Broncho-Pneumonia in Young Children.

One might well ask the subject of this dissertation, if some general remarks on the clinical study of diseases of children, what has struck me most since entering upon the practice of my profession is the inadequacy of the time given by students of medicine to the study of diseases of children. It is no doubt an important study in itself, but greater stress should be laid by the teaching bodies, upon the attendance at a children's hospital as well as a general hospital. But it is doubtful even if the teaching bodies, held the most elaborate and frequent classes on this subject if many of the morning 4th year men would have the time to avail themselves of the classes. If, during a short four years course, one did attend more to the classes on diseases of children, it would be, all probability, to the detriment of some more routine (by tradition) subject. Enthusiastic as one may be, the attendance on the class of diseases of children during one's last junior session must of necessity be somewhat disturbed by the coincidence in time of the Final Professional Exams. While more or less spread themselves all through the
short summer session, leaving what between.
the time engaged in the lectures & the
anxiety connected with the little calumns
of mind which should accompany all
pursuits of knowledge more especially clinical
observation. of the class itself at the
Children's Hospital Edinburgh, nothing is wanting
except that it might be much larger.
The instruction given in the clinical cases, as
far as I was able to judge, was excellent,
similar in every respect to the clinical instuction
given in the wards of the Royal Infirmary,
but the time for attending the class was too
short & hedged with the difficulties mentioned
above. the remarks apply to the special subjects
the eye & the ear & throat, in both of which clinical
instruction was given but the time at one's
 disposal in a 4-years course was too short
for anything beyond the ordinary routine
subjects & routine. after graduating I spent
a further course of study at hospital on the
eye, ear throat nose & gynecology besides
general surgery & medicine. here again
not having their importance, children's diseases
were neglected except so far as the
diabetes of the eye ear & throat were concerned.
It was not however till entering upon a
responsible practice that the fact of the
neglect of the study of diabetes in children
while at hospital, was fully impressed upon me. I found as no doubt many others have found that attendance upon children forms the bulk of one's work in General practice. But long after graduating I was forced to accept the change of a large mixed practice, consisting of well-to-do people and poor people. It was chiefly among the latter that those observations were taken. The subject I have taken up is Pneumonia in young children, meaning by pneumonia, the Catarrhal form of pneumonia, called also Broncho-pneumonia or 'lobular' pneumonia in contradistinction to the Compens or 'lobar' Pneumonia of the adult. These little patients, whose clinical history, I observed and noted, were brought or taken to me by the parents—generally the mother—for advice and treatment, and consequently I had to set myself the question: What is causing this disturbance of health about which the mother is so anxious? I could not as in the case of adults ask any of these little children or infants the question: What do you complain of? In the case of the adult one often gets a lead as to what is wrong from the answer, but in a little child! there is very ill! and one has got to get about and try to find out by examination and observation what is really wrong with the child! Attendance on sick children teaches one two important things, not to be very observant, nor to be very systematic!
the mother's story is often of great value but in some cases it is misleading and more than once I have been misled by trusting too implicitly to what the mother told me about her child.

I am afraid that many of my earlier cases of pneumonia in children were diagnosed as severe bronchitis wrongly so for want of systematic examination of the child's chest. Indeed by neglecting careful examination of the whole of the chest in a sick child, one would often miss physical signs of the greatest importance and significance. It was in several cases, the association of one or two small and definitely localised chill patches in the lower back of a young child with symptoms of pyrexia, fast breathing and great perspiration that first called my attention to this very important and highly interesting subject of Catarhal Pneumonia.

With the symptoms pneumonia of adults I had become fairly familiar from regular attendance in the wards of the Royal Infirmary during the evening as well as during the afternoon class show and the lecture but the Catarhal Pneumonia of children, I knew more in name than in reality, so that when I practice I had to make out the natural history of the disease in the best way I could without many preconceived ideas.
In the course of my practice, it was my fortune, whether good or bad, I know not, to meet with many cases of this Catarhal Pneumonia—children, many of them I hardly recognized as sick or almost of want of definite physical signs, others I readily was able to diagnose from definite symptoms and physical signs, but as the patient got their experience and practice more light on the subject—more especially as I had taken rough notes, once interested in the subject the thought struck me why not take up this Clinical Study of Catarhal, or Brochial Pneumonia of young children, as a subject for the graduation thesis. The subject had one great merit to commend it—that it is practical and clinical.

I propose to follow a course somewhat of this sort:

1. History of cases and their course as simplified mainly by nine cases.
2. The cause of Brochial Pneumonia.
3. The symptoms and physical signs.
4. The diagnosis and prognosis.
5. The Pathology.
6. Treatment.
History of Cases

Case 1: Mrs. H.B.'s little girl, of 11 Acorn St., Camberwell; aged 3 yrs. This child had measles about one year before present illness; she also had a discharge from R. ear following the fever. The discharge had stopped since, there was no sign of feebleness. The child had been rather subject to colds; no enlarged glands. Father & mother & rest of family healthy.

I was called to see this child on the 7th Nov. 1889; she was lying in bed, fairly well nourished, breathing fast, pupils contracting; cheeks flushed & child rather heavy looking about the eyes. The present illness started a day ago with sickness although the child had been suffering from a slight cough for three weeks before. The tongue was rather furrowed & the breath confined; temp. 104°; pulse 130. At my first visit I could discover only a few median rash & chills in the tongue & had to withhold my diagnosis, till more positive symptoms or physical signs turned up. The case at the time struck me as looking something like typhoid although there were no fits on the abdomen.

On inquiring about the drainage of the house, it seems that for some time back, the father & mother had noticed a bad smell in the house & had even seen rats come up from ground floor - these clearly pointing to some defect - drainage.

I prescribed a mustard Pdt. 2fl. zit., q. p. am. 2fl. zit. aq. chlorid. 2fl. zit., 2fl. zit every 4 hrs.
8th Nov. 1889, saw child again today - still feverish -

Temp 103°, breathing & pulse both fast; no mucus
in cough. Sputum still present; call kept food down.

Bowel open once - tongue furred - no distention in abdomen -

No looseness over abdomen.

Chest region - no impairment of respiration but

Rales heard over both sides.

Ordered for boracic alcohol 1/2 drachm. 1/2 drachm

Aq. menth. Pip. & 3/4 drachm a day.

Note from today: physical signs there was nothing definite to go

upon except that the trouble lay between hypochondriacal region.

9th Nov. 1889 - called to see child - very little change - general

appearance; chest rather cloudy. Inhale working with difficulty-

Temp 102°.4; pulse 140. Breathing stopped & she could

keep milk down; bowel open once.

Physical signs - the percussing sound of chest - a peculiar

Note of sound of the left side of chest attracted my notice

as going over the percussion of the front carefully, the

white of the left front was found to be hypochondriac.

The Right - front resonant. The stethoscope did not

make any great difference between the two sides - both

hearth sounds were little quieter than Right, but there

were rales on both sides equally.

Back - marked dulness over lower part of left lung.

The Right back & upper part of left back were normal

over the dull patch there is distinct fine respiration

accompanying high pitched bronchial breathing.

The dulness on the left side was so marked that even

the mother noticed the difference while I compared the
left side with the right side! On the right side there were few coarse rales.

Rough diagram of some physical signs on 14th Nov. 1889

Advised husband and house parties to keep side of chest.

This hypopneumatic note is today's physical signs which me as being quite peculiar. I had heard it demonstrated while a undergraduate in the Royal Infirmary wards at Cheltenham by Prof. Blaenfield on a case of Pneumonia in an adult. In that case the hypopneumatic note was explained as pointing to the presence of consolidation below the surface of the area of lung over which the hypopneumatic note was elicited which was not seen. In front, the consolidation was observed where the hypopneumatic note was elicited which was not seen. I forget at present whether the consolidation did come to the surface of the lung. In that case, but the demonstration impressed me at the time so that when I got back from Boston with the little child, I at once knew that there was, I all probability, something to account for it. The present case was the first time in my own practice that I had come across the hypopneumatic note as a physical sign in this disease of being a child I resolved to watch.
carefully what its significance might be. On looking up the subject at the bin. I saw this case was of care. I learnt that this note was generally associated with pleuritic effusion at the base of the lung. But the present case is evidently not one of effusion into the pleura, because the breath sounds are loud and well conducted to the ear. The dullness which is about as high as the angle of the scapula did not extend into the axilla as it would do in the case of effusion into the pleura. Besides the accompanying to the breath sounds were most intense over the part which was most dull, which would not be so in effusion into the pleura.

10th Nov. 1889  Child about the face — getting rather pale & thin; pulse 135, fairly strong & regular; breathing past & shallow, temperature 103°; tongue furred; ears & lips & cheeks a little blue. Cough frequent; bowels open twice. Physical signs same as on previous visit, there being a lymphatic note over upper part of left front along with a dull patch in lower part of left back. Crepitations were well marked over the dull area, over which too there was bronchial breathing; no apparent extension of dull area, which extended from bare to scapular angle & from near frontal column to parts, collarbone border.

11th Nov. 1889 — child about the face as before
  temp. 103.2; pulse full & strong.
  Physical signs — child with bronchial breathing &
  Crepitations — left knee back — on right
  back three times & a few Crepitations — no
Dors of Resonance: richness quick stopped.

13th Nov. 89 — No apparent change — Temp. 107.2

Physical signs: same as before.

15th Nov. 89 — Child brighter today — tongue cleaning
Temp. 107.6; pulse regular but still fast.

Physical signs: Symmetrical pulse, last — left front
hearing already resonant. Auscultation — rales in
front of chest with wires.

Back — left — dulness nil — no marked but resonance
still impaired; no marked bronchial breathing but
crepitations & fine rales over whole of left lower
back. Apex of left & whole of right back breathing
normal, with fine rales; a few crepitations
in right lower back.

Note — the consolidation: left — suddenly cleaning up.

14th Nov. 89 — Child bright — tongue clean & red — Temp. 100.4

Pulse strong; breathing easier & more — no wheezes
notworking; tongue troublesome; bowels open once.

Physical signs: Both front resonant
Back — slight impairment of resonance — left
lower back — crepitations & rales still apparent
on left wires.

15th Nov. 89 — Child seems quiet herself today
Temp clean; bowels open — the cost & urin.

Breathing normal, Temp. 98.6

Physical signs: as before.

16th Nov. 89 — Child bright & cheerful — Temp. 99.6

Dulness disappeared from left base — few rales
& Crepipitation still present though less obvious.
17th Child looking better - takes food fairly well.

Temp. 98° - a few coarse & fine rales, with cramp.
i left lower back, rest of chest fairly free from
fine rales. The child soon lost all trouble in the chest.

This child evidently suffered from an acute & short attacks of Catarhal Pneumonia in
both lungs though, chiefly, as far as physical
signs went, on the left side of the chest.
The high temperature, the dulness on lower left-
back with bronchial breathing & rales on the
dull area, together with bronchitic signs
& a few rales over right lung, all
point to the presence of Broncho-Pneumonia.

A great point of interest in this case was the
presence of a tympanitic note over the left front during
the first part of the attack. This peculiarity was in
this case clearly associated with consolidation of the lung
as the base of the same side. The treatment in this
case consisted of: chiefly - warm room - bruised,
occasionally with mustard, parboiled to the lungs in
the earlier part of the inflammation & laterstimulating
elixirs - turpentine & camphor. Toward the end
of the attacks - doses of Syr. Ferri lod. three
times a day was given as the child was very
latter pale & anaemic.
Case 2  Mrs W J Child, a boy, aged 2 yrs. 4 mos. of 3 Ridgale Rd. Peckham. This child always been healthy; complete dentition, breast feed. Had chicken pox about 6 mos. before. Healthy family - 10 children all living, the youngest I delivered 3 months before. This little one according to the mother had an attack of measles in the middle of February 1899 - the fever very prevalent at that time. The poor women generally treat measles in their own way - not sending for medical advice until something unusual turns up to frighten them. They gave some preparation of Saffron to "bring out the rash" unlike the poor in Scotland who have great faith in the efficacy of sulphur for the same purpose. Measles in this child had since disappeared leaving a cough of a few days before coming to me the child got much worse - feverish - terrible ill, went off its food. On the 3rd March 1890 the child was brought to me by the mother. It looked ill; was very pale; breathed fast; skin felt hot, pulse 146, temp. 102°. The tongue was thickly furred; the bowels open.

On examining the chest in front there was oedema on both sides of chest but plenty of rales & hoarseness all over both fronts.

Back there was slight emphysema - oedema over both lower backs just below inferior angle of scapula. Over both lower backs there were fine crackling respiration and at points bronchial breathing could be heard accompanied by expectoration.
Ovaries right & left breast & vulva were coarse & anemic. There was some slight straining of the lower ribs & epigastric region. I directed whether to apply a few hot poultices with a little tincture rubbed over them before applying & then after the chest was well closed to wrap whole of chest in wool & keep child as warm as possible. Of medicine I gave 1/2 teaspoonful of Syr. Ferri Olaph Co. three times a day & of food - milk - beef tea regularly every hour or two hours as seemed necessary.

I saw the child twice a week at home as it got well in about three weeks; temp varied from 100°25°102°. This was evidently a case of Carbarrhal Phrenonia following neglect after measles. The child had as is usual in measles bronchial Carbarrh, which though exposure went on to Luncels-Phrenonia.

Case 3. Mrs S, little girl aged 8 yrs. in the same house as the last patient. Their child belonged to a healthy family - two children - one died of whooping cough. This little girl had measles about the same time as the previous patient & apparently got through the fever all right but the child was left with a bad cough & wheezing at the chest. This cough has been, according to the mother, getting worse & worse till the child felt quite ill - stopped playing, cough stopped & child had great difficulty in breathing. She had been very ill for over a week when the mother brought her to me on the
12th March 1890. From my notes she presented the following appearance:—The child was lying in its mother’s arms in a drowsy state & slowly opened its dull eyes when disturbed—both no notion of things around it & made no attempt to cry when being examined. The child’s face was entirely pale with exception of fair flush in cheeks—the eyes were being looking—the respirations working with respirations—heart & pulse very fast—leps 153.8. There was slight frothy on lips & tongue was floored & rather dry. The child was very thin & wasted. Being nothing but skin & bone. On looking at the child at first I had in my mind the possibilities of it being acute tubercularis or Pneumonic Pneumonia. Judging from the history given by the mother & the appearance of the child.

Chest region:
Both lungs apparently clear—breath sounds vesicular but coarse rales accompanying breath sounds. Invalise there were a few rales & slight crepitation.

Pulv. Right—more or less dull all over lower right back entering into right axilla, over the dull area breath sounds vesicular & accompanied by Copious Crepitation both with inspiration & expiration.

Left—No expansion of respiration—fine rales & a few Crepitation heard generally over the left lower back. Breathing was vesicular.
Diagram of Case 3. During physical signs on 19 March 1870.

There was no bronchial crepitation either being at all on the right side; there evidently was some considerable amount of consolidation. The diagnosis was broncho-pneumonia; although acute tuberculari could not be positively excluded without further examination. The history included: rubbing both sides of chest with hands of Camphor & afterwards wrapping child up in a woollen jacket; milk, beef tea, bread, to keep child's strength and a mixture containing glycerine & camphor.

This case persisted for over a week but it did not pick up, & as the mother could not give it proper attention, it was sent to hospital, where it died in about three weeks.

These two cases (2 & 3) both from the same house & both under the same surroundings, are very distinctive ones, showing how measles or either the bronchitis which is part and parcel of measles, if neglected may run on to Catarhal Pneumonia & then in its turn to death as it did in Case 3.

This I have seen in several instances; a child apparently strong & healthy, has measles with which there is a good deal of Bronchial
Catarh chiefly of the larger tubes (coarse cates) in the child gets over the measles all right when, either from being allowed out in the cold too soon—or the lachrymal catarh has subsided—as in the case of the poor who heat measles themselves & think that as soon as the rash & more obvious symptoms of the fever become developed & vanish, that all danger is over, or from getting cold in some occult manner, the child begin at an interval short a long from the measles, to get ill again—slight & troublesome cough left after measles almost leaves the child, but the breathing gets labored, child gets feverish & pale, it will be found in a great many cases that broncho-pneumonia has set in from direct infection of the catarh from the large lachrymal tubes into the smaller tubes & air cells giving rise to broncho-pneumonia as seen by consolidation & rale[s] (fine sound).

Case 4—Mrs. J.B. child of J.T. Southampton St. Cambwell.

[Strikethrough]
a little girl, 2 yrs. 10 mos. old; father & mother.

[Strikethrough] Sihen & healthy; 3 children, 1 child breast fed.

[Strikethrough] Always well. She was bought on the 17th March 1839.

Suffering from a bad cough—thought to be whooping cough, which was prevalent at the time. The child victimed after each fit of coughing. Mrs. J. B.

Temperature 99° Breathing easy & slow. Cough coming, child a few times & lachrymal head one cheek first & back especially on sternum. Tired—hot baths every night to legs.
+ lower part of body to relieve congestion of chest - the chest cote rubbed night & morning with liniment of emuls ; 4 ozs. of Dr. Brown's 4 in. draught also to soothe nervous system - douchi & rub - to relieve short-coming attacks of coughing.

On 4th March 1880 the child fit much worse

- breathing fast & laborious 60; pulse 140
- temp. 103.2; the child looked very ill.
- chest - both lungs resonant - a few rales & drench over front of chest.
- back right - resonant - rales & drench present.

35th March 1880 - child very ill - pale - breathing fast 60; pulse 145; temp. 104°; cough, worry lower chest mucus in nose & difficulty in inspiration.
**Physical signs**

**Front** - Resent - breathing venous - rales & ratches.
**Back** - Right - Resent - some ratches here & here back also rales & ratches.
**Left** - Sulmes from near line to inferior angle of scapula - fine ratches here over the area with localised breathing at some points at others, breathing somewhat feeble.

**Back**

...diagram showing physical signs of Case 1 on 24th March...


**Physical sign** - Same as on previous visit - well marked abdomen, left lower back with localised breathing & fine ratches over dull patch. Some ratches & fine rales on right lower back.

27th March 1970. Child about the same - getting very thin & pale does not have any attacks of coughing with the whoop. Breathing 70 - pulse 150, feeble - temp 103°2, moribund, working, child dying on its back.

**Physical sign** - Both fronts resonant - rales with venous breathing over front of chest.

**Back** - Right - no ratches - rales chiefly fine over right back & a few ratches in lower right tall.

**Left** - impaired resonance but not so dull.
ni lacer back as on previous visit. Breathing lungo- 
verumiar in lacer back. accompanied by Capilations. 
left auricular  Capilations well marked. in upper auricla.
right auricular a few rales.

28th March 1890  Breathing G1 ; pulse 150 ; temp. 101.4
Child getting thin weaker. Telves stills firmly well
+ got beef tea & Breast very 2 hrs. Keeps in
showing most of its time.
Physical region - drums becoming irregular. Here &
there was slight back; breathing lungo verumiar will
Capilations. left auricular dull patch at
2 pole with high pitched breathing & small fine
Capilations. Childs eye hemi in left auricular.
R. creakling coarse rales all on right back.

30th March 1890 Child looks a little better - breathing 55-
more feeble but walk about 300. temp. 102.
Prospers more; no trace getting clear.

Diagram of chest, showing physical region on 27. Nov. 90.
Physical region: R. + left foot eczemat with an eczematoid rale.
Left knee back - increased resistance on lower back - breathing
inches verumiar at one points, verumiar at others, breathing feable
in left side compared with right - Capilations all on left back.
Left auricular - dull patch at apex of, auricular will fine Capilations.
30th March 1890 - Child looks better - breathing 45 - pulse 125 - temp 99.4\textdegree\ - bowels fairly clean - breath opiated.

Physical signs almost same as previous day. Temp lower.

Back getting weaker but ai does not seem to be getting into air cells well as breathing - feeble on left side when compared with right side where heart sounds are louder accompanied by coarse cracking expiration.

31st March 1890 - child's breathing easier - very pale - thin - ribs all hollow - very little indrawing of lower chest in front - Temp 100.2\textdegree\.

Physical signs - chief point is high pitched breathing in left upper sterna - fine rale alternating here also.

2nd April 1890 - child thin - looking food better - milk - beef tea - hardy + egg beaten up. Temp 99\textdegree\.

Less raleitation heard near left chest.

3rd April 1890 - child looks stronger - temp 99.8\textdegree\.

Rales + adventitious sounds getting less in both sides. The chest well rubbed every night with spirit of camphor + oil of turpentine equal parts + wrapped up the worst. I put the child on teaspoonful of syrup every 4 hours.

From this the child slightly pulled some - very gradually gaining strength. It was not till after two weeks passed that the chest was quite free from adventitious sounds. This child got well bottled after + no doubt the food nursing pulled the child through her illness.

This case was a very tedious one for first the child had whooping cough & it was
after or during the whooping cough that the catarrhal pneumonia set in. There was doubtless some collapse of lung, especially the left where there was at times considerable deficiency of breath sounds; moreover the dull patch did not remain for any length of time, but varied somewhat from day to day. The catarrhal pneumonia was practically bilateral in the case—delirium with high pitched breathing and crepitations on the left side, crepitations on the right side. With whooping cough one would almost expect collapse of the lung as during each fit of coughing there was plainly a gradual diminishing of air in the lungs. The child sat back in the face during the cough, partial asphyxia followed, diminution of blood in lungs and this brought about by violent cough during air out of the lungs to the point in the larynx preventing air getting in during the fit of coughing till at last evidently so much air is driven out of the lung as is compatible with life. A may be the half asphyxiated condition the child gets into, causes a relaxation of the inspiratory condition in the larynx, and then comes the long drawn inspiration which causes the characteristic "whoop" from which the disease gets its name. If during a fit of coughing one listens over the chest of a child with whooping cough one is struck by the fact that there is no proper inspiration at all—what one hears through the stethoscope is that a quick expiratory murmurs cut
no attempt at inspiration at all—till at last the
inspiratory murmurs, from the lungs, are
heard. Then comes the whoop of the mispiration.
It is very doubtful if such a weakly child, the lungs are
properly inflated by this whooping inspirations, for
the fact of the whooping noise itself points to some
considerable disturbance at the lungs or in the trachea
of air into the lungs before. Again one can see
on watching the child with whooping cough that after
the fit of whooping is over, that the
child is in a state of collapse, it breathes in a
very shallow manner for sometime after. The
black or dusky (cyanoses) face during the fit of
when it is succeeded by face characterized by
entire pallor, the emphysema it seems being
most marked. Hence it is likely from the exhaustion
of air cells by the violent respiratory efforts during
the fit of whooping, and the shallow breathing
of the child after the fit, that the lungs are
put in a state of conditions suitable for collapse.
One can judge best of all as to the amount
of air getting into the lungs a being driven out of the
lungs by watching the lower part of the
chest. During the whooping fit all the soft parts
of the chest are compressed upwards until the
whoops comes when they come outwards
owing to the expansion of the lungs within, but
if the child be a weakly one or if the child
be likely then the weakened chest wall—
bones, cartilage & muscle - does not lead to rebound
unless to some extent, so readily as to a pressure deficiency, or
either. In the chest & the negative pressure so
left within the chest & this negative pressure so
doubtful of him leads to bronchiolitis of some
weak part of the lungs. This will be more so
if there is in the case generally of some cataract
of the bronchial tubes, which become somewhat block-
when, as in the case of the bronchi. They were
congestion & swelling of these walls, narrowing of so-called
the lumen of the bronchi air passages, or by the
productive of the cataract forming so-called
plugs, so leading to choking of the tubes,
all these together with weakness of the chest walls
leading to the doubt pronouncing collapse of
the lungs. This collapse of the lung can
be demonstrated in these cases of whooping cough
fairly readily, for one frequently co-aces upon, on
careful examination of the chest in a weakly especially
in a Ricketts child, impalpable patches almost dull,
& with feeble breath sounds - which almost next day
will have disappeared or at least the physical
signs whereas at one visit will often not be get
at a subsequent visit - clearly pointing to a
sudden collapse & a sudden repopulation.
there was not, as far as one could definitely
judge from physical examination, such collapse in this case (4) & one would certainly not expect
such as the chest was well formed of the child
fairly strong although the chest weak after fur the illness.

Case 5 - Mrs. H's little girl of 4 yrs. age. Febr. 13 mos. - a poor thin & weakly looking child. This child had been breast fed but was given from a early period
in its life 'bits of anything' - crusts, bread & butter - the other children were not very sick - never cholera - suffered from cough. Father & mother alive. This child had been under my care 6 months before with Perichondritis chiefly
of the large tubes - this got well under treatment. She was again under my care 3 months ago for measles, which was of ordinary type - rash well out, temp. normal, Glands healthy, tonsils clear, tongue loose. She got over the
fever all right - the Perichondritis cleared up 
with the excepiton of some slight ulceration about the mouth, the child looked well.

Present illness - I was called in to see the child on 23rd June 1876 & was told by the mother that she had been told to the outpatient department of a Children's
hospital - the 'Welsh' - for diarrhoea & chest trouble for the last three weeks but that the child got
so bad she was told not to take the child to & fro to the hospital but to call in a local medical man. I could not find out why the child was
not admitted as an in-patient.

I found the child lying in bed - breathing hard & in a laboured sort if way with restless wriggling. The
child looked thin & miserable, pyorrid & resembled
emaciation or even burning. Child's face very pale,
foreskull widely open, box shaped forehead - two
central veins above & below - tongue coated white fur.
Temp. 102°; pulse weak & fast. The child extremely wasted - breaths very relaxed - diarrhoea about a dozen times during 24 hrs; diarrhoea has been going on, sometimes better, sometimes worse, for about three weeks. 

Note of treatment at Hospital: In stools were offensive watery, mucus greenish i colds. There was a good deal of cough.

**Chest:** No breading of ribs, but lower part of chest & upper part of abdominal wall in lower slightly with respiration. Both fundus resonant & quite venereal breathing with coarse rales.

**Back:** Right there was a fairly definite dull in the centre of lower right back, reaching to angle of scapula but not to base below mentioned to part. Pain little tender.

Auscultation gave bronchial breading at one or two points - over dull patch, venereal breading at other points - over dull patch. Crackling crepitation accompanied breathing over whole of dull patch - went marked where bronchial breathing existed. Over rest of right & back were a few coarse rales.

---

**Diagram of Case 5:** Infant physical signs on 23 June to fairly resonant - coarse & fine rales all over left back.
I directed mother to apply a mixture & linseed poultice to the chest for a hour after that to wrap chest up, in flannel. For food boiled milk which would swell two or three teaspoonfuls of brown water to a pint of milk, give regularly every 8 days. Prescribed powders - Hydro s acetic Put. eur. aromat. griv. Fort. feb. citr. 3 gr. 2 one each day after which lone powders without Hydro every 6 hrs.

24th June 1830 - saw child today - found less about the face but quieter - diarrhoea less & colours of motions more natural.

26th June 1830 - child quiet, breathing fast, looks pale & collapsed. diarrhoea still Keeping on - ordered for diarrhoea -

Fort. salicylic 3 gr. Fort. brackets 3 gr. inulae 3 gr. 1/2 malt
Rip 0.5 gr. - 3 hrs. every 4 hr till diarrhoea stops

Physical signs - dull patch on right back + infirered lymph node left back back; on both sides crackling crepitation. the breathing was more hoarled + higher pitched on right side; over rest of chest a few coarse rales.

Breath - Venereal healthy x few rales

Infused lymph node - dull patch - high pitched

Diagram of case 6 - showing physical signs on 26th June 1830

26th June 1830 - child looks better & less disturbed in breathing; diarrhoea less - tongue less coated red at tip of tongue; evidently begin to clean up before backwards.

Tongue - Deum up, few over centric of tongue

Strip at tip, clean + red
Physical began

Front - a few blisters at both ends.
Back - all patches present on right side. But patch on left side noticed two days before this disappeared. There were crepitation on both sides. This sudden disappearance of blisters on left side puzzled me at the time, but on going over my records again I got the case right - there was no left.

Ordered - mustard plasters to both backs for five minutes & after that a few fenugreek seeds rubbed in.

30th June 1890 - child better - temp. 99°4; coryza.
Examination of chest. Lung emphysematous as on previous visit - well worked. Child patch over R. lower back with buckthorn & crepitations. A few coarse rales were noticeable. Right back & left back resonance good but fine rales & crepitations present. Diarrhoea less number of stools a day - less offensive & better colours & bile. Will keep with sulphate - fever down.

2nd July 190 - child much improved & coryza thickly on being examined. Diarrhoea quite stopped - tongue clean - temp. 97°8. Poor thing - taking milk well. One patch on Right back but so involved - crepitations less accompanied - no rest of chest less. Ordered whole of chest, back & front to be well rubbed every evening with vegetable oil of ointment. Child to take 

1/2 teaspoonful of codliver oil three times a day.

5th July - child seems quite himself again - coryza less being obtained - breathing quiet - temp. 98°4. Right back blisters quite disappeared, leaving remnant with a few coarse rales accompanying venous breathing.
Mrs was my last visit - advised motion to increase gradually amount of codlins oil. I saw the mother about 3 months after who she said the child was quite well of bed picked up flesh again.

Note this was a case of broncho-pneumonia coming on in a weakly baby's child. The pneumonia itself was clearly secondary to the Rheumatism which the child had & for which it had been attending hospital till the pneumonia set in, so  on evidences manner judging from the history the child probably had some pneumonia for some time before I saw it. On first visit there was a distinct dull patch with Copious Phlegm over one lung. A point of interest in this case was the sudden appearance of a dull patch in left lung & a more or less tabular disappearence of the same after lasting a little over a day. The patch was probably collapse of lung as the temp was normal high.

In the case 100°-102° the child had very weak chest walls it was entirely weak thoracic. Its weak was the child 1 so wanted that I was impelled to see the doctor was right. Clean up - the way it did, but marked improvement in child's appearance came on after the dull patch went away! The open fontiilla which was also cut depressed at first the delayed deitition & box shaped projecting forehead pointed to Rheumatism although there was no hearing of ribs, nor enlarged epiglottis carbituba. There was no positive sign of Congenital Syphillis although child according to mother had mutton.
Case 6—Mrs W's baby—a boy, aged 4 mos., of 1428, 
when Dr. Earlewell—att the breast—has been well 
up to present illness—well nourished but small. I was 
sent for to see the baby on 18th Oct. 92. The mother 
says that the baby was quite well till five days, 
before when she began to cough & have difficulty 
in breathing. When I saw it, the baby was in the 
mother's arms, breathing fast with some difficulty. 
Cough was frequent, sputum was moist—face was 
rather darkly—pulse fast & feeble; respiration 107.8. 
Smells confined two days. On examining chest— knew part 
of chest—slightly indrawn with respiration—chest 
运动—first—breath ruminates & accompanied by 
Bronchitic sounds—Bronchi, coarse & bubbling 
Rales. The Rales were principally of fine bubbling Rales. 
Bronchi tend chiefly on sternal. All over back 
the bubbling Rales heard especially fine sounds 
both ears. Oiled & Myd & cur. gr. 3/4, 
and: 
1 1/2 ounce 5 dr. 

of 
Brienne. 3/4, gr. sect. 3/5. hp. Anadr. 3/31 

sp. S 7/8. 3 sp. 3 b. —braces used; physicians 
to be applied all over chest of the mother to free 
Child of temporary of Brienne. If child gets very weakened 
in breathing.

Note: The case is evidently one of acute Bronchitis; 
all were lungs' but more especially of smaller tubes. 
The hardness of face, together with fast & laboured 
breathing, with Bronchitic physical signs all point 
to the case being chiefly a Capillary Bronchitis.
19th Oct. 1890 - Called to see Baby - very ill - breathing fast - uRt three with rigorously - secretion very purplish as mucus was furting up into the mouth. The nurse had sucked after mucus - the matter had to be washed it next twice during last 24 hrs. with apparently great relief to the baby. Cough frequent; temp. 103.8 - still deeply in face. Physical signs - no delusions or perseveration - accompanied by copious - chiefly fine moist bubbling rales - at one or two points - still these breaths breathing was high pitched but the fine rales at these points were of a high pitched kind. To express when the rales that - on listening at bases I placed the stethoscope off cart-rib on the abdominal wall - m to the a diaphragm put on the chest - the sound distinctly being conducted by the a diaphragm put on the lung on the side of the chest - I noticed the diaphragm to the stethoscope. It was by accident I noticed this. With steady to deep, quick, short, fast - I gave a very guarded outlook to parents as the high temp. 103.8, fast breathing & chills together with drawn state of child all made prognosis very grave - so young a child.

26th Oct. 1890 - Father called today to say child died at 4 a.m. with convolution. On inquiring if any nourishing has been carried out the father said child had not had any bread, because he, the father, belonged to a temperance society and it
was against the rules for any member of the family to have baby! This shows that it is one thing to order a remedy but quite a different thing to get people to follow out a diet-book of treatment.

Note: The little infant was carried off very quietly by the Capillary Bronchitis, and probably some broncho-pneumonia, from the presence of small pitchy breathing with harsh rales at base. There had been measles in the house & several of the other children had just got over the measles. Whether the baby

the bronchitis was the only bronchitis of measles I am unprepared to say, but it was quite possible & very probable! There were no spits about the baby.

What the convulsion meant — at the end of the infant's life meant I do not know. Perhaps the onset of a large collapse of the lungs or sudden onset of cerebral pneumonia — the extra influence or the shock of the convulsion coming on top of an already oxygenated baby at once putting an end to life. This case is a very interesting one of one which represents a large class of fatal cases in young children, either the severe Capillary Bronchitis preceeding the child by suffocation or through a broncho-pneumonia or a rapid collapse of lung coming on a child already breathing & struggling for life! The rise of temperature in this case on the second day together with the high pitch of breathing at certain points pointed to the onset of Broncho-pneumonia & almost excluded collapse of part of lung!
Case 1. Mrs. W. J., 83's, baby, a girl, aged 9 mos. of 7 Mary Ann Place, Beekman; the youngest of a family of seven, all well; no deaths; in the + better well; a cowpers to mother just died of consumption.

Previous History: about 4 months previously I had been attending the child for Berelitis; chronic diarrhoea. The mother at that time was frequent, slimy & greenish & turbid. Contained unsightly food—often very offensive. The diarrhoea had been going on for 6 weeks before the child came under my care & it had brought the child to a skeleton. It was only when the child began to cough & suffer with its chest that the mother sought advice. At that time it was extremely wasted, pale, emaciated, weak, eyes sunken & dull, no teeth, no thumbs, long thin fingers, yellowish. It vomited a little but the diarrhoea was the chief ailment & to add to its sufferings a burning of large & small lakes was present. The child lay in emaciated for about 2 weeks till diarrhoea stopped & then it got well again. The diarrhoea was controlled by diet, milk & thin water, with pulse, etc. aurum & an occasional dose of fly & 2cebr. & 5cebr. As the child was reduced to this I advised the mother to rub cold linseed oil into the abdomen & sides of chest with benefit. Soon the illness the child regained. The illness lasted over two weeks when child began to improve.
Present illness - the baby was brought by the mother on the 27th of Dec. 1870 for advice. The mother said it had been well up till about three hours before when after they had had their tea at 5 p.m. the child was taken ill as if with "pain in the stomach". The child when brought to me was lying in its mother's arms - looking ill - Features picked up & drawn back as if in pain, the breathing was fast & expiration was accompanied or rather caused by a harsh grating like 'cough'. The child's legs were drawn up. Pulse: fast & feeble: Temp. 107.2. 

Looking for fast & peculiar breathing I examined the chest & could get no sign of any departure from normal. The heart sounds were normal & accompanied by no noise. I was at a loss what to say the child was suffering from what the mother asked what was the matter with it? The child looked very ill & of course there was something wrong with the stomach. On account of the fast & peculiar breathing & limp & also weakness of the urinal, I made a provisional diagnosis of some chest inflammation & resolved to wait & watch. I told the mother there was some inflammation deep down in the chest near the stomach & she was perfectly satisfied. Most of these poor people are perfectly satisfied if you tell them there is 'inflammation' somewhere. The child held itself somewhat rigidly with its legs doubled up. At the time I thought this due to
ome pleurisy deep down on the diaphragm surface of the pleura & causing pain with walking agility of abdomen & swelling of legs. Again I thought it might be due to some perineal uneasiness as it came on not only after eating but after a meal part of which the child was too stiff, I order my tincture pectoralis to lower part of chest & upper part of abdomen & prescribed a mixture of nod, speck & mag. card. until an evil was somewhat forest & bowels copious.

Note: my diagnosis at this time uncertain - the trouble might be due to some inflammation on pleural surface deep down on diaphragm - giving rise to pain & swelling of abdominal walls & swelling of legs, but giving pain in the gut - intestinal colic common in badly fed children would also give symptoms of pain & swelling of legs.

But there was the temp. 101°. Cole would not send that up so that there was probably some chest trouble besides.

23 Dec. 1870 - was sent for as the child was much worse. It seems the last application of the night before had relieved the child for the night & it breathed easier & seemed less pain according to the mother. But this morning it took a bad turn & so the mother sent for me.

Now child lying in bed - breathing fast - moist & dilating along with inspiration. The breathing was accompanied by a sort of that grunt like eeeh with inspiration. Pulse 125. Temp. 102.8; child looked very pale.
features picked up at it day little a bag it did not cry as object to examination of the chest or stomach. Chest - no abnormal sounds with heath from which were venereal. 

Note - Except for the past health and the dilating until the expiration great, there was nothing in chest which to point to inflammation of any of the chest contents - pleural heat or lung. Yet there symptoms were without perceptible begin made one localize the tendency in the chest. There was no lumen in abdomen to the palpation not draw its legs up as at first - yet the child itself was worse. the probability that there was some colic at least relieved by hot applications to the abdomen (catharsis).

23rd Dec. 1890 - child the same, symptoms were pronounced - tongue furrowed, thieves open tongue, checks - healthy. Pulse 80, pulse full, pleth 103.4.

For first time during the illness was any definite physical sign noticed - higher expired with on percussion of left chest that it was an anesthetic that gave the most definite departure from normal - distress of higher pitches to apparently prolonged expiration - bronchial - a few coughs at first time.

Diagram showing physical sign on 23 Dec. 1890

Note: today's physical sign want to confirm the previous diagnosis. This made it a case of probable consolidation of lung deep down on left side.
& thus accounting for the mental muffled & distant bronchial breath in the head over left base.

24th Dec. 1878
Child very ill, dying all day - pallor marked - no wake, dilated markedly - breathing fast - temp 103.2; pulse fast & feeble about 140. Tongue furred - child not taking much nourishment - a little milk - deep tea - Powell spec fic.

Child - Front - breath not loud & have venular breathing; no accentuation. Powell - no dulness, venular breathing; no abnormal signs. Left - dulness up to level of 5th or 6th rib - health sounds even dull patch, high pitched bronchial accompanied by fine crepitations with inspiration chiefly, but also expiration. At some points over dulness, bronchial breathing clearer, more marked. The dulness extends to post. axillary border.

Left apex & axilla - Breaths were venular; no dulness.

25th Dec. 1878 - Child lying as before - dying - does not take any notice of things - it does not object to being examined. Resp: 80 - pulse 136 - temp: 158.6

Physical Signs
Dull patch at left base has extended up as high as inferior angle of the scapula & into middle of left axilla.

Powell venular breathing

Diagram showing physical signs in Dec. 25. 1878
all win dull area high pitches with fine crackling crepitations; more marked with inspiration; at some points breath sounds almost tubular in character.
26 Dec. 1890  Child very ill - eyes shut - very ap- 
parently unconscious. Breathing 60; pulse very fast; temp. 103.4. 
Imagined covered with thick white fur - child taking less milk. 
Received 5-10 drops of brandy in milk every hour. Bowels open.

Physical signs - Front - Right - Local venous health sounds - 
no accompanying. Resonance impaired on left - front - back. 
Breath sounds dull and high pitched hoarse, with some 
resonance on right side only. Child's color dry, thin, 
dull.

Diagram of front & back giving physical signs 9.40 a.m.

Left - dull - no resonance.

29 Dec. 1890 - Child about the same looks pale, without 
working; lips & ears much less red. Child covered with red blisters.
Breathing - 60; pulse very fast. Feels cold. Inadequate larynx.

Physical signs as on previous visit - left lung completely 
dull. Front & back with high pitched brassy hoarse; all dull. 
Resonance of respiratory sounds at base.
28th Dec. 1890 - Child free as previous visit. Temp. 104°.2

Perichondial breathing most marked - left iliacus region.

29th Dec. 1890 Child still slightly ill - wanted to a Steth.

Throat furres much, open and ominous. Temp. 102°. -

Taking little better - talkig 10-20 breaths of airly only when necessary - who child feels a 'bad heat'.

Physical region - about same as on previous visit - left

lung weakly dull front & back with high pitched

bronchial breath and, accompanied by Crepitations - at

some points with inspiriing & expirating - at others chiefly

with inspiriing. Crepitations not detected at Right-Side.

30th Dec. 1890 - Child has a short brendy cough - healig

56; temp 104.2; pulse a little thinner - tongue still

furred; mouth Open kines- very dry. Child talking

more with - bead tea. Physical region - left lung still

dull - bronchial breathing with Crepin. Crepitation heard front &

back of left - the breath here at one or two points - add of crepita-

tion intensity bronchial - the breath & Crepitation seem as if

in the iliacus. Vocal easy well heard Sibilapal region.

Right side - quite room - lung beneath breathing, no

accompanying.

31st Dec. 1890 - No change - a little less strong - temp

102°. Bowels open once.
24 Jan. 1871 — Child lying as usual — a little brighter & less whimpering — breathing, but child was lying away from head, & my best efforts to move it. No attempt to move out of bed. Temp. 100.3 — Chest condition same as on previous visit.

25 Jan. 1871 — Child lying as usual, but at times — fairly bright — in beginning to cough a great deal — a slight hoarseness; coughs — brings up nothing; temp. 101.4. Tongue less furrowed — chiefly to side & back — ; breaths open — chest more full — about 12 pm day according to the weather. Chest — same as before. Left lung remains dull compared to right, with occasional flecks of dark blood; breath sounds accompanied by crepitating mucus. At first, sound as at first, neither dull nor breath sounds so high-pitched as at first. Right lung still remains vented — crepitating time happened at the base.

Note: the chest especially left side has been treated by frequent irrigations with mustard & the same occasionally added to day. I ordered the mother to apply every other day at different parts of left side of chest, mustard’s plasters for 10 minutes & afterwards while of chest to be wrapped up with. I put the child on Mr. Harry Claypool Co.

23rd Jan. 1871 — Child lying as usual — does not attempt to sit up — is a little brighter — notice things when within talking distance & can repeat it. Temp. 99.6 — breathing less labored, but will with a little. Cough is frequent. Left lung is a little less dull & louder, but still dull compared with right. Breath very much improved. At 5 pm — I laid down and slept with the child, crepitating present but less efficient.
4th Jan. 1841 - Child about the same - Temp 100°
5th Jan. 1841 - about the same - does not seem to perk up.
Temp 99°
6th Jan. 1841 - Child still lying in bed - does not like to be
disturbed - in crossed eyes, who chest - being examined.
Temp 99°
Physical exam - same as before - left chest quite dull, dull
at back. The abdomen: left lower back is not so tender
as at first - getting somewhat fatter. Breath sounds
quiet. No rales at height pitches - bronchial breathing chiefly
at pericarmonic region - upper aillary - rest of left lung
sounds unrestricted breathing - no emphysema heard all over Left.
Right side - normal - breathing cut to low - at
height but lower than left side - no emphysema
at base. No coarse rales in either side. Local
cough on left side at upper traps. when child cries.
7th Jan. 1841 - Child as before - resumes freely at night -
according to mother gets better + less as night - Temp 100°
Breath sounds healthy. Father went out of town, is
taking two leucopils of brandy to each bottle full of milk.
8th Jan. 1841 - No signs of abcess closing away from the
left side which still remain markedly deficient in
sounde when compared with the Right side.
Right side remain apparently quite healthy - normal
breath sounds unrestricted + no accompaniments.
9th Jan. 1841 - Child brighter but still pale thing week.
Smiles at mother + will take hold of finger - does
not seem to rally now - urine a little purer
all over a little more firm + sounds then healthy - pulse
feable + still fast - Temp 107°4.
The left leg still dull - breath much decreased at near two points over back & front. Respiration all over left side. Breathing a sort of labored in a very left chest. Right side - breathing regular, no accompaniments.

10th Jan. 1891 - no change - process evidently being chronic - pulse feeble - temp. 98.6 - Physical signs as before.


14th Jan. 1891 - Temp. 98° - child taking a quart of milk daily.

16th Jan. 1891 - same as before - Temp. 98.4 - region of weakness a little less marked but still present when left is compared with right - respiration a little less.

18th Jan. 1891 - child still lying in bed - but wants to be moved - temp. 99.8 - pulse feeble & weak - weight then - chest the same - there was very little mov'g of intercurrences - I have felt of chest - the left moved less freely than the right - looked fuller than the right - walking on effort the probable. The day after I called a neighboring practitioner to look at the child - he did not think there was any effusion present - the ascraithic needle was not tried as the child was so low - he warned the friends objected to any surgical procedure whatever. It would not be of benefit to the child into hospital.

The child lingered on - I spent every day. Until the 26th Jan. 1891 - the child quite suddenly & quietly. The physical signs remained the same.
up to the time of death - dullness more or less all over chest

lung - chest sounds bronchial & cracks synchronous with
crepitations there were no bed ones in child although
it had been dying all the while - apparently preparing
to be investigated - it was reduced to 89% of time -

mother - eyeballs - all vitals strong.

tie!

the case at first was a doubtful one for 3 or 4 days

in spite of careful examination of the chest. the

course of the illness, judging from mother's say was

fairly sudden & there had not been anything to the

mother any cough before & certainly on the 1st day

there were no bronchitic features that I could detect.

so that - without a preceding bronchitis the catabral

pneumonia which the child evidently had was not a

secondary but a primary affection in the case!

unless of course there was a bronchitis without any

recognizable physical signs. the catabral pneumonia

granting that - the diagnosis was correct - was essentially

one sided although some crepitation were discernible

at different times on the opposite side. the diagno-

sing between pleurisy & croupous & lobary pneumonia

& catabral pneumonia.

in favor of pleurisy was dullness which gradually

existed seen to first but again pleurisy was

the presence of high pitched bronchial breathing all

over & absence of crepitations all over

dull area which would not be to b i pleuritic effusion.

again the high sustained crops was again pleurisy &
the fact of a left sided effusion at the
nipple, as— the case, was incompatible unless of
cause the heart were shown down by adrenin, which was
inprobable in the case.
In favour of Crespon's pneumonia was further noted— its-
lobar distribution & at points almost tubular breathing
but against Crespon's pneumonia was the presence
of Crepitation on opposite side; the presence of
Crespon's Crepitation with the tubular breath notes
all along the attack, the course character of the
Crepitation, differed from the fire Crepitation of the
true Crespon's pneumonia & again the temperature
was not very high as— Crespon pneumonia
but was a temperature which went up & down rather
irregularly unlike the motions temperature of true
Crespon or Lobars pneumonia. The absence of
Bronchitic marks in the case pointed rather to
Crespon pneumonia, for— Catarrhal or Broncho-
Crespon pneumonia Bronchitic marks are as rule patients.
This present case was evidently one of Catarrhal
or Bronchos pneumonia taking a lobes form as
to distribution—that is to say the individual
lobules of the tubular pneumonia ran together
& formed confluent or lobes masses, as far
as physical signs could demonstrate
It was only on the 3rd day of the illness
that Alpinist physical signs were detected, these
were slight impairment of resonance at left base,
& direct bronchial (inspiration chiefly) breath notes.
From these physical signs together with the local chest symptoms — faint beating, also semi-wakening — I made the diagnosis of consolidation at root of lung — at my rate not at lung surface — as day by day passed the signs of consolidation became more and more pronounced till at the end of the 1st week the whole of the left lung was quite dull-front, back, and sides. The consolidation seemed in this case to first come to the surface at the base and then slowly creep up the back involving the front and apex the last. The local emphysema continued for five weeks up to death of the baby — only the symptoms and signs were not quite so pronounced as during the first two weeks. The consolidation emphysema of lobar bronchial pneumonia but at that period of the illness I strongly suspected an effusion — empyema into the pleura — but the needle was not used to so decide — sign — pus was got. The case was one however of sudden death — pneumonia (extensive) — the child passed off very quietly — according to the mother getting moderately well half a hour before she could get to it, the baby was dead. Death no doubt took place from syncope consequent upon wasting of entire ability produced by the severe pneumonic inflammation. This case was a very interesting instructive one both by its uncertainty at commencement as to the exact local
Condition again by the gradual involvement of the whole lung by the inflammatory process, which seemed to spread in the lung much the same way as erysipelas does in the face—bit by bit as days pass by. I happened to be attending a severe case of erysipelas of the face & the analogy between the two strikes me forcibly. In the case of the erysipelas the inflammatory process could be watched & the inflamed area could be definitely worked out from the healthy unaffected skin by a mere n less especially in forehead! abrupt manner. The difference between the consolidated inflamed lung & the fairly healthy lung could also be fairly accurately worked out from day to day. In the case of erysipelas the inflammation started on right side of nose & gradually spread—laterally & upwards—till both eyes were closed—forehead red & intensely painful & even ears red & painful. In the case of the lung inflammation the process probably started at the root—reached the base first & the gradually came to the surface at pints upwards from the face till the whole lung was consolidated! the right lung with exception of a few cavities at base & along lower spine was unaffected & formed a good standard for comparison of the left lung!
the pneumonia in the case was almost entirely one-sided.
A point of interest in the case was the entire absence of any intestinal trouble. The child was one of four before and been the subject of chronic diarrhoea. Yet, the illness appeared to be no more
yet they were not regularly once or twice a day
but there was nothing like diarrhoea as the
unless — I looked at them in several omissions — were
natural in colour — not offensive — others to any degree.
there was very little gastric trouble. The tongue
was very furry. The child went off its food
at first — but there was vomiting not more than
six times during the illness.
A point of interest in the case was the bringing up
of the baby. She was one of five — the youngest all
healthy — father a little subject to cough — within a
day or two, healthy woman but complained of no nausea
relatively. It was a full-time child and apparently
born healthy. The mother had to go out to work
so the child had to be bottle-fed. A dairy cow's
milk was tried at first but some of the
foods — puddings or others — caused diarrhoea.
formed the baby's diet. The baby from
about 3 to 5 or 6 little bits of everything
not only that, but from inquiry I found that
was sheer — always eating a sliding stool.
this rubbish or sneezing feeding no doubt was
the cause of the chronic diarrhoea. Before added
to it no doubt was the cause of the poor
growth & development of the body. The mother herself admitted that the body had been wasted. The child from an early age never seemed healthy: starting diarrhoea early was wasted to 8irls of time always very pale cheeks, sunken eyes, was slight of small for age, backward in teeth, head laws not sucking properly, no bending fast; of no elongation of ears of long lines. There was no doubt that the impurities did not set up diarrhoea & malnutrition & this was the child. Next to the attacks of catarrh an acute bronchial catarrh & later on pneumatic catarrh the last proving fatal probably finding an easy victim in the wasted pale & debilitated child brought up by the catarhral pneumonia probably did not set to kill the child, but it the constipation remained - the glands at the spot of the lungs being choked from over work & absorption + is not being able to absorb the products of inflammation in the lung - the while process remains at a standstill just as in the case of typhoid in children. Often there is a chinking of the mesenteric vessels from overwork of the glands remain large & one unable do the work of filtering absorbing the waste products of digestion & so leads to fatwan of the patient. I have seen this condition in the East Morlein
rooms both in the case of Pneumonia + Bronchial pneumonia + also in a case of Typhoid. The child had suffered in a feverish condition, with severe headache together with diarrhoea, as whether the primary bronchitis was chronic the lungs are so laid open. As a Catabolic inflammation in the air cells I know not, but clinically at the time of onset of illness + during the centrifugal bronchitis could not be detected, so that the case looked more like one of Pneumonia + not secondary Bronchial pneumonia!

Case 8: On 3rd Jan. 1970 was called early in the morning to see a baby 10 mrs. old.

Former history, I attended the mother when the child was born. The labour was about 8 hours very severe pain + one feature of interest in that labour was the occurrence of a case of a rare position of the head which was with occiput-brown's faciem (R.O.P) early: labour, the occiput was described as the perineum instead of over the pubis. The usual 'internal rotation' of the occiput from its position in a position to a position opposite the pubis during descent did not take place but the occiput rotated backwards into the hollow of the sacrum + was achieved over perineum, the face coming after, then the pubic margin instead of the usual delivery, the child was born large. The child was breast fed for 3 months but on account of mother's ill health it was brought up on the bottle. Don't quite reconcile feeding.
about 4 mos. before present illness I attended the child for a severe attack of bronchitis, which was chiefly characterized by difficulty of breathing cough & the physical sign were bronchitis - sibilant, coarse & fine bubbling rales all over the chest. Previous to this the child was free from any such attack, but when she was 4 mos. old, I noticed the child's breathing & could hear rattling & wheezing which on hearing with the stethoscope was attributed to be due to cabbag6 of the trachea & lungs, & was confirmed by the fact of chronic bronchitis & worse & worse until for 4 mos. before present illness the child was given more & more of respiratory irritation & the child was held up. There was still the sibilant of the old bronchitis, at the chest - the wheezier of the chronic bronchitis - this remained & would not give way to all sorts of treatment. The baby had chickenpox, but no other illness; no teeth out when eight months old.

Present illness - for 3½ days was called to see the child. Mrs Y., the mother of 3 Franklin Rd, Peckham said that yesterday, the 3rd Jan. 1911, the child was apparently quite well, with exception of the slight wheeziness which it had always. Towards evening, the mother's attention was called to the child because it looked ill, pale & did not try to walk as it has been doing previously.
On 3rd Jan 1841, I saw the baby - it was lying in its crib - breathing fast & a labourous sort of way. The child was pale & weak with its poor condition - a slight fever, no enlargement at ears of long times - no beating of ribs, but flesh was flabby.

The child's face was a consumptive, it was pale & hollow to the touch & the first breathing was accompanied by wheezy noises & rattling in the chest which could be heard standing by the crib.

On examination of the well formed chest - removed

- suprasternal - auscultation gave hoarse, coarse 
- fine bubbling rales & noises of all sorts - squeak & cough - the coarse chiefly in front & the fine rales chiefly at the back. The tongue was slightly furred - the mouth - pale & fest

- wrist - pulse fast, hot & steady - Brouch Court's temp. 91.8. Waken

I filled - hot solution in chest with hot water - & a mixture cutting phren.

While on my rounds of visiting, the mother told me great horse about 1½ hrs after I left her - to say the child was dying. I visited again & found the child on its mother lap, in a semi-conscious state - its limbs were mm thin to the edges - its hands, fi...
fixed alternately. It seems after I had left on first
visit that the child had a 'fit' during which it be-
came quite rigid, eyes fixed, hands upper-3d, and
shook a little after-3d. I ordered iat-3th with
feversin i i i at once to be repeated if fit
Once on again. The child had convulsions
the first fit. It had two fits during the night-
during which the lips jutted & eyes rolled about.
It had urinated the powder just before the first
fit so I ordered another to feel-free action of bowels.
5th Jan. 1831 - *no* child today - drowsy, lay in
crib & did not like to be disturbed. Respirations fast 55
breaths a littleanner but also was walking & made fast.
Temp 103.6 - the chest was & until the one
condition as a previous visit last the child
breathed with a sort of grunt & glib with expiration.
6th Jan. 1831 - child very drowsy but could be wakened-
could not apparently recognize his mother & did not object
or cry during examination. Reexp. fast 65; pulse strong
full - Temp. 103.2 - Brumels Prena, the urine very foamy
occasionally after a fit of coughing. "Fit" (canicr) quite
stopped.

**Chart** - 1st - It was on going through the entire
systematic examination of the chest that the late
state of affairs became apparent. On percussion
of the front below the clavicles, there was a marked
difference between the two sides - on the left
front there was the usual resonant hollow
note on percussion; over the right side i found-
This was a hypoplastic note—raising one of foremen
lutea a dissipated thromb. This note reached by 4th
pit below from clavicle & to anterior axillary border
a right side—axilla on left.

Front

[Diagram: Hypoplastic note with fracture R. Eng.]

Diagnosis: Hypoplastic region on 8th Jan. 1891

Auscultation: Rales on both sides, no difference—bull
joints between two sides of front.

Back: Both apices الآن - the right
chest region less resonant than the left.
From the scapula to the lower border of chest on the
right side there was dulness on percussion. The
same region on the left side was resonant & if softly
slightly hyperresonant. The dulness on the right
side was on whole of right back with exception
of a strip near spine. The dulness extends into axillary
region just beyond post axillary border.

Auscultation there were rales &株洲 & cough sounds
much the same as in front of chest. Auscultation
below scapula on left side gave rales & sounds of
worse quality.

Back

[Diagram: Auscultation region with rales]

Percussion—pale & feeble

Percussion area above right spine.

Diagram: Hypoplastic region on 8th Jan. 1891.
On ancestral en dull area a Right side, then was fine exsudation especially with inspiration. The breath sounds themselves were of a high pitched character & we could get at one or two points over the dull area bilateral & even tubular breathing. What was most striking was the high pitched character of the breath sounds even of the exsudation itself, which might accompany inspiration. The exsudation was somewhat blurred at some points of the bubbling rales which somewhat masses the fine rales. The exsudation ended as if they were in the stethoscope.

8½ Jan. 1841. The child very ill. Breathing fast about 60 & still with a sort of grunt at the end of inspiration.

Pulse rather weak & fast; temp 104°. Ordered Purgative only when exsudate required. Purgatives –

12 Sparrow’s mixt up 7/10, ½. Serum ins 1 v. mag. nephr. 1 v every 3 hrs. The child had sort of “bad turns” as the nurse called them, especially during the night; they were characterized by extreme pallor & weak breathing, the nurse hardly knowing the baby was alive – sort of stupor!

Chest – much the same as on previous visit –

Symptoms W6 on Right, from + dullness all over right lower back up as high as spine of scapula down to spine & from right up to spind Column into mid. Axillary line.

The dullness had relaxed a little since last visit – up tospind Column laterally & upper spine of scapula above. The dullness was very marked & definite on percussion.
it was as if tapping a board when compared with percussion of the left back, which was quite different. Auscultation gave more definite signs of pneumonic consolidation.

**Diagram showing physical signs on 8th Jan 1891.**

There were five crepitations all over rib area & the breath sounds were high pitched & were hoarse at most points. At one or two points there was distinct tubular breathing especially the expiratory part of the breath sound.

On left side the breath sounds were loud & vesicular but were accompanied by crackles by rales & rhonchi all over & back.

Note: As to convulsions, the baby had at once of illness.

The child has 4 teeth - 2 in middle incisors below & above - the lower ones were cut at 7 months & the upper two about two months later. On one side of upper ones the gum is red & swollen & above the gum is a swelling the shape of a tooth - possibly a tooth about to come through the gums membrane on one side of the central incisors. The teeth causing irritation may have had something to do with the convulsions - the baby always blan...
the teeth but in this case there was much trouble in the lung to account for the convulsions at the onset of the illness so that probably the edema and swollen state of the gum may be considered only a factor in the causation of the fit. In many cases irritation was a factor about to come through it all that we can find in a case of convulsion we are compelled to have the teeth. But I take it that in this case the convulsions were symptoms only of the onset of the lung inflammation or edema of inflammation from smaller bronchi into the alveoli and air cells, causing such a profound disturbance in the child's nervous system that the motor areas and cells became affected (reflexly & so caused) the convulsions which was only a symptom of motor cell irritation from whatever source. Fainting—fallen albit well but had one ruler who is subject to "fits" & was has 4 children 2 of whom had "fits" while tabbing. Mother pale & anaemic—has a soft throb or murmur with 1st sound of the heart—best heard at apex but best also heard in mid. This murmur I discovered while she was lying in after the confinement—she did not seem to pick up even at the end of 10 days but remained as she had been all through her pregnancy very pale looking like a patient with lead poisoning but since were all right no were with. I examined the heart & so discovered the murmur—then came out a history of Rheumatic fever 4 years ago with bad health ever since.
Children were all strong and healthy except the one who was under treatment. The one went to it—a boy. This older one used to suffer—now 3 yrs old. From 'angina' of chest put the same as the little girl was very troublesome and suffers so tell it has all its teeth. This boy has a 'fit' when cutting cans or 'age' teeth. When it suffered at some time with a bad attack of 'dyspepsia' I was given up by a medical man if he has a 'fit' again when cutting last double tooth.

So that in these two members of this family there is a disposition to convulsions whilst none of the other children had fits either when teething or when attacked with illness. It is worthy of notice that both these children were born since the mother had her last attack of 'Rheumatic fever' was damaged in her heart is all probability of the same.

9th Jan 1891. Child has a 'bad head' last night. He was said to have been very pale and struggled for breath—was relieved by sleeping. Pulse fast and feeble. Temperature 55.0; temp. 103. Physical signs little altered from previous visit. Still sympathetic pulse over right front though not so marked as previously. At back of right breast the diaphragm was not marked below scapula. The entrance diaphragm rested on previous day entailing from base to scapula was less so when compared with diaphragm regions, but it is still still confined with left.
Assaulted by convulsion, men loose & have part of right lung & also an occasional bubbling & crackling. On auscultation over the intercostal region, bifid fluid crackling. Auscultation were heard accompanying breath which were tubular in character, most definite & distinct at first; a diagram makes x, just inferior to angle of scapula.

Diagram: First physical sign on 9th Jan., 1840.

The tubular breath was accompanied by a sound marked by crackling, crackling, while on inspiration there was inspiratory. With inspiration the breath would seem as if produced in the stethoscope. So distinct & intense they are. The crackling at first marked x are like crackling of dry leaves when first a few dry leaves squeezed in the hand.

CLERICAL ✗ exactitude in writing is well marked at time today.

Judging from physical sign - less dull & coarse tone present.

10th Jan., 1841 - Child crying in bed - less convex & recognised, mother passed a restless night - coughing a little, but struggled for breath during night.
Physical signs — tympanitic note on right side instruments but as these were tight abdomen not R. Abdomen — Auscultation over face gave cheering with inspiration & expiration but no bubbling coats as on previous visit; on right side on Xheche on a few coats.

Back — Percussion gave resonance all over left back bone as well as apes. On right side in lower back as high as five times ribs the note was dull compared with same region in left lower back but not so dull as it was on 1st day of sickness & so to dull as it is, dull region from spine to below inferior angle of scapula.

Diagram — Xheche physical signs on 10. Jan

Auscultation — gives on left back (dry) Xheche all over left back. Over right lower back (rough) are very fine crepitations both with inspiration & expiration — more rougher with inspiration. These crepitations were like those produced by rubbing heated boards.

Over the intercostal region (dull) & cracking crepitations accompanying distinct high pitched rhovial breath — must be flapped as if in the stethoscope.

R. axilla — diminished resonance - tracheo venous

breathing with crepitations + coats.
the child cries more today seeming to object more to the chest apparatus than in previous occasions.

While examining Right Scapula again the crying of the child was heard very distinctly through the stethoscope — vocal resonance!

Note

Points of interest shown by today's physical signs are:

1. The loss of the hyperaemic note over the lungs.

2. The change in the accompany of the breath sounds on the left side of chest from moist sounds, latest bubbling note, to dry sounds only.

3. Apparent shifting of the bulk of the lung inflation from the lower part of the right lung, where it was most intense at first, to the upper part of the right lung, as shown in the difference in hyperaemic sounds between the upper and lower part of the chest.

4. The upper part dull sound of right lung — the breath sounds were shrill, high pitched, and accompanied by intense chest movement.

Crepitation, which were chiefly with inspiration (lasting part of) while the breath sounds were low pitched, short of breath, and were accompanied by very fine crepitations, which were both with inspiration.
Note: The question at this line arose in my mind.

What really was the chance? I had, from first-detection
of consolidation & high pitched breathing & crepitatin-
made a diagnosis of Pneumonia.

The clinical feature to far has been

1st. There was a general diarrhési - a character of large
small bronchiol tubes.

2nd. Suddenly the child gets worse - labored &
difficult breathing - cally collapsed - has 'fits'
Breathings Changes in character becomes quicker & easier
thigh with a grunt. The face & conjuncti - the late-
cut of profuse vine - color - the child gets very
pale & drooping & in 3 or 4 days local signs are
Detected for the first time, except for the bronchi-
tic signs. There was Sign of consolidation in Right back
with cophous crepitatin while in the left side
there were cheunchi & rales which gradually get
less & less as the sign of consolidation recede in the
Right side.

Condition which the above might represent-

1. Pneumony with effusion.
2. Collapse of lung.
3. Pneumonia (croupous)
4. Pneumonia (Broncho-Catarhal)

Pneumony with effusion - dulness present to this
but against this was absence of any distinct movement
in right empyem to left - heart not shifted.
Crepitation somewhat different from friction ruts which
generally precede dulness in pneumony but in this
case the agitation increased as the dulness deepened.
i found which would not be to i pleasing with effusion where as effumis begin the friction and diminish or at least diminish are: children: intensity.
the dulness i: the case certainly spread against
fun cone as it would do i pleasing with effusion
but it did not go to the front although high up
in the back & again from being physical
sign the lower part of right side i: less
dull than the upper part of right chest.
against pleasing with effusion where the case un-
resembled was viscous intensity & dulness of
health never are one distinct from the age
where ever in effumis me can hear health was
from a collapsed lung. In pleasing with
effumis i children the breath sounds are not
lost is absolutely as i the same condition
the adult i whereas will effumis the
chest seems almost silent. The temperature i
the case was high & continues so which would
not be so i viscosity pleasing. There put: no
doubt exclude pleasing with effumis
2. Collapse of lung — hard to conclude absolutely
though the high temperature was against
collapse of lung. With a collapse of lung
so great as to produce such an amount of
dulness there would be low heart & a
general collapse of the child itself. Against
collapse was the absence of my diminuition.
breath, 20, 30, 40, the presence of crepitation at some
time as dulness appeared.

3°. Pneumonia (Bronchus), the mucus met with
in the windpipe of the dulness and the chest. The
were all in favor of
bronchial pneumonia, but against this form of
pneumonia was the presence of a bronchial
Cattarrh preceding the illness; the age of the
child; the presence of crepitation over the
parts which were most dull.

4°. Pneumonia (Catarhal), in favor of this form
of pneumonia was the preceding croupish, the
age of the child, the presence of profuse
crepitation where dulness was not marked and the
general pallor and dulness brethning of the
child. At times the ease resembled bronchial
pneumonia especially as it was 'lobar' and
lobular in distribution.

The case was in all probability one of
Broncho-Pneumonia (Catarhal) lasting a lobar
distribution. At any rate the case is still
going on & case be watched!

11th Jan. 1879. Pat. had better night after a great
deal of coughing, in earlier part of night, brought up
phlegm, the child has a flush on cheeks. Pulse
fast & regular - Resp. count 50; Temp. 103°.
Pulmonary open normal motion.
Physical sign same as in previous visit.
Right expansim - Right foot - High March rate - Sometimes bruits air \- Left foot - Remat -

 Auscultation - Left lung - Sound accompanied by dry rhonchi, no moist rhonchi - Right lung - Sound not so distinct as in Left lung and accompanied by rales & rhonchi - but no Crepitations.

Back - Movement as seen by ribs laterally - apparently more on both sides.

Percussion - quiet - dull in the whole of right side - Resonance more left side - The difference between upper & lower part of right back is not so marked as in previous with

 Auscultation - Breath sounds were louder over ribs - High pitched - broncho venous & accompanied by fine Crepitations (insp. & expir.)

[Diagram]

Dr. Gold - Being physical diagnosis on 11th Jan 1819.

Over a area we note freq. interruption again - the patient becomes drowsy with it - (Penetrate forehead -), the breath sounds are high pitched bronchial, almost tubular & accompanied by Occurring Crepitations especially marked with inspiration. All men this area when I called the Child's cry could be heard through plethysme - Vocal resonance -
19th Jan. 1891 — very foggy last night.

Last night was a restless night. Woke up all night with the child — not nurses in any house! Engaged a great deal. Child's cheeks flushed. Child getting very flabby & thin.

R. temp 106.8; P. 140. Febrile. Respiratory temp 107.4.


Back R. local findings felt distinctly on R. side when child is up, but absent on left when lying down in bed. When child cries, the vibration was quite marked on the right side.

Percussion — note remnant all over left but vanished all over right side — quite dull at base next to 3rd rib. Again dull from about angle of scapula to the right apex. Between 3rd & 4th ribs & angle of scapula. Remains my slighty impaired sounds will resemble on left.

Percussion: Breath and vibrations with occipital & vertebral arch.

Inspiratory: Occipital & vertebral arches.

Expiration: Trachea, bronchi, & breathing table.

Consultation — can lower part of chest as high as 6th rib. Breathing looks normal with inspiration with lungs' & expire. In middle zone for 3 to 6 rib the breath sound was more bronchial with expiration will inspirate...
Chiefly. The whispered voice seems again to open the breath and make high pitched musical almost tubular sounds as if we were listening over the bronchus at inspiration or exhalation. The breath sounds were accompanied by occasional crepitation. The high pitched tubular musical breath sound was most distinct in the left axilla near spine but was heard near clavicle mid way the axilla.

At R. open the breath sound was somewhat stiffer by the accompanying crepitation (mrb points).

13th Jan 1891. Child passed better night - left the thermometer at night 69°F. At 9 p.m. last night and found it 104.6°F again at 5 a.m. = the thermometer registered 103. The baby was well once we removed bivit - very pale, esp. face but fairly dry, but the sort of skin with Kopitskin, Temp today at 3 p.m. 107°F. Ears: rather relaxed - tongue coated with white fur except for tip which at tip.

Thick white breathes up fur on clavicles.

PhysiqueFigur

Front - R. Hypoplastic with quille last being paroxysmal.

Forearm - F. Remnant - early with venulent breath last sides.

Back - dull note all over. Right lung for two to open & to part bullae, less dull in middle of lower back. Breath sounds & accompaniments much the same on last visit - the 17th

The chief point of interest is the ease
bronchial almost tubular breath sounds in the right
anteroscapular. (Scapular down found out of the way) & apical
regions accompanies with occasional crackling crepi-
tations. This bronchial breath and was as if one
were listening very the trachea - inspiration & expiration
equal & the fine crackling crepitations with inspiratory chief.
The child's crying & gasping could be heard all over
upper part of right chest.
Left - Breath sounds normal & accompanied by
more rhonchi & rales than on previous day.
14th Jan. 1891 - Child had restless night coughing
less. Temp at 9 p.m. yesterday was 102°.6
Temp. at 2:30 today pm. 98°. Pulse slower
Respirations faster. Bowels - incomplete less
cotyled. Since yesterday there has appeared a
venereal eruption over one half of scalp & pretty
down the neck - a sort of herpes truncatus - the
mother wished it. for erysipelas.
Physical exam. - R. Trunk - inflamed into - breath sounds
venereal with a few rhonchi & fine rales.
L. trunk - Remains - venereal bed with rhonchi
Back -
R. Back - Venereal very little improved ex-
cept for a strip over last ribs. Still not fair
up to level of anterior pronunciun.
Over lower right back the breath sounds were
venereal & broke venereal with rales & crepitations.
The fine crepitations of previous day were lost-
being replaced by coarse sounds. Rales & crepitations in lower back.
Pulse at the base of the right lung - no 2nd 3rd ribs - the respitotions were fine & distinct - but the breath sounds higher up, both below the angle of scapula were getting more like those on left side - coarse sounds!

Back

Diagram showing physical sign on 14 Jan. 1891.

On percussing from below upwards at a line at about 2 fingers from the spine on the right side the liver note i.e. the heart note was suddenly lost at about the level of the ribs. This dull note extended to the upper abdomen of the abdomen to a little put on part border (fold of iliacus dorsi). Neer this dull area the breath sounds were clear high pitched bronchial & at one point along (tibular) - characters. Respiration accompanied the breath sounds chiefly with respiration but some with inspiration as well.

Note - The chief point of interest is today physical signs in the vessels between upper lower part of right chest.

In the lower part of R chest Respiration is only slightly impaired & breath sounds were getting more like normal side (left).

In the upper part of R chest there was dullness & the breath sounds still high pitched & the thing with cracking respiration. Below this certainly a change toward normal but above the costal part Viscera will well marked bronchial breath sounds!
15th Jan. 1891
Child had restless night—crying a great deal—Temp. 99° Resp. easy; pulse rapid & ting—
Breath open—Rash on neck & forearms dying up.

Physical region
Right front—slight inspiratory versus with feeble voice. Left front—rough inspiratory & expiratory.

Back—

Diagram given physical region on 1/5/91.

Right back—Renaux as high as 6th rib slightly has remnant then left—withe venereal breath mix. bilateral—few capillaries.


Hand—Abdominal—inspiratory to Right side for 10 minutes.

16th Jan. 1891
Child very fretful & cross—exp. inspiratory.

Rash on R. side of head dried up—has slight discharge from Right ear. Breathing freely—Supine does versus
Resp. easy & slow; Temp. 99.8, pulse strong & well felt at wrist.

Physical region
Right remnant—breathing venereal—mix. occasional biles thick & even expiratory. Left front—
Venereal breathing with occasional rhonchi.

Right back—Renaux slightly raised all over R. chest, lies in to breath then back. Breathing mix.
Venereal in some parts of thick L. venereal—others on R. flanks—capillaries hale & venereal all over R. chest.

Abdomen—brochial breathing heard especially well under clavicle to spine & even on off side more left.
14th Jan 1841

Child very restless, crying at night. Freq: 120, temp 98°.

Physical region - both lungs; resonant; breathing vehement and only a few thoracic vibrations.

[Diagram showing physical region in the 14th Jan.]

Removes one in right side and left except at base of each clavicle. Breathings resonant on right back with ales and thoracic dull. Right at base of each clavicle. Breathings resonant on left back and right back. Right - resonant. Venereal health and no excretion. Vocal resonant loud.

Ezuation very difficult. Occasional crying and restlessness of the child. Ordered Right chest to be packed with r. f. to right and left. Under these circumstances.

31st Jan 1841

18th Jan 1841

Little patient both quite bright, entire. 

Child will take liquid of Chinese, when offered to them.

Breathing quiet + clear; pulse sting - 200; 9 ½. Freq: 130, temp 98°.

One acc. child not employ so much and has passed the night better. First since fall of cold, able now to work - child not cries + crying as one two previous days.

Physical region - for both lungs; equally resonant.

Assessment: Left - weak inspiration + thoracic all areas.
left front. Right - cough breathing; chest & a few rales.
Backs - Resonance apparently equal in the two sides.
Breath & venereal accompanied by a occasional rale
in the left; & constant rale in right. No fine
crepitations in right side. A few rales in infra- scapular
region; no bronchial breathing in upper right chest.

19th 1.91 Child sleeps well at night—very little
cough; is quite bright & seems to be picking up
The me - Eugene. Clear & no.

Lungs — Both fronts resonant; on percussin - Breath-
gives venereal & accompanied by a few squeaking rales
in right-nose but no accompaniments in left-front.

Bowels — Both nice resonant. breath & venereal
no crepitations either at base, anterior or above. A few
squeaking rales heard over the area right-back
no accompaniments left-back.

This was my last visit to this little one, as the
temp. was normal, the pulse & breathing than the
child apparently quite herself again except for
the want of flesh. The local mischief
had quite cleared up leaving the sight lung
like the left.

This illness was judging from symptoms &
physical signs a Catarrhal or bronchio-
Pneumonia, confined to one side all
though the illness although there was present
before the illness & all though the illness
a severe Catarrh of the Bronchial tubes
on the left side & partly on the Right side (front). During the height of the illness the Bronchial Cataract on the left side ceased somewhat while the Bronchial Cataract on the Right side (Consolidation, Bronchial, wheezing, Crepitation(fine sound)) evidently ceased because during the height of the illness, Bronchial, wheezing & Crepitation (fine sound) only were heard over the R. back & no Bronchitic sound rale & rhonchi (coarse sound). As the consolidation in the Right side cleared up, the Crepitations were replaced by coarse rales & a few rhonchi, but these gradually cleared as child got well & in last visit the left chest was almost quite free from adventitious sounds, while over the Right back was a few Bronchitic sounds (rales & rhonchi)

This case resembled Bronchous pneumonia

in its onset, high temperature & an almost crisis-like fall of temp. In one side's lobes forms but differs from Bronchous Pneumonia in its being preceded by a Bronchial Cataract; in the age of the child; in the somewhat irregular temp. & in the presence of Crepitations all through the illness, the Crepitations appearing even where the Consolidation was worst pronounced & where the breath sounds were most bronchial & high pitched.

It was I think a case of Pneumonic lobes.
Case 9. A. Glenn, 17 Regent St., Peckham, a boy, a small, weakly, thin, bright child, 17 mos. old, the youngest of a family of seven, all of whom are thin. Through the me, he to this me has 'two legs.' His chilly parents live in a very poor quarter—dorm population, narrow close street. The mother a hard working woman, always has good health; the father has been in my care for ciliary catarrh of uncles (chronic), tickly furrowed tongue, and occasional attacks of vomiting of blood. The was & always has been a great tea drinker, no quine.

Current history. Breathe felt for about 8 months & then put on the bottle. In April 1890 I attended the baby for a chronic ciliary catarrh associated with wasting & diarrhoea. The illness lasted nine weeks & had been going on for 3 weeks or so before I saw child. The chief Chest physical sign I noticed was a rustling at that time, was the presence of a well-defined patch of dulness in the right-lower back, just below angle of scapula & not quite down to the base. Over this dull patch were fine crackling expectorations & rattle high pitched breathing. The rest of chest bronchitie signs were present. This condition of chest lasted for over one month—the child well all the time, lying in bed, so well that I could be examined easily. The temp. varied from 100°-105°—the respiration, worked 4 times fast breath & a hacking cough. The chief physical signs from my angle were—dull patch in centre of right-lower back with expectorations, there were hoohichte sounds over the rest of the chest. The slow normal breath sounds on the left side in this case attracted my attention on account of its loudness,
Compared with breath sounds in Right-side. One is apt - as I was much in two cases! - to think that the breath sounds appeared breathing signs; fingers down at so many great attention to the side with the breath; breathing whereas the absence in the side in which the breath sounds were normal to be typhoid fever, except not the chill pitch itself where the absence and was high pitched above breathie character.

Resident: a few cases

Resident: remember

Breath sound: Pericardite

Cases: of a few chill

Weighing: among physical signs. Case A. H. April 1890

Wasting was a marked feature in this former illness: April 1890 it occurred soon after child fell ill and soon brought child to a skeleton.

Breathlessness was also a marked feature - cattin uncontrollable.

Pneumonia, febrile & was probably brought on by bad feeding.

The anterior fontanelle was wide open & there was marked 'breathing' of the ribs. After the breathlessness was stopped by attention to food & the child put on Atwood's oil, semolina & plenty of milk - the lung inflammation - Catarhal Pneumonia - cleared up & the child picked up. Remained well till present illness. The child was brought into my consulting room on the 17th Jan. 1891. The breathing with first attracted my attention, was quick & very laborious expiration being accompanied by a sort of grunt-like sigh.

The Child was not very feverish, very pale & there was a quick, feeble pulse. The mother said the child was taken ill three or four days before with difficulty of breathing & cough. She had lived once time
remedies but the child got worse. On examining the chest
the child was properly unrested for a few days after wards
was both sides of chest front & back, there was no ap-
parent loss of respiration. (Albus) 8 lbs. 6 oz. liv. 28, 79.
8 am. mort. of legs anaesthetic & 9, 11, 9 hrs. Heart
applications (unctions) to chest & child to be kept warm.
19th Jan. 1891 - saw child at its home today - has it ship-
ped. Surgeon warned was the first thing noticed. He
added it was the 'falling away' as they called it, more than
the chest trouble that caused the parent anxiety. There was
no diarrhoea. There was still marked absence of the
ribs, the last two ribs being especially well marked
with some knobs at their tips! The chest shelf was
very strikingly changed - distended. The ribs of the
chest were very much in strain, presenting a remark-
able distention - best represented by putting a glass
syringe, declined at level of the nipples.

<table>
<thead>
<tr>
<th>Stem</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="" /></td>
</tr>
</tbody>
</table>

There was a groove

---

on either side of the

Stem, entering

from costal margin

up nearly to open of

arthritis, making the Stem slit & cut like the heel of a boot.

There was another groove running along costal margin

downward, the back & leading to produce a sort

of elevation of the costal margin with inspiration.

The instar of the ribs was most marked with inspiration.

But what was noticeable (I think of great point) the

instar did not wholly disappear on expiration, probably
Shewing great negative pressure with the chest, the two sides were equally affected by respiration, the abdomen instead of rising gently from the chest margin, was prominent & large percussive resonant - the rubs below costal margin & gently could just be felt. There was little if no abdominal movement with respiration.

Chest - Physical signs - Right - fine - inwards & downwards. - Heart - pulsation & respiration. - Left - fine - normal with rubs.

Back - Right - fine - respiration on both sides, & on both sides a few crepitations. The back muscles seemed feeble all over both sides of back - in interscapular region - respiration present. On lifting over sternum area a little the breathing was feeble - a few crepitations.

Diagram - Lung physical signs was 21st 1. 91

The chest was so distended & the child so thin that we could hardly find a surface to place stethoscope flat on the chest.

The child breathing very fast, pulse was fine & feeble - only felt at wrist - difficult to count - Temp. 100.8° - also keen with very marked - breath. No voice - tongue furrowed - teeth four incisor above & below - fontanelle still widely open - ends of long bones enlarged.

Note - this poor little child was evidently suffering from Collapse of both lungs & also from Cataract of pneumonia - there were no hemolytic in 3 parts.
There was the great tearing of ribs, the injured
remains & deficiency of health, together with the
absence of any great fever (103°?) all these pointed to
Collapse of the lung. Besides the child was under a
collapse's state itself. The expectoration chiefly points to
a lung from Ecarsthal pneumonia. Man is
rubbing while chest with humid-cutting amonia, turpentine
& olive oil, the chest to be wrapped up: wool after the
child kept near the fire. 8 & 9 am at 11 drops
i was also ready any 2 two.

24th Jan. 1691 I was called to see child today. Found
it lying on mistress lap, going an occasional
whine, as if in pain: breathing uneasy fast
whistling: dilating widely with first. & breathing with marked
seep withcyanosis, the child quitted expression,
restless, had to be nursed, noticed people, this not
object very much to examination: very pulse is visible
to be bluish, and sunken eye balls & lips & nostrils.
Very poor others about the child, which the
mother tells me is due to twice vomiting at night;
the skin damp & cold: tongue furious while
touch. Spew daily, pulse feeble & very rapid —
leap 90. The vein in the neck stood out very
prominently, especially with cyanosis & when child
coughed. This fulness of veins probably points to
some difficulty in blood getting into chest
owing no doubt to obstructed emaculation
though the lungs & consequent engorgement
of right side of heart & veins.
Physical signs - Right foot - callus, dull, extending into right ankle. Breathing was hachial with few expellations.

Left foot - venereal bloody, no accompaniments.

Diagram: Hemic bilateral tearing of chest wall 34.91.

Back - Right - not very venereal - breathing venereal with expellations in lower back.

Left - Resonance a little improved, breathing venereal venereal with few expellations, breathing feasible at some points.

R. anilla - dull - breath weak: venereal with expellations.

L. anilla - breathing hachial at one point - venereal at other, with few expellations. The milky region going to chest cliniolion presented a large superficial cavity.

Note - Baby 10 days: will not cry. The child to be wrapped in any flannel or wool at the fire.

25th Jan. 1691 - Child died at 6 a.m. this morning. It had been crying for about two hours & then passed off. I asked the parents, called 'creaming cowards'. The woman the wife, father in the case were not made. When was the parents were too poor to pay for extraordinary attendance & apparently did not care for gratuities, attendance either from the Parish or from myself.

Note - This was the second attack of scarlet fever, pneumonia in the child - the first being recount to Brucelitis & being recovered from. The second attack being recount to collapse following with probability a slight Brucelitis - a sickness.
Child. It was evident in this case that the collapse was the chief feature; that the Cataract process was set up in the collapse areas.

From the moment I saw the great distortion of the chest associated with such great constitutional disturbance & symptoms, I gave the parents very little hope for the child's recovery. The injury of the ribs in this case was like that we see in a case of ankylosis in its earliest stage, when the child's efforts at breathing seem to do nothing more than thrust in the lower ribs & the upper part of the abdomen. With the present case there was no evidence to indicate if air might be breathed by the chest, above as at nose & larynx, but the obstruction to air was in all probability due to blocking of the smaller bronchi bronchioles, though old cataract, plugs & lumps of bronchiolar mucous, & this preventing air getting into the air vesicles, which in consequence the collapse, & this is known leading to diamond pressure within the chest, & to causing chest walls to be pressed inward by the atmospheric pressure when child breathed. The weakness of chest wall itself would cause collapse of the lungs.

Diagram showing comparison between the normal & the inflated chest wall.

Horizontal lines.

at level of nipple.
This child presented nearly all the symptoms of Rickets. The child was a puny, thin little thing. Even the muscles seem to have wasted from bone and which causes the bone anemia - so that there was general malnutrition of the bones throughout the body. The malnutrition was due to improper feeding. The mother had to go out to work. Soon after the child was born so that it did not get breast for very long, the consequence being that the child was given anything to eat - biscuit, bread, potato & none of the proper food when quite young. The result of this improper diet was gastric ulcer. This trouble was seen by diarrhoea & vomiting, which I had to treat & after the case Rickets - all its severity - general malnutrition, irritable child, Oe. farmacale, long bones with bow shapes, fulness, delayed healing, enlarged epiphyseal heads, all of which this child presented in a marked degree. Indeed the case was the worst case of Rickets I ever saw. The lesson there gone in - the case of Rickets market fully is, that it represents an exaggeration from what one constantly coming across in practice - Rickets associated with lung mischief generally in form of bronchitis, slight & severe, but very like in the form of Catarhal Pneumonia. There is no doubt one relation between weakness of the chest walls - seen in Rickets - & the presence of lung mischief. There can be no doubt that the lungs weakened by the general malnutrition of the body, as well as by the more or less plastic & yielding chest walls, imperfectly perform-
their walk & as a consequence of the disturbance in the normal physiological process of respiration & circulation of blood in chest, the lungs in Piedebrown are rendered peculiarly liable to inflammatory action, hence we get lobar pneumonia very frequently in children. The lobar pneumonia was renamed because to collapse in the medulla of carateral pneumonia in the 18th. Thus it can be seen that Rickets through weakening the chest wall predisposes to inflammatory action in lungs, as a rib is not only beaded & bulged at its end but weakened in its shaft - a clinical fact overlooked on account of the drifting & more obvious 'beading' of the rib. The ribs bend & give way atmospheric weight & muscular contraction (diaphragm) just in the same way as the shafts of the long bones give way near the frning of the child's body - the leg bones when child is allowed to walk. A similar giving way & narrowing of spinal body space i.e. the scoliosis where the intercostal muscles are driven inward by weight of spinal column above the rib cage in sitting or walking. The Phelebe Child as in this case - if sitting generally gives by the mother, but always been "weak at the chest" - has suffered from cough. This is general lobar pneumonia. When a child (Piedebrown) is thought suffering with catarreal pneumonia the clinical lobaritis leading to Asthma Collapse of lung - the final victim & then to catarreal pneumonia on top of the Collapse of lung. So that if that be the sequence - Bronchitis, Collapse of lung, Catarreal Pneumonia - the Cat. Pneumia i.e. Pertinax.
Case 10
Southampton St., Beckham for the 14th Feb. 1891.

The baby, 8 mos. was lying in bed, breathing fast about 84 to minute — pulse 148 — temp 103.6. The baby was well nourished, presenting deep and well rounded folds. Skin down thighs, flesh fairly firm when taken up between fingers. Tongue slightly foiled with thin layer of white fur; dentition well.

Two central incisors in upper jaws were evidently about to come through the mucous membrane as there was redness & swelling over site of central incisors. The swelling extended from margin of jaw (gum) up under the upper lips & was of the shape of a blot. There were two such swellings, one for each tooth, no sign of any trouble in lower jaws.

Previous History — this baby the youngest of a family of 3, all healthy, fat & well-built. Staying & healthy, hard working people — was brought up on the breast with exception of a little extra food. It was a female child. About 3 months ago 10th Nov. 1890 — I was called up late at night to see this child — supposed to be dying. I certainly found it in extremis — noisy with rapid and shallow breathing at all — the chest both sides, back & front gave Brouchon's sounds — fine labor; throrough dilatation of cervix. The pulse hardly felt at all — temp. 103°. This was an attack of Bronchitis which had so bad they went for help. It was chiefly on the smaller tubes, of a
Suppurative sinus due directly to the malar tubes of cholechoidal being tocked up with secretion which the baby was unable to get rid of by angling. I noticed likely to have a mustard & linseed poultice at once all over the chest — the chest to be made with will, wine of speeie & after that to drop doses of hot milk every 2 hours. On calling next day the baby was a good deal better & in about a week there was almost free from chest hiber.

Present illness — the baby was taken acutely ill the night — midday ill on Thursday evening 12th Feb. 1891. With vomiting & soon after the mother notices the baby to be ill & to breathe fast, the baby "went off its food" which was some biscuit, milk & milk but she could take the breast a little. The mother applies poultice to the chest with slight relief, but as baby still remained unwell she applied to me for advice on the 14th Feb. 1891. I found the child as noted above. Breathing 84; pulse 148; temp 103.6° fever frequent & greenish.

Physical region

Front — the only point of note is that the left front seems more cromant than right front. Auscultation — Breathing sounds slightly muffled & less clear on right side but loud on left side: no accompaniments on either side. Back — no impairment of Respiration.

Others — breast provided to child & 7/8ths milk at 3/4.

Mr. Pierce, 27
A.G. Cke. 37
15th Feb. 1891

Child lying down - face pale - temp. 102.4; Resp. 70 - pulse 150 - breathing with short
grunts till 'egh' with expirations - little cough - tongue
furrowed except at tip & edge.

Chest - Regional Region

R. Front - Respiration slightly impaired - heart & mids. muffled
but accompanied by Crepitation - very fine but apparently
constant - no tubular or bronchial breathing.

L. Front - Resent - Breath & mids. appear lying no accompaniments.

Back - Right, all are open & as far as level of impair
angle of scapula little difference - respiration enters
with left side. Breath mids. near the scapula (apex)
Somewhat less distinct than in left side & accompanied by
fine Crepitations, especially with inspiration. Breath 30-45
harsch when Crepitations are not present. The child's cry
heard very distinctly over the area at one two
points - over Scapula. Right Aulla - Crepitations heard
very distinctly at apex of aulla. Over rest of Right
Chest, breath mids. very weak - no accompaniments. Left - Venereal
no accompaniments.

Diagram of Front & Back, showing physical signs on 15th, 1891.
16th Feb. Child lying on her back - bed, drowsy, making no effort to sit - coughs very little - does not disturb. Resp. 70; pulse 150. Temperature 102.4. Physical signs same as on previous visit.

Crepitation - right upper front & back & at apex R. mamma.

Left of right lung gave no crepitations but slightly muffled breathing.

Left side - constant both front & back. Breath sound - muffled.

14th Feb. Child lying breathing fast & deep, pulse 146, feeble, scarcely felt at wrist. Temperature 102.8; skin moist. The baby does not exhibit any inclination to be taken into mother's arms & does not like to be disturbed. Has been coughing since 5 a.m. - short, dry hacking cough. Bowels - motions healthy, once daily - a good deal of phlegm & sputum. The baby was very bad at 4 a.m. when the mother thought she was going to die. Physical signs - right foot & hand a little less present than left; muffled breathing, venous with occasional fine crepitations. Left foot - venous - breath sounds loud & exaggerated venous - no accompaniments.

Voice - right, slightly diminished resonance over tracheal region & down as far as 3 ribs below angle of scapula. Breath sounds somewhat muffled but no crepitations as on previous day. Breath sounds over this impaired area (separates) at several points had a high pitched tracheial (almost tubular) expiration but no accompaniments. Child's cry seems more difficult than on left side.

Left side - breath sounds loud but venous - no accompaniments.

Was called to see the baby at 9.30 p.m. 17th Feb. - found her lying in bed with open, close, flush in cheeks, entirely drowsy, cheeks and skin working vigorously, but she did not object to excitement for the last 24 hours. Pulse about 150; Resp. 70; Tem. 103.6: Respiration irregular.

As baby was so ill, only examined front of chest - right foot, slightly diminished resonance; breath sounds high pitched tubular & accompanied by very fine crepitations. Left foot - venous - loud venous, breath sounds.

Followed mother's advice & R. foot & upper back for 5 minutes, & to be followed.
18th 2.91 - Child quiet as usual - face rather puffy & dusky - pulse 130

Resp. 70; Temp. 107.1; Cough short & frequent. At 6 a.m. she left a
thick yellowish mucus to me. Temperature was 109.7; Impearl coated with yellow white film.

Physical signs - Right font, enlarged tonsils exposed with teat; breast was
furred & movies with a few fine capillaries. Left font - en elevated venous breathing.

Back - Right, enlarged breathing almost amounting to stridor from upper to
lungs - little less dull on last 3 ribs.

Diagram given physical signs on 18. Feb. 1891.

19th 2.91 - Breach sound - i upper part of right - breath sound and conical
except at one spot - i intercapular region where there was tubular
breath sound but no definite capillaries - vocal ery did not move.

Doctor's note: From today's physical signs one could see that the inflammatory
process had spread from upper part of the chest, where it was evident
at first, over the entire chest, the whole of the lower part of the chest.
On previous visit (evening) a dilated tubular expansion has been
noticed in upper part of chest - this dilated breath sound no
doubt showing that the process has started at some depth
from the lung surface (pleura).

19th Feb. 1891 - Temp. at 10 p.m. yesterday was 109.2 - Child very bad
during night - coughing frequently. She is still lying down; she
does not move enough to go to mother's arms. Harbors aching widely
with inspiration - Ears & eyes rather dusky but face very pale.
Pulse 140; Resp. 65; Temp. 100°. Bowels acted once during night.

Motions natural: colour &c. accompanied by "faint" (may be) vague fever. Baby looks a little better than the day previous; does not seem to be able to take heat.

Physical signs:
- Right front - heart & 3 hand venous with occipital egitation; slightly impaired resonance on percussion.
- Left front - normal - hand venous heart at 3. - no accompaniments.
- Back - whole of right back firm a little dull on percussion apparently more so just below scapula. Breath sounds - at apex 4-5 venous regions. Bowels venous with occipital egitation, no tubal bellowing from angle of scapula to 3rd intercostal space. Right back dullness & high pitched trachea. Small tubular with only occipital egitation - impunit egitation or base equal - slightly pitch & height. There exist 3 ribs & 2 dull hollows. Heart in position. Small accompaniments somewhat marked by constant cracking egitation will both inspir & expir. Chiefly without. Vocal cry key: distinct over right lung.

Diagram: showing physical signs on 19.2.91

Right axilla - dull on percussion & 3th venous heart at 30-50 with occipital egitation.

Left back - Remnant except at base over last 4 ribs for about two inches from spine on left side. Over this dull patch the heart sounds are distinct. High pitched tubular, (just as if listening near the trachea) without egitation, reminding one of the tubular breathing in consolidation stage of adult (croup) pneumonia.
Note on 19.3.91 - there has been an extension of mischief to left lung while blister has been sound & healthy as far as one's means of examination bread. This extension was not accompanied by any marked rise in temp 104.2 on evening before 4 am. today. The patch on the left lower back close to spine came from absence of respiration more like a patch of collapse of portion of the lung. There was a similar patch in middle of lower right back, over this however a fair respiration had been heard.

20th Febr. 1891 Temp. at 10 p.m. yesterday 101.2. The baby still having eyes shut - thrashing - mother still dilating with inspiration. Respiration - 74 pulses, weak, fast, uncountable 10.9.4.

Physical region - front of chest - both sides, especially right.
Appearance - the percussion over right was now hypo-elastic.
Breath sounds - bronchial without accompaniments - no marked difference between R. & L. fronts as on previous visit.

Back - same as on previous visit, but region more pronounced.

Diagram showing physical lesion on 20th Febr. 1891.

Right back - dullness from open to base & into scull, bruises more pronounced just behind angle of scapula. Breath sounds bronchovesicular at base & in intercostal region with respiration. From angle of scapula to about 3-5th left-rib breath sounds tubular or laryngeal respiration (like chest).

Left - similar to right, except as before, over last pair of ribs right-side breathing broncho-vesicular with marked fine respiration; respiration in R. scull. Still very well.
heard Mr. Right-Chest. Left side - over last 3 ribs anchors marked lund blowing tubular a congugal healthy without accompaniments.
Breath just influences to cough - this dull patch on left side was well above this dull patch it was vesicular although with expectorations even as far as left collar. There was slight impairment of pericardium dull patch at left lower angle of scapula on left side. As bowels were not their freely.

21st Feb 1891. Temp. at 10 pm last night was 107.8. The baby dry as usual a little less droopy - coughing less - Temp. at about 1 today 106° pulse little sluggish since about 130. Resp. 60. Tongue less coated - while few no tongue also showed to roof mouth looking as motion little better. Bowels opened 3 times during night. 'line' (senes) i. Hs 893. Drank in addition of lime water to will early this ill.

Physical signs same as on previous day only expectorations were distinct of a mucous. Sympathetic void less to it on both fronts which were today slightly impaired with fever - on right front healthy vesicular with a few expectorations on left side vesicular no accompaniments.

22nd Feb 1891 - the baby still lying in bed though not so dry
- Opens eyes not noticing the mother - teats still well lit - region of Ankleless not so marked in Blue. ears - he baby's hands & body markedly wanted - Bowels open twice, tongue furres accept at life - pulse well formed difficult to count accurately, temp. 98.8 Resp. 60 - varying getting to 80 in 60 minutes was classed as 0(5,5)
Physical signs – Both lungs seemed to be hyperpertant, that on right almost symmetrical. Breath sounds venaicular in both lungs with on right an occasional crepitating, no accompany on left font. No coarse sounds on either side.

Back – Right ulcers present though less marked who compared with left which was also impaired in resonance. Breath venaicular on upper part of right back with occasional crepitating but in lower back breath sounds broncho-veneicular with constant crepitating. Area lower part of R back crepitating was occasionally bronchial (little 'chee'). The accompany were in quantity than on previous day. Area of tubular breathing on R back.

previous visit about today.

Left back – Slightly injured in resonance on lower back. Thighs only markedly so was last time close to Spic. Wat. last sound area tubular breathing virtually heard less than on previous day. Rest of left chest venaicular breathing with occasional crepitating.

Breath; the trouble – The lung has, judging from today, physical sign, begins to decline in severity, for the lung is only 84 above normal, breathing getting slower also pulse not so fast.

The baby itself in less distress & expected to exuviate of the chest, the cough still troublesome. The crepitating are less & there is less high-pitched bronchial or tubular breathing over both lungs.

23rd Feb. 91 – Baby still lying in bed though not so dry

Cries when touched. Tongue furrowed thickly back part only.
Ponches twice. Temp. at 10 a.m. yesterday 107.4 – today at 10 o'clock 98.4. Pulse faint, feeble. Temp. 70.

No passing of gas, all chest with respiration.
Physical region - Front - both venereal healthy - remnant, that in Right side symphatetic.

Back

Rena exerted - venereal healthy no acute palsy.

slight impairment with bronchial breathing + crepitation.

Rena exerted - venereal healthy no acute palsy.

thick patch from scapula to level of 3rd cost-rib.

bronchial, well heard: bronchial breath with fine creastion crepitation, both sides.

Respiratory slighty impaired.

Venereal health no symptoms with Crepitation.

Diagram shewing physical signs on 23rd Feb. 1899

24th Feb. 1899 - Temp. last night at 10 p.m. 98°2.; this morning 1:30

pm, 98°. - Resp. 50, pulse feeble - the baby much brighter - eyes open wide, things & erys a great deal, scripts working still - cough inconspicuous. Breath short nice - tongue with faint purpl color, back foot furred.

Pulmonary region - Both fronts remnant - venereal health no acute palsy.

Back. Right - impaired resilience, except a small patch at angle of scapula. Breathing venereal with crepitation at apex & intercostal region. Below angle of scapula 3rd cost-rib healthy small patches bronchial marked by loud crackling crepitation, both well heard & expired. Over last 3 ribs, breathing venereal will crepitation. Right axillary impaired with crepitation, well marked.

Left back - Impaired resilience - all over back. Breathing bronchial with feeble crepitation a small still patch close if spine at left-rib, over rest of impaired lung back & in left-rib venereal breathing with crepitation.

Crepitation in left side not so well marked as in right side.

Older 38 yr. Ferri Phyllo 4 once a day, not noticed.
Leaves to both chest for five minutes.
25th Feb 1841. Body much lighter - eyes open - white things -
leap last night at 10pm, when body seems according to the
matter must remain - 98 6 today at 1 30 pm - 99 6
pulse 180 - respiration - 54 - tongue a little fresher me protein
half; me first half clearing - congested swelling in gums
are upper central徽s mentioned but no teeth - think yet.

Physical signs:
Both gums rampant - arching venereal health;
without any accompagnato - R. dorlas - accompanied with
venereal health points - L. dorlas - venereal health accompagnato.

Back:
Right - bone as in previous day but more resonance - respirations
there are all venereal back especially below angle of scapula
respiration is high pitched tracheal, in the inspiratory expiratory
accompanied by somewhat by anison respirations.

Left back:
Lower part of left lung as high as 4th lowest rib
& close to spine highly impaired; larmare - no this area healthy
tracheal but with respirations - also me test of left lung.

Ribs - there were coarse sounds (hales) accompanying breathing
which has now become venereal all upper lungs except for
patches in middle of right back & lower part of left back
where the accompagnatos were slight sounds (respiration)
The impairment of larmare was not remarkable - there being
only two patches - one in middle of right back & the other
at base of left back. Now both these impaired patches
the breath mists remains high pitched bronchial accompanied
& somewhat marked by respiration.

26th Feb: today face not to pale; no breathiness - nostrils
not dilating - chill quiet - failure of slight - still liquid
beads when things cry loudly - a thing it has not done
since onset of illness! - I - eyes open & bright - pulse 189
Resp. 60 - Temp. 99.2 - Bowels open twice - lungs moist - only a little fur on back part.

Physical Signs

Back

Respiratory

- Venous breathing with crepitation
- Skin pale with nails
- Crepitation on back, chest, and abdomen
- Heart sounds normal
- Pulse 50, B.P. 90/50

Chills

- Remant of fever persisted
- Venous breathing, no accompaniments
- The chief sign today: persistence of two distinct chills patches, one in the middle of right back, the other on the left back.

Chills and back

- Breathing and spinal processes healthy
- Chills present in back and apparently without crepitation.

Crepitation present near base of right back and right nipple.

27. 2. N. - Baby quite bright and active. - Breathing easy and healthy, not chilling.
- Pulse 114, R.R. 50, Temp. 99.8 - Nausea.
- Clean and complete - Bowels twice daily. Very little cough now.

Physical signs - Both lungs and chest - Remant and health sound

- Venous breathing, no accompaniments.

Diagram of Back - Sharp physical signs on 27. Feb. 1891
Back - Right - Lemorne only slightly injured near middle of spine, just below the angle of scapula; the head and few injuries were in high pitch of lumbar, with crepitations which spread as if they were the plethysmoe. There are no coarse sounds. Crepitation head also at apex of right axilla although Lemorne not injured there. At Right base apparently Lemorne vesicular breath and crepitations.

Left back - Lemorne not injured except at base close to spine from 4th rib to 5th last rib. This patch was very dull, as if pressing a block of wood. The breath sounds over the dull area as lumbar (just as if one were hitting an anechoic) accompanied by finer crepitations mostly with inspiration.

28th Feb. 1891 - The baby quite bright now to be in motion; arms and Still taking sup. Ferri. Pulp. Co. apparently well backed.

The stool - coming off in fine flakles - a sort of peeling especially from off arms, neck, and perineum; probably due to fever or want of bathing of whole body. The face was very red and of SC which was generally especially face, very pale : Pulse 105, 4.8 ; Temp 99°.

Physical signs - less marked than on previous visit. Front - Lemorne with vesicular breathing. No crepitations. 

Back - fairly normal all over a few crepitations lower back & anechoic region. 

Left back - normal except for dull patch at base close to spine - behind back crepitations over this patch marked with inspiration. Ordered: Child to be rubbed with 

Drawing showing physical signs on 28th Feb. 1891

The child from now get Magnus daily the physical signs all leaving. At the end of following week March 7th the cut has appar
central incisors were while young. Illing was noted in each
part of illness. I saw the child a month later, in April 1891. He
was quite well and his cat was over central incisor.

This case whose natural history I have just written was undoubtedly
one of Cataractal Pneumonia. The case things it might
have been are Lobar pneumonia, Pneumonia, and Collapse of
portions of the lung. In favour of Lobar (Compon) pneumonia
was sudden onset of illness, the high temperature, and the
marked signs of considerable consolidation with troubled and aus-
torcular breathing. The Lobus distribution of the consolidation was
pointed also to Lobar (Compon) pneumonia but against Lobar (Compon)
pneumonia was the long period of illness, the absence of any definite
process, as in the presence of such process, consolidation over dull areas especially
where breath sounds were most intensely bronchial, although at
times during the patient illness I noticed bronchial breathing
without accompanying consolidation, but it did not last for any
length of time. Against Lobar (Compon) pneumonia in favour
of Cataractal = Broncho Pneumonia was evident after a
few days of inflammatory process from Right side to Left
side - the affection was Bilateral.

As for collapse of the lung, it would be difficult to
exclude this condition although the high temperature was lower
against collapse of lung at again the presence of consolidation with
high pitched distinct heart sounds & the persistence of dull patches
marked the case as an inflammatory as the air cells rotten
than a pneumonia or collapse of the lobules. There was
of course have been lobules of collapse present with the Cataractal
pneumonia process but the signs of the latter outweighed those of the former.
I think the illness could be fairly put down as one of Acute Catarhral or Broncho-Pneumia.

A very marked & striking feature of the case was the absence of any bronchitic signs. There were no coughs (Acute or Chronic severe febrile) during the illness except on the 25th. 2.91 when I noted in the right side a few rales but these were poor ones! The figuring given by the mother was that the child was taken about 1 week previously with difficulty of breathing & rales but there was no history of Bronchitis except the bad attack, while the Baby had when I attended him in Nov, 1890 & from which he completely recovered. At the onset of illness there were no bronchitic ones or any accompaniments whatever. The only abnormality which drew my attention was a local spot of either lung very taking its rise by the back. "Left-drum sounds were clearer than Right; Front & Back slurrily muffled & less clear on Right side but louder on Left side: no accompaniments on either flanks." Again: Back "no impairment of Respiration & no abnormal sounds on auscultation." This absence of Bronchial Catarhral makes the case latter an absolute one for the absence of Catarhral of the tubes is rather against Catarhral or Bronchial pneumonia which is generally always associated with & preceded by Catarhral of the tubes & in favour of Tubar Bronchial pneumonia which is as a rule not preceded by Bronchitis. If the observation as to absence of Bronchitis, this case is correct, then this case must have been a case of Pneumonic Catarhral Pneumonia, for even if there were collapse of lung, there must have been Bronchitis.
If Catarhal pneumonia is always a transient affection, these in this case there must have been a Catarhal of the Bronchial tubes giving rise to no discoverable physical signs. The consolidation in the case took a lobar form especially in the Right side - probably middle lobe - so that I would call it a case of "Lobar Catarhal Pneumonia" from a clinical point of view.

Physical signs were delayed - appearing - the case became the Child (baby) had been ill two days before it was seen first then there were no definite signs although what was present was definite enough (although obscure) to call my attention to the one lung. The muffled breathing in the one side will loud breathing in opposite side was all I had to go upon but the muffled breathing in right first proves enough to have been a sign of advance from what was noted on first date in the illness & a definite sign of consolidation on Right with expectoration. The baby's cry head very distinctly at night in 15th 2. M. 1912 as in the case as early & useful regime as to what was to follow. Again before definite clonic, a physical sign had appeared in this case; a high pitched bronchial inspiration was heard over opus thoracalis beginning early in illness - 17. 2. M. - this breathing became the inspiration seems to be mainly affected, being reduced high pitched rattle persisting (bronchial) while the inspiration seems to diminish - about normal although as the disease advances as it did in this case the inspiration also took on a high pitched bronchial character as well as expiration, then there was
as in the case in 1892, high-pitched bimodal breathing which when it got a bit more intense I call tubular although the difference is minor one from a clinical point of view! The illness while this boy — a thing of large baby always well except for the Pneumonia Nov. 1890! — had just one thing was a severe one judging from the effect upon the baby. Before the illness the baby was bright and cheerful; when the illness came the baby lay like a log in bed, very drowsy and only drowsy when disturbed by coughing and moisture given in food or on examination of chest. It was noteworthy that after one had finished examination of chest the baby would go off into its drowsy condition (like a deep sleep) apparently only wanting (presumably a baby) to be left alone; after the moisture of the lung diminished the baby brightened up, was less drowsy, opened eyes, and noticed things, especially its mother till it got so well that it wanted to be in its mother's arms (usual as a baby!). Compare this little men's clinical history with that of a child suffering with bronchitis, even severe. The baby or young child suffering from bronchitis will invariably want to get to the mother's arms and will not as a rule by itself without moving — just like a log — sit — drowsy, about to ... eyes, all bright when ill and if very bad with bronchitis, less an anxious look about the face as it is awake and not drowsy as in a profound sleep, or in the care of the infant or young child with Pneumonia (acute) as in the care of this present case.
Thus I have given the clinical histories of ten cases of catarhal, a more acute pneumonia in young children, together with some observations in the form of notes which struck me at the time as being of some interest in connection with each case as its progression towards this (milder) illness. I might have added more cases, but they were at a period further back than that from which these ten cases came under my observation. Indeed in my earlier work in practice many cases which I then consider only as croup alveolitis, from ignorance of the subject and want of care of system in examination, I would now class as catarhal pneumonia as well as the bronchitis, which they evidently did suffer from. But that they had some symptoms as for violence, chomness, and cyanosis, which the bronchitis prone and simple would not sufficiently account for.

In short, some of these earlier cases puzzled me, and it was to unravel this puzzle and make out something definite whenon to hang one's faith that I started in this somewhat ruleless research. For I myself consider it one of the most unpleasant and unsatisfying states, speaking from myself, for anyone to be in—to have a case of similar cases were one's care not to have a grasp of what is the disease or underlying trouble from which one's patient suffers. Actual practice has a dulling effect in this respect; one has to set to find out even though the road be a long one till the ultimate truth is found. One cannot always or even often have a constant at one's elbow; even if one
Could the practice of frequently calling in a consultant except in cases of absolute necessity for a second opinion or, for example, the induction of early labour in case of definite risk of obstruction or pelvis too narrow to be corrected by labour—would this be deemed to attempts at individual if unoriginal observation? All the same, while revising the chest of even these comparatively few but highly interesting cases, I often, because the subject was quite new to me, wish for the presence of one of my former teachers to explain much such a physical sign or symptom! For example, why? In one of these cases, does one get at points over the chest—almost pure bronchial or titular heath—sound without—accompanied—just little ideas the breath and Qui慟ons pneumonia through six times per second where the titular heath and s were got; there were sounds crepitations ill—from off with the same breath and, one might almost the chestedge a little one way in the other! This sort of breathing high pitched bronchial sounds titular without—crepitations are any accompaniments—used to how make me think that I was dealing with a case of Qui慟ons pneumonia but that crepitations were absent elsewhere heed not over inspiration as well as expiration while I cut the case ni Qui慟ons pneumonia.

I will now after clarifying somewhat describe from a clinical point of view (2) the Causers of Broncho Pneumonia for the question is Causation of Catarhal pneumonia leads the question is Catarhal
or Pneumonia a Primary or a Secondary Disease?

The answer is I think that since I have learned why it should not be either one or the other but that as a matter of fact from Clinical observation it is very often nearly always a Secondary Disease. If secondary what causes it to be so? For take a bronchitis of the larger or smaller tubes what causes the process if inflammation to change is grown so to break open tubes to the alveoli and air cells. No doubt it does so by extension but what is it that in many cases in my practice causes a sudden getting worse of a bronchitis be it child or of a young child? If they can be detected in the physical signs what causes this somewhat surprising symptoms increase in lungs from a bronchitis to a pneumonia lead indently extension of exudate from larger bronchial tubes into the bronchitis, to into the alveoli and the extension is an active one judging from the signs of exudate we see in decline of affected lung. So answer the question why does the extension take place in an infant or young child? if necessary to ask another question why does the same sort of extension take place in the many cases of severe than capillary bronchitis, one sees in adults, often than it does? This latter question I would answer that the adult chest is a well-staged apparatus like as well as muscle than the infant chest and again in infants' capillary processes seem to have more liability to extend and spread than in adults whether from greater instability of the nervous system or mechanism in an infant or from more...
virility or instability of the mucous surfaces in the infant or young child, it is difficult to say. The fact remains, however, that irritation of mucous surfaces in the young child cause analogous disturbances of the organ generally, while the same irritation in the adult would have slight or perhaps no effect. Table for violence are irreducible from a fruit, which on one occasion—motte—has given young child—this will often if retained on the stomach cause great disturbance—fever, I have seen it up to 103°, fever lasting weeks—all of which in leaving the same time subsides on giving the child simply an emetic as a preparation. Oil, or the fruit—often what the neglected throat weakness or the cause of the trouble, the child gets very soon violent burning of the stomach of irritation severe diarrhea, this example will show the extreme liability to receive from irritation of the mucous surfaces in the young child. Again the difference is straight if chest walls of muscles as well, between the adult and the young child must have an effect in setting up a condition of a pathological process, once set up as in a bronchitis, in the case of the weak chest of the child be it a healthy one or a quickly one. In the case of the adult the thin and firm (rigid) chest walls together with a powerful diaphragm and other muscles—lungs is as well as voluntary—forms an efficient ready means of getting rid of secretion in the tubes in cases of bronchitis by coughing or simply being made to vomit (as a set practice is great benefit in the adult). But in the weak and yielding (non-rigid) chest wall—empirically small muscles of the rib and child throat in the opposite condition to that seen in the adult except in the case of old people— the inability of the child to
get rid of the laryngeal secretion - a laryngeal cataract forms if it be not an immediate cause, will at least form a very important factor predisposing to catarrh of the cataract into the alveoli and air cells. It will also form an important factor in the production of collapse, which is partly mucus from the alveoli frequently associated with cataractous pus in the child's lung. Thus it is that as a secondary condition cataractal or broncho-pneumonia develops in which laryngeal cataract is present in whatever degree.

It is very liable to come in in the course of whooping cough, in which cough if the cataract of the larynx is one of the chief features. Again i measles cataractous pneumonia is very apt to come on a little if the laryngeal cataract associated with measles be neglected and is with the poor among whom we see such of one's cases of broncho-pneumonia. The infant or young child the subject of P. cataractus is for the same reason more liable to suppurative if cataract of the alveoli and air cells on top of the laryngeal cataract which like diarrhoea is so common & almost a feature of P. cataractus. Again in cases of weakly, badly fed children the subjects of diarrhoea, this cataractous pneumonia is found as in milia, in the cases of "baby farina" which came before the public lately two if not three of them died & it was found post mortem that cataractous pneumonia was immediate cause of death, showing clearly their diarrhoea & neglect predisposed to broncho-pneumonia. In all these cases, whooping cough, P. cataractus being
the priming predisposition to which is an ennemi of which set up catarhral pneumonia. Children the subjects of chronic catarhral catarhral we liable to intercurrent attacks of catarhral pneumonia as in case 8. The question again arises what causes this enemie of catarhral to take to the abrodis and cells. To humble the weakened chest walls & weak lunging power (mucous) if the young child & infant pre- aminic to catarhral pneumonia & the benignus spumus to collect & set up fresh inflammation by their presence or to cause Collapse & this we term to become catarhral pneumonia though a part if pneumonia engorgement the influence of cold as an exciting cause of this enemie if catarhral from tubes to the abrodis cannot be disregarded for in nearly all these cases the attacks continued with the presence of cold & damp weather ponchic, a thick fog with all its irritating substances in suspension was present & seemed as far as we could judge to have a prejudicial effect directly on the little patient — for example in the last case 10 the evening was called to see it; and it was worse, was one of dense yellow foams of a very irritating nature from the effect on the bronchial tubes. There is no doubt the cold & damp changeable climate of the county helps to produce catarhral tubes & also in the abrodis. It would be an interesting study itself, the comparison between the mark of attacks & prevalence of catarhral pneumonia & certain meteorological conditions, such as cold, moisture & barometric pressure. In such a condition as collapse of portions of lung to it not the weight of the air that is the important factor in its production. As an air again (the lungs) condition
of the atmosphere while one particle breathe in of no
small extent: the causation of disease in the lungs
be it tubercular or catarhgal pneumonia + a great value in
the treatment of long affecting catarhgal pneumonia among
them: Of the causes of death: Catarhgal is tubercle pneumonia
I will only mention that I find one case of that nature
a case of Cancer; The following measles - the cheek (left)
became surrounded with + despite blistering through leaving
a hole - the cheek, thigh which the molar teeth could be seen.

The ulcerative process was kept : adequate fluid well by
means of antiseptic but the little girl rank up a pneumonia
in all probability of tubercle origin due to particles of
bubonic, septic pus being inhaled & setting up a Catarhgal
process in the ulcers from which the child eventually died.

The case of pneumonia - seen: epithelial cases only
was two of which have been under my care as these cases
are now all sent back one to fever hospital! We should
always look out for the causes of things + I am of the
same frame of mind as the writer - I forget whom!
who wrote, "Felix, qui potuit, rerum cognoscere causas"....

3) The Symptoms of Catarhgal pneumonia

In considering the symptoms of Catarhgal pneumonia
it is well to remember that in the vast majority of cases
this inflammation is secondary to some condition of
ill health or disease such as the tubercle after
measures a simple tubercle itself. In many cases
one gets a history of long continued diarrhoea
preceding the more alarming + serious illness (from the point
of view of the friends!) Catarhgal pneumonias.
If the infant or young child - for Catarhal pneumonia is commoner & almost restricted to these - has been under one's care for some time previous to the onset of Catarhal pneumonia, this preceding illness has been one in which Paroxysmal catarh forms the initial feature. This was the case in some of the cases put down in the paper. Case I had a slight & almost unnoticed by the mother, Berchtold's cough & red sneeze, which left hectic & the inflammation gave rise to Catarhal pneumonia, again in the case of a preceding whooping cough, which had a Paroxysmal Catarh (slight), Catarhal pneumonia set in. But in spite of Catarhal pneumonia being a secondary disease & came after a preceding illness, it has its own special symptoms & origin, well marked & noticeable, distinctly marked in them, but in all the symptoms are insufficiently well marked from the preceding illness as to enable for it a separate, though secondary, sequence, ensue as a clinical entity.

The general look & posture of an infant or young child suffering from pneumonia of this type is significant of the disease. The child is lying in its cot or bed - not in its mother arms as a rule seen in Bronchitis! Its face is extremely pale & as a rule somewhat dusky & even moist when breathing is momentarily embarrassed by cough or by mere respiratory irregularity. Its rate of breathing, it is as a rule always more rapid than seen to care about what is going on in the room around it - quite a nervous thing, as is often the case in a young child - & the baby or child usually is on

it lacks slightly inclines to me a little, add to this the evident feverishness, dilating masts & the art of short grunt like 'eh!' while I would say amen - and one has a short account of what one sees and finds entering the room of a child suffering from a fairly severe attack of catarrhial or Bacles pneumonia. The above look protane & breathing would, with a preceding history of Bacles, be rare without a preceding history. When Bacles' cases 7 & 10 at once put one on the lookout for catarrhial pneumonia.

The entire pallor of the face is a marked symptom quite unlike the flushed face seen in case of laryngitis pneumonia. The pulse is as a rule very fast and of a feeble character so as to make counting the number per minute a matter of some difficulty. Indeed one has often, if desiring to get the actual number, per minute, to count it through several consecutive minutes and then what will the actual small rise of the radial artery in a child or infant of the slightest movements (about like stalking Russia even I suppose) of the hand even though the child has eyes. That apparently does not know one has held the wrist, it is often a matter of the greatest difficulty and impossibility to get an accurate record of the pulse rate. This difficulty will explain, why in recording therefore I left the pulse rate unrecorded merely noticing the feeble character and extreme rapidity of the pulse. If the pulse be a fast one, i.e. over 100; the feel about the wrist divided fine perception of which even such a small & feeble pulse - in the infant with catarrhial pneumonia.

X
I have found... elsewhere, either from entire inability or peculiarity I was unable to get any satisfactory information as to the state of the circulation, that we could always get information as to the condition of the circulation by looking over the heart itself, which... a beating fast... quite dictaband... put it seems to gain information from. In several cases especially where there was a constipation of contract... collapse of a portion of the lungs... fulness of the veins of the neck... vitall reasons... being due in all probability... interference with the circulation through the lung. This feature was especially well marked: came of where there was present a good... relation... to respiration as well as to circulation. Symptoms or signs like these are of value, because if to the respiratory embarrassment... have been added to the already overworked child or infant, circulatory embarrassment... as well, then the outlook is certainly grave.

Given a disturbance locally in the lung, to the circulation of blood, then it follows that the heart will be working at a disadvantage. Perhaps I should put it at an advantage from a mechanical point of view from the heart's point of view... but not to the system of the infant or child... large... What I mean is that the obliteration... engagement of an collapse of lungs... due to fulness of veins in neck, dullness of lips... one, two months... of years... will tend to... the heart with little... at least less than usual... blood... to work upon... so the heart will be... a position of advantage as far as no position on left...
of head-pyrexia- but as a disadvantage as far
as Right side - emesis because of the obstruction - the
lung - the heart as a consequence will tend to ease
go any test - it will be very feasible for a safety
potently so heart does not really work at an advantage
becoming the heart with some amount of resistance has yielded
above & below - emesis - thus the heart will partially
pulled ventricle. The engorged Right side existing
at the time live as the underfilled left side no
doubt affords an explanation for the entire pallor
of the darkness. Where in young children 4 infants
suffering from Catarrahal pneumonia - the reason
being that the systemic arteries are not being
gilled properly. The entire pallor might also be
due to the prosthetic effect of inflammation
of such a vital organ as the lung - the infant or
young child. There is no doubt that although the
temperature rises - Catarrahal pneumonia to a considerable
height - higher than in bronchitis - the disease has a
prosthetic effect upon the child making the disease
more of an "asthenic" type than the "athletic"
Croupous pneumonia - adults.

The entire chominess of the infant or young child -
a marked feature. In this state - it will according
to what the mother says - remain all day & night
while the inflammation is at its - height - the infant
soon gets into this state - when once the Catarrahal
pneumonia has set in - it remains - this state till
when the element of the attacks has passed generally
in about two weeks. Usually the patient being convalescent at the process begins, indicating the symptoms all diminish in severity; but the physical signs (a little altered) remain. This condition was well seen in Case 7 where the symptoms of rigor were more pronounced for about two weeks after a somewhat milder attack of the disease. At the end of the two weeks, the child passes into a subacute stage, ultimately dying with the local condition very little changed though diminished in activity of inflammatory signs. This morbid state is similar to profound sleep with this difference, that the baby or child—usually easily awakened out of even a deep sleep—requires a certain amount of coming. Even the manner of the child, which will result—palsies seem to assume all their pathognomies—can be endured with ease, the baby or child is not causing except when it is beginning to get well. When leaving, babies or young children in this state, I usually examine the front of the chest of a child while the child is lying on its bed, taking at the same time observations in its face, the pulse & respiration of the tempo (i.e., baby's or the child's groin). When I have finished the front of a child, if I get the mother to lay the baby or child across her lap, then I examine the back—the arms being drawn forward, with the feet in the supine position for examining a baby or young child for even though it is not all in a prone, while lying on its back, a child across it—within these the child calls in much of what is more important: it can shift about as in case when sitting up. The examination of the
Well of a baby or young child when it is ill; it is a matter of the utmost difficulty. After the succession of the baby or child suffering from fever to remission to fever, it will usually relapse into its chronic condition again. This chronic condition is, I think, somewhat analogous to some of the adults.

The temperature in these cases is of an irregular nature. There is a difference, so I mark marks between the morning and evening temperatures. It varies a good deal in the morning, but, if you will tell your physician or his case, they will tell you that their baby gets a good deal worse towards evening—being very febrile about 9 o'clock in the evening. It was to get this evening rise of temperature that I left a thermometer with the mother in all her cases. Very often it is useless to leave a thermometer with the mother either a poor or a well house. I have the majority of them will know to me in the morning or afternoon, and, when they do, I will arrange the thermometer. The way I generally do is when I want a temperature, I mark my arms in 30 minutes. When the nurse has not been able to place the thermometer in the groin, the leg under the arm, etc., I take it for 5 minutes. After that, I replace it in the case and leave till I call. If I think it well worth while to leave the thermometer, I do so simply taking the temperature myself once a day during illness, and I am not well enough informed as to the temperature during the illness. There is taken twice a day. Is not enough but still it is better than taking it once a day only! If you mark the case, I got to know definitely from the temperature.
Temperature observations: there were not taken often enough during each 24-hour period in better cases, when a properly qualified nurse had charge of the case, I would get her to take the temp. every 3-6 hours and record it on a chart. I will represent on a rough chart the temp. of two of the patients taken more often than in the case of others.

Temperature chart 1:

<table>
<thead>
<tr>
<th>Date</th>
<th>Temp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8th</td>
<td>105</td>
</tr>
<tr>
<td>9th</td>
<td>104</td>
</tr>
<tr>
<td>10th</td>
<td>103</td>
</tr>
<tr>
<td>11th</td>
<td>102</td>
</tr>
<tr>
<td>12th</td>
<td>101</td>
</tr>
<tr>
<td>13th</td>
<td>99</td>
</tr>
<tr>
<td>14th</td>
<td>98</td>
</tr>
</tbody>
</table>

Temp. taken midday on certain days. Being as well.

Temperature chart 2:

<table>
<thead>
<tr>
<th>Date</th>
<th>Temp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>14th</td>
<td>109</td>
</tr>
<tr>
<td>15th</td>
<td>108</td>
</tr>
<tr>
<td>16th</td>
<td>107</td>
</tr>
<tr>
<td>17th</td>
<td>106</td>
</tr>
<tr>
<td>18th</td>
<td>105</td>
</tr>
<tr>
<td>19th</td>
<td>104</td>
</tr>
<tr>
<td>20th</td>
<td>103</td>
</tr>
</tbody>
</table>

Temp. taken midday on certain days.
When the tempo goes down nearly to normal, one does not
find that the physical regimen has a same decrease in
severity. For example the case - the tempo fell
to about 99° but the physical regimen did not show a
corresponding improvement. As a rule at the onset a
new illness, or soon after the baby gets very
ill, the temp is found to be fairly high as
a rule men 102° or near 102°. This
indicates elevation coming in a case of 'bronchial
catarrh' after weakness or in the course of whooping cough
altogether with severe cough of pure and breathing almost
armlessly points to an expansion of the catarrh from the
lungs into the abdomen - even though actual physical
regimen of catarrh or bronch pneumonia be not detected.
With a high tempo, as in case of the 46th Child Case 2
collapse at least would collapse of lung could
always be excluded. The temperature of catarrhal
pneumonia differs from that of the pneumonia (eponymous)
of the adult in that it is irregular and not sustained
at a high level like that in eponymous pneumonia in
in children at least, subject to ups and downs.
The tempo in the pneumonia of adults may fall from a high temp to a low temp even to a
subnormal temp. The tempo of the infant with
catarrhal pneumonia goes down gradually and even
where normal it reaches it sometime tells another
rise upward. The temperature in catarrh pneumonia
is an erratic one no doubt due to some aids
to the well-known instability of temp. (pneumonia)
In early life, the temperature in infants and young children is easily set up and conversely no doubt easily let down again! This is a fact that, deploring for myself, I always bear in mind with regard to the temperature of children. I once saw a child about 3 years old come in with a temp of 104.6 and beyond the child feeling hot and feverish and looking pale, nothing could be done. The next day one finds the temperature down to normal, and the child looking a little pale and sickly but nothing abnormal to be discovered - too rash & no long symptoms! At first I thought the case might be a case of catarhgal pneumonia in the root of a fever, but nothing was developed, and the child was well in a few days. This case in the adult would assuredly be symptomatic of some grave disorder - fever, typhoid, or some disease (appendicitis) but in this child one could discern nothing of form the way in which the temperature came down again, there was probably very little carrying the burden! Whether irregularities in the temperature in catarhgal pneumonia are caused by acceleration of the process of catarh in the lungs I do not know. Certain it is that when the physical signs show lessening severity of catarh in the lungs, one infers that the child is especially the temperature improves although the converse does not hold for one may get the temperature down with physical signs still being considerable long/fever. Again very often - as for instance in early stage of a catarhgal pneumonia - the temperature is high
Yet judging purely from physical signs there is little to admit for the high grade of fevers as in Case 10 for the first day or so the physical signs were merely mild yet the temperature was a high one for a young girl – 108.6, 109° &c. Yet we must bear in mind the fact that in these cases of absence or apparent absence of physical signs that the lung may be affected deeply down, quite away from the chest wall, so not making any trouble manifest to our methods of observation.

This was no doubt so in the Case 10 & others. If the nature
for a few days there were physical signs abundance
the process of evacuation – the alveoli evidently being the
mechanism came to the surface of the lung. Again in those
cases where the temperature is high & physical signs not
observable might there not be an engorgeamnt of
the lung & lungs with blood due to "chill" or cold
producing a high temperature more intense & yet the
engorgement producing the physical signs, till the
respiratory surfaces began to discharge & quiet one to
respirations & Cuba in to filling up of the alveoli.

patin Cells & no giving rise to fever of marrow &
high pitched heart sounds. Of local symptoms the
fast breathing at once settles me no sitting the room
of a chill suffering from broncho-pneumonia. The actual
rate of respiration may be very high in me of my cases
it amounted to 90 per minute – Case 10 – at the
great point of importance in that there is a disproportion
between the usual ratio between pulse & respiration.
The respiration increases 1 rate far more than the
pulse does in respect to the amount of pyrexia present. Roughly speaking the respiration in the infant and young child up to about 3 years is about 30 and the pulse rate is about 110 per minute—also in a proportion of about 1.5 to 3, normally, but in Catarhal pneumonia the respiration may rise to 70 or even to 90 per minute, as in case 10, and the pulse rate to 150 or 160 per minute, giving a disproportion or ratio of 1 to 2. Evidently clearly that the respiration has increased out of the normal proportion of a child (1.5 3.5).

In case 10 if the pulse has increased normally then for a respiration rate of 90 per minute one would expect a pulse rate of 315 per minute but what one does get in practice is 90 to 160.  See Case 10 on 17th 91 evening. This fact of abnormal disproportion of pulse-respiration ratio is one of great importance clinically even in ordinary cases as it shortens one's diagnosis; but it is of extreme value if one of the few symptoms present of any great value pointing as it does locally to the chest. It is in short a local symptom of great value because it is in those pneumonia cases, Catarhal as well as Typhous, that the greatest disproportion arises and hence it becomes a specific symptom when in its entire form as in the above instance. It was of great value to me for example in case 10 which was very obscure at first, resembling a Typhous pneumonia; in fact, much for several days as a Catarhal pneumonia!!
the working of the alae nasi is another local symptom, it is
obvious that it is a symptom found in most respiratory affections,
and can only be of service in localizing the trouble when there
is no physical sign to be felt—then it
is of great value. In the influenza it is generally very marked
and varies with the respiration, which if fast or labored, causes
the nostrils to dilate—and close more markedly.

The sort of grunt called 'egle,' with aspiration is a local symptom
which I would explain as dealing with Cæsarean pneumonia. It is
a symptom of which I have never seen any mention in books intill
I thought it very distinctive of this Cæsarean pneumonia. The cause of the
alveolar grunt in the young patients, I do not know. Perhaps it may
be due to pain? However, in most of these cases I have noted, it
was peculiar as I was about the first thing I noticed for one heard
the full grunt even before actually seeing the patient. Perhaps
it may be due to a slight associated pleurisy causing pain
as interfering with the action of the lungs to
each respiration?

The blueness of the face is a symptom pointing to— in these
cases of Pneumococcal pneumonia—respiratory embarrassment. It is
present in greater or lesser degree in most cases of Cæsarean pneumonia
as a useful sign in gauging the amount of
embarrassment to respiration & aeration of blood in the lungs.

Ducking in with inspiration of ribs, intercostal spaces &
epigastrium as a useful & even frequent symptom in young
infants & young children. In all cases it is present to
a greater or lesser degree generally in proportion to the strength
of the chest wall. If the chest wall (bones, muscles) be weak
as in Pickwickians, or weakly, badly nourished children.
then the amount of evening so great, ribs especially giving way to atraumatic pressure with each inspiration. This was marked Case I where Ricketts was present where there was Collapse of lung as well as Catarhhal pneumonia. But if the baby is child be a thing me with strong healthy chest walls, the inward of the upper intercostal wall along costal margin takes place (the strong ribs & muscles leaving right of the abdomen wall being sucked into thorax). This I have seen in its entire state in a Case of Croup. Apart from height of chest walls & muscles the inward during inspiration varies with the amount of obstruction to entrance of air into the lungs. In the case of Catarhhal pneumonia the obstruction probably has its seat in the bronchus which either from narrowness or from plugging by secretion or from virus acidity to congestion, get their lumina obliterated & so hinder air reaching the bronchi.

The cough in Catarhhal pneumonia is of a distinctive character. It is a harsh, hacking, dry cough. By its character I mean the cough seems to be being nothing to do — no secretion to cough up — quite a different sort of cough to the Bronchitis cough which comes in a paroxysm & nearly choked the patient & accompanied by vomiting of expectoration into the mouth or throat probably to be swallowed by the baby or young child. But the cough of Catarhhal is that pronounced does not seem to embarrass patient any much judging from the little moisture of mucus in & apparently does not throw anything into the throat as in Bronchitis. Of course where there is much bronchitis present as well as Catarhhal pneumonia then the expectoration of the CatarhRace & frothy mucus do come into the mouth. The Cough of the Bronchitis preceding the Yeast Catarhhal pneumonia changes i Catarh as a rule.
In some cases it seems to be suppressed. From the chronic pulmonary cough of bronchitis it changes to the acute hacking & mucous cough combined cough of catarhal pneumonia. In case 10, while apparently it was but a passing bronchitis the cough was very hoarse, more lasting than in cases 2 to 3 months, of more of a whistle. It is a clinical fact, see case 8 for example. That underlying this change - the cough when once the Catarhal pneumonia has set in, as a change in the physical sign within the chest. On the onset of Broncho-pneumonia the physical sign of Bronchitis greatly diminishes in severity & may even become almost absent while the physical sign of Broncho-pneumonia are very distinct.

The gastro-intestinal or circulatory or Catarhal pneumonia it affects to a great degree - in some cases there is vomiting at outset as in some cases there is diarrhea commencing at some time as Catarhal pneumonia - the motions being thin. In case 10, slight - but very often there is a history of long continuity preceding diarrhea & there seems to be a close relation between the long catarh & the intestinal catarrh - the latter when long-continued predisposing to real purulent actually occurring. Catarh of the air passages of the lung probably thence the intermediate illness of Bronchitis.

In most of my cases there was intense thick coating of the tongue consisting with severity in the Catarhal Pneumonia. This thickly-Coated tongue formed a very good & valuable index wherein to judge as to the turning point of the inflammation in any of those cases - the tongue beginning to clean from before backwards in a very definite & regular manner - the general symptoms of the patient improving at the same time. The child 'goes off its food' as a rule till the severity of the inflammation subsides & then generally there is the inclination for food. The tongue as a rule are freely dry, even though diarrhea be not present. This is a point of note among
that there was a tendency to catarhia—the intake of the symptoms to speak with the long, more marked. Compare this catarrh in the child with the catarhia in the adult affected with pneumonia (catarrh). In some of these little patients, there is a tendency to catarhia, affecting the nostrils, the ears, and to delirium in the adults. The Sti infec

the probity in the patient, as a rule, to moist a great deal due to seeping up of the bulbo by the mucus! Of nervous symptoms must be noted the presence of catarhia at the outset, as in case 3 of very frequently at the death of the child. In the latter case the catarhia is probably the cause of death, but it may only be symptomatic of an inevitable approach to the end of the child's life. The catarhia merely原有 became the child already on the road to death. Other cases there are keen. When repeated catarhia occurs there probably do come death by catarhia though their severity a shock! Where a special case has been called to see a child which had

catarhia and the fever rising, any special case that has friends matter at chest a well marked area of the epithelium on lower back. This catarhia of catarhia will Catarhial pneumonia.

in general find when the child to is about a state of coma of collapse. I saw of these cases I only had time to pay one visit when the next day we had been sent word that the baby is dead and died twice the visit.

The association of catarhia with pneumonia do is come especially in a fact: I have seen in four meeting several cases of it is worth bearing in mind for the outlook of grave if the catarhia occurs after the pneumonia has been in.
I have seen the case of a Pickly Chil, emaciated, just about to come on; judging from twitchings of muscles, the sinking of thumbs & exubrantly frequent & colicous of hiccous, when the day after, not came the rash of measles.

**Physical signs**—these may be about a great deal in the chest. Grogginess & apparently only Bubonitic wind, the high temperature, the increased rate of respirations, & the character of the cough all point to Bubonitic with nothing else to put me in a state to look out for sign of pneumonia. Very often Croupous are the first sign detected even by the physician. It is no wonder at its change—the breathy sound. In children, the Croupous acquire a high pitched whistling. Very early sign of the high pitched whistling is the high pitched character of the cough of croupous. This was a very well marked in case 4041, where I had the opportunity of seeing the cases before definite physical signs were present. Even though in the Croupous very often there was certain signs (cough, croupous) the high pitched whistling can be detected at this high pitched quality of respirations breathy to croupous as these will be called bronchial breathy, the croupous are coarse & the Croupous (Croupous) apparently being far unusually in Croupous pneumonia will the bronchial breathy never before ones Croupous free Respiration. It is interesting to compare the other: Croupous pneumonia with Croupous must of necessity resemble. In Croupous pneumonia Croupous is a rule as the first definite sign is noticed even before Anubus, after the Croupous if at the same time, they disappear, comes the bronchial breathy which is the Croupous free Croupous with Croupous.
In the majority of cases dull patches sometimes small - almost inapparent! - sometimes large - to be felt! - can be mapped out by percussion in the cases of Pneumonia. Then these dull patches bronchial breath may be accompanied by crepitation thoracica both with primum and secundum. It is as a rule only over large patches of dulness that well-marked bronchial breathing is found. The breath and voice of lung may be absent, but usually there are crepitations elsewhere than over the dull patches. Begin of consolidation as a rule are bilateral although they are generally more marked on one side than in the other giving the pneumonia a one-sided look. One where the origin of consolidation are almost wholly confined to one side, on other side there is louder fine crepitations from side to side for example see case 7 where the whole of the left lung was affected, often to base but where the right remained free except for presence of few crepitations! Again one gets cases where the consolidation is confined to where there is no evidence from physical sign of the catarrhal pneumonia being bilateral as it generally is, for example of this see case 8 where there was quite a general bronchitis, then the body got very ill of origin of consolidation appeared on the right side only of remains in the right side all through the illness although there were bronchitis was on the left side yet I could not detect any sign of consistence of the air vessels,rescia as the catarrh of the bronchi remained only intensely in the Right side. That Case 8 in the bronchial catarrh in the left side diminished in severity. Perhaps Case 8 was a case of Pneumonia pneumia living in a body the subject of Chronic Bronchitis? there were too many
Cephalis, all things the illness—case 8 of the cephalis was present when the bronchial health was most marked which would not be the case if it had been欧美 pneumonia. In this pneumonia one gets bronchial or areas tubular without cephalis, but cephalis are generally found in cases. The area of lung is accompanying muffled the one kind of bronchitis. The cephalis is catarhal pneumonia; and for a favorite site, the lower back of it is very often more marked on the right side than in the left. The catarhal pneumonia is a large area due of course to the coalescence of tubular patches, which are when separate not to be detected by physical signs except cephalis, but when all else together—empyema—quite sure to well marked physical signs—dullness or percussion, bronchial or tubular health sounds accompany, bronchis. Indeed but for the presence of cephalis accompanying the bronchial health in which we here see a dull patch (empyema—tubular) is catarhal pneumonia, it would be difficult from physical signs alone to distinguish such a dull patch in catarhal pneumonia in the young child from a similar dull patch in bronchopneumonia. The distribution of catarhal pneumonia is often just as tubers (empyema—tubular catarhal pneumonia) as it is in the child or bronchopneumonia. So that this bronchitis obtuse tuber is from a clinical point of view quite misleading and in itself as one who has been misled by these terms, because very often see cases! And just large patches (tubers or from) in this case of catarhal pneumonia the disease becomes familiar during comparatively early with bronchopneumonia, both clinically and microscopically. This distribution of tubers of bronchial health of from become in my eyes always, associated more especially in the case of the term tuber, with bronchopneumonia which may be always called tubers although clinically catarhal pneumonia may take in just as affixed a tuber from from the coming together of individual tubular patches.
using the term tubular pneumonia which no doubt clinically is misleading to any one not conversant with tubular pneumonia; the term Cæbral pneumonia is better still. Bœchus—pneumonia is of better significance. The term tubular takes us away from a pathological or misleading sense! When the emphysema clears up, Cæbral pneumonia there is generally of the same time, a marked improvement in the symptoms of the patient. In Cæbral pneumonia the symptoms are the result of atelectasis, (crisis) and then follows physical recovery! The Cæphatation in Cæbral pneumonia are of a coarse barberry than the fine Cæphatation heard in first stage of Cæmpos pneumonia. It is in connection with more cases of Cæphatation in young children one must consider how much coarse. It sounds the normal breath, and in an infant, in a young child confusis with breathing: the adult. The Cæphatation are heard early in Cæbral pneumonia and if there be much bronchial Cæbral present at once, the bronchitis sounds almost as the Cæphatation (fine sounds) increase. This was well exemplified in Case 9, where the Cæphatation were heard in inspiration only, the Cæphatation in which cases, thus a cracking Cæheltia, just like dry the paper being squeezed in the hand. The Cæphatation seems to be Cæphatation but this character they probably take at the end of inspiration, and in usually at first where there is complete delirium & where breath sounds are tubular, then the Cæphatations are confined to inspiration only. The Cæphatations in most cases thus a cracking Cæheltia, just like dry the paper being squeezed in the hand. The Cæphatations seem to be high pitched but this character they probably take in the breath, and they accompany which are generally high pitched. Cough does not affect the Cæphatations. The Cæphatation appear most intense, moist cracking, & seen as if produced in the stomach, where the Aebness & bronchial (tubular) breathing are most marked. These Cæphatations may persist even when others cannot be detected, but they lose their intense crackling character so often as accompanied by true rales!
some hic. the expectoration, even though, children be absent, as of a
very fine variety but less i pitch. the bronchial breathing may
be absent if children be not present, but as a rule its present
at always so if there is any children. the bronchial breathing is best
noticed even tubulars when the patch of weakness is large. in babies
early in course a case the bronchial breating so especially will continue
in the first, clear we get as to the nature of the lung affection. usually
a patch of children cleans up the bronchial breathing disappears. the bronchial
breathing may be of a high pitch it makes in these children very notice-
seeing as if the blowing were right into the ear. Its analogue in
health is the health and got on placing the stethoscope on the breast
of a child. the vocal cry is sometimes entirely absent in these
cases as in case 8 and case 10. in the bronchopneumonic cry or sounds
can be heard before atonish physical signs are well marked - that i it
is heard where there is probable consolidation deep down at the root it
yet giving me to no appreciable weakness in percussion in aspect of healthy
lung tissue intermixing yet giving rise to fairly distinct tenderness
of the child's voice (cry) at so affording a clue to the mischief at the root.
It is very often present when the high pitched distant bronchial
expulsion deepens i present a promise case! it is a bronchopneumonic cry.
In many of these cases it is not heard for the simple reason the
baby is young child does not cry being too ill to show sign to cry.
The vocal furnishers i have only got in two or three cases i
babies or young children (in case 8 it was extremely well
marked). in that case i happened to have the hand laid flat on
the back of the child testing the expanding chest, when the child
happened to cry the inspiration became evident. it was about in
the other wise that came. when present it affords valuable
evidence of consolidation of the venereal portion of the lung!
The lymphatic node got on tumour was present in the
out of all my cases of long disease of whatever nature. It
was these 2 cases, no.-well marked! No. 8 & 10, associates
with constitutional of the lung or the one side. Therefore, when present it
afflicts absence of 7 points that constitutional change in the lung. It is
said to be present in pleurisy with effusion but it myself have yet had
a case—although I think I have seen a case or two is hopeless mood.

What the physical entity lies underlying the entity I do not know if it would
without some pathological evidence to formulate any theory or hypothesis.
It is generally put down to the presence of relaxed lung tubes but
I think the opposite condition might just as well account for it
—a state of acute enphalgesia—see case 10 no. 2.31
when both sides were hypersemant & the right even lymphatic! It is
noteworthy that in that day there were region of constitutional at both sides
that the vate about the trunk which I always mentioned first, was made
before the vate about the back—being the value of any lymphatic
node in front! Sometimes we get a hypersemant node on a portion
of lung— I remade me case well which showed this!—when the
breathings were absent about not least any feeble on the one
portion of lung—the underlying entity being probably Collected
of lung with nursing enphalgesia! Again entities one gets
a case where there is no evidence of disease & yet the breathings
are feeble or weak confined with another portion of lung or with
opposite side. This entity probably points to collapse of
a portion of lung & there is in that temperature elevation is caused
for diagnostic purposes for a similar entity or weak or muffled
breathing—got?—Eosophes of commencing Catarical pneumia
see case 10 first day! The above are the physical signs which me generally meets with — Cases of Catarhal
pneumonia + of all the physical signs - Capitation are the very
enchant-ones! & we may get cases in which Darkness
cannot be detected, in which there is no bronchial breathing,
no vocal, any + yet the presence of true Capitation in a
Case of Bronchial Cachexia with high temp + other symptoms almost
Ceritainly points to Broncho-pneumia. Of course just as in the case
of Symptoms so in Physical signs - the accompanying Bronchitis
or the presence of Congestion of lung will modify accordingly
the signs of any case of Broncho-pneumia! To again
note the Cachexial pneumonia becomes Chronic, the physical signs alter
very little indeed + by then it is Cachexical Tuberculosis of
the lung or again if the darkness be marked one has to decide
the possibility of pleuritic Effusion generally in the form of Empyema.
Empyema is generally seen to follow Broncho-pneumia but there is no
reason why it should not occasionally follow a Broncho-pneumia. These
any circumstances one sometimes has a child brought into one's consulting
room in which there is COMPLETE DENIAL + no know bread - the child has
been ill + not attended by any medical man - with a parapneumotic +
perhaps bronchial breathing. A case like this I have seen repeated,
might either be a Case of Chronic Cachexial Pneumia (Consolidation)
or a case of Emphyema. The Needle in the only case of true, but I
have seen the pleuritis of a Needle covered with as many negative+
results (pus or serous).

**Diagnosis + Prognosis** - the diagnosis of Broncho-pneumia
has been enounced at fair length - detail under each case
was seen observations, Called to a Acute Care -
a bursin of pneumonia Bronchitis be it from whooping
coughs, measles, + simple influenza, with a sudden getting
worse of the only a child would call one's attention to
Cataarrhal pneumonia, but also to the possibility of collapse of a portion or portions of lung. Between these two conditions physical examination might at a moment or two help one. There is, evidently, more than one reason why the absence of physical signs could make one lean to the symptoms, general and local. In the case of collapse of any amount of lung, even though the breathing is very rapid at the base (from working of the child apparentlly very ill — see case 9) yet the temperature after all may amount of disturbance elsewhere in the child, be a low one, whereas in the case amount of disturbance is cumulative, increasing with amount of collapse. The temperature generally registers a high degree somewhere about 103 or even higher. The aspect of the child differs materially — the child in collapse of the lung has a pushed up, anxious look, and dry cough, frequently at the point of indrawing of lower chest in greater than in Cataarrhal pneumonia, again the child in Cataarrhal pneumonia has an actually pale look, so generally very drooping, and little notion of things around it, whereas in cases of children in whom there was evidence of internal collapse, in which the child seemed to sit up and be very restless, the temperature, however, in the feet prints of trachoma, height, are more like the symptoms of collapse of the child — pitched and drawn features, cold and clammy skin, small ineffective pulse — all well seen: Case 9, in which though there certainly was some Cataarrhal pneumonia present, yet mainly was a case of collapse of lung time. When signs of congestion are present then of course print to a Cataarrhal; but yet they may be present with collapse, the general rule for a minor condition that manifest itself during life but well been in the poet, "Morning Hours."
When signs of consolidation are present — then the lesion to the
be concluded are pemphigus, or empyema pneumonia.
In pneumonia with effusions, the temperature is less than in Croup pneumonia; it does
not keep up so high for such a length of time. Again the physical
signs are difficult — the expirations of emphysema and the bronchial breathing,
tight present in children with effusions, yet point more to pneumonias.
The mere absence of vocal cry or vocal facility in a young child does
not tell much one way or the other, for there are seldom put by young children.
Displacement of the posterior as the heart — of the exploring needle
are the only means of telling in young children the presence, in
a doubtful case, of effusions.
Between croupal pneumonia and
Croup pneumonia, both of which may take on a lobular character,
Signs of consolidation, the temperature points to a difference — in
croupal pneumonia it is not quite as high, but so much more
in temperature than the cold. Croupal pneumonia, the chest
palpable — Broncho pneumonia would point out as a distinguishing feature. In
the physical signs the presence of emphysema, cough + hoarseness with
impairment of inspiration of Broncho pneumonia. All of Croup pneumonia
is slight, the expiration are soon lost, are very limited both as to breath and
will inspiration not much to area of lung affected. Whereas the expiration of
Croupal Pneumonia may be heard where changes cannot be detected. Bronchial
breathing is felt + heard, but it is more finely tubular. Croup pneumonia
I think chiefly so, because the expiration involves the heart
sounds in Croupal pneumonia. We in Croupal pneumonia where the heart
sounds have been intensely bronchial + even tubular (see Cases 7, 8, 10).

The crackling emphysema have also been present accompanying it sometimes
marking the expiration intensely bronchial. Heart sounds.
This
betes in a distinction between these two pneumonias, on which I
would place great faith because it is almost always. The young
child I had near my case with Croup pneumonia was
High temperature, flushed face, no 대, but well marked & strictly local physical signs: Blisters in middle of right cheek & ears, vesicular breaths, and without expectoration except at the beginning. I soon got whip-sawing pleurisy. In cataract pulmonary, large ameloid patches may be present—see my own case. I see the ameloid—vocal cry, vocal vibration (case b.) and intense bronchial breathing—let me warn you all that this disease resembles expectoration and the ameloid runs in the same rest of flesh. The bricks pneumonia means often & no mistakes—coughing pneumonia—to be one-sided but as a rule expectoration if not deadly will be detected in the middle nine lines, the bronchitic rales, which almost diminish greatly as the abatement of the disease nears. In chronic cases of consolidation in young children the exploratory needle—the only true way of distinguishing between the solid lung tissue and the fluid is the presence both of which when chronic give distress & cause symptoms!

Prognosis—very doubtful. In pneumonia in young children & babies. Indeed if I were asked what really carries off the majority of very young children among the poor & the rich, I would say Pneumonia. It sometimes being a healthy animal may be said only to kill a healthy infant or unweaned child acting like the proverbial shears in—"the last straw that breaks the camel's back." Yet, no doubt it is true that even when bricks pneumonia attacks a comparatively healthy walking child but the intensity of the infection is always so great that a favorable escape can never be foretold. Bricks pneumonia is a mortal malady—sometimes, the body getting through an attack as in about 2 weeks as in Cases 3, 8, 10., with perfect recovery while in the other hand, they may die in a short time & quite in five or six months after the disease as in Cases 7, 15.
of course if the child is slightly improved in the subject of
Rickets it falls a subject to Pneumonia, then the
outcome is very grave as in Case 9 again in Case 10
Case 10, where there was a severe Cystitis, the child
had a case of Lepto + high fever, there the onset of
Cystitis in the case of an already severe Cystitis, moderately killed the
child by commencing it too late; Convulsions even late on in
the illness has a very bad look & if combined with severe
fever, few survive the second cases - i.e. Cystitis, mark apparently means
death to the child. When the child is healthy & better
food fairly well, all one can say is: that, if everything goes on as
it should, the child will recover. In Cases 8 & 10 two beautiful &
healthy babies - the illness was of a severe type - baby strong & normal
for about a week or ten days, breathing fast all the time, yet
will come thru these two cases with all right well to the delight of
the mother, who has not gone to bed the whole time, although if once
they had slept while relieved of having the babies.

5

Pathology. there were two things which struck me
in the post-mortem room - i.e. the presence with patches (lobes)
of consolidation of similar fashion dark, depressed
patches - as much depressed below the lung surface as
the consolidated lobes were pustulant coins above the lung
surface and 2 the lobar distribution of Cystitis where as
seen by opening the lung - this lobar distribution of the consolidated
lung due to the lunging together of adjacent patches of
Consolidation. in other words, the consolidated lobes
concealed to form the lobe. This was well simplified
in a case of Pneumonia which I saw in the
post-mortem room. The case was, I think, there were;
Case of Mrs. H.; child aged 1 year 6 mos. Pneumonia.

P. M. R. lung; fairly healthy - Apetite - full of air & of a normal colour - there were one or two patches on the right lung of solid lung - shadows - looking the same.

Left lung: upper lobe - one or two little patches, small, little, with interstices, dark, think, appears patches between them - posterior upper lobe fairly healthy, lower lobe - quite solid & heavy like firm tumour, appearance of bull - feels tough & very compressible - like healthy lung - not friable. The whole of the lower lobe was involved from root onwards to pleura.

Left lung:

Dough appearance of outline, appearance of right lung.

The appearance of the lung as follows: in the left lung like the lobular distribution of consolidated. Indeed the whole consolidated in this case was difficult to distinguish from that we see in pneumonic as it was difficult to make out the lobular arrangement in the lobe. The interstices were helped this lobe to be one of interlobular pneumonia. The lobular distribution is the one most usually found in the post-mortal organs - patches, small & large. Patches on the surface of the lung, while usually patches appear below the surface of the lung of a dark, think, or brown blood. Colours; lobular collapse at first too time in to the pleura, small areas, and consolidated patches of dilated air cells - emphysema.

On a cut section of the lung, the bronchi & smaller bronchi are deeply engorged especially the smaller.
ones out of which by pressure fluids probably catarreal
products can be squeezed. In section the visceral portion
of the lung is connected with the solid elevated patches
large or small (lobules) on surface of lung, i.e.
seen to be solid - the smaller bronchi & bronchioles &
catarrhal cells fill here & less with products of catarrh.
This proves i as a rule been in both lungs . On microscopic
examination one sees evidence of some catarrh both in the
smaller bronchi & in the alveoli round cells. Under a high
power catarreal cells are seen to fill the air vessels with
apparently little else than cells quite a subject to the catarreal
seen i. Croupous pneumonia where the cells are alveol about.
Yet in some section we can see even zones where well marked
of fibrous exudation though in these cases it is always
accompanied by more cellular elements of catarreal nature
than in the true croupous pneumonia. The
process of a fibrous exudation into the air cells in these cases of broncho-
pneumonia may explain to account for - the presence of the
true tubular breath - found in a few times. Whereas & used in several of my cases of broncho-pneumonia it is doubtful the fibrous exudation would
lead to a more complete blocking up of the visceral portion of the
affected part & to const the tympanical tracheal breathing to the
case. However the 3.3.3 complete & pure fluids catarreal cell
blocking up of the air venules & bronchioles, would produce
tubular breathing but with expectoration - the expectation being due
to the mere fluids filling up (contents) of the air cells & Bronchioles
i Broncho-pneumonia. This disease of my subject I was surprised
very briefly because I only at great trouble, was able to
see a few post mortems on children at hospital, because in
principle practice the opportunities for post-mortem examination are few. Again in a purely clinical essay little the present an elaborate knowledge of the pathology, even if I had had great opportunities for post-mortem work, would be unnecessary although in itself a study of great value. One can only study malaria anatomy and pathology when connected with a hospital where however one does not as a rule make regular observations. Don't get through pointed out the observations of some writers of more experienced hand. Even a home surgeon or a home physician must be controlled in examinations by his "chief." It is difficult in private practice, where no help is at hand so one must make examinations of some sort in the other. While at Edinburgh I attended regularly - not for purposes, as many do, of getting a certificate, the summer term of many, but for a practical acquaintance with morbidity. It was from the post-mortem of the adult during a summer's winter session that I learnt most of my pathology. The few post-mortem in children I have seen have seemed to point out main facts in the morbid anatomy of Brucella pneumonia & hence access to physical signs. If one could see physical signs there appears the mischief that is going on in the lung is I think the chief aim of a clinician & I don't think we can assess the two such or very particular in teaching for & finding physical signs.

Of treatment much might be written but as the treatable in most cases of Brucella pneumonia should be if as simple a therapy as possible it will be unnecessary to write much about it. Besides the treatment has been varied with each case.
Bathing of the child's skin with tepid water is a good thing in bringing down the temperature if too high. If a strong salt solution will do, but I am afraid the motion of such things as see in a bath to bring down the temperature would not find favor in the eyes of many of the parents.

Thus it has come to the end of this essay. I brook up the subject because it was one about which I knew very little and because it was interesting of great moment to me as a practitioner. Some of the truths connected with practice have prevented me from fully into many points, but if the observations be true, I am satisfied. It would not have been to any great advantage to have added some cases in all the patients, but thorough experience in practice, study of a few cases is better in its results on one, than the cursory and necessarily imperfect study of many cases. I must conclude now with the quotation from Popper:

"And what is not, is not—
Would it were Worthy!"

A clinical study

by Minnie Erpe Trotten

M. B. E. M.

2nd Class Honors 1889
A warm room is of great importance. The feeding of the baby or young child is the greatest difficulty equally as the arrow. A spoon must be a breast one. Milk or dilutes or milked is the best food during the illness. It is of great service to add lime-water if diarrhea is present. A cup of tea is just the slightest tinge to intestinal catarrh as seen by sneezing (shoo) children. Beef tea, meal juice or other easily taken drinks are of service but these, as well as milk, should be given with care regularly at meal times of medicines ammonia preparations with broad ammonia or opium and small doses of castoreum when the purges begin to be frequent. I have used but did not see what benefit derived from expectorant medicines. As with a baby or young child sick, no tincture while suffering from bronchitis does good, but the same tincture in Brooke’s tincture is apt to depress. The child can be given if it does good. Small doses of Brooke’s tincture is service in cases where the child is apt to get too heavy or too emaciated in strength or gets a sort of muscular attacks. Antimonial wine & gleece — remedies which depress I do not give as I think the child with catarrhal pneumonia does not bear my depression. Of local application

burning & bruised poultice (i.e. hot) are of great service early and may be continued till inflammation abates somewhat; when the

century is best kept up by warm’s plaster applied down there over the chest. Pate still painting will burn the foot in a mild form of century irritation in babies. In the case of poorly nourished children the Dr. Ferri’s and Cothier oil are useful. As a rule that woman keep their children when ill, too warm, too much wrapping up so that after she finds the child bitter in perspiration more especially if the room is kept too hot. Each little patient must be treated on his or her own peculiarities of no definite rule can be laid down.