

SOCIETY PROCEEDINGS

PHILADELPHIA PEDIATRIC SOCIETY.

December 13, 1904.

The President, DR. JOHN H. JOPSON, in the Chair.

INCONTINENCE OF FECES IN CHILDREN.—This subject was discussed in a paper by Dr. M. Ostheimer. He said that whereas enuresis was common in children, incontinence of both feces and urine is unusual, and incontinence of feces alone is very rare. In certain cases some cause, either general or local, can be found for the condition; in another class the general nervous condition of the patient is responsible. Sometimes the incontinence is observed from infancy, and in other cases it appears suddenly after the third year in children apparently healthy. The author described twelve cases from literature which illustrated the classification he had made, and added four which had come under his own observation. Treatment by fresh air, nourishing food, strychnin and various tonics was successful, although the condition might recur in case the patient became run down for any cause.

HEMORRHAGE OF SYPHILITIC ORIGIN IN THE NEW-BORN.—This subject was treated by Dr. W. R. Wilson, who called attention to the fact that hemorrhages in the new-born, although frequently due to other causes, often accompanied the more generally recognized evidences of syphilis. The form of syphilis in which this symptom appears does not necessarily exhibit any cachexia, and is referable, consequently, to a constitutional tendency. It is likely that the syphilis is not directly responsible for the hemorrhages, but that they are due to degenerative changes in the blood and vessels, resulting from the syphilitic condition.

About one and one-third per cent. of the children born at the Lying-in Charity Hospital in Philadelphia between 1901 and 1904 suffered from hemorrhage, and the greater number of such infants died. In about 22 per cent. of them a history of syphilis was found in the parents, or else syphilis was proved in the infant.

Dr. Wilson explained the various forms under which the hemorrhage might appear, and discussed the question of its immediate cause. He thought that the pathological condition of the vessels in syphilis was not sufficient to account for the hemorrhagic tendency, since the extravasation is most commonly observed in the form of capillary oozing. More probably it is due to a disturbance of the relation between the character of the blood

and the containing capillaries. The fact that bleeding from the cord persists in spite of ligation shows that the coagulability is reduced, and the efficacy in such cases of drugs, calcium chlorid, for instance, calculated to increase coagulability is another bit of evidence in the same direction.

Syphilis in which these hemorrhages occur usually fails to show the characteristic symptoms, and when any such are present they are more often the congenital manifestations than the hereditary ones. In the hemorrhagic cases the infection would seem to have been generally remote. Icterus is present in some degree in nearly every case of hemorrhage.

Dr. Wilson reported seven cases, all fatal, and three of still-birth, which illustrated his conclusions.

Prompt treatment is demanded by evidence of internal hemorrhage in syphilitic children. Rest is of primary importance, and the infant should be kept in the incubator and disturbed as little as possible. Inunctions of mercury may be used, but in case of extensive skin hemorrhages without rubbing. Oil baths may alternate with these. In fever or intracranial hemorrhage the ice cap is useful. In case of severe melena, nourishment should be given in small quantities, frequently repeated, with a view not to encourage peristalsis. For internal use the following drugs are employed: suprarenal extract, half grain doses repeated; Adrenalin solution, 1-1000 one drop repeated; Gelatin water, two drams to one pint; Fluid extract of ergot, dose one drop.

Dr. Jopson spoke with strong approval of Dr. Wilson's clear statement of the classification of the various forms of hemorrhage of the newborn.

DURATION OF THE PRODROMAL PERIOD IN RÖTHELN.—This question was discussed by Dr. D. J. M. Miller, who opened his paper with a summary of the literature upon this point. The accumulated testimony seems to be that the prodromal period in röteln is commonly very brief, not over 24 hours, or lacking entirely, and that only in rare instances does it extend over a period of 2, 3, 4, or even 6 or 7 days. Dr. Miller, however, believes that this longer type occurs much more frequently than indicated, owing to the fact that physicians are not called in until the eruption appears, and the preliminary symptoms escape the notice of mothers and nurses. In the only instances, three in number, where he had been in a position to determine accurately the duration of the prodromal period it had been prolonged until the fourth, and in one case to the sixth, day. This last case exhibited a distinct remission during the second, third and fourth days. The occurrence of this remission, mentioned also by Emminghaus, may partially account for the prevalent ideas as to a brief prodromo-

mal period, the exacerbation being easily mistaken for the onset.

Dr. Westcott had also noticed a distinct febrile prodromal period in rōtheln, and regarded as of considerable importance in distinguishing the disease from mild scarlet fever. He himself had seldom seen the so-called scarletiform type, but scarlet fever of a mild type was so often encountered that whenever a rash was at all suspicious in character that diagnosis should be made provisionally.

Dr. Miller said that he had also never seen the scarletiform eruption in rōtheln. It more often resembled measles.