great rarities anomalous forms such as calcaneo-varus and equino-valgus are seen.

The general appearance of congenital **equino-varus** is seen in the figures. The heel is drawn up (equinus) and the anterior half of the foot is adducted and rotated inwards upon an antero-posterior axis, the adduction and rotation taking place at the transverse tarsal joint. Considering this deformity more in detail, it will be found that abnormalities exist in the muscles, ligaments, bones, and fasciæ of the foot, and, though the subject has long been under investigation, we owe to Mr. Parker and Mr. Shattock our most recent information upon the share taken by these several structures in the maintenance of the malposition. We use the word 'maintenance' to show that we believe that the deformity is due to persistent fixation of the foot in a distorted attitude rather than to any active displacement caused by muscular or ligamentous contraction. In describing the anatomy of talipes we acknowledge freely our indebtedness to Mr. Parker's work.<sup>1</sup>

In talipes equino-varus, the posterior ligament of the ankle joint, the anterior part of the internal lateral ligament, and the astragalo-scaphoid and inferior calcaneo-scaphoid<sup>2</sup> ligaments are those which are especially tight. In addition to these the plantar ligaments and plantar fascia help to maintain the concavity of the sole of the foot which co-exists with the equino-varus.

<sup>1</sup> *Congenital Club-foot*, 1887.

<sup>2</sup> Constituting the 'astragalo-scaphoid capsule' of Parker.

In severe cases the whole of the ligaments on the inner side of the foot are shortened, and there may be adventitious fibrous bands.

Besides the ligamentous structures, the tibialis posticus and anticus, as well as the flexors of the toes, the short muscles of the sole and the muscles of the calf, acting upon the tendo Achillis, contribute to the maintenance of the deformity, though it has been shown that, with the exception of the tendo Achillis, all the rest may be divided, and yet, unless the ligaments are also cut, but little effect can be produced upon the malposition. This is, however, not always the case, and it is probable that the share taken by the different factors in talipes is not always the same. Mr. Parker places the resisting structures in equino-varus in early life in the following order of importance :—

- (1) The astragalo-scaploid capsule. (2) The tendo Achillis. (3) The skin of the inner border of the foot. (4) The bony framework of the foot. (5) The other ligaments and muscles.

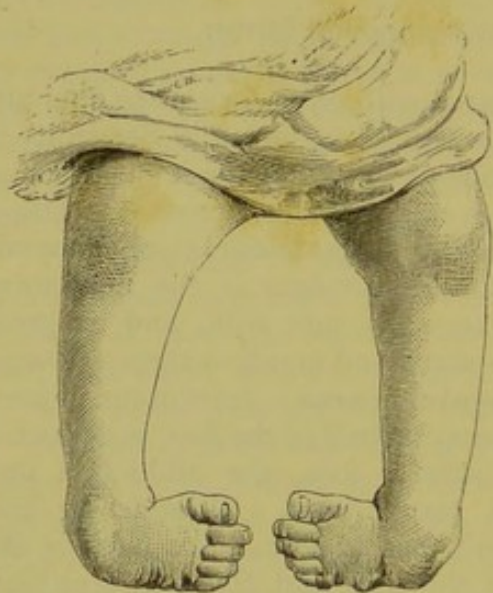


Fig. 111.—Severe Talipes Equino-Varus.



Fig. 112.—Very severe Talipes Equino-Varus.

As to the bones the trochlear surface of the astragalus is increased posteriorly and diminished in front, and the neck of the astragalus is lengthened and directed more obliquely inwards than normal; the articular surface on the head lies further inwards than usual. The 'calcaneum lies in a position of exaggerated rotation inwards beneath the astragalus, and in one case was found fused with the navicular.' The lower ends of the tibia and fibula are rotated inwards. The exact form of the astragalus appears to vary with the severity of the case.

The drawing up of the os calcis tends to throw the head of the astragalus downwards, and the front of the foot is inverted at the transverse tarsal joint, and so the scaphoid slips partially off the astragalus and comes to

articulate with the tibia. The cuboid, cuneiform, and metatarsals are also rotated inwards, and further retracted by the long and short muscles so as to contract the sole of the foot, thus producing *cavus*. In some cases all the tarsal bones show a tendency to curvature with the concavity inwards, and the direction of their articular surfaces is altered. The fibula may lie entirely behind the tibia, and the tendo Achillis, being brought close to the inner ankle, may lie nearer the posterior tibial artery than in the normal foot. In a case we dissected the flexor longus digitorum lay directly over the tibialis posticus. Bursæ are found over the prominences of the foot, and may exist even in intra-uterine life.

In early stages and slight cases it appears that the astragalus is natural in appearance, in more severe deformity it is wasted and the neck deviates; there is not, however, any constant relation between deviation of the neck and deformity. In one case that we have seen the rotation of the foot inwards was, we thought, at the scapho-cuneiform, not at the transverse tarsal joint. The ordinary result of these changes is adduction and rotation inwards of the front half of the foot, with elevation of the heel (fig. 111).

In **valgus** the whole foot is everted at the ankle or the subastragaloid joint, as well as rotated outwards at the transverse tarsal joint;<sup>1</sup> and, further, the sole is flattened, or in infants oftener convex downwards, the tibialis posticus and calcaneo-scaphoid ligaments being stretched and the peronei shortened.

In **equinus** the tendo Achillis and posterior ligament of the ankle joint are shortened and the astragalus is drawn back, so that only the front of the trochlea is between the malleoli; there are other less important displacements of other tendons.<sup>2</sup> Talipes equinus is said to be an exceedingly rare condition as a congenital deformity; we have seen a very pure example, in which intra-uterine pressure marks upon the knees and shoulders were very obvious. In **calcaneus** the chief contracted structures are the extensors of the great and lesser toes, the tibialis anticus, and the anterior ligament of the ankle joint; the borders of the foot are convex towards the sole, thus the foot is flexed upon the leg and the patient walks upon the heel. The trochlear surface of the astragalus is prolonged forwards as far as the navicular facet, and the inner malleolar surface is prolonged forwards (Parker and Shattock). We have noticed extreme projection backwards of the os calcis in congenital calcaneus, as if the foot was partially dislocated backwards at the ankle, a deep depression existing over the front of the joint. Hollow club-foot (**cavus**) depends upon shortening of the muscles of the sole of the foot and the plantar ligaments, as well as the flexors of the toes, the tendo Achillis, and the tibialis posticus. By the arching of the foot and the drawing up of the heel the extensors of the toes are put upon the stretch, and hence the toes are drawn up in hyper-extension, so that the deformity known as 'hollow claw-foot' is usually produced.

The compound forms of talipes need no special description, as they consist of combinations of the simple varieties.<sup>3</sup>

*Etiology.*—Many theories have been proposed to account for the occur-

<sup>1</sup> So that valgus is not the exact opposite of varus.

<sup>2</sup> Vide Mr. Parker's book.

<sup>3</sup> Holmes Coote, in *St. Bart's. Reports*, vol. ii., 1866, describes a form of talipes

rence of club-foot, and it is probable that most of them are true in certain cases ; we do not think any one cause alone will explain all cases of club-foot.

Little considered talipes due to 'a morbidly excitable, retractile disposition' of muscles, comparable to the reflex torticollis of later life.

Central and peripheral nerve lesions, causing spasm or paralysis of muscles, may account for some cases, where, for instance, spina bifida or absence of brain (anencephale) are associated with talipes ; on the other hand, Parker and Shattock found both cord and nerves perfect in a case they examined. In opposition to them, however, we must point out that the nutrition of the talipedic limbs is often impaired, and they are fat, flabby, and toneless ;<sup>1</sup> the muscles may, however, react normally to electricity. Intra-uterine pressure associated with deficient amniotic fluid (Cruveilhier) is no doubt the cause in some children. We have found talipes associated with intra-uterine constrictions and amputations from amniotic bands,<sup>2</sup> and in another case, alluded to above, the deformity co-existed with pressure marks ; but the distortion is also found where the liquor amnii is abundant, and such explanation hardly accounts for single talipes as the only malformation.

A persistence of the natural early foetal position (Eschricht) explains some cases (of equino-varus and, later, calcaneus) ; in others, again, deficient development of parts is the cause, as in cases where congenital absence of the fibula has produced valgus, and this may be compared with fig. 122, of absence of the radius producing club-hand.<sup>3</sup> Hueter supposed that obliquity of the neck of the astragalus was a cause, but, as shown by Parker, this may occur without talipes, and talipes may exist without it. Intra-uterine joint disease possibly explains some cases, and adhesions are found in certain instances in the joints. Cruveilhier, Förster,<sup>4</sup> Parker and Shattock, and Silcock have pointed out that where the limbs are interlocked in abnormal positions they will exert pressure on each other quite independently of the amount of fluid ; we have frequently seen cases where clearly the feet had interlocked : the one foot, being in a position of extreme calcaneo-valgus, was received into the concavity of the other, which had severe equino-varus.<sup>5</sup> For further discussion of the subject we must refer to the admirable works, so often quoted, of Messrs. Parker and Shattock, and, in acknowledging our indebtedness to them, we can confirm many of their observations by our own ; we think that nearly, but not quite, all of the cases can be explained mechanically by pressure or position *in utero*, bad packing as it were, and

consisting in rigidity of the tendo Achillis with subsequent development of flat-foot, of which it appears to be an early stage ; he calls it 'rectangular talipes equinus,' the foot being kept at a right angle with the leg.

<sup>1</sup> Possibly this may be explained by the absence of natural exercise *in utero*, when the feet are interlocked or misplaced.

<sup>2</sup> Parker and Shattock also mention a case of theirs.

<sup>3</sup> Club-hand is, however, probably the result of pressure causing arrest of development of the præ-axial border of the limb.

<sup>4</sup> *Missbildung des Menschen*, Taf. xxvi., fig. i., from Cruveilhier ; the figure is copied in Bodenhamer, as the subject had also imperforate anus.

<sup>5</sup> Confirmation of this view of the causation of talipes is found in the other deformities similarly produced, such as 'genu recurvatum, &c.'

so-called 'club-hand' is, we believe, due to the same cause. One of the strongest proofs, to our mind, is the tendency seen in children to assume, long after birth, the position they occupied *in utero*, with the feet or hands locked in the talipedic attitude. The result of habitual positions in producing curved bones in rickety children is interesting also in this relation (*vide* figs. 51, 52, 57).

It is sometimes said that talipes is merely an arrest of development, a 'failure to unwind' the foot from its earlier or later foetal position: we think this hardly fully expresses the truth, there is something more; an actual pressure and squeezing together of the parts in an abnormal position is certainly what has occurred—in most of the more severe cases at any rate.

As to the degree of deformity, we cannot do better than quote Mr. Parker's words: 'When the cause begins to act very early in, and continues throughout, intra-uterine life, the deformity will be a very fundamental one; whereas, if the cause begins to act at a later period, or if it be continued for a short time only, the resulting deformity will be less severe.'—*Brit. Med. Jour.*, October 27, 1888.

The *treatment* of all cases of club-foot in children can be successfully carried out without any but the most simple apparatus, except in the rare instances where, from neglect, old cases may require tarsectomy; we shall, therefore, confine ourselves to description of the methods we have found most useful, and omit all reference to costly and complicated appliances. The general principles of management are the same for the different forms of club-foot; so that we may take an ordinary case of equino-varus as a type. Several questions have to be considered, such as (1) When is treatment to be begun? (2) Is a cutting operation to be performed; if so, what structures should be divided, and at what age? (3) When operation is required should all the tense structures be divided at the same time, and should reduction of the deformity follow immediately on the operation or be delayed? (4) What is the best apparatus to apply? (5) How long is treatment to be continued?

(1) It might be thought unnecessary to insist upon the treatment of club-foot being begun immediately after birth, but we have more than once had cases, several months or more old, brought for relief, in which not only had nothing been attempted, but the friends had been told the child was not old enough for any treatment yet. Of course with a child a few days old more can be done in a week than is possible in a month with an older child. Treatment should be begun without a day's delay. (2) The question of tenotomy has been allowed to become largely one of fashion, some surgeons advising it in nearly every case, and others insisting not only upon its needlessness, but upon the harm resulting from it. The rules we follow on this point are:—If the child is seen within the first few weeks of life, operation is very rarely, if ever, necessary. During the next two or three years two points have to be considered: first, what amount of care can be expended upon the case; and secondly, how rigid are the resisting structures, i.e. can the deformity be reduced by moderate force? If the child can be thoroughly well looked after, and its splints applied regularly and intelligently, operation is not *necessary* in most cases under two years old, although it undoubtedly shortens the time required for reduction, and is sometimes desirable—certainly so where there is much rigidity, and any doubt about the efficiency of the care

and management. Where the rigidity is so great in a child over three months old or thereabouts that the deformity cannot be completely reduced by reasonable force, operation should at once be performed; such cases are, however, comparatively rare. We see no advantage in forcible 'redressement' over a cutting operation. (3) In equino-varus there is, we think, little doubt that if all the resisting structures are to be divided, those which maintain the varus part of the deformity as opposed to the equinus should certainly be cut at the same time, and before there is any attempt to remedy the equinus. The plantar fascia rarely requires division except in neglected cases. Authorities differ as to the risks of immediate reduction after tenotomy. We do not think the matter is one of great importance, and generally settle the question by the interval that is to elapse before the next visit; if more than two days, we usually correct the deformity at once. (4) As to the question of apparatus we may say at once that we have never used, or seen the advantage of, the more complicated instruments—shoes modified in various ways from Scarpa's, taliverts, and so on; they are too expensive for the hospital class, and in all classes we are quite satisfied with the results to be obtained by much more simple means.

Practically we find one of three appliances will meet almost every case: two are of Dr. Little's invention, and the third is a slight modification of Barwell's artificial muscle plan. To take a case of equino-varus in which the varus is to be remedied first. The first appliance is adapted only to infants or children a few months old. It is simply a strip of thick block-tin long enough to reach from the knee to just beyond the end of the toes when the foot is pointed (fig. 113). This is bent to fit the foot along its outer side in its full equino-varus position. It is then bandaged on, no attempt being made to remedy the equinus or varus; when it is securely fixed to the leg and foot, the front of the foot (i.e. the part beyond the transverse tarsal joint), together with the tin, is gently bent outwards so as to slightly improve the varus, leaving the equinus unaltered. The foot is left in this position till the next day, or longer if absolutely necessary, when the bandage is reapplied and a little further correction employed, and so on till the varus is somewhat over-reduced. The equinus is then dealt with in the same way, the splint being applied to the back of the limb. The second appliance (fig. 115) is simply Dr. Little's tin splint. It may be used with the foot-piece fixed at a right angle with the leg-piece, or better movable, so as to remedy the varus alone first. This splint is applicable to older and more rigid cases, as it is a much more powerful appliance than the last. It is useful sometimes to have a slit cut in the metal at the angle between the leg and foot pieces, running a little distance along the edge of the sole; through this slit the bandage is carried, and so the heel is more securely fixed down. The third apparatus is Barwell's artificial muscle, applied somewhat simply. We use it in two different forms. The first form consists of Mr. Barwell's strip of tinned iron strapped to the front of the leg; on it is soldered a hook. A strip of strapping is carried round the front of the foot, and to its free end is fixed a loop of stout indiarubber cord or drainage tubing; this is then stretched up to the hook above, so as to correct the deformity. The second way of applying the muscle is that shown in figure 114. The object of using the straps instead of the tin

splint and plaster is to allow the apparatus to be taken off in order to rub and wash the leg, friction being a point to which we attach considerable importance, as tending to prevent, or at least remedy, the great muscular wasting which occurs in the course of the treatment of talipes if any rigid appliance is kept on constantly. The plan we adopt usually is to use one or other of the tin splints, generally the first, until the deformity is so far corrected that the muscle can be efficiently applied; the latter is then worn till the cure is complete.

As to the duration of treatment no hard-and-fast rule can be laid down; it varies in each case with the rigidity of the parts, the age of the patient, and the care expended upon it. In one case a few weeks, in another many months, may be required before the artificial muscle stage is reached. As soon as this can be profitably applied the drudgery of the task is over, but



Fig. 113. — Little's plain Tin Splint.

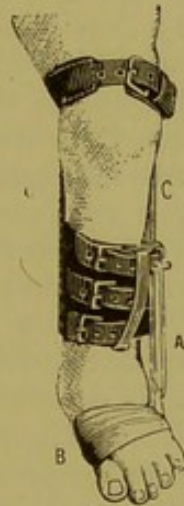


Fig. 114. — The Artificial Muscle Appliance shown correcting the deformity in a case of Congenital Equino-varus (from a photograph). A, the rubber strap or 'muscle'; B, strapping round the foot; C, the side straps connecting the upper and lower legs. The apparatus is a modification of Barwell's original plan. It is better to have the straps made to lace up than to buckle.



Fig. 115. — Little's Tin Talipes Shoe, which may have a joint at the junction of the sole and leg pieces.

the case cannot be considered cured; hence the answer to the fifth point, that of the duration of treatment, can only be general. As Dr. Little points out, no case is safe from relapse until the patient is old enough to watch himself and correct the earliest sign of return of the deformity, although by the use of the artificial muscle another dictum of his, that there must be no walking till the deformity is remedied, may be set aside. Great care is required, in applying the splints, not to be deceived by the rotation of the limb, and until the artificial muscle can be applied so as to slightly over-correct the deformity no walking is to be allowed; after this point is reached it does no harm, but rather good. The essence of the matter is largely in the amount of trouble taken with each case by the surgeon and the friends.

Some other points in management must be also considered. Manipulation, i.e. firmly holding the foot in a slightly over-corrected position, is

exceedingly useful, and should be daily employed each time the splints are removed—or, if unfortunately, from pressure sores or other causes, the apparatus has to be left off, frequent manipulation prevents time from being lost. The leg should be firmly grasped in one hand, in such position that the patella looks directly forwards, and then the other hand should be used to steadily turn the foot into position, bearing in mind, in each case, the seat of the deformity; thus in varus the ankle joint must be steadied and the rotation made at the transverse tarsal joint.

Pressure sores are to be avoided by regular daily renewal of apparatus, and avoidance of rucking up of plaster or bandages; though, perhaps, strapping is more apt to cause sores than webbing,<sup>1</sup> it is, we think, more efficient in the early stages of treatment; in the later stages thin saddler's felt is excellent for the foot strap (B, fig. 114), *vide* fig. 116.

Should it be decided that tenotomy is required in a given case, the rules for its performance are as follows. To divide the *tibialis posticus* the limb is laid upon its outer side upon a firm pillow, the posterior border of the tibia is felt for, and the tenotome passed in two fingers' breadths (in an infant) above the inner malleolus, in such position that its point just hits the edge of the bone; the knife is then slipped close to the bone, between it and the tendon, and its edge turned towards the tendon; the foot is then held so as to correct the deformity, and by a gentle levering motion the tendon is divided, cutting towards the skin; as soon as the tendon is felt to snap the knife is withdrawn and a collodion pad and bandage applied. Occasionally bleeding is free, but readily stops on pressure, and no bad result follows. If the edge of the tibia cannot be felt, a point midway between the front and back of the limb marks its position. The better plan is to divide the *tibialis posticus*, together with the ligaments, through one puncture opposite the transverse tarsal joint in the posterior crease of the sole.

The *tibialis anticus* is best divided upon the dorsum of the foot, just before its insertion into the inner cuneiform; it is easily felt, and the knife passed beneath it, and division effected as in the posterior tendon.

The *tendo Achillis* is, perhaps, the simplest of all. It should be cut about  $\frac{3}{4}$  in. above its insertion, at its narrowest part, the knife being passed well beneath it (i.e. nearer the tibia), from the inner side while the limb lies on its anterior surface. Personally we prefer to pass in the knife while the tendons are held tense and can be plainly felt; others prefer to tighten only after the tenotome is beneath the muscle.

We are much in favour, in suitable cases, of Mr. Parker's plan of dividing all rigid structures at the transverse tarsal joint, and not limiting the section to the tendons or fascia. The tubercle of the scaphoid should be felt for and the knife passed in at the inner border of the foot, just behind the bone; the edge is then turned towards the joint and made to cut well into it, dividing everything until the foot readily yields; by thus severing the ligaments subsequent reduction is rendered much easier. Where this plan is adopted, the *tibialis posticus* is divided at the same time as the rest of the rigid structures; the internal plantar artery is probably usually cut, and we have once seen a traumatic aneurism result, but no serious ill effect need be

<sup>1</sup> *Vide* Golding Bird, *Guy's Hospital Reports*, i 82.

feared.<sup>1</sup> The anterior and posterior ligaments of the ankle joint require division in some cases of calcaneus and equinus respectively.

It should be remembered that in second tenotomies the characteristic snap is often not felt.

We are not satisfied with the results of fixing feet in plaster of Paris, either with or without tenotomy, but much prefer an arrangement where the pressure may be altered frequently.

Where the artificial muscle plan is being employed, if tenotomy is required at all, it is usually the tendo Achillis that needs division, since the plaster is apt to slip up towards the heel in such cases. Where the other splints are used, it is better, since the varus is corrected first, to divide the tibial tendons, &c., 3 or 4 weeks before the tendo Achillis; some surgeons prefer always to divide the Achilles tendon first. The peronei rarely require division; if they do, the section is made two fingers' breadths above the outer malleolus. The extensor longus digitorum and proprius hallucis are divided just below the annular ligament.

Congenital valgus is best treated by a muscle applied so as to exert pressure in the opposite way to varus; it is, however, not so readily corrected. The rare equinus requires muscles on both sides to draw up the toes, usually after tenotomy. Calcaneus is best treated by the tin strip (fig. 113) or jointed splint (fig. 115).

Talipes cavus is often remedied by division of the tendo Achillis only; in other instances the resisting structures in the sole may require section.

There is no doubt that tenotomy alone is in many cases inadequate, and will, with the exception of division of the tendo Achillis, be largely given up in favour of the more complete and scientific operation of 'syndesmotomy' (division of ligaments) described by Parker. Of 'open division' of all the resisting structures, including the skin, we have little experience; we have, however, had one or two cases in which after 'syndesmotomy' at the transverse tarsal joint the skin has given way under the strain of forcible reduction of the deformity. The only harm resulting has been delay in the healing of the wound and some little increase in difficulty in the application of the 'muscle.'

Excision of one or more bones of the tarsus for inveterate club-foot, as employed by Davies Colley, Davy, Lund, and others, is an operation to be reserved for severe cases in older children, and only employed when there is no hope of remedying the deformity by other means.

The operation we prefer consists in making a **⊥**-shaped incision on the outer side of the foot, the horizontal limb running along the outer border, and the vertical part passing across the centre of the cuboid. The flaps are reflected, the bones exposed, the tendons being drawn aside, and a wedge of bone is removed entire or piecemeal from the outer side of the foot; a chisel is the most convenient instrument for the purpose. Various lines of section are employed, but the general rule is to remove the cuboid always, and as much of the adjacent bones as the individual case may require; the cuneiforms, head of the astragalus, bases of the metatarsal bones, and front of

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<sup>1</sup> Other cases of aneurism following division of the plantar fascia are on record—*vide* Walsham, *Lancet*, January 28, 1888.

the os calcis may all require to be taken away.<sup>1</sup> After the operation the foot should come readily into position; all bleeding having been stopped, and the dressings applied, the limb is at first fixed lightly on a back splint. The wound usually heals quickly, and until it is superficial we prefer not to use forcible corrective apparatus; usually in about a fortnight a muscle may be applied. We look upon the operation as a very valuable one in suitable cases—for instance, where the patient walks upon the dorsum of the foot and pressure sores are prone to develop, while all the structures are rigid (*vide* fig. 112).

Excision of the astragalus alone, we think, is best adapted for paralytic cases—in such instances we have removed the bone with excellent results; it may be done without division of any important structure, by an incision over the ankle joint, carried from the tibialis posticus to the tibialis anticus, and another one at right angles to this, along the inner border of the latter tendon. By a little careful dissection the bone can be got out, the only difficulty being with the interosseous ligament. After the operation a shapely foot with a good arch still remains.

The most common forms of **paralytic (acquired) Talipes** are equinovarus and valgus; these, so far as the deformity goes, are usually readily treated by the artificial muscle method, and the effect is usually immediate and to a certain extent satisfactory; it does not, of course, remove the weakness and flabbiness of the foot, but it prevents actual turning outwards or inwards, and makes walking much steadier and more sightly. In some cases light steel supports are of value. Where, however, from long neglect the deformity is irremediable by these means, the method of excising the astragalus already described may be required. In very severe cases of infantile paralysis, where the foot is perfectly powerless, and especially where the paralysis extends above the knee, and the knee joint is flexed, the limb being flail-like, short, and useless, amputation may be required; this, however, should never be done in childhood, since there is a possibility of improvement. The attempt to convert the flail-like distorted limb into a stiff stable support by resection of the knee and ankle joints has been tried, it is said, with satisfactory results; in a case we operated on in 1884 there was very considerable improvement. Walsham<sup>2</sup> has practised shortening the tendons by excision of a part and suture of the divided ends, thus correcting the deformity and allowing the lax muscles to act; we have also tried the plan, with fair results in one case.

These paralytic limbs are, of course, prone to become the seat of chilblains and ulcers from defective nutrition.

Apart from the cases above mentioned of paralytic talipes, where the structures are loose and flabby, are the deformities in which contractures

<sup>1</sup> The principal modes of tarsectomy are:—

1. Excision of a wedge of bone, irrespective of joint lines (Davies Colley).
2. " " cuboid (Little).
3. " " astragalus (Lund) (chiefly, we think, applicable to acquired talipes).
4. " " astragalus, cuboid and scaphoid (West).
5. " " wedge from the neck of the astragalus (Hueter).
6. Linear osteotomy of the tarsus or of the leg above the ankle joint (Hahn).
7. Excision of a wedge from the transverse tarsal joint, &c. (Rydygier): *vide* Rydygier, *Berlin. Klin. Woch.*, February 5, 1883; also Lorenz, *Wiener Klinik*, 1884, H. 5 and 6; also Goldschmidt, *Rev. Mens. de Maladies de l'Enfance*, from *Centralb. f. Chir.*, No. 17, April 1884.

<sup>2</sup> *Brit. Med. Jour.*, June 1884.

have taken place as a result of paralysis of certain groups of muscles. Of these the most common are talipes cavus (arcuatus or plantaris), in which after paralysis of the extensors of the foot the muscles and ligaments of the sole and calf contract, producing varying degrees of deformity and concavity of the sole of the foot, together with elevation of the heel (equinus). In some instances the pointing of the foot produces secondary retraction of the toes (hollow claw-foot) by the strain of the extensors of the toes. The distortion resulting from the conflicting forces occurs mainly at the ankle joint, the medio-tarsal and the metatarso-phalangeal joints. All grades of deformity are met with, from slight exaggeration of the arch of the foot to the most extreme equinus. Much more rarely the converse deformities are met with.

In slight cases, manipulation or the use of artificial muscles without any operation will remedy the distortion, but in the severer forms of old-standing division of the tendo Achillis, or of more or fewer of the resisting structures in the sole, will be required. After operation an artificial muscle should be used, and kept on till all tendency to recontract has ceased. Some good figures of these cases are given in a recent paper of Mr. F. R. Fisher's, *Lancet*, January 19, 1889.

Patients, the subjects of club-foot, often suffer from complications of this condition. Bursæ develop over the points upon which pressure is made, and these may become inflamed and suppurate, giving rise to obstinate sores, which will not heal and acquire callous edges. In some cases rest and ordinary treatment suffice, in others tarsectomy or even amputation may be called for. Pirogoff's or even Chopart's operation should usually be done in such cases in preference to Syme's amputation.

The whole foot and leg in severe cases is smaller and weaker than the other, and often shorter. The wasting of muscles, &c., is extreme in some instances, even when no paralytic condition has existed.

The movements of the ankle joint become altered, and it develops into a ball-and-socket rather than a ginglymoid joint (Jorg). The metatarsal bones are usually shorter than normal, a condition due to the contraction of the plantar fascia, according to Borck.

Treatment of club-foot in all cases must be kept up constantly until all tendency to relapse ceases. Dr. Little remarks that such patients require watching until puberty, and, as already pointed out, the result depends entirely upon the amount of care and perseverance expended upon them.

Relapsed club-foot after tenotomy is much more difficult to treat than it is in cases where nothing has been done; tenotomy should, however, be repeated and the usual methods carried out.

**Flat-foot.**—Apart from congenital and paralytic valgus is the common condition known as spurious valgus, pes pronatus acquisitus, pes planus, or commonly flat-foot. Though this affection is not by any means peculiar to childhood, it most commonly comes on in the later years of childhood or adolescence; sometimes, however, it occurs earlier.

The condition is essentially one of relaxed ligaments and muscles, and comes on usually in weakly, overgrown children, who have been kept too much on their feet—especially if they are rickety also. It is one of the conditions arising in so-called 'rickets of adolescence.'

The prominent part assigned to relaxation of the inferior calcaneo-scaphoid ligament in the production of flat-foot is hardly deserved, since the tibial muscles, the flexors of the toes and pollex, the short sole muscles, the plantar ligaments, the plantar fascia, and the peroneus longus all take a share in supporting the arch, and the condition is in most cases the local expression of a widely spread weakness rather than the result of yielding of any one structure. In a few cases flat-foot is the result of injury.

Lowering and inward projection of the head of the astragalus, with loss of the arch of the foot and its elongation, are the prominent features of the affection. The sole may be flat or even convex, and the inner border early becomes convex also; there is usually pain over the head of the astragalus, often also across the dorsum of the foot and beneath the outer malleolus, and not at all uncommonly also in the first metatarso-phalangeal joint (so-called 'metatarsalgia').

The prominent projecting mass on the inner aspect of the foot is not, however, by any means always the head of the astragalus only; it is often the tubercle of the scaphoid, since this bone is frequently pressed downwards and inwards by the astragalus, so that yielding takes place rather at the scapho-cuneiform than at the astragalo-scaphoid joint. In some cases the prominence is shared equally by the astragalus and scaphoid. In any case where the deformity is marked there is a deep depression on the dorsum of the foot, due to the slipping away of the head of the astragalus.

In early stages the deformity is only seen when the patient is standing, when the whole foot may be seen to collapse and spread out in a toneless fashion, the transverse arch also giving way. In later stages the foot becomes fixed in its distorted position, and cannot be replaced. In intermediate stages replacement is possible; sometimes in manipulating the foot adhesions give way and the

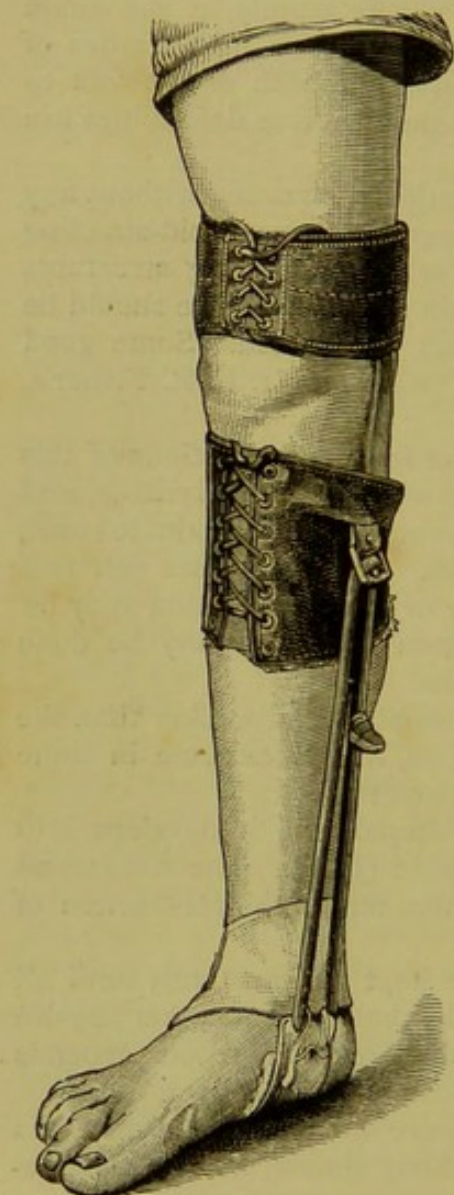


Fig. 116.—Shows an 'Artificial Muscle' applied for Flat-Foot.

arch is restored for the time. These adhesions are the result of chronic inflammatory changes which are specially prone to occur in the metatarso-phalangeal joint of the great toe, but may attack several joints and the sheaths of the tendons.

The treatment of this disease consists in preventing the child from standing long at a time, and improving its general condition; next, the deformity must be reduced; in ordinary cases an artificial muscle, applied so as to

support the head of the astragalus, is perfectly efficient in relieving pain and restoring the arch of the foot, and any reasonable amount of standing and walking can be done from the first as soon as this is applied. It is the only form of apparatus we use now, and it very seldom fails if properly applied. In some cases it may be necessary to break down adhesions first, but in children this is rare.<sup>1</sup> (Fig. 116.)

Standing and walking on tip-toe, dancing, and friction are all useful supplementary means, as pointed out by Ellis,<sup>2</sup> who is of opinion that the flexor longus pollicis is a very important factor in tying together the pillars of the arch of the foot (*Lancet*, February 9, 1884).

No operation is ever required for acquired flat-foot in children.

A form of distortion in which there is adduction of the foot, or rather rotation inwards, in which the deformity depends upon a rotation of the whole leg, is sometimes met with. It gives rise to the condition popularly known as 'duck toes.' The unsightly gait may be due to congenital malposition or to rickets; it has been proposed to call the deformity 'club-leg,' and to remedy it by osteotomy of the femur (*vide supra*, chapter on Rickety Deformities; also Parker, *Brit. Med. Jour.*, Oct. 27, 1888).

**Wry-neck** or **Torticollis** is a fairly common affection in childhood, and may be due to any of the following conditions:—

1. It may be congenital, probably due to malposition *in utero*—possibly sometimes to mal-development.<sup>3</sup>

2. It may result from injuries at birth, lacerations of muscles, &c. Volkmann has found the sterno-mastoid represented by a band of cicatricial tissue.<sup>4</sup>

3. It may be spasmodic, due to central or peripheral nerve lesions or reflex irritation.

4. It may result from suppuration in the neck, due to either glandular abscesses or cervical caries, causing matting together of the parts and contracture of the muscles.



Fig. 117.—Congenital Wry-Neck.

<sup>1</sup> The best paper on the subject with which we are acquainted is that by Mr. Golding Bird already alluded to (*Guy's Reports*, 1882). From it we have learnt much.

<sup>2</sup> Some surgeons believe that weakness of the peroneus longus is the essential factor in flat-foot, and recommend faradisation and galvanism.

<sup>3</sup> Intercalations of more or less developed vertebral bodies may produce wry-neck of one kind, as it may lateral curvature.

<sup>4</sup> Sterno-mastoid tumour (p. 21) has been said to be followed by torticollis, the injured muscle subsequently becoming contracted. Petersen, however, thinks the hæmatoma is a result of injury to the previously shortened muscle.

5. Burns or other injuries may, of course, produce cicatricial torticollis.

In its most simple form wry-neck is due to contraction, limited to one sterno-mastoid, which is felt as a hard tight cord in the neck; the head in such cases is drawn down towards the shoulder, and the face turned towards the opposite side (fig. 117).

In other instances the sterno-mastoid is not alone affected, but the scalenes, trapezius, and cervical fascia contribute to the deformity.

*Treatment.*—In slight cases in quite young children regular daily stretching and manipulation of the rigid muscles may suffice to get rid of the deformity. In the severer forms of the affection tenotomy is the only effectual treatment. The sterno-mastoid, and sometimes the trapezius, require division.

For tenotomy of the sterno-mastoid the knife is passed through the interval between the two heads, and its edge turned forward against each in succession; the child's head being held stretched by an assistant. Care must, of course, be taken not to wound the anterior jugular vein at the front edge of the muscle, nor the external jugular at the posterior border, nor to carry the knife so deeply as to endanger the carotid sheath. We usually divide the muscle through a puncture at the anterior border; if preferred, a blunt pointed tenotome may be used. Where the cervical fascia is also tightly contracted it may be necessary to divide it, but this step is by no means free from danger, and in such case it is safer to make an incision over the muscle and gradually dissect through the rigid parts in an open wound. Some surgeons prefer to divide the muscle at its



Fig. 118.—Artificial Muscle applied for Wry-Neck after division of the Sterno-mastoid. A Sayre's jacket is applied to the trunk, and traction made from a poroplastic cap or ring of strapping.

middle. Two days after the tenotomy the apparatus (fig. 118) recommended by Mr. Southam should be applied. The following case is characteristic.

*CASE.*—*Torticollis.*—John Wm. G., age 5 years. Admitted August 5, 1885. A neurotic family history. The child has never been strong. The deformity is congenital, but has been getting worse lately, and is increased when the child is not well; has lately had toothache on the left side. On admission the left sterno-mastoid is contracted in its whole extent, forming a firm, prominent band; the interval between the tendons is deeply marked, the sternal tendon being the most prominent. The chin is rotated  $1\frac{1}{2}$  inches from the middle line downwards and to the right; the platysma is also prominent. August 13, tenotomy of both heads through the interval, the cervical fascia was also partially divided. Antiseptic operation and wood-wool dressing. 14th, no pain; the head was packed in sandbags. 17th, a plaster of Paris jacket was put on with hooks fixed in it, and a rubber

muscle was applied parallel to the right sterno-mastoid, attached to the head by circular bands of strapping. 20th, another muscle was applied in a corresponding position at the back. 22nd, made out-patient. He was seen subsequently, and hardly any visible deformity remained. November 10, 1885, quite well.

Spasmodic torticollis, if it does not yield to medical treatment, may require stretching or resection of the spinal accessory nerve—all causes of reflex irritation, carious teeth, worms, otorrhœa, enlarged glands, &c., having been previously removed.

The other forms of wry-neck require treatment on general principles, or are irremediable; special care must, of course, be taken not to overlook the presence of cervical caries.

In all cases of wry-neck where manipulation is admissible steady and regular attempts should be made to remedy the distortion; friction and steady stretching of the neck with the hands should be tried, and the child made to practise before a looking-glass, trying to hold the head straight. To supplement these means, various apparatus, collars, &c., may be used; the one we have found most efficient is that figured for use after tenotomy. In quite young children, of course, no voluntary help from the child can be obtained, but the friends must be instructed what to do, and in older patients it is a good plan, as Mr. Roth has pointed out, to get the child familiar with the exercises before the tenotomy is performed, so that no time may be wasted afterwards.

Congenital cases, where the sterno-mastoid alone is involved, are usually completely curable; many of the spasmodic cases get well either spontaneously or after removal of some source of irritation. In cases where the scaleni are involved there is more difficulty. So far as we know, these muscles have not been divided in such cases, but there seems no reason why they should not be, provided a suitable case occurs. In many of these cases the face is undeveloped or distorted on the affected side; secondary lateral curvature of the spine may also result.

It is believed that the condition already described as sterno-mastoid tumour sometimes leads to subsequent development of torticollis from cicatricial contraction of the muscle, and Owen has actually watched such a case (*vide* footnote, p. 585); in the many cases we have seen, no such result has followed during infancy, but further observation is needed to settle whether there is any constant relation between the two.

No treatment is required unless there is evidence of syphilis, in which case the usual hydrarg. c. cret. should be given.

**Congenital Deficiencies and Malformations of Muscles** are often slight, and interesting from an anatomical rather than a surgical point of view; in other instances, such as those where the pectoral muscles are absent, in association with arrest of development of the chest wall, the malformations are irremediable; in others, again, some help may be obtained by elastic cords ('artificial muscles'), or possibly by the transplantation of muscle flaps; for the most part, however, these conditions are beyond the present reach of surgery.

**Tenosynovitis** is an affection common in, but by no means peculiar to, childhood. Tubercular tenosynovitis is, however, not rare, usually as a secondary condition to joint disease, but occasionally occurring alone; its

existence is to be suspected when swelling and suppuration occur in the course of a tendon in a tuberculous subject, and its treatment must be on general principles—rest and constitutional measures in early stages, and careful scraping out in the severer ones. We have once or twice seen suppuration in the large palmar sheath, and in one instance it occurred in a premature child only a few weeks old, coming on without assignable cause; secondary pyæmic abscesses elsewhere followed, but the child ultimately got quite well.

**Bursæ** in children are not usually very well developed. Patellar bursitis is, however, not very rare, and we have seen it lead to disease of the knee-joint; the olecranon bursa is also occasionally enlarged, while effusion into the semi-membranosus bursa is not uncommon. Ganglion is most common in the radial extensor tendons and in those of the thumb; in recent cases the fluid may be dispersed by pressure, in others it should be punctured with a grooved needle and the clear gelatinous contents let out; a pad with firm pressure should be kept on for three weeks afterwards, or the sac is likely to refill. In obstinate cases the sac should be laid open and as much of it as possible dissected away.

**Malformations.**—Other congenital malformations may be conveniently considered as (1) those due to errors of growth in the embryo itself—inherent errors<sup>1</sup>—and (2) those due to abnormal intra-uterine surroundings—acquired errors; or they may be classified as deformities by excess, deformities by deficiency, and deformities by distortion. In either case it is somewhat difficult to assign to their proper place all the malformations met with, and fortunately it is of little practical importance, as far as treatment goes, that we should do so.

Among inherent errors may be classed supernumerary fingers and toes—polydactylism; some cases of web fingers and toes—syndactylism; tripodism; congenital tumours of the dermoid class—with which might be put the cases of so-called foetal inclusion. Possibly certain less-marked malformations, such as those affecting only some of the structures of a limb, congenital varices, venous and lymphatic, congenital muscular abnormalities, &c., should be placed here, though these, in so far as they are of surgical importance, are more conveniently considered under the organs to which they belong. Many instances of inherent errors are better seen in the head and trunk, such as failure of closure of the dorsal and ventral laminæ and of the visceral arches of the head, meningocele, spina bifida, harelip, extroversion of the bladder, &c.

Among acquired errors are all those due to intra-uterine pressure, either by the walls of the uterus itself, by amniotic bands (Gurlt),<sup>2</sup> by pressure or violence applied to the uterus from without, or by mere malposition of the foetus *in utero*, at whatever period of gestation they arise.

In considering what malformations should be placed in this group, we must remember that it is probable that pressure or violence acting in a very early stage of development leaves much less obvious signs of injury than if it

<sup>1</sup> 'Vices of conformation.'

<sup>2</sup> Or, as Montgomery has pointed out, by bands of lymph stretching from one part of the foetus to another; cf. *Intra-uterine Amputation*, pp. 589, 590, and *vide* Todd's *Encyclopædia*.

is inflicted at a later period ; thus constriction or pressure during the later months of pregnancy may leave distinct cicatrices, while the same forces applied earlier may cause deficiencies without any marks of violence or scars.<sup>1</sup>

In this group will be placed deficiency of limbs, fingers, &c. (**intra-uterine amputation**), as examples of the highest degree of deformity ; also congenital constrictions and dimples, together with congenital synostoses or deficiencies of parts or the whole of a limb, such as absence of one or more of the carpal or tarsal bones,<sup>2</sup> of the lower end of the radius or ulna, causing club-hand ; or mere faults of position such as are found in club-foot, flexed or hyper-extended joints, &c.

The proof that some of these deformities are the result of errors of the embryo, and others of abnormalities of the environment (intra-uterine pressure, &c.), is in many cases easy, in others impossible. Thus polydactylism and congenital tumours cannot be the result of intra-uterine pressure, while congenital deficiency of limbs is shown to be at least sometimes due to constriction by the fact that the amputated limb has been found lying loose *in utero*, and in other instances the limb has been found incompletely severed, or even an unhealed stump has been present. On the other hand, the absence of the amputated limb, and the smooth, scarless appearance of the stump sometimes met with, may be explained by the fact that the limb may become disintegrated by maceration *in utero*, and if the separation took place at a very early stage the scar might disappear during growth or become indistinguishable, from its small size. Pressure, again, might well produce entire arrest of growth of a limb without amputation, and thus no scar would be left, while in other cases pressure might produce fusion of parts together, as in web fingers.<sup>3</sup> Evidence in favour of this is afforded by the coexistence of amputations with webbed fingers (both, in such cases, the result of pressure, though even here the webbed condition may have been due to mere retarded development from constriction).

CASE.—*Web fingers and toes, &c.*—Albert B., age 9 months. Admitted November 2, 1885. No history of deformity or maternal impression. Left hand, 2nd and 3rd fingers are united as far as the 1st interphalangeal joint ; there is no nail on the 1st finger, a very imperfect nail on the 2nd. Right hand, the 1st finger has a deep constriction around the last phalanx, with a bulbous enlargement of the end of the finger ; the 2nd finger has a similar constriction, but the part beyond is small and almost without nail. There is a very deep constriction round the right leg, about one inch above the ankle, almost reaching to the bone. The child can stand on the leg and moves the foot freely. Left foot, there is only one phalanx in the great toe, and no nail ; the nail of the 2nd toe is very rudimentary, and there is a small outgrowth on the 4th toe. Right foot, toes perfect, but the foot is hypertrophied and flat. November 5, Didot's operation on the hand. 7th, healing well. 12th, stitches removed ; flaps have united largely, but there is some granulating surface. Sent home on November 13. The flaps subsequently gave way partially, but were again nearly healed, when the child died at home of broncho-pneumonia.

<sup>1</sup> Vide *Med. Chir. Trans.*, 1877, for a case of complete absence of both upper limbs without any scar ; this was supposed not to be due to amputation.

<sup>2</sup> Bryant records a case of congenital absence of the fibula, os calcis, cuboid, and three outer toes.—*Diseases of Children*.

<sup>3</sup> Web fingers are, however, no doubt in most cases due to mere persistence of the foetal, spade-like condition of the hands.

Suppression of an intermediate segment of a limb, as where fingers are found springing from a stump of the upper arm, is probably due to pressure.

Again, inherent and acquired errors may co-exist, and would be likely to do so. A local overgrowth of the embryo might well disturb the relation between the uterus and its contents, and lead to deformity by pressure.<sup>1</sup>

Lastly, reversion, atavism, and so on, must not be left out of sight in considering these questions, which cannot, however, be further discussed here.<sup>2</sup>

Whether double monsters, dermoid cysts of the ovary and testis, and congenital tumours of various kinds are the result of foetal inclusion, parthenogenesis, or gemmation is a question that cannot be entered upon here; it will be sufficient to say that some cases are certainly the result of 'fused' <sup>3</sup> embryos, e.g. double monsters, adherent twins, and so on, while some congenital tumours are equally certainly mere errors in the closing in of the folds of the blastoderm or of the local involutions by which certain organs are formed.<sup>4</sup>

**Supernumerary Digits** are found attached in various ways; thus, a mere little fleshy outgrowth with or without a nail, and with no bony support, may be attached to a more or less normal finger, or the end of a finger may be bifid, with two nails. In other instances a supernumerary thumb with two phalanges may spring from the joint between the 'metacarpal' bone and the first phalanx, a common joint existing for the two thumbs, or the extra one may be attached to the side of the proper one. It is sometimes not easy to

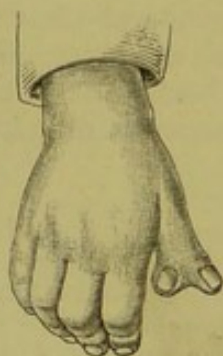


Fig. 119.—Double Thumb.

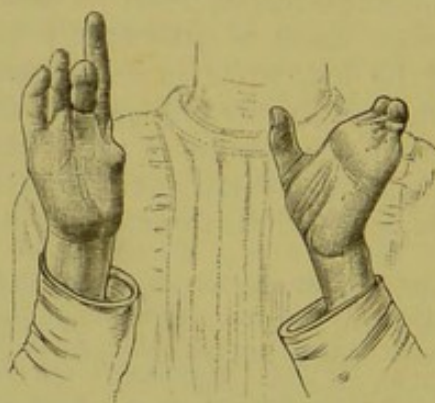


Fig. 120.—Intra-uterine Amputation of Fingers.

make out which is the supernumerary and which the natural digit; in such cases the most useful one should, of course, be left.

In any case of supernumerary fingers the additional one should be removed in infancy so as to allow the other as far as possible to be trained into its proper position. Where a joint is common to the two fingers care must be taken not to injure the articulation nor to allow it to suppurate, for

<sup>1</sup> Deficient development of one-half of the body, with facial paralysis, has been met with (Barker, *Clin. Soc. Trans.*, 1884).

<sup>2</sup> *Vide* Bland Sutton's Lectures, *Lancet*, 1887-8.

<sup>3</sup> 'If during development the medullary fold remains cleft, two complete foetuses are formed from a single ovum,' and every degree of combination from twins to very rudimentary 'parasitic' foetuses may result.—Bland Sutton, *Lancet*, February 11, 1888.

<sup>4</sup> Numerous figures and references will be found in Förster's *Missbildungen des Menschen*.

fear of a stiff joint resulting. Supernumerary toes should be removed if they cause distortion of the foot or are likely to lead to trouble in wearing ordinary boots.

For figures and details of the different forms of polydactylism we must refer to Annandale's work on *Diseases of the Fingers and Toes*.

Occasionally cases are met with where more or less of a limb is deficient and the member ends in a pointed or truncated extremity like an amputation stump; this may occur at any point in the length of a limb. Sometimes only parts of one or more digits are deficient, sometimes the amputation has been incomplete, and a deep sulcus round the finger or limb, with often a bulbous expansion on the distal side of it, marks the seat of pressure. This constriction in some cases is so tight that there appears to be little left undivided except the bone, and this condition we have met with associated with talipes; the movements of the limb were, however, good, and evidently the deeper structures, though compressed, were not divided. We have also seen these constrictions associated with dimpled depressions over the knees and shoulders, and rigidity of the joints, also the result of intra-uterine pressure; in one instance there was also microcephalus. Most of the cases of intra-uterine amputation, and of these constrictions, are the result of pressure by amniotic bands or foetal adhesions, as already pointed out; but it is undoubtedly occasionally true that pressure by the umbilical cord, so gradually exerted as not to interfere with its own circulation, may produce the same effect.<sup>1</sup> We have not seen a case of constriction requiring any operation, though it has been suggested by Mr. Edmund Owen to pare the adjacent surfaces and unite them so as to obliterate the groove.

Nothing, of course, can be done for congenital amputation except the use of prosthetic appliances, and it is wonderful what use these patients can make of their stumps. As already pointed out, in some instances there is a distinct scar, in others a smooth, unbroken, cutaneous surface, and sometimes rudimentary digits remain attached to the end of a stump containing only the humerus or femur; this is rather an arrest of growth by pressure than a true amputation. So too, sometimes, the femur or humerus is congenitally very short or deficient. (Fig. 121.)

**Club-hand**, so called, is a rare affection, resulting from arrest of development of more or less of the radius or ulna, with consequent abduction or adduction of the hand. It is not in any sense really comparable to the ordinary forms of club-foot, and is little amenable to treatment. Something, however, may be done by manipulation to remedy the deformity and possibly encourage growth of the shortened bone by friction and removal of

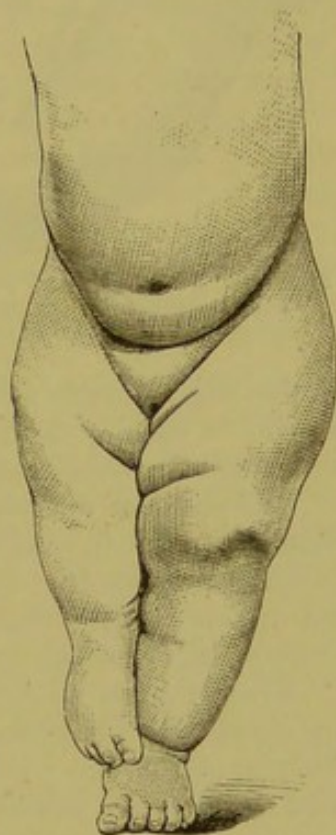


Fig. 121.—Congenital Arrest of Development of one Lower Limb.

<sup>1</sup> Vide Neville, *Brit. Med. Jour.*, 1883, p. 209.

pressure (fig. 122). Less often the hand is fixed in flexion or hyper-extension, and in these cases sometimes tenotomy may be required. Similar deformities may, of course, result from cicatricial contraction after injury. In one instance the radius was entirely deficient on both sides, and the ulna was fractured and repaired, probably *in utero*. At the suggestion of one of our Resident Medical Officers, Mr. J. H. Thompson, we transplanted some

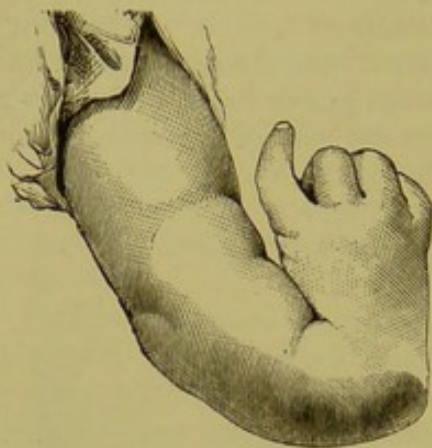


Fig. 122. — 'Club-Hand,' so called. There is absence of the radius and thumb, with abduction of the hand.

bone from another child into an incision between the muscles of the forearm. The wound healed perfectly, and the bone was growing at the time of the child's death from an independent cause 2 or 3 weeks later; the position of the hand was much improved. Careful bandaging and the use of splints will do good in some cases if treatment is begun early.

**Web Fingers.**—Various degrees of this deformity are met with: thus there may be a mere extension of the normal web forwards to the first interphalangeal joint. In other instances metacarpal bones and phalanges may be fused together, or bound in very close contact throughout the whole length

of the digit; occasionally the union is only at the distal ends.<sup>1</sup> The deformity is usually more or less perfectly symmetrical, and often associated with a similar condition in the feet or with some other deformity.

Where there is complete bony fusion of two adjacent digits no attempt should be made to separate them; where, however, only skin and subcutaneous tissue unites the two fingers they should be separated. Simple division of the web is of little use, since the wound granulates up from the bottom and more or less reunion occurs.

Several plans have been devised to meet this difficulty, such as applying an elastic cord between the fingers and fastening it round the wrist after division of the web; perforating the base of the web and putting a thread or wire through the orifice and allowing it to heal, and then dividing the web. Another mode consists in dividing the web and then bringing a flap of skin from the dorsum or palm across between the fingers so as to interpose a bridge of skin at the base (Norton). The best plans are the last-mentioned and that advocated by Didot, in which a dorsal flap from one finger and the web, and a palmar flap from the other finger and the palmar aspect of the web, are cut; the rest of the web is then divided, and the flaps are wrapped round the raw surface of the finger to which they remain attached. In doing this operation, however, it will be found that there is not sufficient skin to cover both fingers, and one has to heal by granulation. Web toes do not require treatment.

**Congenital Rigidity of Joints and Contractions.**—As already stated, children are sometimes born with joints, chiefly the knees, elbows, and shoulders, which are stiff, or, on the other hand, unduly lax; and sometimes

<sup>1</sup> This could hardly be the result of failure of the natural differentiation of the fingers in foetal life, which results from the phalanges outgrowing the webs.

these joints are fixed in flexion, sometimes hyper-extended, or at least hyper-extensible. In such cases there are not rarely marks of pressure about the joints—depressions and adhesions of the skin. Probably the conditions determining such deformities are like those causing talipes, viz. intra-uterine pressure or malposition; thus the ‘*genu recurvatum*’ sometimes seen results from the limbs being packed in hyper-extension along the ventral surface of the body. Failure of developmental rotation accounts for others.

Diligent friction and passive movement, together with the application of splints, as the individual deformity may require, will sometimes effect great improvement<sup>1</sup>; in other instances little success attends treatment.

One or more of the fingers or toes may be congenitally contracted either in flexion or extension; the contraction, often slight at first, tends to increase as the child grows. Hammer-toe is a result of this condition: the contraction here is usually of the tendons, but sometimes of the fascia only, as in Dupuytren’s contraction. In many instances it has been shown that contraction of the ligaments of the interphalangeal joints is the cause of the deformity.

Stretching and simple splints, with or without tenotomy, in ordinary cases, and amputation in the more severe forms of hammer-toe, is the treatment required. If neglected, troublesome corns or bunions and distortion of the nails may result from pressure of boots. Division of the lateral ligaments, or in some cases even resection of a joint or part of the shaft of a phalanx, may be the best treatment for hammer-toe.

It must be remembered that some of these patients with distorted limbs are cases of cerebral deficiency, and for them of course little can be done.

**Congenital Dislocations**, so called, of almost any joint may be met with: thus the temporo-maxillary, elbow, and wrist joints, the joints of the spine, toes, &c., have been found displaced, though such deformities are by far most frequently met with in the hip. These conditions have been variously explained: injury *in utero* or at birth, intra-uterine inflammations, convulsions, pressure, nervous, bony, and muscular lesions, have all been assigned, as in club-foot, as causes of congenital dislocation. It is most probable that, as in club-foot, intra-uterine pressure from malposition is the most frequent cause, though not the only one. In all cases more or less deformity of the bony articular surfaces is found, and this is of the utmost importance, since it largely prevents the possibility of anything like complete reduction.

In ‘congenital dislocation’ of the lower jaw the condyle and glenoid cavity, as well as much of the bony framework of that side of the skull, have been found stunted. Occipito-atlantoid dislocation, both backward and forward, has been described: in the former the head is flexed, in the latter hyper-extended.

Dislocations of the clavicle in the varieties met with in later life are also mentioned by Guérin.

The humerus may be displaced downwards, forwards (subcoracoid), or backwards (subspinous), with arrest of growth of muscle and bone, and deviation from the normal shape of the articular surfaces.<sup>2</sup> Displacements of

<sup>1</sup> Berkeley Hill records a good case in which there was so much rotation that the heels looked directly forwards. By the use of apparatus and tenotomy an almost perfect result was obtained.—*Brit. Med. Jour.*, July 12, 1884; *vide* also 1883.

<sup>2</sup> Dislocation of the humerus appears to be often associated with other conditions of

the elbow and wrist have also been met with.<sup>1</sup> The most important of all these malformations is **Congenital Dislocation of the Hip**, since it is by far the most frequent, and sometimes seriously incapacitates the subject of it. In these cases the acetabulum is small, shallow, and may be filled with fat or 'webbed over'; the head of the femur may be nearly normal or much stunted. A more or less perfect capsule may be present, and this may be thickened; or, again, a sort of interosseous ligament may exist: the ligamentum teres is atrophied, the muscles around the joint are wasted. The affection may be unilateral or more often bilateral. The femur is usually freely movable and slides up and down upon the dorsum ilii to an extent of sometimes two inches or more.

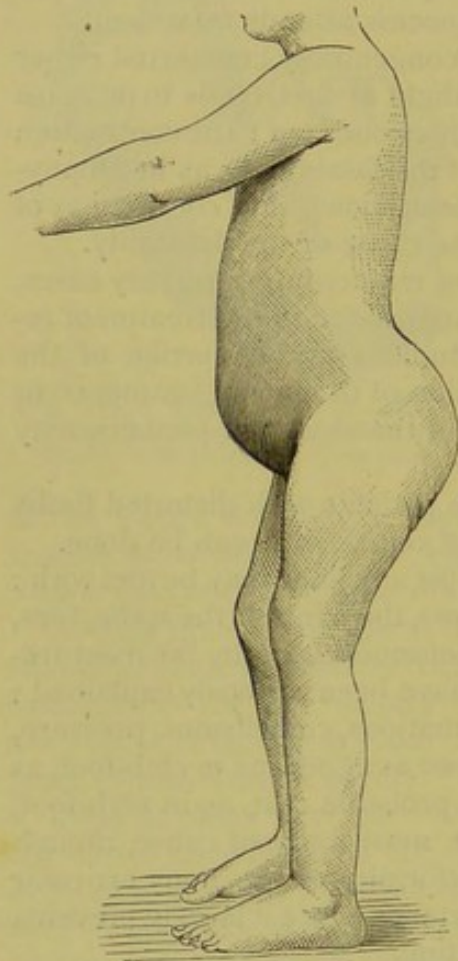


Fig. 123.—'Congenital Dislocation' of both Hips. Not a severe case.

The affected limb or limbs are usually imperfectly developed throughout. There is always a good deal of lameness in severe cases, though we have met with slight degrees of this deformity in which the joint was not very much altered. There is marked lordosis and a peculiar 'waddling' way of walking which is very characteristic. Usually the displacement is upwards and backwards, but it may be almost in any direction; the limbs are sometimes adducted markedly.

Besides the ungainliness of the walk, it is possible that the deformity of the pelvis may, as Adams suggested, be important from an obstetric point of view. There is little to be done for these cases, though it has been recommended that the affected limb should be supported and fixed in a state of extension, and it is said that a certain amount of increased stability in the joint may result. Section of the muscles surrounding the joint, and even excision, as well as scarification of the deeper tissues and surface of the ilium, have been practised with the object of giving increased stability to the joint, but it

is unlikely that any of these plans will gain favour. Prolonged extension in bed we have found do harm rather than good, though some successful cases have been recorded. When the affection is unilateral a thick-soled boot on the short limb will improve the gait, and in some cases a pelvic girdle with pads to support and fix the end of the femur has been of service. The history of the case, the absence of pain and rigidity, and the peculiar gait distinguish the affection from hip disease. Rickety lordosis sometimes

malformation; in a case shown us by our friend Mr. C. E. Richmond there was sub-spinous dislocation of the shoulder, and dislocation of both hips.

<sup>1</sup> An account of all these malformations will be found in Hamilton's work on *Fractures and Dislocations*.

closely resembles congenital dislocation, but careful examination of the relative positions of the trochanters and iliac spines will prevent a mistake. The affection is by no means rare, and we have seen many instances of it.

So-called **Congenital Dislocation of the Knee** has been already mentioned as 'genu recurvatum'; this joint is also occasionally found with partial backward or lateral displacements. If seen in quite early infancy, these deformities are fairly amenable to treatment by manipulation and splints, and we have been able to completely remedy the deformity of 'recurved knee' by these means.

Besides the deformities already described, it is necessary just to mention the occurrence of cases of **Congenital Fissure of the Sternum** from non-union of the different centres of ossification, or rather non-closure of the ventral laminae, sometimes associated with ectopia cordis. Cases of deficiency of the ribs over a larger or smaller area, and lack of development of the muscles of the chest-wall and of the mammary glands, may be met with; we have seen hernia of the lung through a gap of this sort.

**Congenital Deficiency of one or both Clavicles or of the Scapula** may also be occasionally seen. A suprascapula has been met with, attaching the scapula to the vertebræ, and requiring removal (Willett and Walsham, *Med. Chir. Trans.*, 1883). Deficiency or imperfect development of the patella sometimes occurs. Many other abnormal conditions may occur—some deficiencies, some excesses, as in the common cases of supernumerary mammae, which are doubtless instances of reversion, and so on; but these cannot be discussed here. Many require no treatment; others must be dealt with on general rules. Occasionally protective shields may be required for such cases as thoracic hernia.

## CHAPTER XXXIII

## DISEASES OF THE NOSE.

THE orifices of the anterior nares are a favourite seat of eczema, lupus, and superficial tuberculous ulceration; other cutaneous affections and nævi are also often met with upon the surface of the nose, *vide* Chaps. XVII. and XXXVII.

The nasal cavities in children are exceedingly often the seat of acute or chronic catarrh, the result of cold, or extension from the pharynx. Catarrh also commonly occurs in rickety, tuberculous, or syphilitic children.

**Acute Catarrh** is generally simply mucous; it may, however, become purulent, or may be so from the first, especially if it is the result of inoculation, which may occur at birth or accidentally at a later period.

**Chronic Nasal Catarrh** is marked by discharge of muco-purulent material from the nose, swelling of the mucous membrane and of the skin of the anterior nares, with often some thickening of the upper lip from irritation; the voice is nasal, respiration is impeded, deafness is often present, the child snores, and in an infant suckling is often difficult, sometimes impossible, from obstruction to breathing through the nose. Occasionally the inflammation extends to the antrum, nasal duct, or frontal sinuses. On examining the nose the interior is seen to be red and angry-looking, often slightly excoriated; it easily bleeds, and there are frequently dried scabs on its surface, while stringy mucus is apt to collect upon the lips in neglected children and gives rise to soreness. Where one nostril alone is affected, careful search must be made for one of three conditions: a foreign body, such as a button, a bit of slate pencil, or a date-stone, &c.; a mucous polypus growing from the region of the inferior or middle turbinated bone—a somewhat rare condition in childhood; or, thirdly, a deviated nasal septum.

Chronic catarrh, from whatever cause, is apt, if neglected, to give rise to ozæna from decomposition of the retained secretion, or from caries or necrosis of the bones of the fossæ; where the bones are involved the fœtor is more intense than in other cases.

Should the inflammation extend to the cartilaginous and bony septum, the nose may lose its support, by softening of these structures, and become flattened and depressed. Where the outer walls are more especially attacked, a broad thickened nose results. In most cases these deformities occur in connection with congenital syphilis rather than in tubercular or simple bone lesions. A probe will usually detect the presence of bare bone, and it must be remembered that in cases of apparently simple polypi a

patch of exposed bone will often be felt. Bleeding from the nose in these affections occurs often in small amounts, but rarely to any serious extent.

*Diagnosis.*—The existence of chronic nasal catarrh is obvious; its cause requires looking for, and this should be done systematically. First, if unilateral, the causes already mentioned, foreign body, deviated septum, or polypus, are to be suspected. If double, the throat should be examined for enlarged tonsils, chronic pharyngitis, and post-nasal adenoids. Evidence of congenital syphilis or tuberculosis may be obtained, or sometimes simply carious teeth or eczema may be the source of the trouble.

*Treatment.*—If the cause is local, an anæsthetic should be given, and the foreign body,<sup>1</sup> post-nasal adenoids, &c., removed. In syphilitic and tubercular cases syringing out with warm alkaline lotions (sodæ bicarb. gr. xx; aq. ʒi), or in older children the nasal douche, are the most efficient means of clearing away the crusts; this should be done 3 or 4 times daily, and subsequently powdered boracic acid or tannic acid and iodoform in equal parts should be blown into the nose through a quill or insufflator, or the nasal cavity may be brushed over with glycerine of tannin or lead lotion. Sometimes a spray may be substituted for the syringing after the nose is once cleared. Solution of hydrochlorate of cocaine, 5–10 per cent., may be used as a spray or brushed on, either before removing a foreign body or in cases of acute catarrh. Cleanliness and care of the general health, with mercury or iodide of potassium, or both together, according to the child's age, are required in syphilitic cases.<sup>2</sup> Any sequestra should be removed as early as possible, and all foul crusts kept constantly cleared away. Cod-liver oil and iron, with the usual hygienic measures and careful cleansing of the nose, together with iodoform insufflation, is the best treatment for the tubercular cases. Nitrate of silver, 10–30 grs. to ʒi, is sometimes used with advantage as an occasional application. In nearly all chronic cases the prognosis is somewhat uncertain, and the course of the disease tedious. Where the above-mentioned methods fail, and especially in tuberculous ulceration of the nasal mucous membrane, an anæsthetic should be given and the affected parts well scraped with a Volkmann's spoon, or cauterised with the wire cautery.

*Nasal obstruction*, apart from the causes just mentioned and those already described under Diseases of Tonsils, &c., may be due to deviation of the cartilaginous septum. This is sometimes congenital—more often it is the result of fracture of the septum, or dislocation from either the ethmoid or vomer, or from the nasal spine of the upper jaw; or, again, it may be the result of a chronic perichondritis, following an injury, and resulting in softening and subsequent deviation of a local patch of the septum. If the whole cartilage is involved, there will be some flattening of the end of the nose;

<sup>1</sup> To remove a foreign body from the nose, a simple loop of silver wire is useful, or a pair of dressing forceps or a small scoop may be employed; sometimes a finger passed from the mouth into the posterior nares is of service, and occasionally the simplest plan is to push the foreign body backwards into the pharynx and remove it from the mouth. In one of our cases the body, a button, escaped into the pharynx while the child was under chloroform, and was found in the vomit brought up by the child on its awaking.

<sup>2</sup> In infants mercury alone, in children over three or four years iodide of potassium alone, or, failing a good result, combined with mercury, is, we find, the most successful plan.

this, however, does not usually occur. Simple chronic perichondritis, causing thickening, hæmatoma of the septum, or abscess, and finally ecchondrosis of the cartilage, may also be met with. The treatment of deviated septum consists in forcible straightening with a pair of guarded sequester forceps or with Adam's special instrument; and the subsequent wearing of a nasal plug, such as Walsham's or the one devised by one of the present writers, is required. In some cases removal of the projecting mass is called for: in such circumstances the muco-perichondrium should be dissected up and laid down again after removal of the cartilage. Hæmatoma, if it does not subside, is best treated by incision—so also abscess; usually in both cases incision on one side will empty the sac on both sides, since the cartilage is perforated. Dislocation is best treated by the use of plugs. For an account of some cases see Paper in *Med. Chron.*, vol. iv., 1886.

**Nasal Polypi** are somewhat rarely met with in childhood; they spring from the region of the middle or inferior turbinated bones as soft, grey, semi-transparent, rounded masses; occasionally they take origin higher up in the nasal cavity. Repeated removals with the use of astringents in the intervals is the treatment required.<sup>1</sup> The polypi should be taken away with forceps; in rare cases the tendency to re-growth is so obstinate that it is necessary to take away the whole of the turbinated bone from which the growths arise, and occasionally it may be requisite to perform Rouge's operation and thoroughly clear out the nose.

Where there is nasal obstruction from chronic catarrh or cicatricial contraction, the use of nasal bougies or plugs smeared with any medicament desired, such as iodide of lead or iodoform ointment, is useful.

**Superficial ulceration** of the mucous membrane of the nose often occurs in cases of chronic catarrh from any cause, and occasionally the ulcers are deeper and lead to perforation of the septum; this is especially likely to occur from pressure of foreign bodies. We have seen perforation of the septum occur in a child simply from picking the nose.

**Chronic Dry Catarrh** of the nose, accompanied by atrophy of the turbinated bones and their coverings, may be met with; it is often associated with ozæna. The treatment is similar to that of ordinary chronic catarrh, but, according to Sir M. Mackenzie, the use of medicated plugs of wool relieves some cases. The disease is a very intractable one; painting with glycerine is occasionally useful.

**Congenital Malformations** of the nose are rare; closure of the anterior or posterior nares, adhesions between the walls of the nasal fossæ, perforation of the septum, and cases of cleft or flattened, or even of entire deficiency of the nose, have been met with.<sup>2</sup>

**Malignant Polypi** of the nose and nasopharynx are occasionally seen in children; early removal is the only treatment, but speedy recurrence is to be looked for.

**Epistaxis** occurs very frequently in children, sometimes as a result

<sup>1</sup> Acid. tannic., parts ii; cupri sulphat., part i; pulv. plumbi nitrat., part  $\frac{1}{2}$ , will be found a good snuff for these cases if obstinate; the milder applications mentioned under Chronic Catarrh are, however, often sufficient. The occasional application of nitrate of silver fused on a wire is sometimes required.

<sup>2</sup> For figs. of deformities *vide* Förster's *Missbild. des Menschen*.

merely of cerebral congestion, the communication between the longitudinal sinus and the nasal veins remaining open in early childhood ; in other cases congestion from catarrh, or ulceration, injury, or foreign bodies, &c., may give rise to bleeding. Hæmophilic patients frequently bleed from the nose, and epistaxis is a complication often met with in some of the exanthems, &c.

Usually the bleeding ceases spontaneously in a short time ; if this is not so, bathing with cold water, or a little ice applied inside and over the nose, will usually stop the flow. Astringent powders or lotions, tannin, alum, &c., may be blown into the nostrils. Sometimes pressure from outside is effectual ; in other cases making the child stand upright, with the arms above the head so as to expand the chest and relieve venous engorgement, will prove successful.

Occasionally the nose may require plugging.

**Nasal deformity.**—Where there is destruction of the whole or part of the nose, plastic operations may be employed. These must be planned according to the individual requirements of the case. We are rather of opinion that a good artificial nose is preferable to most of those obtained by plastic operations. Where, however, there is loss of only a small part of the nose, or where there is flattening without loss of substance, attempts should be made to improve the appearance of the child by filling up the gap or elevating the depressed part. It will be found that there is great difficulty in obtaining a good prominent nose by any method, and too much should not be promised. For details of the methods of operating we must refer to systematic works on Operative Surgery.

## CHAPTER XXXIV.

## DISEASES OF THE EAR.

**Diseases of the External Ear.**—The auricle may be congenitally absent or crumpled and distorted : for the former condition an artificial ear may be fitted, for the latter usually nothing can be done.

In cases of deficient development of the pinna the ramus of the jaw may also be stunted, i.e. the first post-oral arch and its appendages may be ill developed.<sup>1</sup>

For an account of supernumerary auricles and fistulæ *vide* p. 137.

Sometimes the ear is unduly large, and stands out prominently from the side of the head ; the appearance may be improved by the use of an ear truss, or in extreme cases by removal of a triangular portion of the ear and careful closure of the gap by sutures, or by suturing the ear to the skin covering the mastoid process.

The pinna is often the seat of eczema and chilblains, which require the treatment of the same affections elsewhere ; eczema most commonly attacks the crease between the auricle and the side of the head, and chilblains the free edge of the ear.

Simple, lupous, or other tuberculous ulceration may also attack the ear, and we have seen the whole auricle rapidly slough away during an attack of whooping cough.

The orifice of the external meatus is sometimes congenitally closed: in such cases, if the tuning-fork shows the labyrinth to be healthy, a careful dissection may be made at the site of the orifice, or the meatus may be reached by incision behind the auricle and the orifice afterwards opened upon a bent probe. Nothing should be attempted until the child is old enough to have the hearing power tested, unless there is evidence of retained secretion giving rise to abscess, when an opening must be at once made.

The common affections of the **external meatus**, which in children is proportionately shallower and broader in a horizontal direction than in adults, are eczema, boils, accumulations of wax or epidermis, and the presence of foreign bodies : the first are not peculiar to children ; the last is, of course, commoner in them. If the foreign body has passed beyond the orifice of the meatus it should be removed by gently syringing, or by means of a loop of silver wire, or by a probe coated with cobbler's-wax or glue. No violence should be used, and it is better to leave a foreign body where it is than to push it further in or lacerate the meatus or membrana tympani in attempts

<sup>1</sup> As in a case of Canton's, *Path. Soc. Trans.*, vol. xv. We have had similar cases under our own care.

at its removal. Insects, &c., in the meatus are readily killed by a drop or two of oil.

Eczema, tuberculous sores, &c., may give rise to purulent discharge from the ear, but usually such discharge comes from the middle ear. In all cases the pus should be carefully soaked up with absorbent wool and the ear examined; sometimes, however, the meatus is so swollen and the child so intractable that no examination can be made: under such conditions the case should be treated as one of otitis media until, either with or without anæsthesia, the ear can be examined.

The imperfect development of the tympanic bone and consequent shallowness of the meatus in children must be borne in mind; in young infants the membrane lies in a more horizontal plane than in adults.

**Inflammation of the Middle Ear** may be either acute or chronic. The causes of acute otitis are catarrh of the nasopharynx, usually associated with enlarged tonsils or post-nasal adenoid growths, cold, and the exanthems, especially scarlet fever; injuries also, by picking or roughly drying out the ear with corners of towels and so on, may rupture the membrane and set up otitis media.

*CASE.—Chronic Tonsillitis. Post-nasal Adenoid Growths. Deafness.*—Annie C., age 9 years; admitted July 1, 1884. Always healthy till scarlet fever four years ago, when she had sore throat, running from nose, and deafness; worse lately. On admission, tonsillar aspect; health otherwise fair; both tonsils bulge forwards and inwards; nasal mucous membrane thickened; upper part of pharynx stuffed full of warty adenoid growths; posterior nares nearly blocked. July 24, pharynx cleared with finger, curette, and Volk-mann's spoon; left tonsil removed, bled freely; much clearer afterwards. Result, great improvement. February, 1885, quite well.

Sir W. Dalby<sup>1</sup> has pointed out that boxing the ears of children may give rise to nervous deafness without a rupture of the membrana tympani, such deafness being usually permanent and severe; or the membrane may be ruptured: in such case the rupture may heal or be followed by inflammation of the middle ear; or, lastly, acute otitis may be set up without rupture of the membrane.

In otitis the result of throat affections the disease may be caused either by Eustachian obstruction, and consequent retention of secretion, or by actual extension of the inflammation along the tube. The symptoms are pain in the ear and head, deafness, and some constitutional disturbance. In infants, who cannot indicate the seat of their trouble, otitis should be suspected if there is fretfulness and restlessness, with tossing about of the head without other assignable cause. If these cases are left to themselves the membrane soon yields, and a purulent discharge escapes from the meatus, giving usually great relief; until discharge appears the condition is often overlooked in scarlet fever, where the attention is apt to be directed to other symptoms. If the membrane is examined in such cases, there will be seen all the signs of inflammation, redness and loss of lustre, and if pus is present it may perhaps be visible as a yellow discoloration of the lower part of the membrane.

*Treatment.*—The throat must be attended to, and antiseptic, sedative, or astringent applications used, according to circumstances; next, the Eustachian tube must be kept open by Politzer's method: the inflation can be performed

<sup>1</sup> *Brit. Med. Jour.*, December 23, 1882.

at the moment of the child's crying. Hot fomentations, with perhaps a leech behind and in front of the ear, and instillation of a drop of glycerine and laudanum, or glycerine and carbolic acid, into the meatus, should be employed. Failing relief by these means, the membrane should be carefully incised, either horizontally or vertically, behind the handle of the malleus, and the discharge allowed to escape—gentle washing out of the ear with warm boracic lotion, and inflation of the middle ear, being also used. As soon as the acute symptoms have passed off, powdered boracic acid and iodoform should be blown into the ear after drying it carefully with absorbent wool two or three times daily, according to the amount of discharge.

The dangers of otitis media are manifold: first, deafness; and secondly, extension of inflammation, which may reach the mastoid cells, perforate the roof of the tympanum, or the suture petro-mastoidea, which is still open in infancy, and so directly reach the brain. Cerebral abscess and meningitis are not remote dangers. Or the carotid artery may be opened by ulceration and fatal bleeding ensue; or thrombosis of the lateral sinus and pyæmia may result. Extension of mischief to the temporo-maxillary joint may occur, with stiffness of the articulation. The amount of deafness depends rather upon the injury done to the labyrinth, to interference with the mobility of the ossicles, or to fixation of the stapes, than to destruction of the membrana tympani.

The dangers to life are to be met by providing free drainage for discharge and keeping the cavity aseptic as far as possible. If there is any pain, swelling, or tenderness over the mastoid process, an incision should be at once made down upon it; if no pus is reached and the symptoms are urgent, the bone must be carefully gouged away just behind and level with the roof of the meatus until the cavity is reached. It must be remembered that in children the mastoid cells are not well developed and vary much in size.<sup>1</sup> Even if pus is not reached at the time, relief may be given and an easier way for discharge made; but the removal of bone should be free if the symptoms are definite, and, if possible, an opening should be made through which lotion can be syringed into the external meatus. In neglected cases extensive necrosis may occur, and the walls of the meatus, or even the greater part of the labyrinth, may come away as sequestra. It is common to find the lymphatic glands just below the ear inflamed, and they may cause much pain, or may suppurate and discharge through the walls of the meatus. In the early stages of glandular inflammation hot belladonna fomentations will often arrest the mischief; if suppuration occurs, the abscess should be early incised. Suppurative meningitis, if diffuse, is not amenable to treatment, but localised cerebral abscess, which may be either in the temporo-sphenoidal lobe or cerebellum, should be treated by trephining the skull and opening the abscess (*vide* pp. 383 and 604).

Facial paralysis, which not uncommonly results from otitis media, is peripheral, and the result of pressure upon the nerve in the wall of the tympanum; the paralysis usually disappears on subsidence of the otitis, but may be permanent. Chronic otitis media may be due to the same causes as the above, but is often tuberculous; it may last for years, and give rise to

<sup>1</sup> Swelling and tenderness over the mastoid process does not always mean inflammation of the mastoid cells, but may be the result of extension superficially of inflammation from the meatus.

occasional attacks of acute ear-ache. Chronic otitis is always a source of danger, and should never be neglected; the tympanic cavity should be carefully cleansed by gentle syringing, and then the mucous membrane got into a healthy state by insufflation daily of the iodoform and boracic powder, or by the use of slight astringents such as alum, gr. iii- $\bar{3}$ i, or sulphate of zinc, gr. i-ii to  $\bar{3}$ i; boracic and carbolic lotions are perhaps the most generally useful. On examination of the ear in these cases the membrane is usually almost entirely gone, and the ossicles more or less completely destroyed; the hearing power is impaired, but seldom entirely lost. The complications met with in the acute variety are also liable to occur at any time in the course of a chronic case. Small perforations of the membrane in children readily heal, but it is exceptional to meet with them.

In very chronic otorrhœa masses of granulation tissue, springing from the tympanic cavity, less often from the membrane or walls of the meatus, may appear, and form the commonest kind of aural polypus; fibrous, mucous, and adenomatous polypi are much rarer. Polypi are to be treated by removal with forceps or scraping away, and the application of some caustic, of which we prefer solid nitrate of silver fused on a loop of wire; crystals of perchloride of iron or chromic acid may be used if preferred, and the ear should be washed out with a solution of rectified spirit as strong as can be borne without pain (usually 1 in 4 to 1-2 can be employed). Boracic and tannic acid and iodoform insufflations should be used between times. It is often necessary to remove these polypi several times before they cease growing. All abscesses burrowing about the ear must be opened and well drained, and the general health as well as the condition of the throat and nose carefully looked after. Eustachian catheters require an anæsthetic in children, and should only be used when Politzer's method fails.

The general routine method, then, of treating otorrhœa ('otitis media suppurativa') may be given thus. (1) Dry out the ear with absorbent wool.<sup>1</sup> (2) Examine with a speculum, and through this puff a powder of equal parts of iodoform and boracic acid once, twice, or three times daily, according to the amount of discharge.<sup>2</sup> (3) Inflate the ear by Politzer's method once daily. (4) Watch for, and open early, any mastoid or glandular abscess. (5) Protect from cold, and take care of the general health.<sup>3</sup> (6) Never neglect the least ear-ache. (7) See that the throat and naso-pharynx are healthy.

It must be remembered that pain in the ear may be a result of carious teeth, cervical adenitis, or any source of pressure upon the nerves supplying the auricle or meatus, as well as of ear disease.<sup>4</sup>

**Affections of the Labyrinth** in children may be either congenital, the result of injury, of extension from otitis media, or of congenital syphilis. The latter form usually comes on about the 7th to 12th year, increases

<sup>1</sup> Where hospital patients cannot be seen daily the friends should syringe out the ear with warm boracic lotion.

<sup>2</sup> We prefer a simple speculum and the use of an aural reflecting mirror, but Brinton's 'otoscope' may be used.

<sup>3</sup> A clean plug of absorbent wool should be put into the meatus and changed two or three times daily or more, according to the amount of discharge.

<sup>4</sup> *Vide* Hilton's *Rest and Pain*.

rapidly, affects one ear first, and leads to severe or total deafness; it is rarely remediable, though mercury and iodide of potassium should be tried. If the case comes under treatment in an early stage there is some hope of recovery. Deafness in children should be seen to at once, and care should be taken, in those in whom restoration of hearing cannot be complete, to make them read and speak aloud to prevent the tendency to become mutes. Deaf-mutes should be taught the 'oral method.'

**Intracranial Abscess.**—Should there be evidence of intracranial abscess, as shown by fever,<sup>1</sup> vomiting, otorrhœa, pain in the side of the head,<sup>2</sup> convulsions, squint, hemiplegia, more or less loss of consciousness, and perhaps optic neuritis, the ear should be examined and well cleaned out, so as to avoid any further retention of pus in the tympanum; a flap of soft parts should then be turned up by a curved incision, exposing the temporal bone above and behind the ear; a circle of bone should then be gouged away, having its centre opposite the posterior superior quadrant of the meatus, and from  $\frac{1}{2}$  in. to  $\frac{3}{4}$  in. from the meatus, according to the age of the patient.<sup>3</sup> Having removed the bone, if no sign of abscess appears, the dura mater should be incised and the brain punctured first directly inwards, then forwards and inwards, and finally backwards, so as to tap any abscess situated either in the cerebrum or cerebellum; if pus is found, the opening should be enlarged, and the abscess drained and treated on general principles. (*Vide* also p. 384.)

While these sheets are going through the press we have had under the care of our colleague Dr. Hutton, and ourselves, a boy 11 years old, suffering from double otitis after small-pox. On admission there was discharge from both ears, with pain in the left, and in the left temple, and a succession of rigors. The ears were full of thick discharge, and each contained a small polypus. The ears were cleaned out, the polypoid granulations removed, and the acute symptoms disappeared. There was no mastoid trouble. A week later the boy became drowsy, with a subnormal temperature; there was no paralysis, no spasm, except possibly of the muscles of the left side of the face, but this was probably rather paresis of the right side. Slight cloudiness of the left optic disc was found; there was no apparent tenderness. The next day a circle of bone was removed from above and behind the meatus, the dura mater opened, and the brain explored systematically, but no abscess was found in the temporo-sphenoidal region. A second flap of skin was then turned upwards from the occiput, and a small aperture made in the skull; a trocar was then passed downwards

<sup>1</sup> Barker points out that a single rigor, followed by subnormal temperature, slow pulse, and 'sluggish, but perfect, cerebation,' may be met with in cerebral abscess.

<sup>2</sup> There appears to be no certain means of distinguishing temporo-sphenoidal from cerebellar abscess, but in the latter the pain is usually occipital, and there is retraction of the head; the amount of paralysis in either case is inconstant. Temporo-sphenoidal abscess is about three times as common as cerebellar according to Barker, who summarises the whole question in a valuable paper in the *Lancet* for June 11, 1887. He also believes that abscess in the brain is much rarer than meningeal or subdural suppuration.

<sup>3</sup> Barker gives  $\frac{1}{2}$  in. above and  $\frac{1}{2}$  in. behind the centre of the bony meatus for subdural abscess over the roof of the tympanum, and  $\frac{1}{2}$  in. directly behind the meatus for subdural abscess in the groove of the lateral sinus. By enlarging the opening upwards and backwards, and then puncturing the dura mater, avoiding the lateral sinus, any abscess in the brain would probably be reached.

through the tentorium into the cerebellum, and offensive pus escaped; the cannula was left in, but the boy died, apparently of shock, six hours later. From examination of the head we should advise in such cases the removal of a circle of bone immediately above the external auditory meatus, at a distance from it varying from  $\frac{1}{2}$  in. to 1 in., according to age; the dura mater should then be stripped back until the roof of the tympanum is exposed, and any pus lying there evacuated. Next, the dura mater should be incised and the brain explored, first directly inwards, in the posterior part of the temporo-sphenoidal lobe, and, failing this, backwards, inwards, and downwards, and finally forwards. Either a temporo-sphenoidal or cerebellar abscess would probably be thus reached. If, however, the symptoms were fairly definite and no abscess was found in this way, the skull might be opened midway between the superior and inferior curved lines of the occipital bone, and the cerebellum explored. It is readily reached in this position.

In our case, which is, we believe, one of the first in which a cerebellar abscess has been opened during life, there were no definite symptoms to point to cerebellar rather than to temporo-sphenoidal abscess, and it was only, failing the latter, that, feeling strongly that an abscess existed somewhere, we sought it in the cerebellum.<sup>1</sup> (*Vide* also Cerebral Abscess.)

<sup>1</sup> Mr. Hulke opened a cerebellar abscess in 1886. *Vide* Jacobson, *Operations of Surgery*, 1889, p. 204.

NOTE.—In examining the tympanic cavity *post mortem*, it should be remembered that the presence of a puriform fluid in the middle ear of infants is common, and apparently rather the result of the changes that take place after the entry of air into the tympanic cavity than pathological.

## CHAPTER XXXV.

## TUMOUR GROWTH IN CHILDHOOD.

**Tumour Growth in childhood.**—As might be expected in a rapidly growing organism, the connective tissue group of tumours is that almost exclusively met with in children. Sarcoma, myxoma, enchondroma, and osteoma are the common forms of new growth, and these are usually in an

embryonic and therefore unstable and rapidly growing form. Soft (encephaloid) carcinoma is occasionally met with, it is said, especially in the eye, kidney, and testicle; but it is probable that most of the so-called carcinomata are really sarcomata.<sup>1</sup> Our colleague, Dr. Hutton, recently had under his care a child with an enormous tumour of the kidney, which proved to be a columnar epithelioma.<sup>2</sup>



Fig. 124.—Sarcoma of the Lower Jaw and Eye-ball in a child aged 19 months.

**Sarcomata** are not rare in children; they are commonly of the small round-celled or mixed varieties, are most often seen as periosteal growths, and often follow injuries. They are met with in connection with the jaws, the skull, and the long bones, most commonly grow rapidly, early become generalised, and are speedily fatal; we have met with rapidly growing sarcoma as a sequel of acute periostitis.

The eye<sup>3</sup> and the skin are not rarely the seats of sarcoma; we have seen a melanotic spindle-celled growth in the skin of the dorsum of the foot. The kidney is occasionally the subject of congenital sarcoma (*vide* chapter on Diseases of the Kidney).

<sup>1</sup> These are also common sites for sarcomata in childhood.

<sup>2</sup> *Vide* fig. 78.

<sup>3</sup> As in the following case, figured above (fig. 124):—

*Sarcoma of Eye and Jaw, &c.*—582 H, Walter W., age 1 year and 7 months; admitted July 28, 1884. At birth, in the left eye it was noticed that the pupil was white; three

Where sarcomata occur in the limbs, early amputation is the only treatment; in the case of renal growths the balance of evidence is against any operation. Testicular tumours should be removed as soon as they are recognised, and growths in other situations must be treated as the individual case may require.

We have met with a **Neuroma** only once in a child, and the case is of sufficient interest to be worth recording in detail.

*Neuroma of Posterior Tibial Nerve.*—Alice M., age 11 years. Admitted May 9, 1885. Healthy girl. Three years ago first complained of pain in the right ankle and walked with a limp. Has been getting worse lately and the ankle has become more tender. On admission there is much tenderness along the inner side of the ankle, extending for about  $4\frac{1}{2}$  inches up the leg. There is swelling and some heat over the painful area, which seemed to correspond to the tendons of the *tibialis posticus* and *flexor longus digitorum*. The case was thought to be one of *tenosynovitis*, and the child was sent out in a plaster of Paris splint on May 20. Readmitted November 5. Condition unaltered. Much pain and tenderness. November 23, the limb was rendered bloodless and an incision made over the swelling in its whole extent, when a firm, pale, lobulated tumour was found connected with the posterior tibial nerve; the growth was encapsuled and turned out fairly freely; it reached from the middle of the leg to nearly the middle of the inner side of the foot, and was about the size of two average fingers. The nerve was inextricably involved and ran through it. The whole tumour and the nerve were removed, about five inches of the latter being taken away. No large vessel was injured, but there was troublesome bleeding from some small ones. She did not bear the operation well. For some days she had hyperæsthesia of the opposite limb. The wound healed well, but somewhat slowly. On December 2 it was noticed that ankle-clonus was well marked. On the 13th the whole sole of the foot nearly to the root of the toes was completely anæsthetic, as well as almost the whole of the plantar surface of the little toe. The sides of the foot, the ball of the great toe, and to a less extent the balls of the 2nd, 3rd, and 4th toes, together with the whole of their plantar surface, were partially anæsthetic. Sensation elsewhere normal. The calf muscles somewhat wasted. In January, 1886, she was practically as on discharge, but could walk a little and move the foot freely without pain. Nutrition of foot good. Microscopically the tumour was a myxo-fibroma. Nerves could be traced for some distance in it and then became degenerated and lost. March 23, 1888, quite well; no return of sensation; foot warm; arch good; walks well; no pain or tenderness.

Of the more innocent growths the **Enchondromata** are the most common; they are usually multiple, occur on the fingers, and may be congenital; they tend to grow with more or less rapidity, and if they cause inconvenience may require amputation of one or more fingers. Removal of the growth alone is rarely satisfactory, since it has been shown that the tumour is very often central in origin, as in the following instance:—

*Multiple Enchondroma of the Fingers.*—Samuel M., age 7 years and 9 months. Admitted January 28, 1885. When five months old swellings were noticed on the fore and middle fingers of the left hand; these have gradually increased and give rise to much

months ago the eye began to swell; three weeks ago the right half of the lower jaw began to enlarge painlessly and to grow rapidly in size. No cause known. On admission, well nourished. The left eyeball was enlarged and protruded; it was irregular in shape and reddened; the cornea was vascular. The lower part of the right side of face much enlarged; large veins on the surface, which was nodulated; swelling involved whole thickness of horizontal ramus of jaw, projecting outwards and into mouth, which could not be closed. Teeth displaced and loose; no ulceration; no disease elsewhere. August 1, swelling increasing rapidly, not much pain, losing flesh. Discharged August 12, and died at home a few weeks later.

pain if injured ; at other times they are painless. On admission, is a thin, unhealthy boy. Several cartilaginous masses are growing from all the fingers of both hands ; the swellings vary in size from a pea to a small nut, the largest is in the flexor aspect of the left middle finger ; this finger cannot be flexed. The fingers are large and distorted, with some lateral deflection of the second and third fingers of the right hand. The worst, the left middle finger, was amputated at the metacarpo-phalangeal joint, and the theca was stitched up with catgut (Treves). A section of the finger showed a cartilaginous tumour the size of a small walnut growing from the proximal end and from the central part of the epiphysial line of the second phalanx. The flexor tendon was stretched over the tumour. A smaller mass sprang from the distal end of the same phalanx. The wound soon healed. The other fingers were not touched, as they gave rise to no great inconvenience.

Another case is shown in the figure. **Osteomata** are usually sessile, composed of cancellous tissue capped with soft cartilaginous or myxochondromatous tissue ; they most frequently spring from the neighbourhood of

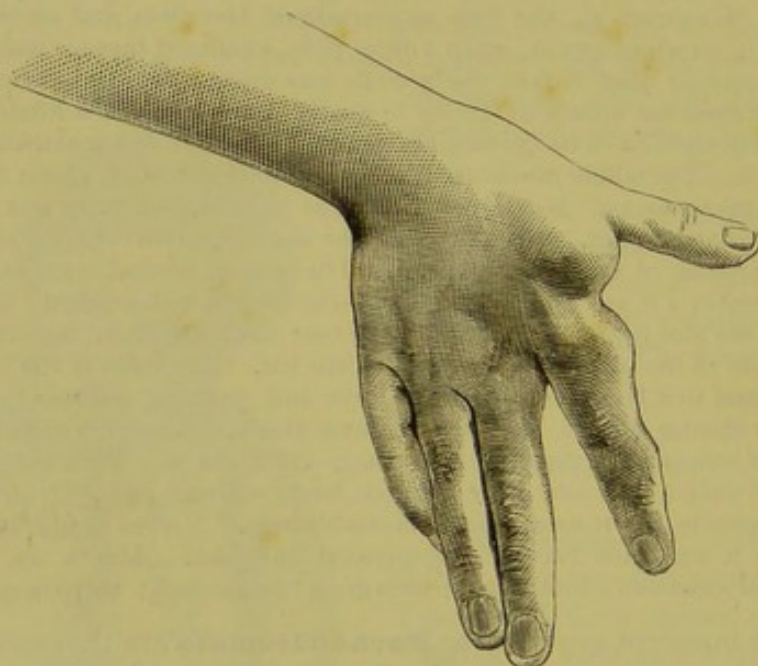


Fig. 125.—Multiple Enchondromata of the Forefinger.

an epiphysial line, may be multiple, and are occasionally hereditary. These growths may require removal on account of their interference with the movements of a joint or of pain ; if chiselled or sawn through at the base, they do not recur. We have most often seen them at the upper end of the humerus, as in the case quoted.

*Exostosis.*—Sarah E. T., age 10 years 6 months ; admitted January 9, 1884. Tumour first noticed six weeks ago ; has grown slightly since ; no cause known. On admission an exostosis as large as a good-sized walnut was found on the posterior aspect of the humerus, two inches below the acromion ; the swelling was bilobed. Removed by chisel antiseptically on January 17 ; the surface was cartilaginous, the deeper part composed of cancellous tissue. Wound healed on January 22.

Besides the growths already mentioned, there is the large group of **Congenital Fibrous and Cystic Tumours** : the former may occur in any part, the latter are said to be limited to the trunk and head ; we have, however, re-

moved a multilocular cystic growth from the back of the thigh in a child.<sup>1</sup> The cystic tumours may be divided into several classes. A large proportion are really cavernous lymphangiomata (lymph nævi); such are hygroma, hydrocele of the neck (a unilocular hygroma), the tumour mentioned above as removed from the thigh, and many others. In the second group are those cystic tumours resulting from degeneration of a blood nævus; in these the fluid may be clear, or more or less stained by admixture of blood pigment. The third group includes cystic formations by degeneration in fibrous or teratomatous growths; and the last includes dermoid cysts, the result of involuted or 'dissociated' blastoderm.<sup>2</sup>

These 'dermoid' cysts may be met with in the course of any of the lines of union of the embryo, e.g. along the median ventral and dorsal lines of the trunk, in the face,



Fig. 126. — Hygroma of the Neck, associated with Macroglossia. Mr. Whitehead's case. The tongue is protruding. *Vide also Nævus.*



Fig. 127. — Congenital Serous Cyst of the Back.

head, palate, neck, &c. These cysts are due to closing in of the tissues over a portion of epiblast, hence the cyst wall is composed of more or less perfectly formed skin, with hairs, sebaceous glands, &c.; lying in the cavity of the cyst will be found sebaceous matter and hairs, and epidermic scales. Perhaps the commonest sites for these tumours are the outer angle of the orbit (orbital fissure), the inner angle (lachrymal fissure), and the median ventral line. In the auricle they may result from inclusion of skin between the tubercles by fusion of which the auricle is formed. Dermoid cysts differ from acquired sebaceous cysts in that they

<sup>1</sup> Morgan has recorded a hygroma of the thigh in the *Clin. Soc. Trans.*, 1884.

<sup>2</sup> The relations of congenital 'displacements' to subsequent tumour growth cannot, of course, be discussed here; probably only a small number of cases are to be thus accounted for (*vide* Cohnheim; also Eve's Lectures at the Roy. Coll. of Surgeons, 1883, and Bland Sutton's Lectures on Evolution in Pathology, *Brit. Med. Jour.*, 1889).

are congenital, that they lie deeper than the ordinary wen, being in the subcutaneous or even in the submuscular tissues, and in the case of the skull they may cause partial or complete absorption of the underlying bone. The skin over a dermoid cyst is usually of natural appearance and of normal thickness, not thinned, and showing dilated capillaries, as is often the case in sebaceous cysts. In sebaceous cysts the aperture of the gland is often visible as a black speck: no such mark is seen in a dermoid tumour. Should the dermoid cysts grow and become unsightly, they should be excised, but it must be remembered that their removal may be dangerous on account of their deep relations, and that, as they are lined with more or less perfect

skin, complete removal is required, and it is not sufficient to lay open and scrape the cyst wall.

Mr. Bland Sutton, in his recent lectures delivered at the Royal College of Surgeons, classifies dermoid tumours as (1) Sequestration dermoids; (2) Tubular dermoids; (3) Ovarian dermoids.

The first occur usually in the lines of union of the embryo, or are a result of accident, a sort of subcutaneous grafting of dermal tissue.

Tubulo-dermoids arise in connection with 'obsolete canals' 'associated with the primitive alimentary canal.' They may exist as 'dermoid cysts,' 'dermoid tumours,' or as 'thyroid dermoids,' or 'congenital adenomata.' 'The first two varieties do not differ from sequestration dermoids, except that they are more complex.' Mr. Sutton calls them thyroid dermoids because of their histological resemblance to the thyroid body. 'They present easily recognisable characters: (1) they arise in obsolete sections of the gut; (2) resemble

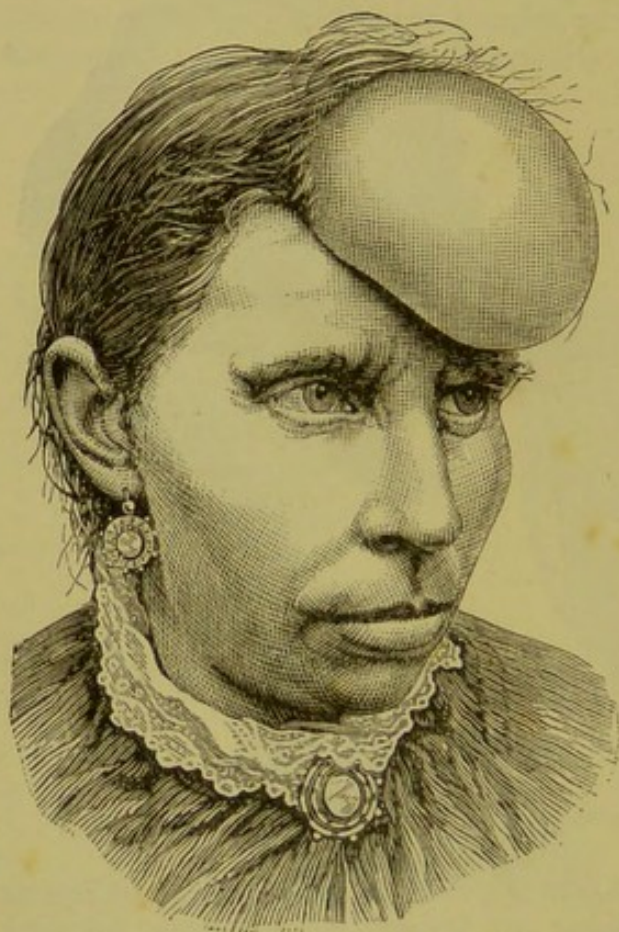


Fig. 128.—'Dermoid' Cyst of the Forehead.  
Mr. Hardie's case.

structurally the thyroid body; (3) are frequently associated with striped or unstriped muscle fibre; and (4) are usually congenital.' 'The most typical specimens occur in the neighbourhood of the coccyx, in the tongue, and in the neck.'

After further details, for which we must refer to the *British Medical Journal*, March 2, 1889, whence the above extracts are taken, Mr. Sutton concludes his most interesting account of these curious growths by remarking: 'It is an interesting fact that the six obsolete canals existing in the embryo of a mammal, namely, the infundibulum, neurenteric passage, post-anal gut, cranio-pharyngeal canal, thyreo-lingual duct, and the duct of the yolk sac, should all have direct relation with the alimentary canal, and each be directly associated with dermoids, often of considerable complexity, and with a peculiar form of tumour,

identical in structure with the thyroid body.<sup>1</sup> Quite recently we have met with a case of an infant, a twin three days old, who was the subject of a large unilocular cystic tumour growing from beneath the coccyx, and forming a somewhat pendulous mass hanging from the perinæum. The cyst was thin-walled, and about the size of the child's head. A day or two after admission the cyst burst, and gave exit to about half a pint of clear yellow fluid—practically serum. We removed the collapsed cyst by excision, and found a fine channel running up into the pelvis for about  $1\frac{1}{2}$  inches. The child did well, and was sent out with the wound nearly healed in March 1889. Sections of the wall of the cyst showed a distinctly villous lining, with a single layer of somewhat indistinct roundish cells.

*Vide* also chapter on Malformations of the Digestive Apparatus.

An important group of tumours in childhood is formed by the **fatty growths** often met with. There may be simple general obesity or hypertrophy of fat, a condition often met with in our experience in association with malformations such as club-foot, spina bifida, giant foot, &c.<sup>1</sup> Jacobi,<sup>2</sup> who has collected many of the cases on record of hypertrophy of the extremities, attributes the condition to intra-uterine venous congestion<sup>3</sup> in early foetal life; if, however, this occurs before the first half of intra-uterine life, during which no fat is said to be formed, myxomatous tissue is developed; if in the later stages, fatty tissue.

Lipoma may occur in any part of the body; it is, however, rarely met with in the head. Congenital lipomata are often not encapsuled; they are sometimes associated with nævus, as in fig. 42 (nævus lipomatodes), or, as in one case of Jacobi's, with spina bifida. Congenital sacral tumours are sometimes mainly fatty, as in one or two of our own cases; but these, and indeed congenital lipomata elsewhere, are by no means always pure fatty growths; fibrous, bony, or cartilaginous material may be mixed up with the fat, as well as nævus, muscular tissue,<sup>4</sup> &c.; these more complex tumours belong to the teratomatous class rather than to the ordinary lipomata. When occurring in the foot congenital lipoma forms one of the varieties of so-called



Fig. 129.—Dermoid Cyst in the Lachrymal Fissure. A tooth is seen growing at the upper part of the tumour. Prof. Young's case.

<sup>1</sup> The cervical fatty growths met with in cretins are also noteworthy in this connection.

<sup>2</sup> *Archives of Pediatrics*, February 1884. Jacobi's list contains obviously very different pathological conditions.

<sup>3</sup> Busey attributes it to lymph stagnation.

<sup>4</sup> *Vide* Butlin, *St. Bart.'s Reports*, 1877.

'giant foot,' of which fig. 131 is a specimen; in some of these cases the growth is encapsuled; in others it is diffuse, and after incomplete removal it shows a tendency to recurrence. In these cases of giant limb, which are

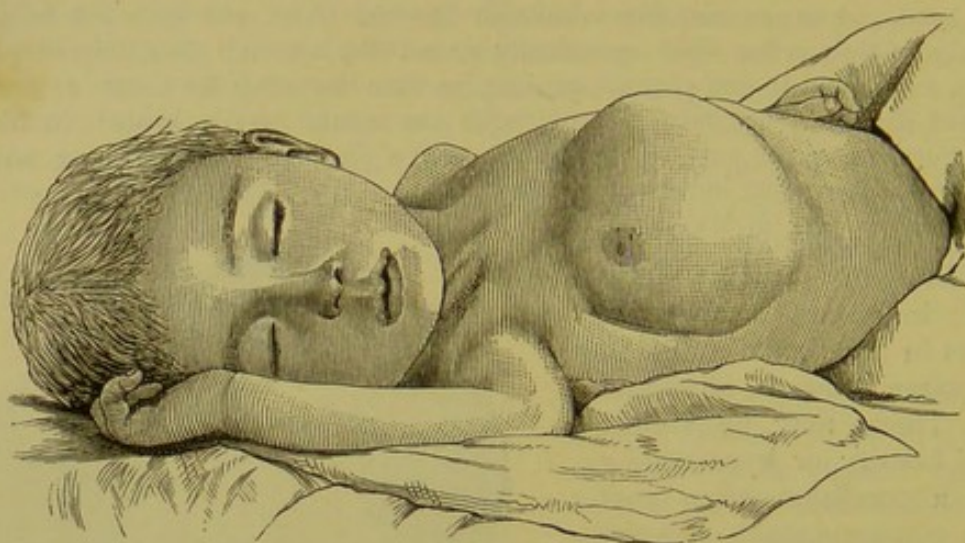


Fig. 130.—Congenital Myxo-Lipoma of the Breast. The tumour was removed and the child did well.

usually unilateral, the rate of growth is variable, and all the constituents of the limb are overgrown in some cases, while in others the bones are enlarged, the vessels, muscles, and nerves being normal.<sup>1</sup> (See also chapter on Nævus, p. 293, for an account of the lymphatic form of 'giant foot.')

Fatty tumours of doubtful congenital origin are sometimes met with, and may be the seat of myxomatous change, as in the appended case.

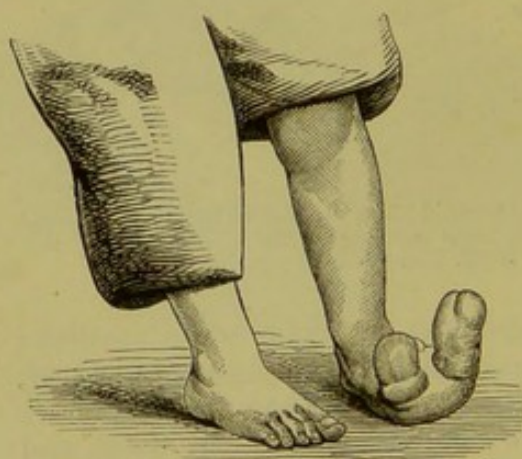


Fig. 131.—Giant Foot (the Fatty Variety), the growth affecting mainly the toes, but also to some extent the sole of the foot.

large walnut or larger. November 5, an incision was made over the swelling between the hamstrings; it was found to project on the inner side of the great sciatic nerve, and was with some dissection shelled out from its deeper attachments to the superficial

CASE.—*Congenital (?) Myxo-lipoma of Thigh.*—William M., age 2 years. Admitted November 2, 1885. Child began to walk last January, but was weak and soon tired; had a severe fall at that time. Four months ago a swelling was first noticed at the back of the left thigh; it has gradually increased in size, but has never been painful. Has been wearing splints for rickety deformity lately. No sores about the legs. On admission, a very rickety child. In the middle of the back of the left thigh is a soft movable swelling, not tender, not well defined, and indistinctly fluctuating (?). The swelling is about the size of a

<sup>1</sup> Vide Anderson, *St. Thomas's Hospital Reports*, 1881; Barwell, *Clin. Soc. Trans.*, 1884; Blackader, *Arch. of Pediatrics*, Oct. 1884; Esmarch and Kulenkamff, *Die Elephantiastischen Formen*, Hamburg, 1885.

layer of periosteum; it extended from the upper border of the popliteal space upwards for about  $2\frac{1}{2}$  inches. The whole growth was removed; it was fairly well encapsuled, soft, and gelatinous. Microscopically it proved to be a myxo-lipoma. On November 16 all stitches were removed and the wound was almost healed. Sent home.

**Compound Congenital Tumours** occur most frequently about the sacral and lumbar regions; their origin is obscure and has been accounted for on the view of included foetation, gemmation, or inclusion of a portion of the outer layer of blastoderm at the time of closure of the dorsal laminæ.<sup>1</sup> The tumours are often cystic, and may contain masses of fat, cartilage, bone, and skin elements. They vary in size, and may attain great dimensions; their

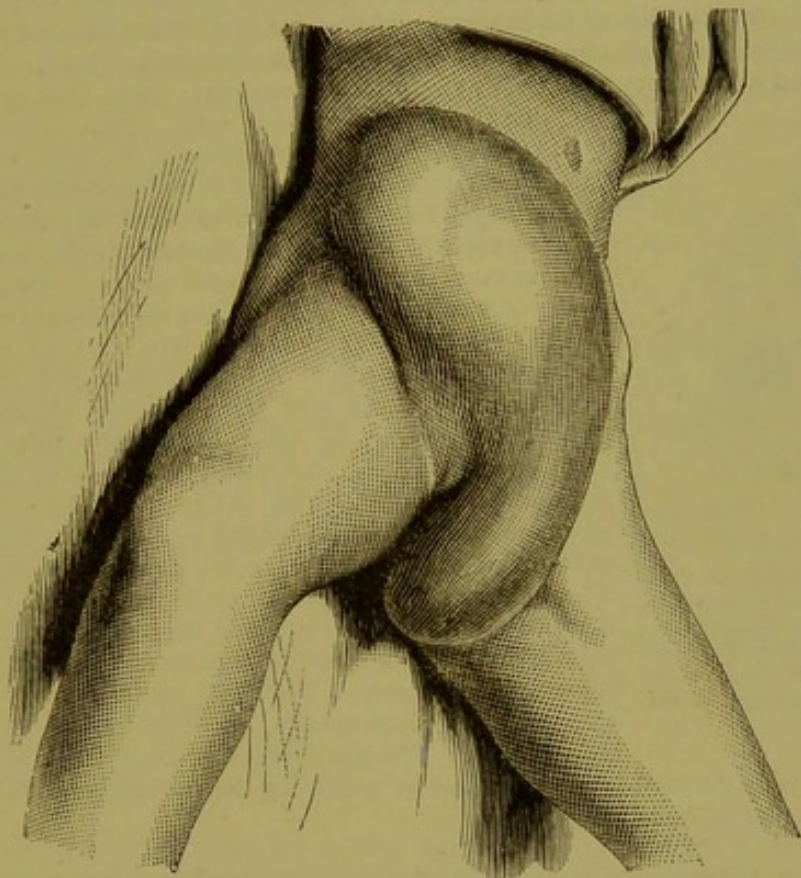


Fig. 132.—Congenital Cystic Tumour of the Groin. Mr. Hardie's case.

rate of growth usually corresponds with that of the child; they may become ulcerated from irritation. Such tumours give rise to trouble by their weight and bulk, and their interference with movement.<sup>2</sup> (*Vide* also p. 611, *antea*.)

CASE.—*Congenital Sacral Tumour*.—Elizth. Ann T., age 4 years. Admitted February 2, 1885. Always a delicate child; more so since an attack of scarlet fever at 2

<sup>1</sup> Mr. Bland Sutton divides these tumours into four classes: 1. Sacral spina bifida; 2. Tumours originating in the post-anal gut; 3. Cystic tumours originating in the neurenteric canal; 4. Parasitic foetuses.—Erasmus Wilson Lectures, *Brit. Med. Jour.*, February 12, 1887.

<sup>2</sup> *Vide Clin. Lect.* by James Hardie, F.R.C.S., *Lancet*, May 2, 1885. Into the subject of teratology it is impossible to enter here, but the reader may refer, among other works, to Förster's *Missbildungen des Menschen*.

years. The tumour has gradually increased to twice the size it was at birth. She has had no fits; vomits frequently after meals; cannot retain her urine, but has no incontinence of faeces; sleeps badly and complains of abdominal pain. On admission, a delicate child. Over the lower lumbar and upper sacral vertebræ is a soft, pulpy tumour about the size of a small orange; the skin is natural over it; there is no tenderness on pressure, and the swelling is not fluctuating. There is loss of power in both legs; the child can draw them up in bed, but cannot support herself upon them. February 13, the tumour was explored with a needle, but no fluid was found; a straight incision was then made over the swelling and the skin reflected, exposing a mass of fat. On dissecting this carefully away a small tumour the size of a filbert was exposed; this evidently contained fluid and could be seen to pulsate; it clearly was connected with the theca; this was left uninjured and the fatty mass dissected away from it. The wound was drained and sutured; operation antiseptic. On making a section of the growth a small nodule of cartilage was found in its centre. February 14, dressed; about half an ounce of blood-stained serum escaped; child vomited once, otherwise well; no convulsions or pain; tube removed. 15th, was sick twice yesterday and awoke several times in the night, screaming. 16th, sick again yesterday; no more screaming; lies very quiet. 18th, dressed; a quantity of serum collected beneath the skin, so tube was put in again; has been very irritable for last two days; sick once in the night; slept well; ice to head and spine; no squint or convulsions; temperature normal. 19th, is a little better. She became steadily worse, and died on the 21st with evidence of meningitis. The highest temperature was 99.2°.

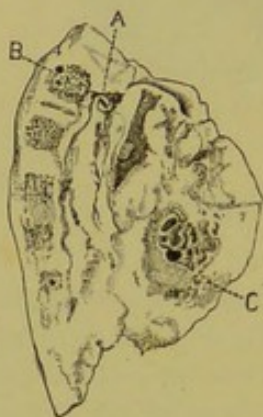


Fig. 133.—Section of Congenital Sacral Tumour. A points to the spinal canal; B to the body of a vertebra; C to a mass of ossifying cartilage in the tumour.

*Post-mortem.*—On removing the brain an excess of fluid escaped; the surface of the brain was congested, but otherwise natural; there was some matting together along the Sylvian fissure, but no other abnormal appearance. *Spinal cord*, excess of fluid and much congestion at the seat of the tumour and for 4 inches above it. The cord ended in a fibrous expansion which spread out over the tumour. Small portions of the tumour extended downwards into the sacrum. The laminae were imperfect at the seat of the tumour; the central canal of the cord was dilated below the mid-dorsal region, and the left cornu of grey matter had disappeared, leaving a hollow space. This was evidently a combination of spina bifida, syringo-myelia, and a congenital tumour of cartilage and fat. The operation was undertaken with the view of

possibly relieving the cord of pressure and so removing the paraplegia, but there is much risk of meningitis in these cases.

As these growths are usually median in position or nearly so, they simulate spina bifida: hence they have been called 'false spina bifida' (*vide* p. 432); they may have attachments within the spinal canal or pelvis.

Any congenital tumour of the vault of the skull or over the spine should be looked upon with suspicion, as likely to have intimate relations with the cranial or spinal cavities. The appearance of the skin, the mobility of the tumour, its reducibility, and the effects of pressure, &c., are the points to be looked to (*vide* Chap. XXV.) It is sometimes impossible to diagnose naevus from other soft growths; the presence of cutaneous stains or of naevi elsewhere, the effects of straining or crying, the possibility of partly emptying the tumour, and its peculiar spongy feel, must be taken into account (*vide* Chap. XVII.)

*Treatment.*—Congenital lipomata, if large, rapidly growing, painful, or inconvenient, should be excised. The congenital sacral tumours, unless for some very good reason, should be left alone—there is much risk of injury to the spinal contents, as seen in the case just related.

Cystic growths may be treated by tapping, injection, setons, incision, or excision; none of these modes are free from danger, and the last is sometimes impossible from the extent and connections of the mass. In large unilocular deep-seated cysts such as 'hydrocele of the neck' tapping, followed by injection with Morton's solution if the cyst refills, is the best plan; if suppuration occurs, free incision and drainage must be employed. The multilocular cysts are often best treated by setons, small threads being inserted and the process repeated if necessary. In the cavernous lymphatic nævi much lymph may drain away if the growth is cut into, just as bleeding occurs from a blood nævus, and there is much risk of septic infection or exhaustion: hence these growths should be removed entire, if at all.<sup>1</sup>

In the case of giant foot the fatty variety has a tendency to steadily grow, and, though pressure may slightly retard it, we have not found it succeed as a means of treatment. Ligature of the anterior and posterior tibial arteries in the following case gave a good result for a time, but after a year or two the growth continued. In such cases the choice is between leaving the case alone and amputation; the latter should only be done when the crippling from the presence of the growth is greater than would result from the mutilation.

CASE.—*Pes gigas. Lipomatous variety.*—Emily C., age 9 months; admitted June 23, 1884. Family history unimportant. At birth it was noticed that the left foot was distinctly larger than the right; since that time it has steadily grown; there has been no pain, and the child's health has been unaffected. [Thanks to the courtesy of Mr. Withers, of Sale, we were able to watch this case almost from the first.] On admission, a fat, healthy child; the left foot much enlarged, chiefly the dorsum and inner side; toes not affected; skin natural, dimples on raising it; at the outer side a few hard nodules can be felt. Measurements:

At root of toes	6½ in.	.	.	Right foot 4½ in. circumference.
At middle of foot	7½ in.	.	.	" 4¾ "
Across heel and foot	8 in.	.	.	" 5½ "
Around ankle	7 in.	.	.	" 5¼ "
Middle of calf	7½ in.	.	.	" 7½ "

Elastic pressure was fairly tried for a long time prior to admission without apparently diminishing the rate of overgrowth. The temperature of the two limbs did not apparently differ, and the child could kick the foot about, though unwieldily. On July 2 the posterior tibial artery was ligatured in the middle of the leg by the usual method, a catgut ligature being employed; the vessel was very small, and its pulsations feeble; a drainage tube was used; operation antiseptic; all went on well. On the 11th the measurements were as before, except the one at the root of the toes, which was ½ in. less; wound almost healed. July 12, the anterior tibial artery was ligatured doubly, and divided between the ligatures; the veins were included in the ligatures. 21st, first dressing, wound all healed; no drainage was used; measurements as on 11th, except middle of foot ¼ in. less. 28th, Martin's bandage applied again; the warmth of the foot seems in no way interfered with. August 4, measurements:—Root of toes, 6¼ in.; middle of foot, 7½ in.; across heel and foot, 8 in.; around ankle, 7¼ in.; middle of calf, 7¼ in. February, 1885, the foot is getting smaller in all dimensions. Subsequently the growth remained stationary for a while and then increased.

<sup>1</sup> For further details *vide* T. Smith, *Clin. Soc. Trans.*, 1880, vol. xiii., and Birkett, *Guy's Hosp. Repts.*, 1860.

**Lymphoma** (**Lymphadenoma**, **Lymphosarcoma**) is sometimes met with in the shape of large masses of glands in the neck (fig. 134) or elsewhere,<sup>1</sup> which slowly grow and give trouble from their size, unsightliness, and pressure effects (*vide* Hodgkin's Disease), as well as ultimately cause death.

Removal of such masses of glands is usually of only temporary value ; it is seldom that all can be got away, and recurrence often takes place in a short time. Section of such a tumour shows a pinkish-grey lymphoid tissue with no caseous foci.

The following was a characteristic case :—

CASE.—*Lymphoma of Neck*.—John T., age 12 years 4 months ; admitted Nov. 10, 1882. Family history good, except that the mother had abscesses beneath the jaw whilst pregnant with this child ; boy himself never very hearty, but had fair health ; 4 years ago a swelling appeared beneath the lower jaw on the left side ; this grew slowly till the



Fig. 134.—Lymphoma of the Neck.

last three months—since then it has increased rapidly ; for 3 weeks has had pain. On admission, in the left posterior triangle is a large globular tumour consisting of lobulated lymphomatous masses ; the swelling extends from 1 inch below the jaw to  $\frac{1}{2}$  inch below the clavicle, which it overhangs ; it is  $5\frac{3}{4}$  inches in transverse diameter ; some of it projects beneath the trapezius, and outlying masses reach nearly to the middle line of the neck ; the skin is movable over it, and it is not fixed to the vertebræ ; no marked glandular enlargement elsewhere, though a few slightly enlarged glands can be felt in the left groin ; some dulness over apex of left lung ; left pupil slightly smaller and less sensitive than right. On Nov. 16 the gland masses were removed, weighing 8 oz. ; most of the glands shelled out easily, some were adherent ; the external jugular vein was tied and divided ; at times when traction was made upon the carotid sheath during the operation the pulse was much accelerated ; the carotid sheath and cervical transverse processes

were exposed. He bore the operation well and lost little blood. Operation antiseptic, with sponge pressure ; recovery uninterrupted ; antiseptics were left off on Dec. 6, and he was discharged with a small superficial wound. Feb., 1883, the boy has been better since the operation, but new masses of glands are already beginning to enlarge, though at and after the operation none could be felt.

Another case is shown in fig. 134.

**Multilocular Cystic Growths of the Jaws** arise from epithelial ingrowths from the surface of the gum, which afterwards become shut off and develop cysts ; they may be congenital or occur in infancy. Besides these, two other forms of cyst are found associated with the teeth (dentary cysts) : (1) Cysts originating in connection with the tooth follicles—follicular, or, if they contain teeth, dentigerous cysts ; (2) Periosteal cysts, originating beneath the periosteum of the jaw.

<sup>1</sup> Cystic lymphomata are sometimes met with, and these growths have been found in the rectum, among other places.

Dentigerous cysts arise from mal-placed or mal-developed teeth, and may occur at any part of the jaws ; they contain clear, serous or glairy, white or coloured fluid, rarely pus. Most often they are associated with the permanent, sometimes with the milk teeth. Eggshell crackling, the presence of fluid, and suppression of a tooth are the common indications of the nature of these swellings. (Eve, *Brit. Med. Jour.*, Jan. 6, 1883. Heath, *Lancet*, 1887.)

For further details on the question of tumours we must refer to the general text-books.

## CHAPTER XXXVI.

## DISEASES OF THYROID AND THYMUS.

**Goître.**—Simple or cystic enlargement of the thyroid is sometimes met with in children, most commonly in the inhabitants of certain hilly districts such as Derbyshire; we have, however, met with cases among town-bred children, both with and without a family history of goître.

In the case figured below half the gland was removed; it consisted of a mass about the size of a small orange; in it were many cysts, the larger of which contained reddish yellow fluid. The child did perfectly well, but died some months later of scarlet fever; the other half of the gland had not appreciably altered after the operation.



Fig. 135.—Cystic Bronchocele in a Child.

We have three times been called upon to perform tracheotomy in young people for urgent dyspnœa the result of pressure of an enlarged thyroid gland; in two cases the patients were young adults, the third was an ill-developed, almost cretinoid child, in whom there was enlargement of the tonsils, with post-nasal vegetations; these had been dealt with once with marked improvement, but on the second occasion sudden dyspnœa, evidently due to pressure of the enlarged thyroid, was brought on by any

attempt at examination, and on administering chloroform the breathing stopped; tracheotomy was performed, and the child did fairly well for a day or two, but died of bronchitis on the 3rd or 4th day. The operation under such circumstances may be of extreme difficulty, alike from the presence of the large mass of gland, from the engorgement of the vessels, and from the altered shape of the trachea, which is compressed laterally. A specially long tube is required to reach down below the constricted part of the windpipe. In simple cases of goître the treatment is the same as for adults.<sup>1</sup>

<sup>1</sup> We have recently divided the thyroid isthmus in a young gentleman of 16 in whom acute attacks of almost fatal dyspnœa had more than once occurred. The trachea was much flattened laterally ('scabbard trachea'). Three weeks after operation the gland had resumed nearly its normal size.

It is not very uncommon to see children in whom the thyroid is slightly enlarged and sometimes painful and tender, but in whom there is no very great deformity and no cystic development. These cases of 'simple bronchocele' may be met with at any age, but are perhaps most common about puberty.

Under treatment with iodine or arsenic internally, and red iodide of mercury ointment, cautiously used, externally, the gland usually returns to its natural size.

**Thymus gland.**—The thymus body or gland reaches its greatest size at 2 years of age, after which it dwindles, and by puberty is in most cases reduced to a mere vestige. At birth it measures some 2 in. in length and perhaps  $1\frac{1}{2}$  in. in breadth, and weighs about  $\frac{1}{2}$  oz. At 2 years of age it weighs from  $1\frac{1}{2}$  to 2 oz. It is situated behind the upper piece of the sternum, reaching as low down as the 4th costal space; it lies partly on the pericardium, the aortic arch, and large vessels.

But little can be said concerning the diseases of the thymus. Some authors have attributed laryngismus and spasm of the glottis to enlargement of the thymus and a consequent pressure on the nerves or trachea itself. It is very doubtful if laryngismus is due in any way to hypertrophy of the thymus, but cases in which there was evident pressure on the trachea by an enlarged thymus have been recorded by Goodhart, Jacobi, and Baginsky. It is by no means uncommon to find small cysts at first sight looking like abscesses scattered through the substance of the thymus; these have been attributed to syphilis. Jacobi has noted an excessive quantity of connective tissue in the thymus of syphilitic children. He has also observed tuberculosis of the thymus in cases of general tuberculosis. Demme has recorded a case in which caseous masses were found. In some recorded instances it appears that sarcoma has originated in the thymus.

## CHAPTER XXXVII.

## DISEASES OF THE SKIN.

DURING intra-uterine life the foetus is surrounded by the liq. amnii, and the skin is in consequence in a soft and sodden condition; at birth it assumes a new function. After birth it is subjected to the drying action of the air, it receives a larger blood supply, and the glands which it contains become functionally active. It is, moreover, exposed to various forms of irritation, such as the contact of the urine, fæces, and various excretions, and the irritation which results from washing. It is hardly surprising to find that under these new conditions the skin is easily injured, especially when we bear in mind the delicate nature of the horny layer of the epidermis. In consequence of the rapid growth which is taking place, there is necessarily a continual building up of the tissues of the skin to keep pace with body-growth, and any interference with the infant's digestion or assimilation of its food is exceedingly likely to interfere with the nutrition of the skin. This is seen in various conditions of wasting during infancy; the skin becomes rough and harsh, or the slightest irritation from the urine or fæces, or friction at the flexures of the joints, gives rise to an erythema, eczema, or to excoriations.

Reflex inflammations are more common during infancy than in later life, a transference of inflammation readily taking place from one part to another, or an irritation present in one place may give rise to an inflammatory lesion at a distance. In this way we find blotches or scaly spots about the mouth and face of children who are suffering from dyspepsia or gastric catarrh, or herpetic patches about the nose or mouth in those suffering from pneumonia or bronchial catarrh. Urticaria or erythematous blotches may be the result of indigestible food in the stomach, or the pressure of a tooth upon the gum, or the presence of acari burrowing beneath the skin.

Lesions of the skin are exceedingly common during infancy and childhood, and we find eczema, intertrigo, urticaria, and lichen among the most frequent ailments at this period.

**Eczema.**—Eczema during infancy, while often proving amenable to treatment, is exceedingly apt to relapse, and in aggravated cases it forms one of the most troublesome complaints with which the practitioner has to deal. Probably most can call to mind cases of eczema in infants a few months old which have improved for a while, then relapsed again and again, upon which numerous ointments, lotions, powders, and medicines have been tried in vain. While the majority of these cases get well as the end of the first year

is approached, or only relapse occasionally, in many cases the eczema continues to give trouble for years, or even for life.

The causes of eczema in infants are various, and, indeed, but little is known for certain about many of them. In some cases, especially in the local eczemas, there is an irritant at work, such as scabies, pediculi, and the fretting produced by napkins constantly wet with urine or fæces. It is interesting to note that if a healthy infant gets an attack of dyspepsia or diarrhœa its muscles become flabby, and there is some wasting; the nutrition of the skin is lowered, and now the contact of urine or soiled napkins set up an irritative erythema or eczema, the irritation of the soiled napkins being powerless to excite an excoriation, until the nutrition of the skin is lowered by faulty assimilation. Among other direct causes of eczema may be mentioned long exposure to a hot sun or drying wind, but these causes are only likely to be effective in children prone to eczema. One of the commoner internal causes of eczema in infants and young children is a faulty condition of the alimentary canal; probably, in some instances, the eczema is due to a mal-assimilation or insufficiency of food, and in consequence the nutrition of the skin suffers. In some cases eczema appears to be due to a vaso-motor disturbance of skin, the exciting cause being a dyspepsia or intestinal catarrh, or the pressure of a tooth upon the gum as it is being cut.

In what class of children is eczema the most common? The answer must be that eczema may be found in children of every type and of every social grade. In the first place, it must be said that eczema is by no means uncommon in infants and children who are apparently in perfect health; and breast-fed infants suffer as well as artificially fed infants. We have frequently noted in hospital that children admitted for some other disease, and who are quite free from any skin trouble, develop eczema as they become fat and well. In these cases there is a strong presumption that overfeeding may have something to do with the eczema: it is certainly true that very fat children are often eczematous, and it is very possible that strong, healthy children with large appetites may habitually be overfed, and the system seek relief, as it were, in an acute or chronic discharge from the skin. Perhaps in some of these cases there is a history of eczema in the parents.

On the other hand, as already remarked, dyspeptic children, and those who are badly or poorly fed, also suffer from eczema.

The so-called strumous children are exceedingly likely to suffer from eczema, especially of the impetiginous type. The scalp, face, and backs of the ears are most likely to be affected; there is much oozing of a semi-purulent fluid, which dries and forms yellow crusts. The lymphatic glands are apt to become enlarged, and subcutaneous abscesses to form.

Vaccination is frequently blamed by the parents of eczematous children; it is certain that a local eczema may arise at the seat of the vesicles, and an impetigo be started elsewhere in consequence of scratching; but we do not think that vaccination gives rise to a general eczema.

*Symptoms and course.*—The commonest places for eczema in infants and young children (local irritants excluded) are the forehead, cheeks, scalp, and backs of the ears. The limbs, especially the flexures of the joints and backs of the hands, are often attacked. The usual form is eczema vesiculosum; in weakly and scrofulous children the pustular variety, *E. pustulosum* or

impetiginodes, is the most common. The former mostly begins with patches of redness, the inflamed patch quickly becoming the seat of numerous papules; in less severe cases the papules may make their appearance in crops on apparently normal skin. In the worst cases the itching is intense and the skin of the forehead or cheeks is hot, red, and œdematous. The papules quickly become vesicular and burst, or perhaps more often the inflamed skin begins to ooze without distinct vesicles being formed. A free discharge from the skin usually gives relief. The skin continues to weep, perhaps for some days, and probably also the eczematous patch is extending, covering the whole forehead and affecting the cheeks, so that at this period all stages of the affection may be seen. In one place there may be redness only, in other places excoriated and weeping skin; at another place the discharge has dried, forming crusts with raw, tender skin beneath; where the eczema is nearly well the skin is thickened and the cutis desquamating. The skin of the thighs, flexures of the groin and knees, the arms, and back, are very likely to become affected, and as the eczema heals in one place it is very likely to break out in another. Sooner or later the eczema passes into the subacute or chronic stage; the skin is more or less infiltrated, there is less oozing from the surface, while there is a tendency to form crusts, and for free desquamation to take place from the skin. This desquamation or scurfiness is particularly noticed on the scalp.

In some cases the eczema is more of the erythematous type. The child goes to bed at night, and when warm in bed the face and forehead flush up, the skin becoming red, shiny, and hot, the itching and tingling is intense, so that the child scratches and almost tears itself in its restlessness and discomfort, while sleep is out of the question. In the course of an hour or two the congested vessels are relieved by a serous discharge through the perhaps already damaged skin, and the inflammatory stage is succeeded by the oozing and crusting stage. The raw and tender skin left after the discharge more or less recovers and dries up, and then there is another inflammatory attack and the process is repeated.

In weakly and scrofulous children the eczema is of a less acute type; there is less redness, burning, and itching, and a greater tendency to pus formation than when eczema occurs in strong and healthy children. The scalp and face are mostly affected; in these places much crusting takes place, the crusts being formed of dried pus, and on raising these more or less puriform fluid escapes. In the early stages pustules are usually present. In the worst cases the whole scalp is a mass of thick crusts, abscesses form in the scalp, glandular abscesses are present in the cervical glands, and perhaps 'cold abscesses' in various places throughout the body. In dispensary practice an eczema pustulosum of the back part of the scalp is almost certainly the result of pediculi.

All forms of eczema in infants and young children are apt to relapse, fresh attacks coming on before the skin has entirely recovered from the effects of the last attack, and the old place is soon as bad as ever. The tendency is for the attacks to involve the same places time after time where the skin has been injured or has 'contracted a bad habit.' Often, however, while healing in one place it breaks out in another. The younger the infant,

the more troublesome is the eczema ; the older it grows, the less likely is it to relapse.

The eczemas, or perhaps more properly erythemas, caused by the contact of foul napkins, or by two surfaces of skin coming in contact (intertrigo), are exceedingly common in dispensary practice ; with ordinary care they never occur in healthy children, but in infants suffering from intestinal catarrh or diarrhœa, where the napkins are constantly soaked with the excretions, a certain amount of soreness may be difficult to avoid. The skin is usually first red, the erythematous eruptions spreading from the anus and genitals ; the horny layers of the skin become detached, leaving superficial excoriations, from which serum and perhaps blood may ooze.

Eczema in older children does not differ from eczema in adults. Any part of the body may be affected—the face, trunk, or limbs, and especially the flexures of the joints. A subacute or chronic conjunctivitis is commonly associated with eczema of the face. The skin readily becomes red and infiltrated, with a dry, rough surface, which readily cracks, making painful sores. The itching is usually severe, and the affected part is constantly fretted and irritated by the scratching which goes on.

Children who suffer from eczema are usually constipated.

*Treatment.*—The most scrupulous care must be taken to keep the healthy infant's skin clean, especially those parts which come in contact with the soiled napkins. A daily bath should be given from the first week, but a prolonged immersion must be avoided as likely to macerate and soften the cuticle too much. A good curd soap free from excess of alkali should be used,<sup>1</sup> and soft water in preference to hard. Some starch powder, such as finely ground rice or maize powder, with 20 per cent. of boracic acid, should be applied after careful drying.

If the parts about the genitals become red or excoriated, attention must at once be directed to the state of the infant's digestive organs, to see if gastric and intestinal digestion are in a normal state, or if there is diarrhœa ; and it will probably be found that something is wrong here. The affected parts must be kept clean, as little friction as possible being used, and thin gruel, or rice boiled in milk, being used instead of soap ; or the parts may be cleansed with a piece of absorbent cotton-wool dipped in carron oil. (Lime water and linseed oil, equal parts.) After carefully drying, boracic acid powder, or oxide of zinc and starch (1-5), kaolin, or finely prepared fuller's earth, may be used to dust on. Where there is constant diarrhœa the ordinary napkin may be dispensed with, and pads made of absorbent cotton or wood-wool used instead, as they more readily absorb the fæces and urine. Unna's 'powder-bags' are sometimes useful ; these consist in bags made of soft, fine muslin, and filled with some dusting powder, as zinc and starch, or Taylor's cimolite, and quilted, to prevent the powder from gravitating to one end. These bags may be made ready and used as required ; their value consists in keeping the parts dusted by the powder, which escapes through the pores of the linen or muslin.

The dietetic treatment of general eczema is often difficult, as it may be by no means clear that anything is wrong with the digestive organs. If the

<sup>1</sup> Unna's 'over-fatty' soap or 'Vinolia' soap make good soaps for infants.

infant is being nursed at the breast, great care should be exercised by the mother as regards her diet : beer, tea, coffee, salt meats or greasy dishes, are best avoided, or taken only in moderate quantities, while milk, fish, fresh meat, and vegetables may be taken freely. The infant, if vigorous and full-blooded, is perhaps taking too much breast-milk, and the amount of milk taken should be lessened. Possibly the breast-milk taken may be poor in quality—containing an excess of sugar, while deficient in proteids and fat—the infant is flabby, poorly nourished, and suffers in consequence from impetigo or intertrigo ; in such cases some form of artificial food must be given in addition to the breast-milk. In artificially reared children the question of diet is of great importance : eczematous infants being brought up on cow's milk are frequently constipated and pass large quantities of undigested curd in their stools. In such cases Mellin's food, Benger's, or Savory and Moore's, may agree better than cow's milk and water. In older children, especially if there is an excess of fat, starchy and saccharine foods should be avoided, and the diet confined as much as possible to milk, cream, eggs, broth, underdone minced meat, and green vegetables.

The medicinal treatment must be directed to overcoming the constipation so often present, and exciting the action of the liver ; small doses of mercury, euonymin, or rhubarb and soda may be prescribed.

( 30 )

Calomel . . . . .	$\frac{1}{4}$ grain
Euonymin. . . . .	$\frac{1}{4}$ „
White sugar . . . . .	I „

*Every other night.**For an infant six months old.*

( 31 )

Mercury and chalk . . . . .	$\frac{1}{2}$ grain
Powdered rhubarb . . . . .	$\frac{1}{2}$ „
Carbonate of soda . . . . .	I „
White sugar . . . . .	I „

*Every other night.*

Small doses of Rubinat or Hunyadi water may be prescribed.

Of other internal remedies in the acute stages, alkalis, such as the citrate or bicarbonate of potass, with nux vomica, are frequently useful. Effervescing citrate of potash and lithia is useful, both in acting on the bowels and kidneys. Carlsbad salts, taken before breakfast in warm water several times a week, may be prescribed in older children. Arsenic is rarely, if ever, of use in the early stages of infantile eczema ; indeed, we have seen cases which were made distinctly worse by it. In older children in the chronic stages, where there is a disposition to excessive desquamation, it is usually beneficial. In the chronic impetiginous eczemas of scrofulous children cod-liver oil and the iodides may be prescribed with great advantage. The following combination of cod-liver oil and arsenic may be given, or arsenic can be added to some ready-made cod-liver oil emulsion.

( 32 )

Cod-liver oil . . . . .	3ij
Yolk of an egg . . . . .	
Liq. arsenicalis . . . . .	5j
Syrup of orange-peel . . . . .	3j
Water . . . . .	ad 3iv (Wilson)

*3j t. d. s. post cib.*

In the management of local remedies much depends upon how the application is used, and much time and trouble may be well bestowed in showing the friends of patients how to apply the dressings, and, what is by no means easy, to keep them in position. Merely smearing on an ointment or dabbing on a lotion may be an entirely valueless proceeding; moreover, the newly-formed cutis is very easily injured. The ointment or lotion requires to be kept in constant contact with the part if it is to be of much use. In infants and young children some method will have to be adopted to prevent scratching; mittens must be placed on the hands, and in some cases it may be necessary to secure the arms by means of bandages.

For application locally the range of remedies is very wide, and various combinations have been called into requisition in the way of lotions, liniments, and ointments. As a rule, in all acute eczemas, where there is much excoriation of the skin, or thin, newly-formed skin present, much washing or rough handling should be avoided. On the other hand, in chronic cases, where the skin is thick, scaly, or infiltrated, baths are of great service in removing the scales and softening the skin. In all eczemas, however, a certain amount of cleansing is necessary to remove the remains of the old ointments and crusts: this can usually be done by gently applying some almond oil—or carron oil answers very well—ordinary soap being best avoided in acute cases.

In all acute or subacute eczemas soothing remedies are required, and must be persevered in as long as there is an irritable condition of the skin and free discharge. The most troublesome eczemas in infancy are those of the face; during the evening exacerbation, when the skin flushes up and is hot and angry, and the infant sleepless and restless from the burning and itching of the skin, hot poppy-head or opium fomentations often give relief. Perhaps more often cooling applications are the most grateful; these may consist of carron oil or calamine liniment.

( 33 )

Prepared calamine . . . . .	ʒij
Zinc oxide . . . . .	ʒss
Olive oil.	
Lime water . . . . .	a.a. ʒj ( <i>Crocker</i> )

or—

( 34 )

Black wash . . . . .	ʒiv
Lime water . . . . .	ʒiv
Mucilage of tragacanth . . . . .	ʒj ( <i>Jamieson</i> )

or—

( 35 )

Liq. plumbi subacetatis . . . . .	ʒss
Laudanum . . . . .	ʒij
Water . . . . .	ʒvi

Any of these may be carefully dabbed on and allowed to dry, to be followed by a soothing ointment, or pieces of lint may be soaked in the liniment and kept continuously applied by means of a gauze bandage. The ointments most suitable for the face in acute or subacute conditions are

those whose basis consists of cold cream or the ung. aquæ rosæ of the United States 'Pharmacopœia,' such as—

( 36 )

Boracic acid . . . . .	ʒij
Cold cream . . . . .	ʒij

This ointment must be spread on lint and kept continuously applied, being changed twice a day and reapplied.

When the eczema has passed into the scaly stage, and there is no large amount of discharge from the skin, more stimulating ointments may be used, and the face kept continuously bound up to exclude the air. There should be a daily cleansing with carron oil to remove the excess of ointment and the accumulated scabs. The following ointment may be applied on lint :—

( 37 )

Ol. eucalypt. . . . .	℥xx
Ung. plumb. oleatis (1 to 7).	
Ung. zinci . . . . .	a.a. ʒss

Lassar's or Ihle's paste is useful, and forms a protective covering to the newly formed skin, but it is difficult to remove if allowed to cake on to any extent :—

( 38 )

Salicylic acid . . . . .	gr. x
Zinc oxide . . . . .	ʒij
Starch . . . . .	ʒij
Vaseline . . . . .	ʒss

(Lassar)

( 39 )

Resorcin . . . . .	gr. x
Lanoline.	
Vaseline.	
Zinc oxide.	
Starch . . . . .	a.a. ʒij

(Ihle)

In impetigo, where the discharge is more or less purulent and much scabbing takes place, the scabs should be removed by poultices or the application of carbolic oil, and some diluted mercurial ointment applied :—

( 40 )

Ung. hydrarg. ox. rubri . . . . .	ʒij
Ung. plumbi oleatis (1 to 7)	ʒvi

( 41 )

Ung. hydrarg. ox. flava . . . . .	ʒij
Ung. zinci oleatis (1 to 7) . . . . .	ʒvi

—or an ointment consisting of five or ten grs. of iodoform in simple ointment may be used.

Eczema affecting the scalp must be treated in a similar manner to that of the face, except that, as a rule, more stimulating applications may be applied. In the weeping and irritable stage the calamine and carron oil liniment (F. 33) or zinc and cold cream may be applied on lint or rags, and a nightcap worn by the child to protect the parts and prevent the infant from scratching. The hair must be kept short and the scalp cleansed every morning with some mild soap and warm water ; or thin gruel may be used. In the more chronic

stages, especially in neglected cases, the crusts must be removed by oiling and poulticing, and some diluted white precipitate ointment or other mild mercurial ointment applied. Lassar's or Ihle's paste (F. 38) (F. 39) is also useful, being put on thickly, thus dispensing with any lint; the crusts and excess of ointment must be removed daily or every few days. Eczema of the scalp, the result of pediculi, should be treated by poulticing, cutting the hair, and the continuous application of white precipitate ointment.

In the chronic general eczemas of older children, especially where the skin is rough and coarse, and there is much infiltration, and the flexures of the joints are affected, baths and stimulating liniments, followed by some soothing protective ointment, usually answer best. Soft soap, the pure green variety, may be rubbed over the parts on a wetted flannel for a minute or two so as to soften the skin; it is then washed off in a warm bath, the child dried, and some strips of lint coated with zinc and lead ointment applied. This plan answers well in hospital, but the application of the soft soap causes smarting, and in private practice the child's friends are apt to think it makes the eczema worse, and fail to persevere. Instead of the soft soap the parts may be sponged with the following lotion every evening for a few minutes, the old ointment having been cleaned off, to be followed by simple zinc or lead ointment.

( 42 )

Glycerin. plumb. acet.	. . . . .	℥ij
Liq. carbonis deterg.	. . . . .	℥ij
Aq. rosæ.	. . . . .	℥vi

In acute general eczema, where large surfaces of the body are affected, liniments applied on rag or lint should be used, and the parts firmly bandaged with gauze bandages so that the application may be kept in constant contact with the skin. Where there is much discharge and the skin inflamed and tender, it is sometimes best simply to powder on some finely ground boracic acid and surround the limb with absorbent wool, firmly bandaged on; or strips of lint may be saturated with carron oil; calamine liniment (F. 33) or glycerinum plumb. subacet. (1-10) may be used. In a later stage, when the skin is thickened and scaly, with but little or no discharge, more stimulating applications are necessary; ointments containing mercury, tar, zinc, or lead are usually prescribed. The ointment should be of tolerably firm consistence, so as not to melt too readily and run into the lint.

( 43 )

Ung. picis liq.	. . . . .	℥ij
Ung. hydrarg. ammon.	. . . . .	℥ss
Ung. zinci oleatis (1 to 7)	. . . . .	℥ij

Ft. ung.

Or Lassar's paste answers very well.

For general eczemas Pick and Unna have employed glycerine jelly medicated with zinc and other ingredients, painted over the skin after melting into a liquid. The glycerine jelly is dispensed in a tin or jar, which can be stood in hot water till liquefied, and it is then applied to the skin by means of a brush. The parts are then covered by a thin layer of absorbent

wool ; large surfaces of skin can be covered in this way. This application is unsuitable if there is much discharge from the skin, as the oozing quickly dissolves away the gelatine. We have found in cases in which we have used these applications that the surface of the application, unless well covered with cotton wool, adheres to the clothes of the patient, and is easily detached. Unna's formulæ are as follows :—

( 44 )		( 45 )	
Gelatine . . . .	15 parts	Gelatine . . . .	15 parts
Zinc oxide . . . .	10 „	Zinc oxide . . . .	10 „
Glycerine . . . .	30 „	Lard . . . .	10 „
Water . . . .	40 „	Glycerine . . . .	65 „
Adding two per cent. of sulpho- ichthyolate of ammonia.		Adding two per cent. of salicylic acid.	

In local eczemas, especially those about the nose, back of the ears, and flexures of the joints, Unna's salve plaisters or salve muslins are very convenient and efficacious. Pieces of these can be cut with the scissors to any shape, and when placed over the patch of eczema can be readily held in position by a light bandage. The zinc and red oxide of mercury salve muslin and tar and lead are the most useful.

**Impetigo contagiosa.**—This eruption is characterised by the formation of crops of vesicles of various sizes, which become converted into pustules. The pustules dry up or become ruptured, leaving a greenish-yellow thick scab. The eruption is most common about the face, especially round the mouth ; it may also occur about the neck and hands. In some cases there is marked febrile disturbance before the vesicles appear. When the patient is seen for the first time, after having been affected for several days or a week, but few vesicles may be present, and only scabs and crusts visible on the face and back of the neck. The disease, as its name implies, is contagious, being transferred by means of the nails from one part of the body to another, and from one child to another in a similar way. The attacks may be acute in character, and the constitutional disturbance severe. It occurs in cachectic children and is rarely seen except in dispensary practice. The treatment consists in removing the scabs by oiling or poulticing, and applying dilute white precipitate ointment on lint. Cod-liver should be given internally.

**Seborrhœa.**—Seborrhœa is a 'functional disorder of the sebaceous glands, producing increase of the secretion, which forms an oily, waxy, or scaly accumulation on the surface.' (Crocker.)

The most familiar example of this disorder is seen in dispensary practice in infants who are badly looked after and rarely washed ; in such there is often an accumulation of a dirty yellow material over the anterior fontanelle, which can be scraped off with a blunt instrument. A certain amount of eczema may be present. What has been termed dry seborrhœa is not uncommon in the scalp of older children ; it may occur also on the face as well as on the trunk and limbs ; the scalp is dry and covered with small scales or scurf, which fly out when the head is combed or brushed. Care must be taken not to mistake diffused ringworm of the scalp or simple seborrhœa.

*Treatment.*—The excessive sebaceous secretion on the scalp of infants can usually be removed by gentle friction with a piece of flannel dipped in warm olive or almond oil, following this up with washing with soap and water; this process may want repeating once or twice, and care must be taken to keep the child's head well washed. If there is a tendency to excessive secretion, a little ung. hydrarg. ox. flav. (5 per cent. in vaseline) or ung. boracis (℥ss ad ʒj benzoated lard) should be applied. For dry scaly patches on the face an ointment consisting of precipitated sulphur in cold cream (℥ss ad ʒj) may be used.

**Erythematous eruptions.**—The term erythema is applied to those eruptions which consist in a redness or congestion of a more or less extended portion of skin, as well as to other eruptions, where there is not only a congestion, but an actual exudation from the cutaneous vessels, as in erythema nodosum.

A simple erythema or congested portion of skin occurs under various conditions: it may be the result of some external irritation, such as the contact of fouled napkins; the application of various irritants, such as mustard, chrysarobin, arsenic; or the bites of insects. An erythema sometimes precedes the eruptions of the specific fevers: this occurs at times in small-pox, chicken-pox, vaccinia; and it accompanies other febrile disorders, which are not usually accompanied by a rash, as diphtheria, cholera, and septicæmia. An erythematous redness is often present when there is a high temperature, as in pneumonia and other febrile disorders. An **idiopathic erythema** or **roseola** is not uncommon in infants and young children, mostly as the result of some intestinal irritation, possibly also due to the irritation of the gum caused by dentition. It is more or less patchy in its distribution, occurring on the forehead, face, trunk, or limbs; there may be no marked constitutional disturbance, and the patches of redness may be the first symptom. In other cases there may be several degrees of fever, restlessness, and perhaps vomiting. The eruption is mostly fugitive, disappearing in a few hours to 24 hours. Other patches may appear as the first ones fade.

**Erythema scarlatiniforme.**—Is a typical 'scarlet fever rash' ever present in any non-scarlatinal case? It is difficult to answer this question dogmatically, but it may certainly be said that in any case when there is a diffuse, well-marked, punctiform rash, remaining visible for at least 24 hours, the disease is almost certainly scarlet fever. It is certain, however, some erythematous or roseolous rashes do closely resemble scarlet fever, and, as they are attended not infrequently with some constitutional disturbance and fever, the difficulty in diagnosis may be very great.

Some children are especially liable to roseolous rashes resembling scarlet fever, as the result of indigestion or some other source of irritation; a roseolous rash is also apt to occur in septic conditions, such as in an empyema, or wherever pus is shut up in a cavity.

The constitutional disturbance in these cases is generally slight; the temperature may reach 101° or 102° F., the tongue may be slightly coated, but the child feels usually quite well, and his appetite is normal. The rash may very closely resemble mild scarlet fever; it is, however, as far as our experience goes, never so intense as it is in a typical or well-marked case of

scarlet fever ; moreover, in some part of the body it is almost sure to be patchy and unlike scarlet fever. The distinction between the roseolous and a scarlet fever rash may be difficult or impossible if one part of the body only happens to be seen, but the difficulty usually disappears if a careful examination of the whole body be made, as in some places, especially the face and trunk, the roseola is patchy, the patches having a sharp outline. Crocker speaks of a roseolous rash lasting 2 to 6 days, and followed by a more or less copious desquamation. We have never seen such a case, and should be extremely suspicious of scarlet fever in such cases. In our experience an erythematous or roseolous rash, while it may closely resemble a scarlet fever eruption, is more fugitive, and rarely lasts more than 24 or 48 hours, and is not followed by desquamation. In the majority of cases the presence or absence of a tonsillitis will decide the diagnosis.

A roseolous rash may follow the taking of certain drugs, more especially belladonna, copaiba, and salicylic acid.

**Erythema pernio. Chilblains.**—Children with slow circulations, especially the so-called strumous, are very apt to suffer from chilblains. The favourite spots are the toes, heel, and fingers ; they begin with redness and intense itching, or aching coming on towards evening, or when the patient is warm. The skin is smooth, livid, and shiny, and ulceration may take place if it is subjected to much friction. Children subject to chilblains should wear warm woollen stockings and well-fitting boots with broad toes and thick soles, and should take much exercise. In the early stages the affected parts may be painted with equal parts of tr. iodi and lin. aconiti, or lin. saponis co. with an equal quantity of lin. belladonnæ. A mild capsicum ointment also answers well (capsici ʒss, almond oil ʒij, lanoline ʒvi), rubbed in with a piece of flannel. Zinc ointment with ung. hydrarg. ox. rubri, or ung. picis liq., in varying proportion, according to the stimulating effect desired, may be applied.

**Erythema multiforme** is mostly seen during early life in association with rheumatism, or in rheumatic subjects ; whatever importance it possesses is derived from this association. The outbreak of this form of erythema is always suggestive of the rheumatic state, and an examination of the heart for endocarditis should always be made. The most common form consists in red papules surrounded by more or less congested skin. In association with the papules there may be flat raised patches surrounded by a zone of redness (erythema marginatum). Sometimes the eruption becomes purpuric, and bullæ or vesicles may form.

**Erythema nodosum** has apparently a close relationship to the erythema just described, though the constitutional disturbance is often much greater. Prior to the appearance of the nodes there may be rheumatic pains and fever, the temperature perhaps reaching 103° or 104°, and the child is apparently quite ill. The eruption appears most copiously over the shins, but the arms, especially on the extensor surfaces, or any part of the body, may be attacked ; it appears as node-like, tender, red swellings of various sizes, accompanied by a burning or itching sensation. The patches come out two or three at a time in various parts of the body. At first rose-red in colour, they then assume a darker-red colour, and as they disappear become of a yellow colour like a fading bruise.

Not much treatment is required for erythema multiforme or nodosum. A light milk diet, a mild aperient with some saline, with salicylate of soda if rheumatism is suspected. Locally, lead lotion with some tr. opii or liq. carbonis detergens may be used.

**Urticaria** is characterised by the sudden appearance of elevated blotches or wheals, at first red in colour, afterwards becoming white and surrounded by a zone of redness. They are attended by much burning and itching. The blotches usually disappear in the course of a few hours, but most frequently there are successive crops. There is usually some gastrointestinal disturbance. Urticaria is sometimes, especially in infants, a distressing and troublesome complaint, the intense itching making the child restless and entirely preventing sleep. Urticaria is the result, in the large majority of instances, of some irritation in the alimentary canal, less often upon teething; sometimes it is due to the bites of insects or scabies. Worms are not an uncommon cause in young children; fruits of various kinds, especially strawberries, fish, sausages, stale meat, sour milk, or any kind of fruit which disagrees, may act as a cause.

The most troublesome form of urticaria is that variety known as **urticaria papulosa** or **lichen urticatus**. This is a very intractable affection and may last for many months or even years. When seen in dispensary practice it is very apt to be mistaken for scabies, as the rash consists of numerous papules often scabbed over as the result of scratchings about the body, limbs, hands, and feet. In the worst cases the whole body is covered with itching papules, in some places, perhaps, becoming pustular, making the resemblance to scabies a very close one, but no 'burrows' can be discovered. The eruption begins as small wheals, which become papules, fresh ones coming out every night in crops when the child goes to bed. Its rest is broken, and its health may be seriously interfered with. It is most common during the period of the first dentition, and the tendency to it mostly disappears at 3 or 4 years of age.

*Treatment.*—An aperient should be given, calomel or rhubarb and soda being the best. Santonin and calomel may be given if worms are suspected. A saline such as citrate of potash or bromide of potassium may be ordered. If due to dentition, the gum may be lanced if a tooth is stretching the mucous membrane. Locally, sponging the wheals with lead and tar lotion (such as F. 42) is perhaps the best application, or each wheal may be rubbed with menthol or painted with collodion. Sulphur baths (sulphuret of potassium, ʒij to a bath) are useful in the chronic varieties.

**Lichen scrofulosus** 'is characterised by very small inflammatory papules, of a red colour, fading to that of the normal skin, disposed in groups or circles, and occurring mainly in scrofulous subjects.' (Crocker.)

This form of lichen is not common in our experience, but it is easily overlooked, inasmuch as it is unattended with any great inconvenience to the patients; they may make no complaint, and it is only discovered accidentally. The important points in the diagnosis consist in the absence of irritation and the presence of caseous lymph glands or other well-marked evidence of scrofula. The papules are small and of a bright red colour at first, gradually changing to dull red, desquamating, and finally leaving a brown stain. They may be present on the trunk or limbs. Their course is very chronic,

fresh papules appearing as the old ones fade, so that the patient may not be entirely free for months or years.

**Psoriasis.**—This affection is common in children over three years of age, but is seldom so severe or so intractable as it often is in adults. It is perhaps even more liable to recur in children than in adults. The symptoms are so similar during childhood to those seen in after-life that no detailed description is necessary. The treatment we usually adopt is to give arsenic, beginning with two-minim doses, and gradually increasing it. Warm baths, with the moderate use of green soft soap, to remove the scales, applying some tarry or mercurial ointment. In hospital patients we have used Auspitz's solution of chrysarobin with great success. The solution is applied to the spots twice a week, the patient wearing old linen to avoid damage.

( 46 )

Oil of cade . . .	ʒss
Ung. hyd. amm. . .	ʒij
Ung. simplex . . .	ʒj

( 47 )

Chrysarobin . . .	ʒj
Gutta-percha . . .	ʒj
Chloroform . . .	ʒx

**Miliaria. Sudamina.**—In various fevers, such as scarlet fever, enteric, and in other febrile disorders, as rheumatism, a number of minute vesicles with clear contents make their appearance on the skin. The clear fluid is sweat, which has been unable to escape from the orifice of the sweat gland; the contents of the vesicles are absorbed or dry up in a day or two, leaving a tiny desquamating spot. In other cases a slight inflammation occurs at the blocked sweat gland, and a minute papule appears instead of the vesicle, though vesicles may also be present; this condition has been called **Miliaria rubra**. The so-called **Lichen strophulus** or 'red gum' is, according to Crocker, a sweat rash; it consists of minute crops of red papules which make their appearance in infants; they are attended often with much itching and consequent restlessness of the infant. A somewhat similar rash has been attributed to dentition as well as to gastric irritation. They should be dabbed with the lotion F. 35 or F. 42, and powdered with boracic acid or some drying dusting-powder.

**Pemphigus** is rare in infants apart from syphilis, but attacks of the acuter form of the disease (*Pemphigus neonatorum*), occurring in epidemics in lying-in hospitals or in the practice of a midwife, have been recorded by continental writers. In these cases the disease appears to have been distinctly contagious: not only has it apparently passed from infant to infant, but also from infant to nurse. In a few cases the eruption is preceded by fever, restlessness, or convulsions; the rash usually appears at the end of the first week. The bullæ vary in size; their contents are clean or slightly cloudy, rarely pustular; they gradually dry up, forming superficial ulcers or crusts. All parts of the body may be attacked, and, unlike syphilitic pemphigus, there is no preference for the palms of the hands or soles of the feet.

Chronic pemphigus is seen occasionally in older children; in some of these cases the children appear to be in good health and complain of nothing except the eruption, for which no cause can be assigned. In most cases there is marked anæmia, and more or less fever and constitutional dis-

turbance ; the latter may be severe. The number of bullæ vary from two or three to perhaps twenty ; they appear as vesicles on the face, trunk, and limbs, gradually enlarging, and finally drying up in the course of a few days. The treatment consists in giving arsenic in full doses, and cod-liver oil. Locally, boracic acid or zinc ointment may be applied. In the severer cases continuous baths are useful.

**Dermatitis gangrænosa infantum.**—In speaking of varicella we have referred to a peculiar form of multiple gangrene of the skin, which is apt to follow varicella in anæmic or emaciated children (p. 258). There is reason to believe that this condition is not necessarily preceded by varicella, but may follow other pustular eruptions (Crocker) ; it has been known also to follow vaccination. It almost always occurs in infants or young children under three years of age, and in many of the fatal cases tuberculosis has been found. In these cases the varicella vesicle or pustule is succeeded by an ulcer, which rapidly extends in size and depth, frequently several joining together, so as to form large sinuous ulcers ; the floor becomes black from the formation of sloughs. In the worst cases the scalp, face, body, and limbs are covered with sloughy-looking ulcers, either separate or having joined together. There may be marked constitutional symptoms. In one of our cases there was recovery, the ulcers gradually healing up ; in the majority of cases a fatal result ensues. The treatment consists in giving the child a generous diet, including beef-tea and wine, and dressing the ulcers with iodoform or other antiseptic ointment.

**Tinea tonsurans.**—Ringworm of the scalp is one of the most troublesome local diseases with which the practitioner has to deal, and one which is apt to bring unmerited discredit on account of the many months or even years that the disease sometimes lasts. In some children there seems to be an especial disposition of the disease to spread, and to relapse when to all appearance it has been cured, or, in spite of the local treatment vigorously carried out for months, no marked improvement ensues and everyone concerned becomes tired of the case.

Ringworm is exceedingly contagious, one child taking it from another in consequence of the spores of the trycophyton being transferred from one to another by direct contact, or by means of hair-brushes, combs, caps, or bed-linen being used both by the affected and the healthy. It rarely affects infants, or children after puberty, its subjects, especially in the chronic form, being the weakly rather than the strong, though exceptions may be met with.

The disease when recent may be recognised at a glance : the patches are circular, the central skin in the smaller ones being red in colour, while at the circumference desquamation is freely going on, the branny scurf giving the patch at this part a greyish or yellowish appearance ; the hairs from the central part may have come away, or they have broken off, leaving stumps. In the larger patches all traces of redness have disappeared, and they are simply bald or scurfy patches of varying size. Chronic diffuse ringworm of the scalp, especially if it has undergone a certain amount of irritation as the result of treatment, is more difficult to diagnose ; there may be much scurfiness, perhaps scabbing and pustulation. In the condition known as kerion the hair follicles suppurate, the hairs becoming loosened at their roots, and

there is redness and puffiness of the patch. The diagnosis of ringworm is made from the stumps of hair left after the hair has broken off. These are best seen by means of a lens of 2 or 3 inches focal length : the stumps will then be readily seen often more or less twisted or bent, and having lost the gloss ordinarily seen on the hair. They are readily extracted with forceps, as they are mostly loose in their follicles ; they can then be placed upon a glass slide with a drop of liq. potassæ and examined after soaking for half-an-hour. The broken hair will be seen to be frayed out at the end, and, moreover, infiltrated with conidia or spores ; the latter are readily seen with a power of 300 diameters if a sufficient time has been allowed for the caustic alkali to dissolve the fatty matters and render the hair transparent. The mycelium is less readily seen than the spores. It is needless to say it is mostly useless to examine the unbroken hairs, and in old cases which have been treated no spores may be present in the scurf. The greatest caution must be exercised before pronouncing that a case is well, or certifying that it is no longer infectious, as cases relapse again and again, and may be the means of communicating the disease to others. Before any case can be said to be cured, repeated examinations must be made with the aid of a lens for diseased hairs, any suspicious-looking stump being extracted and examined microscopically ; it is well to remember also that scurfy patches, even when the hair is growing freely over them, are extremely suspicious. In every case some mild parasiticide should be continued to be applied for some time after the disease appears to have been eradicated. In seborrhœa or non-parasitic scurfiness the whole scalp is affected, and, though the hair may come out, there are no broken stumps and no sharply defined patches of scurfiness as in ringworm.

The course of ringworm is apt to be exceedingly chronic, and when undertaking the treatment of a case it is well not to be too ready to name a definite time when it will be well.

**Tinea circinata.**—Ringworm of the body is frequently associated with ringworm of the scalp. It is first seen as a raised red spot, which becomes scaly at the periphery as it enlarges, while the centre may present more or less healthy skin ; as the ring enlarges it becomes more or less broken and fainter. It may be present on all parts of the body ; it is perhaps commonest on the face and neck. The diagnosis is generally easy, though sometimes the patches of scurfiness on children's faces may be mistaken for ringworm, but do not assume the formation of a ring with a normal skin in the centre ; if any difficulty occurs, an examination of the scales scraped off the patch for spores would decide.

**Treatment.**—The treatment of tinea circinata is a comparatively simple affair, and is readily affected by the continuous application of some mercurial ointment or solution for a few days or a week. It is well to commence treatment by removing the scales as far as possible with soap and water, and then some dilute white precipitate ointment may be gently rubbed into the patch morning and evening. An ointment containing sulphur,  $\text{ʒss}$ , and ung. picis liq.,  $\text{ʒj}$ , to the ounce of benzoated lard also answers well. Carbolic oil or carbolic acid in glycerine (1-8) may be used.

In the treatment of ringworm of the scalp the first step to be taken is to cut the whole hair off with a pair of scissors to at least half an inch, leaving

a fringe if thought desirable ; the scalp can then be carefully examined, and it will be usually found that there is more extensive disease than was at first thought. Wherever there are any patches of ringworm the hair must be cut close to the scalp both over and *around* the patch. The scalp should be thoroughly washed with soft soap or carbolic soap, removing all or as many of the scales as possible. The ointment or application selected should then be rubbed in by means of a mop of rag for a few minutes, at least twice a day. Very many parasiticides have been recommended ; the one we have mostly used, and which is certainly as successful as any, is the oleate of mercury, and we fully endorse Dr. Alder Smith's praises of it. An ointment containing 5 per cent. is used for children under 8 years of age, and 10 per cent. for older children ; a small piece of the ointment is rubbed vigorously into the affected patch every morning and evening ; if there is much tenderness it must be omitted for a day or two. Once a week at least the ointment should be washed off with soft soap, and effects of treatment carefully noted. Oleate of mercury is especially suited for the diffuse form of ringworm ; it apparently penetrates better than iodine or carbolic acid, which tend to harden the epithelial tissues ; this power of penetration is obviously of great advantage when the fungus extensively affects the hair-roots.

In the early stages, when there is a single circumscribed patch of ringworm or only a few patches, some more powerful remedy than the 5 per cent. oleate of mercury may be used with advantage. The 10 per cent. ointment may be applied, or carbolic acid and glycerine (1-6 by measure) may be rubbed into the patches night and morning. Coster's paint (iodine  $\mathfrak{z}\text{ij}$ , oil of cade  $\mathfrak{z}\text{vi}$ ) is also useful in recent cases painted on the patch, removing the crust every few days and reapplying. Glacial acetic acid and hydrarg. perchlorid. (gr. iv ad  $\mathfrak{z}\text{i}$ ) as used by Alder Smith is a good application, as is also Auspitz's solution of chrysarobin in chloroform (F. 47). The last two must only be used to circumscribed small patches, and are not suitable for young children or those in whom inflammation is readily set up. It is well to keep the rest of scalp well oiled with carbolic oil when strong applications are being applied to some local patch. A light skull-cap should be worn to prevent the ointment smearing the bed linen at night.

While in the diffuse or chronic forms we prefer mercurial preparations, yet some cases appear benefited by a change, or at any rate a change of ointment will sometimes work wonders in the eyes of the friends. An ointment containing equal quantities of carbolic acid (Calvert's No. 2), ung. hyd. nitr., and ung. sulphuris (Alder Smith) is a good and useful one ; or the following, recommended by Jamieson :—

( 48 )

Precipitated sulphur	.	.	.	.	.	.	.	$\mathfrak{z}\text{j}$
White precipitate	.	.	.	.	.	.	.	$\mathfrak{z}\text{ss}$
Thymol	.	.	.	.	.	.	.	gr. x
Vaseline	.	.	.	.	.	.	.	$\mathfrak{z}\text{j}$
Simple ointment	.	.	.	.	.	.	.	ad $\mathfrak{z}\text{j}$

Whatever form of application is adopted, it is tolerably certain that much patience will have to be exercised before the disease can be pronounced

cured. Weeks and even months may elapse, and while progress has been made perhaps scurfiness and diseased stumps can be detected; or, perhaps, while the disease appears eradicated in one place, it is spreading in another direction.

Epilation is useful in all stages, but timid and young children are too nervous to submit to much being done in this way. In cases which have proved intractable and resisted all treatment for months a local patch of inflammation may be set up by means of croton oil. The usual method is to paint some croton oil on over a patch of half-an-inch to an inch in diameter, to repeat it the next day, and to follow it up by a poultice; the patch becomes red and puffy, suppuration takes place about the hair follicles, and the hairs readily come out. To this boggy condition the term *kerion* is applied. It is important to apply this treatment to only small patches at a time.

After the disease has been apparently cured it is well to continue for a time with some remedy containing a mild parasiticide. One of the following usually answers for this purpose:—

( 49 )		( 50 )	
Powdered borax . . . .	ʒj	Tincture of cantharides . .	ʒij
Tincture of camphor . . .	ʒj	Tincture of capsicums . . .	ʒij
Glycerine . . . . .	ʒij	Tincture of nux vomica . .	ʒss
Orange-flower water . . .	ad ʒiv	Castor oil . . . . .	ʒij
		Eau de Cologne . . . . .	ad ʒiv
(Bulkley)		(Bulkley)	

**Alopecia areola.**—Alopecia consists of smooth, shining, bald patches on the scalp. It occurs at all ages, both of childhood and adult life. Its cause is uncertain, though there is a consensus of opinion that it is not due to any fungus. In some cases it follows severe headaches, in others occurs without any known cause, though it occurs mostly in those who are below par and out of health. It may occur first in patches, and perhaps after a while involve the whole scalp. It is extremely intractable, and little influenced by treatment, local or constitutional. Cod-liver oil and tonics are usually given, and stimulating lotions, such as—

( 51 )	
Tr. cantharides . . . . .	ʒss
Tr. capsici . . . . .	ʒss
Ol. ricini . . . . .	ʒss
Sp. v. rect. . . . .	ad ʒiv

**Favus.**—Favus is not a common disease in this country, but is occasionally seen among out-patients at a children's hospital. It is known at once by the peculiar yellow cup-like depressions formed by the crusts, and by the peculiar 'mousy' smell. These crusts can be raised from the scalp by means of a blunt knife, carrying the hairs with them, leaving a pitted skin, which, however, crusts over again in 10 or 12 days. The favus crusts may be present on the body as well as on the scalp. The subjects of this disease are generally cachectic and have been ill-fed. The fungus—*achorion schonleinii*—closely resembles the *trichophyton* of ringworm, but the mycelium is more

jointed, and the gonidia are more numerous and larger, though they vary much in size.

The disease is very chronic, frequently lasting for years. The treatment consists in removing the crusts, applying parasitocides, and administering cod-liver oil and iron.

**Scabies.**—Scabies is very common in infants and children in dispensary practice, and by no means unknown among the well-to-do classes of society. Among the former there is rarely any difficulty in diagnosis, as they usually do not present themselves till the disease is well-marked and pustules have formed, while in private practice the diagnosis may be difficult when local, as, for instance, on the hands. In infants and young children scabies gives rise to more irritation than in adults, and in infants at the breast urticaria and erythema of a more or less severe nature may be frequently seen. In infants the hands may be quite free, while the face and legs or genitals may be affected. In cachectic or weakly children there is usually much crusting and many pustules, pus being transferred from one part to another by means of the finger nails. The diagnosis is not usually difficult: urticaria, simple eczema, and lichenous rashes may be mistaken for it. The presence of burrows, the irregular distribution of the vesicles and papules, as well as the intense itching, are the characteristic points. We have, however, sometimes been in doubt regarding the nature of itching rashes present only on the backs of the hands. A cure is readily effected by a hot bath with the copious use of yellow soap, followed by sulphur or storax ointment; the bath and ointment should be repeated for four or five nights in succession, and the clothes should be stoved.

( 52 )

Sulphur . . . . .	5j
Balsam of Peru . . . . .	5ss
Simple ointment . . . . .	5j

( 53 )

Storax . . . . .	3ss
Simple ointment . . . . .	3iss

( 54 )

Naphthol . . . . .	5j
Simple ointment . . . . .	5ij

**Simple onychia** in children may be looked upon as a variety of the subcuticular form of whitlow, in which the nail matrix is involved instead of the skin of the finger. It is usually the result of some slight injury such as nail-biting, running a splinter beneath the nail, or too close cutting of the nails. Early letting out of the matter and removal of foreign material, with subsequent warm-water or lead lotion dressing, is all that is required. Occasionally suppuration goes on intractably beneath the nail, or recurs again and again after drying up; in such cases the nail should be cut away over the inflamed spot, and the surface scraped clean, and some solid nitrate of silver applied.

**Onychia maligna** is a more formidable affection, nearly, if not quite, always due to injury of the finger end. The whole nail matrix becomes inflamed, the end of the finger is swollen, congested, and bulbous, the nail becomes loosened, curled up, and blackened, and there is much burning pain; a dirty, sero-sanguineous, often foul discharge comes away, and the mischief

may go on for months if neglected, and even give rise to necrosis of the terminal phalanx and permanent distortion or destruction of the nail. The treatment we have hardly ever found to fail is dusting the raw surface over with powdered nitrate of lead night and morning for a few days; the nail should be removed if the disease has involved anything more than the upper part of the matrix. We have often seen onychia of many months' standing get practically well in a week under this treatment. Occasionally it is necessary to scrape away the diseased tissue and remove a sequestrum, but this is quite exceptional.

**Lupus.**—Mention has already been made of superficial tuberculous ulceration of the skin (*vide* p. 305), but the special form known as lupus vulgaris needs a short notice here. The affection consists in the development of small circular deposits of inflammatory material in the thickness of the true skin. These deposits, known as 'lupus tubercles,' are found usually in patches which tend to spread by the formation of new tubercles at the margin of the patch. At first isolated, after a while the tubercles coalesce and break down, forming a larger or smaller superficially ulcerated patch, which is usually coated over with thick scabs or crusts. In earlier stages there is no obvious ulceration, and a thin pellicle covers over each 'tubercle.' If allowed to spread, extensive destruction of the skin may occur, and the deeper structures are in certain cases attacked. It is, however, very rare for lupus to penetrate through the deep fascia, and it probably never attacks bone. The most extensive destruction is usually of the nose, where the whole of the lateral and alar cartilages may be eaten away, leaving a short, pinched and shrunken organ. Almost any part of the body may be attacked, but the face is the favourite seat, and especially the tip and sides of the nose. Less often the disease attacks the mucous membrane of the lips, cheeks, and septum nasi, and we have seen the tonsil and soft palate involved by extension from a patch of lupus at the angle of the mouth. Chronic in its course, and intractable to any but very thorough treatment, lupus is one of the most troublesome of the skin diseases met with in tuberculous subjects, especially as great deformity and disfigurement are often produced by its ravages. On scraping out a 'lupus tubercle' a hollow or pit is seen in the thickness of the dermis, while at the edge of the patch the superficial part of the skin is undermined.



Fig. 136.—Hairy mole of the face and scalp. A large part of the patch was removed by the use of the actual cautery and nitric acid.

**Treatment.**—The general treatment is that of tuberculosis, cod-liver oil and arsenic being of especial value. Locally nothing is so effectual as thorough removal of the disease mechanically. It is best to give an anæsthetic, and thoroughly scrape away and dig out all the soft tissue with a sharp spoon. All the material that can be scraped away should be removed; healthy skin will not break down under the use of a Volkmann's spoon. After the scraping the actual cautery or solid nitrate of silver may

be applied, but the mechanical removal is the most important part of the process. There is free bleeding at the time, but this speedily stops. The

sore should be dressed with iodoform ointment, and a careful watch kept for the appearance of fresh tubercles, which should be at once attacked in the same way.

**Papilloma.**—Warts are very commonly met with on children's hands, and often appear in crops. They frequently disappear spontaneously, but if they are troublesome may be readily cured by some caustic application, or better by the steady use of salicylic collodion.

**Hairy and pigmented Moles** occur congenitally, and sometimes cause great disfigurement, as in fig. 136. If small they may be treated by excision. If extensive the growth may be removed in sections by the application of the actual cautery or strong nitric acid, but it must be remembered that any of these methods necessarily leave a scar. Mere overgrowth of hair may be removed by electrolysis and epilation.

## CHAPTER XXXVIII.

## INJURIES, SHOCK, HÆMORRHAGE, ETC.

THE various injuries met with in children can only be very briefly described here, and only those more or less peculiar to childhood will be mentioned.

**Injuries to the Head.**—In young children it is not uncommon for one of the bones of the vault of the skull to be dented or dinged in, and a well-marked but shallow saucer-like depression may be felt. Care must be taken to distinguish this lesion from cephalhæmatoma (*vide* p. 19). The symptoms of brain injury in such a case are usually those of concussion and often speedily pass off; recovery usually takes place without any bad symptoms, and the depression in most instances gradually becomes obliterated by pressure from within and modelling of the bone.

The treatment of such cases is simply rest and quiet; no operation is called for. Sometimes, however, where the depression is more abrupt and marked symptoms of compression exist, especially if the fracture is compound, the general lines of treatment for such cases in adults must be followed. In children the rule, however, is not to operate.

**Traumatic Cephalhydrocele** is the name applied to a condition where there has been a simple fracture of the skull, with probably in all cases laceration of brain and laying open of one or other lateral ventricle. The fluid contained in the ventricle escapes beneath the scalp and forms a soft, fluctuating, usually pulsating swelling; this is distinguished from hæmatoma in some cases by its later onset and steady increase. The swelling, however, may appear immediately; sometimes it is not found for some months after the injury; in any doubtful case aspiration would settle the point.

Cephalhydrocele is most often met with in children under two years old, but may occur as late as the 12th year; it is most common in the parietal region. We have seen several of these cases. There is often extensive absorption of bone after the injury, so that a considerable gap is left in the skull. Hydrocephalus not rarely ensues.

*Treatment, &c.*—Tapping appears to be of little use,<sup>1</sup> and pressure and quiet are the only treatment.

The mortality is high: some 40 per cent. of the patients die; in some instances temporary recovery takes place and meningitis develops later.

Occasionally after compound fracture of the vault a free escape of similar fluid occurs, as in one case of our own: there was a compound de-

<sup>1</sup> Lucas, *Guy's Repts.*, 1879 *et seq.*; T. Smith, *St. Bart.'s Repts.*, 1884. Erichsen, Southam, Godlee, Howard, and Conner have recorded cases.

pressed fracture of the frontal bone, which required elevation ; an abundant flow of clear fluid took place from the wound before operation ; the boy recovered without any bad symptom.

**Fracture of the base of the Skull** in children is a much less serious injury than in adults, and is often completely recovered from. Traumatic meningitis is rare in children, and they generally recover well from concussion and brain laceration.

Dr. Allen (*Lancet*, Oct. 24, 1885) has described a fracture dislocation of the atlas occurring in infants ; the lesion is marked by hyper-extension of the head and a liability to 'epileptic fits' on attempts at extension or pressure downwards upon the head. The injury is probably inflicted during parturition. *Vide* also Guérin, *Gaz. Médic.*, 1851.

**Injuries of the Chest.**—The only fact about chest injuries that is peculiar to childhood is that, in consequence of the flexibility of the chest-wall, visceral lesions without fracture of the ribs are not uncommon. When rupture of the lung occurs the laceration is usually in the neighbourhood of the root of the lung, and the usual complications—emphysema, hæmothorax, and hæmoptysis—are often present, though the last is less often seen, since young children rarely expectorate, and the blood is swallowed.

**Injuries of the Abdomen** have no peculiar features ; if the immediate shock is recovered from, subsequent complications are rarely fatal unless from some severe visceral laceration.

Fracture of the pelvis in childhood is less likely to be complicated by visceral injuries than in adults, since sub-periosteal fractures and separation of epiphyses take place in children. We have met with a case of fractured pelvis in which the urethra was separated from its normal position beneath the pubic arch and displaced backwards towards the anus, the injury occurring in a little girl.

Rupture of the membranous or spongy urethra is not uncommonly met with in boys as a result of falling astride some projecting edge, e.g. the top of a palings or of a gate, or the bough of a tree. The symptoms are pain and swelling in the perinæum, escape of blood from the urethra, inability to pass urine, and distention of the bladder unless it has been recently emptied. A gentle attempt should at once be made to pass a catheter ; if this succeeds, the instrument should be tied in for 3 or 4 days and then changed ; after a week or 10 days it is sufficient to pass a full-sized catheter daily. This is the orthodox treatment, but a traumatic stricture usually results, requiring the passage of instruments frequently throughout life. Extravasation of urine often occurs either immediately or within a day or two of the accident, and necessitates free incisions into all the infiltrated parts. To avoid these misfortunes probably the best plan is, immediately after the accident, to cut down upon and suture together the ends of the torn urethra. This we have done with excellent results in an adult and, as a secondary operation, in a child.

**Injuries of the Limbs.**—The peculiarities of injuries to the limb bones in children depend mainly upon two facts. 1. The bones of children are soft, contain relatively little earthy matter, and are therefore less brittle than those of adults. 2. The epiphyses are yet ununited, and the periosteum is thicker, more easily detached, and more freely supplied with blood than in older people.

**Greenstick Fractures.**—A greenstick fracture is one where more or less of the thickness of a bone has bent and yielded instead of snapping across; there is probably really always a fracture. Simple bending of bone without fracture is of doubtful occurrence, in health at least, though it may occur in rickets and osteomalacia. Many fractures in children are subperiosteal, and to this fact and to the incompleteness of the fracture is due the absence of marked symptoms in many cases, so that fractures are not rarely overlooked; indeed deformity, obvious mobility, and crepitus may all be absent, and it is common enough to see a fractured clavicle of a week or a fortnight's standing, or even longer, in which the first sign that attracted the parents' attention was the 'lump in the neck,' consisting of callus round the fractured ends. Hence after any severe injury each part and limb should be systematically searched, especially in very young children, for all probable injuries. The treatment of greenstick fractures is the same as for ordinary fractures, any displacement being at once forcibly reduced.

**Separation of Epiphyses.**—It has been well established by Holmes and others, especially by the French surgeons, that a pure epiphysal separation is very rare; the condition is nearly always a combination of separation of the epiphysis with a fracture of the shaft; that is, the line of separation runs partly through cartilage and partly through bone. The periosteum in many of these cases remains untorn, and, as Mr. Hutchinson has shown, it is in many instances extensively stripped up from the diaphysis, and necrosis may follow. Hence the symptoms of epiphysal separation or diastasis vary considerably; thus there may be little or no displacement, crepitus may be absent, or very indistinct; and undue mobility may be only recognisable on very careful manipulation. We have seen many cases in which there has been a history of previous injury, supposed to be a strain, in which the amount of thickening found at the time of examination makes it almost certain that a more or less complete separation of an epiphysis had occurred. This is especially common about the lower end of the humerus, and our experience fully bears out Mr. Hutchinson's statement that these accidents are exceedingly common, and in any doubtful case of injury about the elbow they should always be suspected.<sup>1</sup> It is, however, possible that in some instances the violence may strip up muscles and the thick, loose periosteum without any fracture or diastasis, and this injury of the periosteum may be the cause of the subsequent thickening.

In well-marked cases there is deformity, undue mobility, loss of power, and sometimes indistinct or so-called 'false' or 'dummy' crepitus; the outlines of the fragments are more rounded than in ordinary fracture, and the line of separation coincides with that of an epiphysis. It must be remembered that an epiphysal junction is not a flat, plane surface, but there is always a cup-shaped hollow in the epiphysis which receives the rounded convex end of the shaft. It is often difficult to reduce and keep in place the fragments, and a certain amount of deformity is often persistent, though this diminishes by a gradual process of modelling as time goes on. Arrest of growth occurs in some cases, not in others; probably this depends upon the accuracy

<sup>1</sup> Curiously Hamilton (*Fractures and Dislocations*) says he has never met with a case.

with which the lesion has followed the epiphysial line, and the amount of destruction of the growing bone or of premature synostosis that results. These injuries are most common about the two ends of the humerus, the lower end of the radius, and the lower end of the femur;<sup>1</sup> occasionally they are met with at the upper end of the tibia,<sup>2</sup> and still more rarely elsewhere.<sup>3</sup>

Diastasis of the upper end of the humerus is occasionally, but not very commonly, met with. It results from injuries such as blows or falls upon the arm, which, in the adult, would probably cause either fracture of the shaft or dislocation of the shoulder. The appearance of the shoulder is characteristic, though much like that of fracture of the surgical neck of the bone. There is no depression below the acromion, but some flattening a little lower down, with a marked prominence on the anterior and inner aspect of the arm, a short distance below the coracoid process. This prominence is the upper end of the shaft of the humerus displaced forwards and inwards; the edges of the projecting bone are more rounded, and less sharp and irregular than in the case of fractured surgical neck, and on reduction, which is usually, though with difficulty, managed, 'dummy' crepitus instead of that of a true fracture is felt. It is difficult to keep the fragments in position, but, as the surfaces are broad, there is very rarely or never any actual overlapping. Since the upper epiphysis of the humerus includes the tuberosities, there is abundant blood supply to the upper fragment, and union usually speedily takes place. The treatment consists in applying a long inside angular

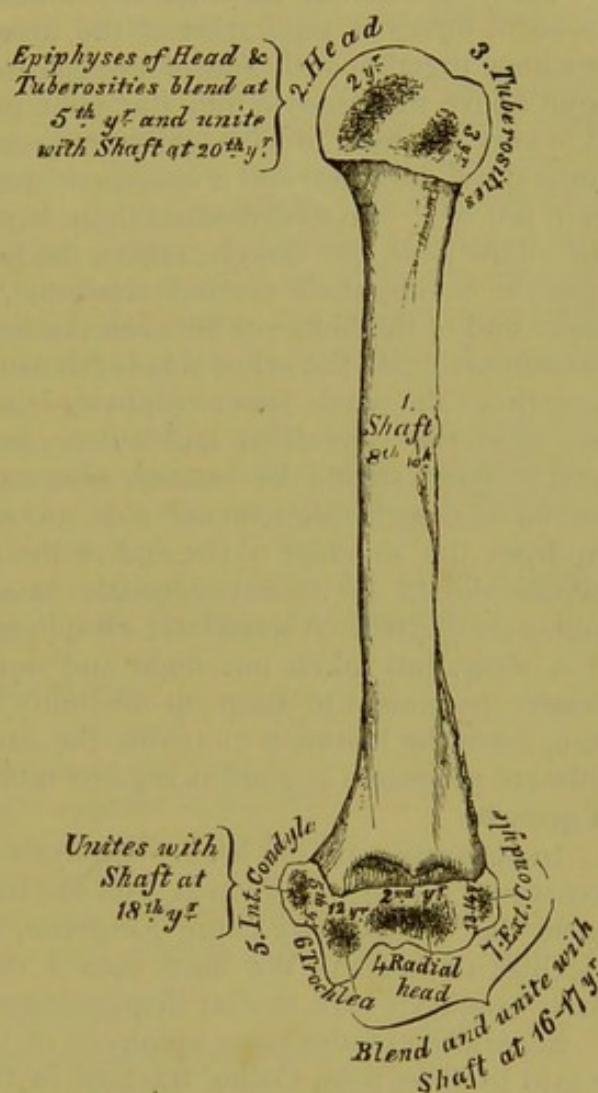


Fig. 137.—Plan of the Development of the Humerus. By Seven Centres. (From Gray's Anatomy).

<sup>1</sup> It is sometimes said that separation of the lower end of the femur is the most frequent accident, but in our experience it is not nearly so common as the diastasis of the humerus. We have once met with diastasis of the upper femoral epiphysis (*vide Hip Disease in Childhood*, by one of the present writers; see also Stimson on Fractures).

<sup>2</sup> Separation of the upper epiphysis of the tibia has been caused by the bad practice of applying extension for hip disease below the knee instead of above it.

<sup>3</sup> For an account of separation of epiphysis due to congenital syphilis (syphilitic telostitis) *vide* chapters on Congenital Syphilis and on Bone Diseases. Similar multiple separations may be the result of so-called 'scurvy rickets.'

splint, well padded at the top and fitting high up into the axilla. The fragments are brought into position, and a felt or guttapercha shoulder cap is then moulded on. Passive movement should be begun in ten days. The deformity is rarely entirely reduced, but good union and a useful though possibly somewhat shortened limb results.

Separation of the lower epiphysis of the humerus is, we think, far the commonest lesion of the kind met with in children. We believe the most frequent injury is separation of the inner condyle, i.e. the epiphysis of the trochlea together with that of the epicondyle. The line of disjunction runs from above the condyle into the joint between the trochlea and capitellum. It is very common to have children brought with an injury to the elbow of some days' duration, and a statement that the limb has been strained or the joint put out. On examination there is pain and restricted movement about the elbow joint, but the olecranon, the head of the radius, and the internal condyle occupy their normal relations to one another. On grasping the lower end of the humerus between the finger and thumb, marked thickening as compared with the other side is felt usually just about the internal condyle; sometimes the whole lower epiphysis is separated and displaced backwards; less often the capitellum and outer condyle are detached. Such cases, if seen at once, should be treated, after reduction of the deformity, by guttapercha or Gooch splint, on one side, and on the other an angular splint, reaching from the shoulder to the end of the fingers. At the end of a week the splints should be removed, gentle passive movement employed, and the splints readjusted. A week later all splints should be left off and the arm worn in a sling, but taken out night and morning for gentle exercise. Violent passive movement to keep up flexibility is not required, and even delays the cure, since the irritation increases the amount of callus thrown out. But the ultimate prognosis is good as regards mobility, though uncertain as to arrest of growth.

In separation of the lower epiphysis of the femur the lower fragment is sometimes displaced forwards, and the backward pressure of the diaphysis upon the vessels may cause gangrene, as in cases of Wheelhouse's, and McGill's of Leeds.<sup>1</sup> We have seen a case of compound separation of the lower epiphysis with similar displacement.

Separation of the lower epiphysis of the radius with fracture of the ulna is said to differ from Colles' fracture in that the palmar projection is more obvious, the hand is not held so obliquely, i.e. there is not so much radial adduction, and the dorsal groove is horizontal instead of oblique. There is more resemblance to dislocation of the carpus backwards, but this is an exceedingly rare injury, and in it the styloid processes do not maintain their normal relations to the carpus as they do in fracture, while the age of the patient and the sensation of crepitus, together with the ease of reduction, but ready renewal of deformity, will point to diastasis.<sup>2</sup>

The diagnosis of epiphysial separations need not be further described here: the locality, age of the patient, and the symptoms mentioned usually make the case clear, and any injury in the neighbourhood of a joint of doubtful character should be treated as if a diastasis had occurred. After a few days the subsidence of the general swelling and the presence or absence of callus will clear up the doubt.

<sup>1</sup> *Brit. Med. Jour.*, May 24, 1884.    <sup>2</sup> *Vide R. W. Smith on Fractures and Dislocations.*

The treatment of these cases is simply that of a fracture in the same position, though lighter appliances may of course be used in the case of children than in adults; thus poroplastic felt, Gooch's splint, Hide's felt, gutta-percha or light wooden splints, may be employed. Most careful padding is necessary in all cases to protect the tender skin; absorbent wool will be found the best material for this purpose.

In separation of the lower epiphysis of the femur the limb should be put up in the flexed position, since, as Mr. Hutchinson has shown, the whole of the gastrocnemius remains attached to the epiphysis.<sup>1</sup>

In all cases a guarded opinion should be given as to the future mobility of the adjacent joint, and passive movement should be begun early—in the case of the elbow not later than the end of the first week, the splints being reapplied afterwards, and movement employed daily after the first fortnight; a week longer may be given for other joints. Separated epiphyses unite with great rapidity, much more so than fractures. Even if there is considerable thickening and distortion for some weeks after the injury, and perhaps considerable loss of power and mobility, so much modelling of the parts takes place that ultimately the result is usually good.

Implication of the musculo-spiral nerve in the callus of a separated lower epiphysis of the humerus is not uncommon, and there may be paralysis of the nerve for a time; usually, however, this disappears, and no hasty operation for the release of the nerve is called for.

The following table of the dates of ossification and union of the epiphyses of the principal long bones is inserted from Quain's *Anatomy*:—

*Humerus.*

- Nucleus of head appears in 2nd year.
- „ capitellum appears in 3rd year.
- „ internal condyle appears in 5th year.
- „ trochlea appears in 11th to 12th year.
- „ external condyle appears in 13th to 14th year.
- The lower epiphyses unite with shaft in 16th to 18th year.
- The upper epiphysis unites with shaft in 20th year.<sup>2</sup>

*Radius.*

- Nucleus of lower extremity appears at end of 2nd year.
- „ head appears in 5th year.
- Upper epiphysis and shaft join in 17th to 18th year.
- Lower epiphysis and shaft join in 20th year.

*Femur.*

- Nucleus of lower end appears at 9th month.
- „ head appears at end of 1st year.
- Head joins shaft at 18th or 19th year.
- Lower epiphysis joins shaft after 20th year.

<sup>1</sup> Stimson mentions that Volkmann has three times separated the lower epiphysis of the femur in manipulations required in cases of hip disease; we once met with the same mishap in a case of acute suppurative arthritis in an infant. The ease with which diastasis occurred was probably due to inflammatory or atrophic softening of the epiphysial line. The child recovered without arrest of growth.

<sup>2</sup> Stimson says sometimes as late as the 25th year.

*Tibia.*

Upper epiphysis appears about time of birth.

Lower epiphysis appears in 2nd year.

Lower epiphysis joins shaft in 18th to 19th year.

Upper epiphysis joins shaft in 21st or 22nd year.

Simple complete fractures of the long bones may be met with at any age, and even occur sometimes in utero<sup>1</sup>; indeed, compound fractures may occur before birth. Such fractures may be found united at birth; they are not very rarely produced during labour by instruments or traction upon a limb.

Fractures of the clavicle in quite young children are best treated by a flannel bandage to fix the arm to the side with the hand on the opposite shoulder, and a soft pad of absorbent wool in the axilla. The child's arm is, of course, kept inside its clothes, and not put through a sleeve; as Mr. Owen suggests, a jersey may be usefully worn over the bandage to keep the limb quiet. In this, as in all fractures, it is an excellent plan to keep the skin well powdered with boracic acid or sanitary rose powder, so as to prevent irritation of the skin.

Fractures of the arm are treated in the ordinary way: the splints should always be carried well up to the ends of the fingers to prevent disturbance of the fragments by the restless movements of children. We are well aware that this is not usually recommended, but we believe it to be the proper, as it certainly is the anatomically correct plan. Fractures of the pelvis are treated by bandaging the legs together firmly with a broad flannel bandage, which is carried upwards to above the crests of the ilia, the child being, of course, kept in bed.

In fractures of the femur in babies under a year old a piece of gutta-percha or Gooch's<sup>2</sup> splint, lined with wool, should be applied to the thigh, and the legs bandaged together with a flannel bandage; this is, we think, the simplest, cleanest, and, on the whole, most effectual plan, though a good result may be obtained by almost any method. In older children, up to the 3rd or 4th year, we prefer the vertical suspension plan, as more cleanly and efficient, and less troublesome after it is once applied than other methods; simple extension by a weight, with Gooch's splint, or an outside long splint, is, however, satisfactory, and a Croft's, a Bavarian, or a Thomas's hip splint<sup>3</sup> should be applied at the end of a fortnight.

After fracture of the thigh in simple cases there should not be at most more than half an inch shortening in young children, and this will very likely disappear after a time.

Fractures of the leg should be treated by a back splint with a foot-piece and two side splints for the first ten days or a fortnight, or more, according to age, and then one of the forms of stiff apparatus applied.

<sup>1</sup> Intrauterine fractures may be the result of falls or of blows upon the mother's abdomen, or of muscular contraction, and are sometimes associated with intrauterine rickets. Almost any number of fractures may thus occur; 200 were found in one instance and 113 in another.

<sup>2</sup> Commonly known as 'kettle-holder' splint.

<sup>3</sup> Thomas's knee splint may also be used very successfully in fractures of the lower half of the femur.

In all cases the most careful watch must be kept for tight bandages ; no bandage should ever be applied beneath a splint, nor should a limb be ever bandaged in extension and then put up in flexion. Pressure sores and gangrene are real dangers in children.

**Primary Amputations** in children are very rarely required, and conservatism should be carried to extreme limits ; when amputation is necessary, if the immediate shock is got over, recovery is usually rapid.<sup>1</sup>

**Primary Resections** of joints are occasionally required, and in cases of injury to the elbow are spoken very highly of by Mr. Holmes. In one instance of compound fracture of the olecranon in a boy about 8 years old we wired the fragments a few days after the injury with an excellent result.

As is well known, any cause, such as hip disease, infantile paralysis, old ankylosis with atrophied bone, rickets, and so on, may produce weakening of the limb and may predispose to fractures from slight violence.<sup>2</sup> This bony atrophy should always be borne in mind when dealing with such limbs.

Mal-united fractures, if recent, and especially if greenstick, should be refractured at once ; if seen after three or four weeks, and union has occurred, gradual reduction with splints often produces good results. Failing this, refracture or osteotomy may be called for.

**Dislocations.**—Almost the only dislocation at all common in children is that of the elbow—both bones being displaced backwards. This is usually said to be more frequently met with in childhood than in adult life. Hutchinson and Owen doubt this ; our own experience is somewhat in favour of it, judging from cases seen at the Manchester Royal Infirmary. Dislocation of the elbow is, however, often complicated with separation of epiphyses or fractures, and the displacement is often not directly backwards, but backwards and laterally, either inwards or outwards. Passive movement should be begun at the end of a week at latest.

Subluxation of the head of the radius is often met with in children as a result of lifting the child by one arm, swinging it round, or dragging it along. The head of the radius slips partially out of the orbicular ligament, and the arm is found to be fixed, powerless, somewhat flexed and pronated ; there is usually pain both at the elbow and wrist, so that sometimes the injury has been thought to be situated at the wrist joint. Reduction is effected by steadying the upper arm, and, with the thumb over the head of the radius, supinating sharply, and then flexing the forearm upon the arm ; sometimes a distinct click is felt or heard, and the power of using the arm at once returns.<sup>3</sup>

<sup>1</sup> We have had once to perform a primary amputation at the hip in a child five years old for a tramcar injury, and, though there was much 'prostration with excitement' for the first two days, he ultimately did well.

<sup>2</sup> When extensive necrosis has occurred a slight injury may produce a fracture in childhood ; this usually unites well, but in some cases union is tedious, and in others does not occur : in such cases resection and wiring is a successful operation in our experience, but if the fracture remains long ununited the wasting of the fragments is apt to be extreme, and in one instance the upper fragment of the humerus was so small that it was found impossible to steady it sufficiently to obtain union. Macewen has dealt with such a case most successfully by transplantation of bone.

<sup>3</sup> This injury has been specially described by Mr. Jonathan Hutchinson, jun., and by Drs. McNab and Lindeman, *Brit. Med. Jour.*, Dec. 5, 1885.

We have only rarely met with a traumatic dislocation (dorsal) of the hip in children. Reduction is easy by manipulation. Dislocation of the patella is occasionally met with ; there appears to be usually some congenital weakness of the part as a predisposing cause, as in the case appended.

*CASE.—Dislocation of Patella.*—Mary Alice N., aged 7 years 6 months ; admitted February 7, 1883. History : Not strong, did not walk till 3 years old ; 7 months ago fell while dancing and dislocated the left patella outwards ; since then has been constantly falling on account of the displacement recurring, especially if she runs ; the injury caused her no great trouble for a week, when the displacement was noticed ; was treated as an out-patient for some time, with pads and various appliances to keep the patella in place, but without success. On admission, the left patella during flexion lies quite on the outer side of the external condyle, coming back to its normal position on extension ; both femora have their external condyles very prominent ; no pain on manipulation or move-

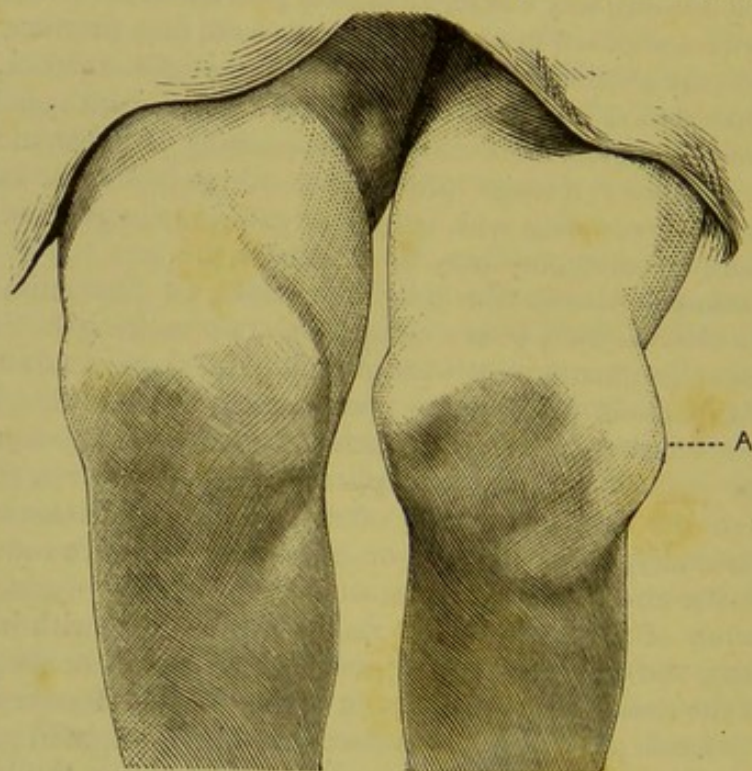


Fig. 138.—Dislocation of the Patella. A points to the displaced bone.

ment ; the patella was unnaturally small and could easily be moved about from side to side ; when walking it sometimes maintained its proper position, and then without warning would slip quite over the outer condyle and make the leg yield. Feb. 17, a lateral incision was made over the inner side of the joint down to the capsule, the patella pushed strongly inwards, and two catgut sutures, passed through the inner edge of the patella, were tied firmly down to the tissues on the inner side of the joint ; operation antiseptic ; back splint. 19th, has had a little pain ; did quite well ; antiseptics left off on March 3, and she was sent out in plaster of Paris splint on the 5th. Seen Jan. 1884, the patella keeps its place and the knee does not trouble her. In this case the patella was apparently congenitally small and ill-developed, and this probably accounts for the condition.

**Congenital Dislocations** are considered under the head of Malformations (p. 599).

**Injuries of the Soft Parts** in children require no special notice ; if the immediate shock is got over, such wounds usually heal with great rapidity, even if very severe, and nothing short of actual gangrene (Holmes) should

be considered justification for amputation. Warmth, opium in small doses, and free stimulation are specially required for all severe injuries in children.

**Burns and Scalds** are exceedingly fatal, chiefly from shock, lung complications, and cerebral effusion. If the first few days can be tided over, recovery is usually satisfactory, and much more rapid than in adults. Careful watch for cicatricial contraction must be kept up, and provision made against it by suitable extension apparatus and manipulation, as well as by grafting. Plastic operations may be required at a later date.

**Shock.**—The question of how children bear the shock of severe injuries or operations, and the effects of loss of blood and of pain, is one of much importance to the surgeon, and may be shortly considered here. First, then, as regards operations in infants and quite young children one great depressing element is removed. They do not anticipate and are not cast down by the thought of the effect upon their future usefulness of any mutilation. In somewhat older children anticipation of pain is of course keen, but it seldom depresses in the same way that it does in adults. Again, the temperament of children is usually mobile, and, even if mental depression occurs, it is not long lasting. So with shock from a severe injury or operation the symptoms are often severe, even more so than in adults, for a short time; but, if by means of stimulants the first few hours can be got over, children very quickly rally. It is common to have a great amount of shock in a child after such an operation as an amputation or excision of one of the larger joints, and yet the next day the child is often as bright as if nothing had happened. On the other hand, occasionally we see 'prostration with excitement' in a severe form in children, and we have known a mental condition practically identical with acute mania coming on after amputation at the shoulder joint, and lasting for some weeks, followed by complete recovery.

**Loss of blood** is always very ill borne by children, and the more so the younger the child. Even the small quantity lost in a harelip operation sometimes seriously endangers the life of an infant a few weeks old, and in all cases great care should be taken to avoid hæmorrhage as much as possible. The only instance of death from amputation at the hip joint that we have had in a child, out of ten cases, was in one where, from removal of a large part of the pelvis, free oozing took place.

Next to loss of blood we should put **cold** as having the most depressing effect upon children, and this should always be carefully guarded against by exposing as little as possible of the body beyond that part actually being operated upon.

**Pain**, if really severe, has a most depressing effect upon children, far more so than upon adults, and many of the cases of severe burn die speedily from the combined effects of pain and fright. Hence no child should be allowed to lie in pain after an operation, and opium should be given freely for the first few hours till the first soreness has passed off, bearing in mind, of course, that opium has a disproportionately strong effect upon children, and that some children bear much smaller doses than others. The general rules, then, to be followed as to the management of surgical cases in childhood are:—(1) Do not let a child know beforehand that he is going to be operated upon, until the time actually comes for the operation. (2) Avoid with the utmost care unnecessary loss of blood. (3) Keep the child warmly

wrapped up. (4) Never let a child suffer pain if it can be avoided ; thus, an anæsthetic should be given for any painful dressing or manipulation, and opium as soon as recovery from the anæsthetic has taken place.

As Mr. Holmes has well pointed out, in children 'irritability is chiefly directed against sudden and acute pain ; but confinement to bed and protracted disease, which wear out the patience and exhaust the hopes of older persons, soon become customary in childhood, and then produce little impression.' As Mr. Holmes shows, freedom from mental depression and healthy, unimpaired, excretory organs probably account for this difference.

Children are, of course, liable to the same **septic diseases** as adults, and pyæmia is, though happily rare in both, quite as common in childhood as in older patients. Diphtheria, and especially scarlet fever<sup>1</sup> (*vide* Chap. XIV.), are very apt to attack surgical cases among children, i.e. those in whom there is a wound or a local inflammatory focus, while erysipelas, though not very rare and occasionally fatal, is mostly of a mild type in children, and, in our experience, the so-called 'erysipelas vagans' is the variety most commonly met with.

No special remarks are required upon the subject of dressing wounds in children : the same rules should be followed as in adults. We use antiseptics—chiefly carbolic, boracic, and mercurial lotions, with iodoform and sublimate wood-wool, or wood-wool wadding—and are fully satisfied of the value of these agents. Mercurial poisoning in children we have not met with, and only iodoform poisoning in a few instances, and those of a very mild type.

In certain cases—for instance, in circumcision—it is well to avoid the fright of a second manipulation by the use of catgut sutures in closing the wound, and it may be remarked that primary union of wounds in children is much more easily obtained than in adults, provided the child is healthy and not too young ; in the very young the tissues are too soft to bear any strain, and in childhood the very smallest disturbance of health is sometimes enough to prevent union of a wound ; hence all plastic operations should be performed only after careful inquiry into the child's general condition. The same slight causes will often produce a temperature chart that would be very alarming if it were not known how little is required to raise a child's temperature. As to the dieting of children after operations, it will be found that children can without harm much more speedily return to their ordinary diet than can adults, and it is common for a child to resume its usual food the day after an operation.

<sup>1</sup> 'Surgical scarlet fever,' so called, is nothing more than ordinary scarlet fever. It is now well known that children who have open wounds, have been recently operated upon, or who have local inflammatory foci, such as abscesses, are specially susceptible to scarlet fever. For further details and references we must refer to papers by Dr. Goodhart and Messrs. Howse and Paley, in the *Guy's Hosp. Repts.* for 1879, and to an account of an outbreak in our own surgical ward by R. W. Murray in the *Brit. Med. Jour.*, June 18, 1887.

## CHAPTER XXXIX.

## ANÆSTHETICS FOR CHILDREN.

(By ALEXANDER WILSON, Esq., *Administrator of Anæsthetics to the Manchester Royal Infirmary.*)

AS regards anæsthetics, children are under much the same rules as adults ; they are better subjects in one sense, since they are less often affected by the degenerative changes which in adults make the administration of anæsthetics dangerous.

On the other hand, they require cautious handling, because they respond so readily to the action of the different anæsthetics : to the stimulating properties of ether, or the more depressing ones of chloroform, as the case may be.

In addition, the way in which they bear operations has to be considered : they suffer more from shock and hæmorrhage, and so need the least depressing anæsthetic, and require to have it evenly given, so that at no time is any pain added to the shock.

For exploratory punctures **local anæsthesia** can be produced by holding a piece of ice dipped in salt against the surface until it is frozen, or the ether spray may be used.

**Cocaine**, used subcutaneously, is objectionable from its mode of administration and on account of the symptoms it sometimes causes, and is not to be recommended for children.

For minor operations **nitrous oxide gas** is well borne by children ; by giving a little ether along with the gas a more prolonged anæsthesia is produced.

**Chloroform** is not quite a safe anæsthetic for children ; a number of deaths from it have been recorded (seven in 1882-86).

It always causes some cardiac depression, often of an alarming character, shown by the pallor and lividity of the face, and feeble pulse—frequently before the operation has been commenced ; the after-sickness generally continues a long time, and an over-dose can very easily be given. It is said by Morton that chloroform is specially contra-indicated in operations for spina bifida and hydrocephalus. On the other hand it is recommended by Horsley in cerebral cases.

**Ether** has these advantages : it is less depressing, the pulse continues strong throughout, the face keeps a good colour, the tendency to syncope is diminished, the after-sickness is of shorter duration, often ceasing when the stomach is once emptied ; and it is difficult suddenly to give an overdose.

It is quicker in its action consistent with safety, so that the distressing struggles of a crying child can be almost at once ended without danger in a way that could not be safely done with chloroform. These advantages of ether are most evident in short operations.

Ether has the objections of requiring some apparatus and of being more unpleasant to the patient. The latter of these can be overcome by giving nitrous oxide first, or even a little chloroform.

For children under 3 years of age chloroform is best; above that age chloroform is the more convenient anæsthetic, and ether (unless contra-indicated by lung disease) undoubtedly the safer.

The **A.C.E. mixture**<sup>1</sup> is not so depressing as chloroform, and so safer, but not as safe as ether. Bichloride of methylene presents no special advantages.

*Preparation.*—An anæsthetic should not be given within 4 hours of a meal. A longer interval is unnecessary and injurious, making the patient feel faint. A feeble child, or one kept long without food, should be given some brandy and beef-tea before operation.

It is well, before beginning, to examine the mouth for any loose temporary teeth which might become detached, especially if a gag has to be used.

Avoid alarming the little patient, for with a struggling, crying child the danger of giving an over-dose is increased.

By a little tact nearly all children can be anæsthetised without any crying, even when inhalers are used.

However, should the child cry, go on steadily with the administration; but do not give it an *extra* quantity to send it off the quicker. As it is breathing much more deeply than normal, rather put less of the anæsthetic in its way.

Children that have been narcotised quickly with chloroform, after struggling, generally show throughout the operation dilated, sluggish, or insensitive pupils, a feeble pulse, and pale face—signs of an excessive dose of the drug.

The administrator should be prepared for accidents, and always have at hand, in addition to the anæsthetic, a pair of tongue forceps, a hypodermic syringe with ether, an electric battery, some nitrite of amyl, sponges, and lint.

Ether is best given with a Clover's inhaler; gas and ether with Hewitt's modification of Clover's apparatus.

In giving chloroform it is very important to have as well a supply of A.C.E. mixture and also ether, so that chloroform can at once be replaced by them if it appears to be disagreeing with the patient, i.e. causing feebleness of the pulse and depression.

Before administering chloroform put vaseline on the patient's face to prevent blistering; place a fold of lint over the nose and mouth, and gradually drop the chloroform on it; when the patient objects to the smell incite him 'to blow it away.' It is a good plan to hold the lint on the nose with the left thumb and forefinger, while the third and fourth fingers spread over the forehead, feel the pulse of the anterior temporal artery, and steady the head; the right hand is then free to drop on the chloroform, &c.

<sup>1</sup> Alcohol 1 part, Chloroform 2 parts, Ether 3 parts.

Hold the child as little as possible ; if it seizes the lint, quickly replace it with a fresh piece rather than wait to struggle for the first ; never try to ' send it over ' quickly. Each inspiration is a dose of the anæsthetic, which takes effect some seconds after its inhalation : so remove the lint at the first signs of anæsthesia, or the patient will get several unnecessary doses. Children are soon ' under,' probably because their chests are so expansile as to hold at one time enough chloroform vapour to narcotise them.

Should there be coughing, in the deep inspiration following the cough do not let the patient inhale too much chloroform vapour, and be careful not to mistake the movements caused by coughing for voluntary movements requiring more chloroform.

Spasm of the glottis, with noisy respiration, sometimes occurs as a reflex action caused by the irritation of the operation ; when accompanied by rigidity of the jaw, contracted or slightly dilated pupils, and a good pulse, it is an indication for more of the anæsthetic freely diluted with air ; it is partly relieved by pushing forwards the lower jaw ; to pull out the tongue is hardly ever necessary, and should be avoided if possible.

*Vomiting*, if the stomach is empty, can be overcome by giving more chloroform : otherwise it is better to stop the administration until the stomach is emptied and then to resume it ; turn the patient well on one side during vomiting, and keep the mouth clear.

For most operations it is not necessary to push the anæsthetic until there is complete abolition of the corneal reflex.

When the child is insensible it is very important to avoid lifting or moving it suddenly and roughly, as such treatment tends to produce syncope.

Often the corneal reflex is absent in both eyes when the patient is but slightly narcotised, and liable to move when a more painful stage of the operation is reached.

In these cases there are other signs of returning sensibility : contracted pupils with increased ocular tension, slight rigidity of the jaw muscles, some movements of the lips and fingers, occasionally stertor from spasm of the glottis ; sometimes there is slight dilatation of the pupils.

When there is a return to consciousness during an operation the administrator must be very cautious not to ' push ' the anæsthetic too freely, for the patient is already enfeebled by the operation and the anæsthetic, and so may easily get an over-dose.

Accidents are of a similar nature to those which occur in adults, and are to be treated on similar principles.

It is well to remember that heat is a powerful cardiac stimulant, and a hot sponge should be applied over the heart instead of slapping the chest with a wet towel. The battery is useful especially as an aid to artificial respiration, by faradising the phrenics ; inhalation of nitrite of amyl, when there is much engorgement of the right side of the heart, by dilating the vessels relieves the congestion.

Schneidberg recommends intermittent pressure over the heart in cardiac failure, and we have found it useful.

Subcutaneous injection of ether (m 5-10) is of undoubted value.



## APPENDIX.

### MILK.

A SUPERSTITIOUS belief in the superior virtues of the milk of 'one cow' is still common among the public, and it is often looked upon as a most important matter to secure this. As a matter of fact, a good average milk is more likely to be obtained from mixing the milk of a *number* of cows than in taking it from *one*, for it is well known that the first portion of milk obtained from the udder is poor in fat, while the last portions are rich, the amount varying from 2 to 8 per cent. If the first part of the milk taken is reserved for the infant, it is tolerably certain to get a poor milk. Whenever a cow is specially reserved to supply milk for an infant care should be taken to see that it is not an old one, and the last portions of milk should be taken for the child.

What is of far more importance than the question of 'one cow' is the question as to how the cows are fed, and the care taken to prevent the contamination of the milk with organic matters. In the vicinity of our large towns it is no uncommon thing to see cows out at pasture in fields watered by brooks contaminated with sewage, of which they freely drink; moreover, they are extremely likely to lie down in the sewage water, and their udders, and consequently the milker's hands, become befouled with sewage. In the winter time the cows are frequently fed largely on turnips and brewer's grains instead of hay, maize, or other dry fodder: possibly also their sheds are infrequently cleaned out and only sparingly supplied with straw, so that the animal lies in *fæces* and their udders may be seen caked with dried excrement. It is no uncommon thing to find a greenish-looking sediment in milk from second-rate dairies, due to contamination of *fæcal* matters. The storage of milk is an exceedingly important matter, for milk readily absorbs gases, and is readily contaminated when kept in cellars or kitchens pervaded with sewer gas or the emanations of decomposing animal substances. The temperature at which it is kept is also important, as it far more quickly turns sour and decomposes when kept in a warm place than in a cool place. This is recognised by many milk purveyors, who at once take measures to cool the milk directly it is received from the cow. According to Soxhlet fresh milk turns sour and curdles at the following temperatures and times:—

- At 32° C. (90° F.) in 19 hours
- At 25° C. (77° F.) in 29 hours
- At 17½° C. (63·5° F.) in 63 hours<sup>1</sup>
- At 10° C. (40° F.) in 208 hours
- At 0° C. (32° F.) in 3 weeks.

<sup>1</sup> Temperature of ordinary kitchen.

*Boiled milk keeps more than twice as long as unboiled milk.* By the addition of a small quantity of milk on the point of turning sour to good milk the preserving quality of the latter is greatly reduced. With the above facts before us it is clear that all forms of 'infant food warmers,' by means of which milk is kept at blood-heat for many hours, are to be condemned. It is clear also that it is wise to use boiled milk only for infants, to boil when received from the dealer, and to keep it in a cool place. Boiling, it is true, robs the milk of a small proportion of its fat and curd, and also of the peculiar aromatic odour present, but this is hardly a disadvantage.

#### STERILISED MILK.

Soxhlet has devised an apparatus for household use by means of which 'sterilising' can be carried out efficiently; or, in other words, milk in bottles is exposed to a temperature of 212° F. for an hour or more. This process has the great advantage of effectually destroying all organic matters, and the continued heating of the casein appears to render it less readily precipitated. The 'steriliser' consists of a sheet-tin vessel resembling a potato-steamer, into which 8 or 10 bottles containing the infant's food—milk, or milk and barley water—are fitted; water is placed in the apparatus so as to surround the bottles, and the whole placed on a stove and kept boiling for  $\frac{3}{4}$  hr. At the end of this time it is allowed to cool, and the bottles are stoppered till required for use. When the infant is to be fed one of the bottles is taken, the stopper removed and replaced by a teat, and the infant fed from the bottle after warming. In this way all organic matter is destroyed, and at the same time the curd is less readily precipitated. The apparatus may be obtained of A. Hailwood, 7 St. Mary's Gate, Manchester.

#### BARLEY WATER.

Place a table-spoonful of best pearl barley in an enamelled saucepan, add a pint of water, and boil for a few minutes, stirring all the time so as thoroughly to cleanse the grain. Pour the water off the barley, replace by a pint and a half of clean water, and simmer *gently* for an hour, and strain. Another and better method is to use barley meal prepared from the whole grain, inasmuch as the greater part of the gluten is found in the cells lining the husk (Jacobi). The grain should be well washed and ground in a coffee-mill kept for the purpose. The barley water used during the early months of infancy should be a thin mucilaginous fluid; in the later months it should be thicker, or barley jelly may be used to thicken the milk.

#### OATMEAL WATER.

A table-spoonful of coarsely ground oatmeal should be placed in a pint of water; simmer gently for an hour, replace the water evaporated.

#### ARROWROOT WATER.

Take two tea-spoonfuls of best arrowroot and a pint of water; simmer for five minutes, stirring constantly.

#### WHEY.

Warm a pint of milk to blood-heat; add a tea-spoonful of 'artificial rennet' (Benger's is an active preparation); in a few minutes the curd will have separated from the whey; break up the curd with a fork and allow it to stand till the curd has subsided; decant and boil the whey. Whey thus prepared may be given to newly-born

infants, cream or milk being added according to its powers of digestion. Whey with some added brandy is useful as a substitute for 'white wine whey,' and generally agrees better.

#### VEAL TEA.

Take 1 lb. of veal free from fat and bone, cut into small pieces the size of dice, place in a covered jar with  $1\frac{1}{2}$  pts. of water or barley-water, cold; place in an oven not too hot, and bake for 3 or 4 hrs.—or it may be left in the oven all night; strain and remove fat.

#### SCRAPED MEAT.

Take of thick rump-steak of the best quality; scrape it with a knife until reduced to shreds. A sandwich can be made by placing a small portion between very thin slices of bread and butter. Some children will take the meat pulp out of a tea-spoon or mixed with gravy or beef-tea. Scraped meat can also be prepared from rump-steak which has been frizzled for a few moments on a quick fire, the burnt outside being cut off before being scraped.

#### RAW MEAT JUICE.

Finely mince a pound of the best rump-steak freed from fat. Place in an earthen vessel with sufficient cold water to well cover it, and let it stand for four hours. Strain through muslin. It can be given with port wine if thought desirable.

#### LINSEED MEAL POULTICE.

Warm a basin, pour in *boiling* water; sprinkle in the meal, stirring vigorously, till it becomes of the consistency of thick porridge; spread on tow or old linen, turning in the edges all round; before applying put it against one's cheek to feel that it is not too hot. Retain in position with a broad flannel roller, secured with safety-pins. Renew every four hours or oftener. The poultice should not exceed half an inch in thickness. Caution is necessary in poulticing the chests of *infants*, in order not to overload the chest and tire out the respiratory muscles.

#### MUSTARD POULTICES.

These may be made in a similar way to the above, the mustard being mixed with warm water, and stirred well into the linseed poultice. One part of mustard to three or four of linseed meal may be used for infants and young children, kept on for four hours, and repeated according to the amount of redness produced.

#### BRAN POULTICES.

Bran poultices are preferable to linseed poultices when the weight of the latter is an objection, as in colic. A flannel bag is filled with bran, boiling water is then poured over it till it is thoroughly saturated; it is then wrung dry in a towel, placed against one's cheek to test the temperature, and applied.

#### HOT FOMENTATIONS.

Flannel or spongio-piline may be used, being wrung out of boiling water in a towel, sprinkled with laudanum or turpentine according to the effect desired, and applied. The fomentations should be retained in position by means of a flannel bandage.

## ANTIPYRETIC METHODS.

**Sponging.**—The readiest means of reducing temperature when the fever is moderate in degree is by sponging. The child should be stripped and lie upon a blanket or sheet with a waterproof beneath ; a large sponge should be used, and the face, trunk, and extremities sponged for 5 or 10 minutes. The water used should be cold, but with nervous patients it is well to *begin* with tepid water. If the child is feeble it may have a hot bottle to its feet during the sponging. Cold sponging is a useful and safe means of reducing temperature in all febrile conditions, but its action is only temporary.

**Packs.**—The efficacy of a continuous pack in reducing temperature depends upon its action on the skin in producing sweating, the cooling effect of the application of the wetted sheet being temporary only unless frequently reapplied. Packs are most useful in conjunction with certain drugs, as aconite and quinine. To apply a cold pack a sheet should be wrung out of cold water and applied to the patient from the neck to the feet ; a blanket is then wrapped round the sheet. It should be reapplied in a quarter of an hour if the temperature appears high, but frequently the patient goes to sleep in the pack, and it may be wise to leave him undisturbed, for an hour at least. Cold packs are often of great service in scarlet fever, measles, and other febrile conditions. In pneumonia packs are often useful, the wet sheet being applied only round the chest.

**Baths.**—The cold or graduated bath is the most rapid means of reducing a high temperature, and has the advantage of being readily applied. The child may be placed in a bath of 100° F. and the temperature of the bath reduced by the gradual addition of cold water. The cold water may be poured over the patient's head if the temperature is high. Cold baths may be used in enteric, pneumonia, measles, indeed in a high temperature from any cause excepting scarlet fever or diphtheria. In severe attacks of these diseases the cold bath is apt to depress too much, the patient becoming cold and collapsed.

**Enema.**—Enemata of cold water have been successfully used in reducing temperature, but can only be of limited application.

**Ice-bags.**—Ice applied to the head in a rubber bag, or flannels wrung out of ice and water, form effectual means of reducing temperature.

**Aconite.**—Given in the form of tincture, is useful as an antipyretic in conjunction with packs. It is necessarily of limited application on account of the depression it produces if pushed.  $\frac{1}{2}$  to 2 minims may be given every hour in pneumonia, the effect being carefully watched.

**Quinine.**—Quinine may be given to reduce temperature in doses of 2-10 grains of the sulphate in syrup of orange-peel, milk, or cocoa ; it is useful for this purpose in conjunction with packs in malaria, scarlet fever, pneumonia, and measles. If given by the rectum, the neutral bisulphate should be used, or the sulphate should be dissolved with the least possible excess of acid. It is well to bear in mind that it is useless to expect absorption from a rectum loaded with *feces*, and a drachm of glycerine must be administered in order to relieve the bowels before injecting the quinine. The quantity given by rectum must be double that given by mouth.

The subcutaneous injection of quinine is not often resorted to in infants, inasmuch as a neutral solution is not often at hand when wanted. In a high temperature due to malaria it would be of service.

**Antifebrin.**—This drug is much used at the present time in reducing high temperatures. It may be given in the form of powder ; or in wine, as it is insoluble

in water. It is better to begin with a small dose and to repeat every three or four hours if necessary. One-grain doses may be given under 2 years of age, two grains from 2 to 4 years of age, three to four grains for older children, and repeated if necessary every four hours. An overdose is apt to produce cyanosis, weak pulse, and profuse sweating. This drug is useful in acute pneumonia, measles, typhoid, and scarlet fever. The continuous use of it should be avoided if there are any symptoms of cardiac failure; toxic symptoms, especially jaundice and albuminuria, may arise.

**Antipyrine.**—This drug is used in a similar way to antifebrin; the dose given must be half as large again to produce the same effect. Antifebrin is to be preferred.

**Pyrodine** is a powerful antipyretic recently introduced, and appears to have a more continuous action than antifebrin. It is a white, sparingly soluble powder. It may be given in doses of  $\frac{1}{2}$ –4 grains, once in the 24 hours. In a child of 18 months with measles and broncho-pneumonia one grain reduced the temperature three degrees. According to Dreschfeld toxic symptoms are readily set up. It should not be given in cases of enteric fever.

### HOT PACKS.

Hot packing is most useful in nephritis, especially when the kidneys are choked. A blanket is wrung out of hot water as dry as possible and quickly applied, care being taken that it is not too hot; it may be renewed in half an hour.

### HOT AIR OR VAPOUR BATHS.

These are useful under similar circumstances to the hot pack; they are best applied by means of a special apparatus, Allen's being the best. A hot vapour bath can be improvised for a child with a 'bronchitis kettle,' or even an ordinary kettle, and spirit or paraffin lamp, a chair being used as a 'cradle.' There is, however, some risk of accident.

### MUSTARD BATH.

An ounce of mustard to a gallon of water (100° F.) is the right proportion. The mustard should be made into a paste in a basin, and gradually stirred into the water of the bath. Useful in diarrhoea, pneumonia, or collapse from any cause; more especially in infants and young children.

### NARCOTICS.

**Opiates.**—Infants are sensitive to the action of opium, and this drug requires to be administered with great caution and its effect carefully watched. At the same time there cannot be a doubt as to its value in many instances, particularly in relieving pain and quieting the overaction of the bowels. In prescribing it to infants, not only the question of age, but also the size of the child and the complaint from which it is suffering, and the degree of exhaustion present, must be borne in mind. It is obvious that the dose of opium suitable for a strong, well-nourished infant of 6 months of age, suffering from colic, might be unsafe if given to a child of 18 months in the last stages of gastro-intestinal atrophy. Infants in the last stages of diarrhoea, atrophy, and pneumonia are exceedingly sensitive to opium, and caution should be observed in giving it to them. Moreover, such infants pass sometimes into a comatose state before death, not unlike the condition produced by opium poisoning, and under these circumstances the immediate cause of death might be attributed to opium. As a general rule, and presuming the infant is a well-nourished one,  $\frac{1}{2}$  gr. of Dover's powder or half a minim ( $\frac{1}{200}$  gr.) of liq. morphinæ hydrochlor. may be given to an

infant of 6 months and repeated in four hours if necessary. Larger doses may be given with safety if the infant can be watched, and indeed, if the infant is suffering from acute colic or intussusception, twice or even four times the dose named may be given. In one case coming under our observation  $\frac{1}{12}$  gr. of acetate of morphia was given to a strong infant of 4 months of age suffering from acute abdominal pain; the infant became drowsy, the pupils were semi-contracted, it remained in a semi-comatose state with sighing respiration for 2 or 3 hours, when it woke up perfectly well. It was evident, however, that the limit of safety had been passed. 3 grs. of pulv. kino co. were given to an infant of 6 months, who was much wasted and suffering from diarrhoea, at intervals of four hours, three doses being given in all. The second dose made it drowsy; it died a few hours after the third dose with all the symptoms of opium poisoning. It had taken in all nearly  $\frac{1}{2}$  grain of opium. One grain of Dover's powder or a minim ( $=\frac{1}{100}$  gr.) of liq. morphia is an average dose for an infant a year old, and may be repeated in two or four hours if necessary. 2 or 3 grs. of Dover's powder or 2 or 3 minims of liq. morphinae may be given to children between 2 and 4 years of age. Children over six years of age are much less sensitive to opium than younger children, and  $\frac{1}{4}$ – $\frac{1}{2}$  grain of opium may be given if necessary to relieve pain in peritonitis or other diseases. It must be borne in mind that idiosyncrasies may be met with, and infants may be found exceedingly sensitive to opium, or, on the other hand, very tolerant.

Subcutaneous injections of morphia are best avoided in infants under a year, and are not often required for young children;  $\frac{1}{50}$  grain would be a full dose for an infant of a year.

**Codeine** is of some value in relieving pain in children, especially in connection with the alimentary system. It may be given in syrup of orange. It may be given in doses of  $\frac{1}{12}$ – $\frac{1}{6}$  grain to infants and young children, and  $\frac{1}{8}$ – $\frac{1}{4}$  grain to older children. It is useful in colic, diarrhoea with tenesmus, and irritative cough—in the latter perhaps not so good as morphia.

**Chloral hydrate.**—Chloral is soluble in water, and may be given 2 or 2 $\frac{1}{2}$  grs. to the drachm of cinnamon water, sweetened with syrup of orange. Infants and children tolerate chloral well; its principal use, combined with bromide, is in convulsions and to procure sleep. It is of but little use in relieving pain. 2 $\frac{1}{2}$ –5 grains may be given to children from a year to two years old. 5–10 grains may be given to older children. Very much larger doses have been given to procure anæsthesia (Bouchut).

**Bromide of potassium.**—2 or 2 $\frac{1}{2}$  grs. to the drachm of water sweetened with syrup of orange or lemons, and sp. of chloroform. The liquid extract of liquorice hides the taste fairly well. 3–5 grains may be given to children from a year to two years of age, and repeated every two hours if necessary. 20–60 grs. a day may be given to older children who are suffering from cerebral excitement or fits. There is little risk in an overdose; children well under the influence of bromide are lethargic, speak with a slow drawling tone, and suffer from acne.

**Antipyrine** acts as a sedative in small doses in infants and young children.  $\frac{1}{2}$ –1 gr. may be given to infants suffering from colic or painful dentition.

**Belladonna** and **atropine** are much used in whooping cough, incontinence of urine, and as external applications. Children are tolerant of these drugs, and larger proportional doses than those given to adults may be prescribed if they are carefully watched. Children of one to two years of age may be given 3–5 drops of the tincture or succus every four hours. Older children 5–15 minims or more, though it is wiser to begin with minimum doses and gradually increase the dose. Atropine is more dangerous, and is best avoided in young children. Children five years old and

upwards may be given minim doses ( $\frac{1}{100}$  gr.) of the liquor, cautiously increased. Temporary excitement and dilated pupils are the result of an overdose.

**Cannabis indica.**—Children bear this drug well; it is usefully added to bromide in  $2\frac{1}{2}$  minim to 10 minim doses of the tincture in whooping cough.

**Hyoscyamus.**—Tincture or succus of hyoscyamus is used as an anodyne in place of opium. Its nauseous taste is one objection to it; it may be given in 5 minim doses to an infant a year old, 10–30 minims to older children.

**Hyoscyamine sulphate** is frequently substituted for the tincture, but, like atropine, it must be used cautiously, or not given at all to infants.  $\frac{1}{200}$  gr., cautiously increased to  $\frac{1}{50}$  gr., may be given to older children; larger doses have been given.

**Hyoscine** may be given with caution in the same doses as the above, but is said to be more active.

### PURGATIVES AND LAXATIVES.

**Mercury and chalk** by itself, or in combination with rhubarb and soda, is very frequently given as a laxative for infants a few months old, or when the stools indicate some irritative matters in the bowels. For this purpose  $\frac{1}{2}$ –2 grs. may be given twice a day for a few days, or for two or three successive nights.

**Calomel** is preferable for older children on account of the smaller dose required; it may be given with soda, euonymin, rhubarb, scammony, or jalapine. A grain may be given with white sugar to a child of one to three years, half a grain to an infant of six months, as a purgative. Half the quantity may be given with other drugs, thus—calomel gr.  $\frac{1}{2}$ , scammony resin gr.  $\frac{1}{2}$ ; calomel gr.  $\frac{1}{2}$ , pulv. rhei gr.  $\frac{1}{2}$ , sodæ bicarb. gr.  $\frac{1}{2}$ ; calomel gr.  $\frac{1}{2}$ , euonymin gr.  $\frac{1}{2}$ . Small pilules made of calomel gr.  $\frac{1}{4}$ , ex. colocynth. co. gr.  $\frac{3}{4}$ ; calomel gr.  $\frac{1}{4}$ , ex. rhei gr.  $\frac{3}{4}$ , answer very well. Some prefer to give small doses of this drug, as gr.  $\frac{1}{6}$ , repeated every hour till the bowels act.

**Rhubarb** forms a safe and non-irritative purgative, and is especially useful in combination with soda when a laxative and stomachic is required. It unfortunately has a nauseous taste, best covered by syrup of orange or spirits of nutmeg.

The syrup is a good preparation, especially in combination with an equal quantity of syrup of senna, of which half a teaspoonful to a spoonful is a dose. 'Mist. rhei co.' is much used as a laxative, given two or three times a day, especially in infants when the stools are 'putty-like' and sour-smelling; thus, syrup rhei  $\mathfrak{mxx}$ , sodæ bicarb. gr. i, aq. menth. pip.  $\mathfrak{zj}$ .

Inf. rhei with sodæ carb. and sp. ammon. aromat. forms a useful carminative for infants—such as sp. ammon. aromat.  $\mathfrak{miii}$ , sodæ bicarb. gr. ii, syrup zingib.  $\mathfrak{mxx}$ , inf. rhei ad  $\mathfrak{zj}$ ; sp. ammon. aromat.  $\mathfrak{miiss}$ , syrup zingib.  $\mathfrak{mxx}$ , inf. rhei  $\mathfrak{mxx}$ , inf. gent. co. ad  $\mathfrak{zj}$ .

**Aloes.**—Much used for constipation, either in the form of the aq. ext. or aloin in pilules. Small pilules containing  $\frac{1}{2}$  gr. of aq. ext. of aloes are readily swallowed by children, or they can be divided with a knife and given in jam. Aloin is useful in treating the constipation of infants and young children; 'anticonstipation' 'tablets' of Burroughs and Welcome, containing aloin gr.  $\frac{1}{6}$ , belladonnæ ext. gr.  $\frac{1}{8}$ , strychnine gr.  $\frac{1}{60}$ , ipecac. gr.  $\frac{1}{16}$ , may be used, half a one being given to infants once or twice a day, mixed with a little white sugar.

**Senna.**—Mostly given in the form of the compound liquorice powder, syrup, or infusion. The former is much used as a household medicine, half to two teaspoonfuls being given mixed with a little water. The syrup is pleasanter to take, being free from any grittiness; a teaspoonful is the usual dose; it is most effective when given with an equal quantity of syrup of rhubarb. The infusion is given in constipation with some bitter, as strychnine or calumba, such as liq. strychniæ  $\mathfrak{mss}$ , glycerine  $\mathfrak{mxx}$ ,

inf. sennæ  $\mathfrak{m}$  xx, inf. calumbæ ad  $\mathfrak{z}$ j, b. or t. d. s. Old preparations of senna are apt to gripe.

**Cascara sagrada** is of much value in habitual constipation in infants and children. It may be given in syrup or some of the elixirs, chocolate bons-bons (Ferris & Co.), or lozenges. Some chemists prepare an extract from which the bitter principle has been removed. 5-20 minims of the liquid extract once a day is the usual dose.

**Podophyllum resin** may be given in powder or 'tabloid' form to infants and children suffering from constipation, beginning with  $\frac{1}{20}$  gr. to  $\frac{1}{10}$  gr. two or three times a day. Liq. podophylli (gr.  $\frac{1}{4}$  ad  $\mathfrak{z}$ j), made by some chemists, is a useful preparation, and may be prescribed with strychnine, bitters, acids, or alkalies.

**Rubinat, Hunyadi Janos, Carlsbad** mineral waters—a table-spoonful or more in warm water or milk, given before breakfast, are very useful purgatives for children over four years of age.

### EMETICS.

**Pulv. ipecac.** is the best and safest emetic for children. It may be kept in the form of powder or the 5 gr. 'tabloids.' 5 grs. may be given, and repeated every ten minutes till vomiting is produced, to infants and young children. 10 grs. may be given in one dose to older children, and repeated in ten minutes or a quarter of an hour. There is great difference in children with regard to the ease with which they are made to vomit. In the later stages of croup or pneumonia, when the face and lips are pale or bluish, it is difficult to excite vomiting; indeed at this stage emetics are useless.

**Apomorphia** is apt to depress too much; it may be given  $\frac{1}{30}$ – $\frac{1}{20}$  gr. subcutaneously, but not to infants.

**Alum.**—Half a tea-spoonful in honey or syrup is useful in whooping cough.

### EXPECTORANTS AND DIAPHORETICS.

**Ipecacuanha** is usually given in the form of vinum ipecac. in doses of  $\mathfrak{m}$  iiss– $\mathfrak{m}$  v to infants up to a year old,  $\mathfrak{m}$  v– $\mathfrak{m}$  xv to older children, repeated every two to four hours. It may be given with  $\mathfrak{m}$  v–x of aq. lauro-cerasi and  $\mathfrak{m}$  x of glycerine to the drachm of water; or syrup pruni virgin. may be added. Vin. ipecac. is apt to lose its strength by keeping.

**Pulv. ipecac. co.** is a useful expectorant (see Opium).

**Antimony.**—Mostly given as vinum, in the same doses as vin. ipecac.; often prescribed with mist. amygdalæ. Both ipecac. and antimony are better given in small doses, frequently repeated, than in increasing doses. In acute bronchitis or laryngitis it is often useful to push either ipecac. or antimony freely till sickness is produced, then to lessen the dose. Both these drugs are given in the early stage of bronchitis, when rhonchi and sibilus are heard.

**Emetine.**—Dose  $\frac{1}{100}$ – $\frac{1}{10}$  gr.; not often prescribed.

**Liq. ammon. citratis** or **liq. ammon. acet.** are often combined with vin. ipecac. or vin. antimon. in doses of  $\mathfrak{m}$  xv– $\mathfrak{m}$  xx for infants up to a year,  $\mathfrak{z}$ ss to  $\mathfrak{z}$ j for older children well diluted, with syrup tolu, aurant., or pruni virgin. to cover the taste.

**Sp. ammon. aromat.**—Dose  $\mathfrak{m}$  ii– $\mathfrak{m}$  iii in a drachm of syrup or glycerine and water for infants;  $\mathfrak{m}$  iv– $\mathfrak{m}$  x, well diluted, for older children.

**Ammon. carbonat.** or **chloride.** Dose: gr. iss–gr. v, well diluted, and disguised as far as possible by syrup aurant., tolu, or scillæ.

**Squills.**—Useful as a stimulating expectorant in bronchitis, when the secretion is free, fluid rales being heard in the chest, and but little being coughed up. *Tincture:*

doses  $\mathfrak{m}ii$ - $\mathfrak{m}iii$  for an infant up to a year old ;  $\mathfrak{m}iii$ - $\mathfrak{m}v$  for older children, repeated every four hours. *Syrup* or *oxymel*:  $\mathfrak{m}x$ - $\mathfrak{zss}$ . The syrup is often combined with ipecac. or ammonia, according to the stage of the bronchial affection.

**Terebene.**—Often useful as a stimulating expectorant ; not often given internally to infants.  $\mathfrak{m}ii$ - $\mathfrak{m}v$  may be given on sugar to older children, or suspended in mucilage and syrup of lemons.

### ANT-ACIDS AND CARMINATIVES.

Alkalies and aromatics are frequently required in the dyspepsias of infancy. Of the former, sodæ bicarb. gr. iiss, magnesiæ carb. gr. iii, combined with syrup zingib. and aq. anisi ad  $\mathfrak{zj}$ , is useful ; or sodæ bicarb. gr. iiss, tr. nucis vomicæ  $\mathfrak{m}\frac{1}{2}$ , tr. cardamom. co.  $\mathfrak{m}v$ , sp. chloroformi  $\mathfrak{m}iiss$ , aq. anethi ad  $\mathfrak{zj}$  given occasionally.

### TONICS.

**Cod-liver oil** takes the first place. It is best given after meals and in the form of an emulsion ; some of the latter are to be obtained combined with lime salts.  $\mathfrak{m}x$ - $\mathfrak{m}xx$  of the oil twice or three times a day is the dose for infants ;  $\mathfrak{zss}$ - $\mathfrak{zj}$  may be given to older children. Dyspepsia, catarrh of the intestines and diarrhœa, should be treated before cod-liver oil is given. Inunctions of warm cod-liver are often useful ; the oil is applied on a sponge and the child clothed in a flannel nightdress.

**Acids.**—Dilute nitric acid ( $\mathfrak{m}iiss$ - $\mathfrak{m}ii$ , aq. ad  $\mathfrak{zj}$ ) is often of much service during convalescence. It may be combined with tr. cinchonæ co., or decoc. cinchonæ and syrup limonis.

**Iron.**—Often given as vinum ferri  $\mathfrak{m}x$ - $\mathfrak{zj}$ , syrup ferri phos. co.  $\mathfrak{m}x$ - $\mathfrak{zj}$ , or tr. ferri perchlorid.  $\mathfrak{m}i$ - $\mathfrak{m}ii$ , in a wineglass of water at meal times. Ferri et ammon. cit. may be combined with alkalies and nux vomica.

### STIMULANTS.

**Alcohol** necessarily takes the first place in the list, and is beyond all question of value in treating acute disease when there is evidence of a flagging heart. It is not a matter of much importance what form of alcohol is selected, presuming it is of good quality. Brandy in the form of mist. sp. vini gallici is the one perhaps most generally useful. In hospital whiskey frequently takes the place of brandy for the sake of economy. Curaçoa, champagne, port wine, more or less diluted according to circumstances, may be used. Alcoholic stimulants are called for in the adynamic forms of scarlet fever, diphtheria, broncho-pneumonia, acute diarrhœa, and other allied conditions. The pulse is the best guide : a feeble, irregular, intermittent pulse calls for alcohol, mere rapidity of pulse does not. Drowsiness, if it does not contra-indicate alcohol, at least calls for caution in its administration, as overdosing with alcohol is apt to make the drowsiness more pronounced, especially that form due to a hypervenous condition of blood. Delirium is often made worse by alcohol, especially if there is evidence of cerebral congestion, the conjunctival vessels being injected as in the early days of scarlet fever. In such cases opium or bromide answers better. Vomiting is a signal for discontinuing alcohol, for a while at least. Unfortunately champagne, so useful as a rapidly diffusible stimulant, is apt to produce sickness. The amount of alcohol given necessarily depends upon circumstances : drachm doses of brandy, or even more, every hour, may be given in some cases of scarlet fever or broncho-pneumonia, with advantage even to young children. In infants alcohol is principally of value in colic and acute diarrhœa, and may be given well diluted with barley water,

arrowroot, or milk. Port wine sometimes seems to agree better than spirit. In chronic disease alcohol is of less value than in acute, as the long continued administration of it certainly has its evils, and is apt to produce dyspepsia and sluggish liver. In anæmia, scrofulosis, and tuberculosis the wine of St. Raphael, port wine, or porter may sometimes be given with advantage.

### FORCED FEEDING.

Difficulties sometimes arise in feeding immature infants and those with cleft palates, the infant being too weak to suck; or the conformation of the mouth may render this impossible. In diphtheria, when the tonsils are enlarged and painful, or in paralysis of the pharynx, 'forced feeding' may have to be resorted to. For weakly infants the 'fountain' feeding bottles have been devised, and the 'biberons pompes' of the French; there is, however, no difficulty in feeding a weakly infant by means of the ordinary boat-shaped feeder if held slightly inclined. Infants with cleft palates have to be fed by spoon or by means of the 'Scott-Battams method,' namely, a piece of india-tubing attached to a glass syringe. In difficulty of swallowing from any cause this last method is the most generally useful. An ordinary glass syringe is taken and filled with milk, beef-tea, or other liquid nourishment, a piece of india-tubing a few inches long is attached, the latter is passed into the mouth to the back of the tongue, and the piston of the syringe slowly pressed from time to time, so that small quantities of fluid are swallowed from time to time. The tube need not be passed between the teeth; if the latter are clenched the tube may be passed between the cheek and the jaws. In cases where the pharynx is completely paralysed a medium-sized indiarubber catheter must be passed through the *nose* into the pharynx and œsophagus, and food introduced into the stomach.

### ENEMATA.

Enemata are required for various purposes during infancy and childhood. A simple enema may be required to unload the bowels and clear away scybala which have collected in the large bowel; or they may be given for other purposes, such as that of applying local treatment to the mucous membrane of the colon, to replace an invagination, or to destroy oxyurides which are present there. Rectal injections are also resorted to as a means of administering drugs or nutriment.

Purgative enemata are generally given with a Higginson's syringe, and at a temperature of about 100°. They may consist of soap and water with the addition of olive oil, castor oil, or turpentine. When the latter is used a tea-spoonful of *sp. terebinth.*, two tea-spoonfuls of olive oil, and the yolk of an egg may be shaken up with four or five ounces of water for a child of two or three years. A larger quantity of fluid may be injected if the fluid is required to reach the upper part of the large bowel. Some care is required, in giving an injection, to do it slowly, avoiding all force. If it is required simply to unload the lower bowel, an injection of a tea-spoonful of glycerine is all that is required. Enemata for the destruction of the oxyurides are best given after a sharp purgative has been administered, in order to drive the parasites as much as possible into the lower part of the intestines. For this purpose the turpentine injection referred to above answers very well, or half a pint to a pint of perchloride of mercury (1-2000) may be used. Repeated 'irrigation' of the large bowel has been much practised on the Continent (*Monti, Baginsky*) in various diseased conditions, such as constipation, dysenteric diarrhœa, catarrh of the large bowel, &c. Large quantities of water or various solutions are injected by means of an india-rubber tube

with a nozzle to fit in the rectum, and a funnel. The forcing of a large quantity of fluid into the colon, especially in young children, is not always easy, on account of the straining and struggling which it is apt to produce, and forcible injection of fluid by means of raising the funnel with tube attached is not free from danger. In irritable conditions of the colon warm mucilaginous fluids, such as a decoction of arrowroot, two to four ounces, with 10 to 14 minims of opium, is soothing, and relieves tenesmus. The subnitrate or oxide of bismuth, suspended in mucilage, and three or four ounces injected, is also useful. In more chronic cases alum, zinc sulphate, or nitrate of silver may be used. On the whole, opiates are the most comforting to the patient.

Nutrient enemata may be given of peptonised beef-tea, or milk with brandy, or some other form of alcohol.

#### DIRECTIONS FOR USE OF DISINFECTANTS.

**Solution A.**—Chloride of lime, 8 oz. ; soft water, 1 gal.

**Solution B.**—Liq. sodæ chlorinatæ, 1 part ; soft water, 5 parts.

**Solution C.**—Perchloride of mercury, 4 oz. ; permanganate of potash, 1 dr. ; soft water, 1 gal.

Stock bottles to be kept locked up, and labelled 'POISON.'

For use :—1 fluid ounce to be mixed with 1 gallon of water.

**Use of A.**—For the disinfection of excreta : Mix well with each stool  $\frac{1}{2}$ -pint of solution A, and allow it to stand for ten minutes before emptying it into the closet. Treat the vomit of fever patients similarly, and keep the sputa-cups of phthisical patients half full of the same solution.

**Use of B.**—(1) For the washing of hands and the cleansing of spatulas, thermometers, and other infected instruments ; (2) for the thermometers to be kept in ; (3) for the sponging of those dying of fever, previous to their removal to the mortuary ; (4) *diluted with four times its bulk of water*, for the daily sponging of fever patients.

**Use of C.**—For the disinfection of clothes : The clothes to be soaked in the solution for two hours, in an earthenware vessel, before being sent to the wash.

**To disinfect a room.**—Tightly close all windows, fire-places, and ventilators. Moisten powdered sulphur with spirit, place it in a shallow iron pan supported on a couple of bricks, in a bowl of water ; light it, and keep the room closed for ten hours. Three pounds of sulphur must be used for each 1,000 cubic feet of air space. N.B. 5 lbs. is necessary for each special ward. Then open all windows, &c., and wash the floor, walls, furniture, &c., with the following solution : Solution C, 4 fluid ounces ; water, 1 gal., taking especial care to thoroughly wash out all dust from window-ledges, corners, &c. Allow free ventilation for twenty-four hours.



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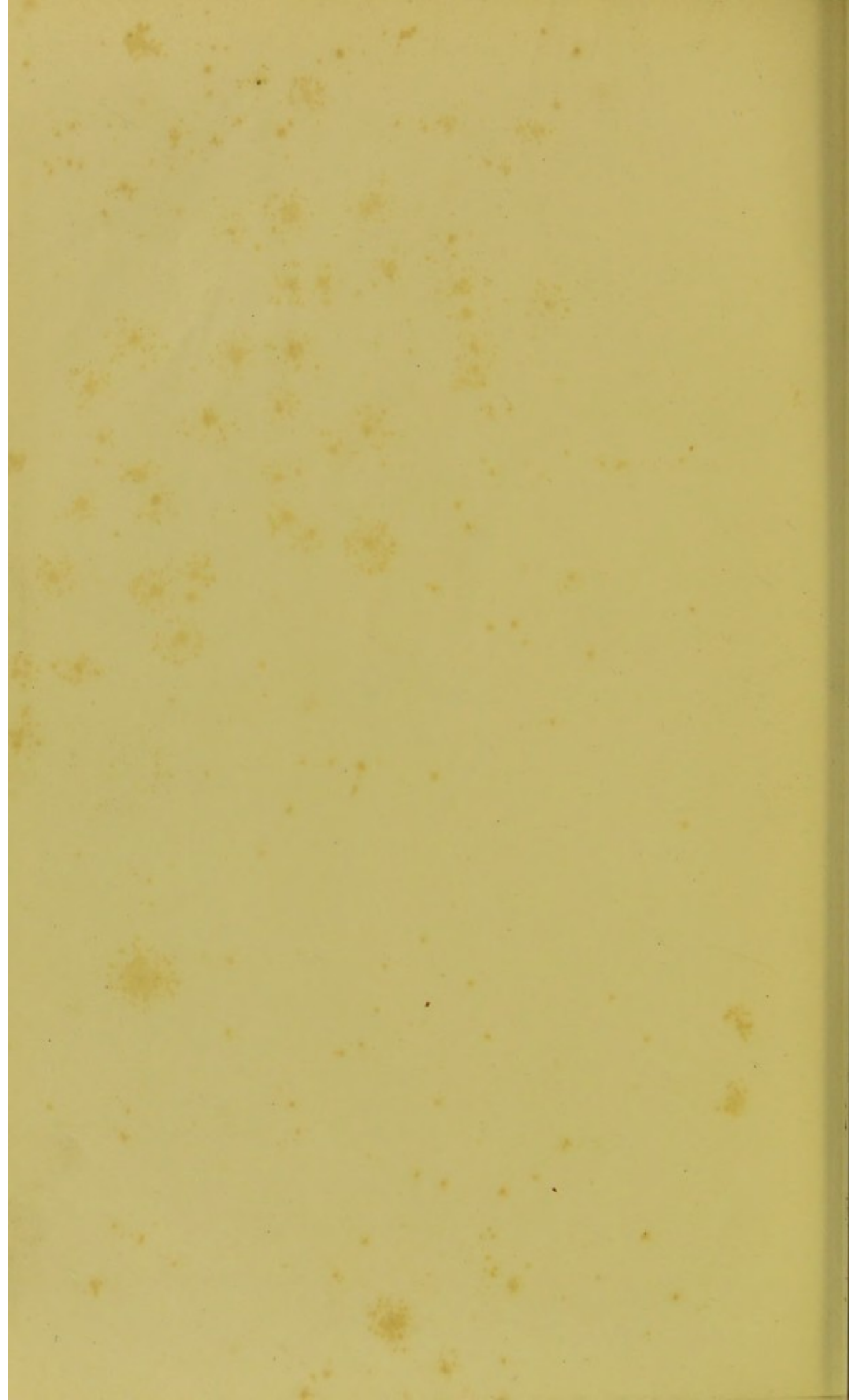
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