ABSTRACTS OF THE CURRENT LITERATURE

THE NEWBORN


Meningitis in a newborn is very rare and especially so one which is caused by B. proteus. The author has reported meningitis due to B. proteus morgani in a newborn infant aged 12 days only. The presenting symptoms gave no clue to the diagnosis but a lumbar puncture done on the fourth day of the illness yielded yellowish cloudy fluid. Smear showed gram negative intra-and extracellular diplococci. Culture revealed B. proteus morgani which was sensitive to streptomycin, chloromycetin and polymyxin B. Treatment with dihydrostreptomycin and chloromycetin completely cured the child with no sequelae. The literature on the incidence of meningitis in newborn infants has been reviewed. The author advises “Any infant who is not doing well or has an unexplained symptom, be it temperature elevation, cyanosis, vomiting or diarrhoea should have the benefit of a spinal tap for a more definite diagnosis”. “The ideal treatment, of course, is to isolate the organism, do sensitivity tests and to use the indicated antibiotic in adequate dosage”.

A. K. Dev.

INTERNAL MEDICINE


For the sake of treatment asthmatic children have been divided into two groups. The first group comprises children who have intermittent attacks of coughs or wheezing associated with cough which may be persistent. In such cases ephedrine in combination with aminophylline and small doses of barbiturate with a coating of isoproterenol placed under the tongue for five minutes and then swallowed quickly relieves the patient. Potassium iodide may be added to thin the secretion. Antihistaminics may be useful for its sedative effect when administered before retiring to bed. Water is a very readily available expectorant. Pot. Iodide and Syr. Ipecac are also useful expectorants. In the second group there are acute attacks of asthma. In such cases where bronchospasm and anxiety are the main causes of distress, subcutaneous injections of epinephrine repeated every 20 minutes if necessary (twice only) accompanied by ephedrine orally are useful. Isoproterenol sublingually may be administered in place of epinephrine by the needle. Aminophylline intravenously or rectally is administered specially in anxious patients; barbiturates also are of use in such cases. Alternately choral hydras can be given orally or rectally. In cases where acute attacks intervene, persistent wheezing and cough, expectorants along with or before bronchodil-
lators are highly effective. In some cases where there is an acute attack of
asthma with each attack of respiratory infection, the infection should be
completely eradicated by the administration of antibiotics. In such cases too,
bronchodilators and expectorants are used to alleviate the symptoms.
Associated dehydration and anoxia should be treated by fluid therapy and
oxygen tents. The use and effects of steroids have been only briefly discussed.
The dosage schedule for a child of 6 years has been given.

A. K. DEY.

Management of Bronchial Asthma in Children: Leon Unger, A.
Alvin Wolf, Janus H. Johnson, and Donald L. Unger—J. Pediat.,
52: 539, 1958.

In the management of bronchial asthma correct diagnosis is very
important. Skin tests should be done in all asthmatic children with all
protein containing material to which the child is exposed. Scratch test
followed by intradermal tests give the best results and the danger of severe
reactions of intradermal tests can be avoided. In the management great
stress has been laid on the strict avoidance of causative allergens and
hyposensitization. Reassurance to allay the anxiety of the patient is
considered to be an important step in the management. As regards medica-
tion in mild cases repeated subcutaneous injections of epinephrine (.10 to
.20 cc.) along with oral potassium iodide (saturated solution 5-10 drops)
accompanied if necessary, with sedatives such as elixir of Benadryl is advised.
In moderately severe cases four-hourly injections of epinephrine to which
.10 cc. of susphrine is added along with rectal instillation of 5 grs. of
aminophylline, along with oral ephedrin are given. The authors advise mild
sedatives only. A teaspoonful of syrup of Ipecac to induce vomiting is helpful.
In status asthmatics antibiotics are usually added. In severe cases continu-
ous I.V. drip of 5% glucose containing ACTH (10 to 20 units of soluble
ATCH per liter) and aminophylline (25 to 50 mg. per liter) is given and
stopped as soon as asthma is overcome. This is followed by I.M. injection
of ACTH gel (20 units) per day. In obstinate cases prednisone (5 to 10 mg)
per 24 hours may be necessary.

A. K. DEY.

Thumb and Finger-sucking: A study of 2,650 Infants and Children:

A total of 2,650 infants and children were studied from a general
pediatric practice. Thumb sucking refers to placing the thumb or fingers deep
into the mouth many times day and night and exerting definite sucking
pressure. All patients were followed from birth. 45-6 per cent of the total
group were thumb suckers. 75 per cent of the thumb suckers began thumb
sucking during the first 3 months of life and the other 35% during the re-
mainder of the first year of life. 11-3 per cent of the total group were breast
fed. Of this 43 per cent sucked thumbs. Majority of the patients took less
than 30 minutes to feed. 41-7 to 43-8 per cent of the "fast" and "average"