PAEDIATRICS

1

Vomiting in children. – usually premonitory symptom of pneumonia, etc.
In children over 12 months – a constant sign of almost any disease – local or general – acute peritonitis, etc.
Under 12 months – caused by
1. Toxaemia eg. Anaemia.
b. Hunger – common in young baby.
c. Reflex vomiting – from irritation of Pharynx.
d. Gastro-enteritis, Gastritis (due to excess Cls)
e. Dietetic mismanagement (overfeeding, wrong diet, etc.)
f. Habit – child can make itself vomit (like cow) examinations.
g. Recurrent V. – periodical or cyclic vomiting.
h. Pyloro – spasms or congenital pyloric stenosis.

Breast-fed baby with persistent inexplicable vomiting must be investigated. Breast milk rarely wrong + artificial feeds of little use. Usually pyloro-spasms. Normally when fed in Stomach pylorus automatically closes – feed lies in lum, mixed with gastric juices + then pylorus opens + feeding forced gently through valve.

In PYLORO-SPASM – the pyloric muscle remains in spasm sporadically. Meal does get through. Muscle does not thicken – projectile vomiting, but some days normal (eg. stools) Small frequent feeds given. Very hungry baby – not fretful. Symptoms ~~after~~ appear after first 10 days of life.

Tr. Aim to overcome spasm.
Smaller feedings, more frequently – reduce to 1 or 2 hourly.
Atropine (Liq. Atropine Sulph. 1–1,000) give 3m. a.c.
Eumydrin Solution, Belladonna, Chenabarb.
Antispasmodics to relax pylorus + pass feeds through.
Usually until thickened foods given (4–5 months) then should stop.
Dx from stenosis – maintains body weight + also early days of spasms.

PAEDIATRICS.

(2)

PYLORIC STENOSIS — congenital — narrowed - hypertrophied pylorus (not very common now, but usually in male first babies) Intractable vomiting becomes progressively worse. S+S Vomiting a few days after birth becoming progressively worse into 3-7 weeks when obvious something radically wrong. Mechanical obstruction - not digestion or diet. V. quite persistant — projectile - no effort.

Ravenous with feeds.
Progressive loss of weight (4-6 weeks sudden loss of weight)
B.A's at first, then none — obstinate constipation.
Visible peristaltic waves over upper ab. when feeding.
No temp. — Look wasted.

Diag. by history - Watch feeding for peristalsis — L-R under costal margin ball-like waves, then up to an hour later - woosh!

Feel tumour - hard, mobile N. small - R. of recti - under liver edge.

S. typical of high up intestinal obstruction. Surgery indicated.
Confirmed by X-Ray (really unnec. but Heather Dick likes to) — Barium given at 6am
— Filmed at 9am - until 100% Ba in stom
— Filmed at 11am + 1a.m.

If after 4-6 hours more than 6% Ba in him diag. right!!! + surg. proc. ∴
Re-hydration necessary before surgery — tissues lax — fluids lost afterwards: necess.
— I.V N/5 ∴ 5% Glucose drip — slow — 7 D.P.M. 12 hours to 3 days nec.
— also note voidment — Not a surgical emerg (like intussusception) 'til fluid level OK.

PRE-OP. (Imm.) P.P. under L.A.(N) (fluids given + all that)
Sometimes open Ether. Soda Phenobarb premed.

Babe dehydrated - lax fontanelle, inelastic tissues through loss of tone, also anaemic.
I.V. for 3 days - hydrates baby + much better surg. risk.

RAMSTEDT'S OP. Post-op. Warmth (for shock) I.V. therapy cont. for approx. 24 hours + discontinue if babe does not vomit. No feeds for 24-36 hours as stomach not functioning normally. Sips of Glucose solution + grad. increase to normal feedings. Back to Glucose if baby vomits. Breast feedings commenced after 24 hours - in small amounts.

Convalescence — Satisfac. usually unless babe not have breast feeds.
Complications — Shock — minimised by tr. above.
Haemorrhage — usually not excessive. Pyrexia 2nd or 3rd day treated ∴ Sulpha's or Penicillin. Rare → Perforations of muc. mem. with resultant peritonitis. No diag. disadv.

PAEDIATRICS.

(2) 24.1.57. APPENDICITIS: dangerous in children – Rare in first 1½, from 2–14 height of cases, then gradual retrogression.

Sts. general to kids: Gen. abdominal pain – shifting → R.
Localised rigidity. Temp. unreliable.
Abdominal breath + constipation.
Vomiting – tachycardia.

Parents relied on for history – often unreliable. Difficult to examine, but vomiting + pain a constant feature, + P.R. exam helpful. Omentum not developed enough in children to localise infection so peritonitis occurs soon after acute attacks. Temperature not a reliable guide in degree of severity. Tongue + abd. breath valuable signs. ∅ diarrhoea, no cough. Immed. surgery important – 24 hours the limit. Position of appendise – if "pelvic" may be confused with gastro enteritis – aggravate bowel, or urine/ureter.

Are pains appendical or not? If appendise chronic, pain is recurrent. If an excuse to dodge school, etc – usually only one – oc hope, but difficult to prove – should wake up in night with it or stop what he's doing. Some rigidity if appendical. Also often Family history eg. Mr Dad had it & all that. Often confused with pyelitis (but rigors, scalding, frequency) "Bilious attacks". Pre-menstrual females + early menses, confused by abdominal pain. Tubal congestion – inflamed appendise associated vomiting indicates seriousness.

Tr. same as adults. up in a week – home in 10 days.

Chronic app. Hist. malaise – spasmodic vomiting – weekly–monthly. Remove app. few weeks after attack.

Causes of appendicitis: T.B's
Thread worms
Faecal concretions.

PAEDIATRICS

INTUSSESCEPTION

- commonest form of intestinal obstructions in children - is the invagination of portion of the intestine into another.

Types: Enteric, colic, Ileo-colic, Appendical, or Ileo-caecal (last most common (98% at this valve)

- commonest age: 5 - 16 months. - in very healthy baby boys.

May be caused by strain when baby beginning heavier diet of educ. foods.

S+S.

Perfectly healthy (before) child has sudden onset of paroxysmal pain of 3-4 minutes - screaming & intense shocks. Recurs every 5-20 min. Assoc. with death-like pallor, feeble pulse, ↓ normal or sub-normal temp. Palpable tumour - "sausage" - shaped. As a late symptom, blood may be passed P.R. - bright-red and fills napkin (c blood) Absence of pyrexia, diarrhoea, cough

CARDINAL SIGNS - PAIN, VOMITING, SCREAMING, PALLOR.

Attacks become more frequent and vomit often. Shock + dehydration present.

Tr. IMMEDIATE SURGERY

Keep warm pre-op's. L.A. preferably used. R. Paramedical Incision - the intussesception reduced by "milking" the invaginated portion to original position + completely reduced.

Intussesception may be gangrenous necessitating bowel resection and anastomosis - the added Surgical Shock of prolonged op's. may be fatal.

POST-OP. As for pyloric stenosis. Treat for shock. Signs of water & Glucose 5% Gradual to usual feeding after 4-8 hours.

ALSO Reduction by X-Ray and hydrostatic pressure.

Catheter passed P.R. Water or milk & Soln. introduced

INTRA-GASTRIC DRIP:

Req's
- Flask (Glass, marked in ozs, pref.)
- Length of rubber tubing
- Drip chamber - Murphy's
- Small rubber catheter
- Glass connections.

Open 8 oz flask, with loosely fitting metal lid.
3 feet rubber tubing.
No. 4 rubber cath.

—over

PAEDIATRICS

Intra Gastric Drip (cont'd) Flask on I.V. stand 2-3' above bed. 6" Rub. tub. connects flask to drip chamber. Further R. tubing (30") is joined to No. 4 cath. by glass conn. Flow regulated by screw clip.

Catheter passed nasally to stomach, using length approx. the distance between nose + Xiphisternum, or longer if nec. to get gastric cont's on prelim. trial asp.

Tube then clipped off, food poured into flask + allowed to drip through after air expelled from cath. + rub. tub.

Tubing passed over hot water bag at head of cot to warm food.

Time taken to run feeding through is ½ to ¾ hour.

Catheter, etc. removed daily for cleaning - but this depends on type of feed use - thicker foods need more frequent cleaning of app.

Alternate nostrils used each day - become sore after long periods.

Sometimes small "coffee ground" vomit occurs - due to oesophagitis build in prolonged use of drip, but clears if drip discontinued.

Irritation lessened considerably if catheter removed after completing the last feeding for the day, + cleaned before replacing for first feed next day.

To re-establish bottle feeding, a small amount can be given by bottle at each feed, with catheter in position - child usually sucks quite well + rind remainder of feed put in flask. Amount given by mouth increased grad. as condition improves.

Uses:
1. Persistant vomiting without organic obstruction.
2. Swallowing air
3. Very sick infants where minimum of handling necessary.
4. Pyloro-spasm.
5. Diarrhoea - renders post colic reflex less active.

PINK DISEASE

~~MENINGITIS~~.

Infantile Acrodynia or **Erythredema**. - Disease limited to children. 4 m. - 3 yrs.

Cause: Prob. unfiltered virus (?) Frq. preceded by an acute URTI, or less often Gastro-enteritis

S + S: Insidious onset. Irritability increases with disease - constant fretfulness
Photophobia, curled up in peculiar posture - apathetic.
Anorexia - loss of weight, stomatitis - dribbling
Muscle atrophy - limbs flabby, cannot walk.
Puffiness of hands + feet - assoc. w "raw beef" appearance.
Skin feels damp - jelly-like feel - has peculiar ammonial odour, usually sudden rash often over napp. area. + itchy
Tachycardia
Palpable glands in neck, axillae.

over.

PAEDIATRICS

Pink Disease (cont.)

Tr. Bung in loop. (for urinalysis, X-Ray, etc.) Disadv.'s – Risk of fretting and cross infec. – child has little resistance to infection + any complications serious.

Supportive tr. – mother best to look after.

1. Diet – of high vitamin value (Parke VB – may be given i.m.) F.W.D.
2. P or Spt if stomatitis or other infec. present.
3. Adequate rest – sedatives to control. – Phenobarb.
4. Care of skin most imp. Thorough bathing, plus spirit – dusting powders
5. Symptomatic tr., protection of eyes from light, eye drops, etc.

Complications. Otitis Broncho-Pneumonia + pyelitis. Sudden heart failure may occur.
Recovery usually complete, relapses uncommon.
Disease may last anything up to 18 months.

These children have sod. chlor. def.
Vit. B complex & Phenobarb ½c vit. diet.

CHOREA, ST. VS DANCE.

Manifestation of Cerebral Rheumatism = can be due to other functional causes, eg. – neurosis, etc. 5–11 years age group – females > males.
Cause unknown – too much school work, worry, fatigue, frights, predisposing causes
S+S Onset insidious – clumsy in movements – becomes worse.
Irreg. purposeless of any or all voluntary muscles. Unable to speak properly – slurred, then imposs. (Habit spasm – lies – not chorea)
Become completely imposs. to help themselves.
~~R.H.~~. Vary in severity – slight to violent. May have hemi-chorea.
Affects heart. Anorexia, vomiting.

Tr. R.I.B. important – minimum 6–8 weeks – rest, no toys, visitors, etc.
Fully nursed – TPR + SP, etch
Salicylates ~~and~~ sedation.
Nourishing diet – vitamins, etc.
Prog. depends on cond. of heart.

Comps Endo- + Peri-carditis freq. present. – S.P. charted to investigate
Prone to intercurrent infec.'s.
Relapses can occur.

Chorea Insanium – sedatives essential.

R.F. disease may only last a few weeks, but convalescence usually for a period of years. Convalescence 4 to 6 weeks after pulse normal - may sit out of bed. Good diet After - sedentary occup.

Prophylactic doses of 5/d daily or oral Penicillin for 1-5 years (No recurrence if P. taken religiously) Strept. does not become acclimatized.

Tonsilectomy does not make any diff. - only for infected tonsils.

PAEDIATRICS.

Rheumatic Fever.

14.2.57.

Acute infec. – ? Origin. Characterised by multiple arthritis & freq. occurrence of inflam. of Endometrium of cardiac valves & resultant cardiac dis. M. more than f.

Sts Freq. occurs after attack of tonsillitis. Pain begins in one of larger joints, usually the knee, wrist or ankle which becomes red, hot & swollen & painful. Its infl. subsides in one, rises in another.. Pyrexia, coated tongue & marked sweating is constant. Albuminuria. Anaemia is a late sign. Headache & vomiting at onset.

In children – often passed off as "growing pains"

Erythema Nodosum:

Rheumatic Nodules:

Tr Make comf. – bed cradle if nec.

Fully nurse – & nurse flat – to help prevent future cardiac damage.

Away from any Strep. infection.

Diet – nourishing, protein vitamins A.P.C. given.

4 hourly TPR & Sp. (at night!)

Local Tr. Lin. Methyl. Sal. (only if patient permits – joints sore) fomenta. Elastines if poss. :– warm wool.

10–20 gr. 4 hrly. Soda-sal – brings down temp.; alleviates pain & swelling – arrests acute progress. given ℞ Soda-Bic. to prevent toxic effects of S. Sal.

(Toxic effects – tinnitus, nausea, & vomit in kids) cease immediately for 24 hours & try other Sal.'s – with vomiting, nausea etc. give alkalines

Deep curve in E.S.R. ofa – bad sign E.S.R. – carried out regularly to assess activity of disease.

Antitoxins no effect on cause of acute case. P.& S/d. given for Str. throat inf.

While child febrile & feverish. After 48 hours temp. should be down.

Convalescence important – poss. mitral v. infec. – rarely other valves – cardiac muscle infection shown by S.P. records. Pericarditis poss, & all muscles may be infected at once. Endo- Myo-

No criterion of severity to indicate complications.

Mitral Regurgitation – perm. comps leads to Mitral Stenosis. Pericarditis friction sound, peric. effusion. Acute onset – pallor, chest pain, & peric. sub.

Not common – intense praecordial pain. Tendency for recurrence of attacks. – 80%

Influenzal Meningitis - insidious onset, attack of ~~the~~ first, 4-5 days stiff neck. Maximum ×P, Str. ♦ S/d given. Chloramphenicol Sometimes as well
If no subsidence in 5 days - broad spec's given.
Haemolytic anti-serum (from rabbits) if diag. early. If late, scrub it.

Kernig's Sign - imposs. to extend the leg at knee joint when thigh flexed on the abdo. = May not be persistently present.

CSF usually crystal clear - in menin. - opalescent, turbid.

Broad Spectrum antibiotics not given unless indicated (Path.)
Pneumococcal - IM 1m° 2 hly ×'P + S/d, in 2-3 days no response - to Br. Spectrums.

PAEDIATRICS.

MENINGITIS.

Acute inf.+ inflam. of the meninges of brain & spinal cord – may be of several types, according to pathl. causative organism.
eg. Meningococcal – "Cerebro-Spinal" or "Spotted Fever".
Influenzal
Pneumococcal
Streptococcal
} srs similar in all acute types, except t/p type.
Tuberculous.
Staphs., Gonno., etc.

Inflam. of Meninges gives rise to excess secretion of C.S.F. & therefore increases pressure & WBC count of CSF.

Characteristic Symptoms include –
Sudden onset – crying in pain, convulsions – incr'd CSF not absorbed b/ irritation
Terrific headache.
Vomiting
Severe pyrexia.
Pain & stiffness of neck muscles.
Head retraction – to Opisthotonos. (when fontanelle bulging > CSF.)
Convulsions & rigors., cerebral irritations.
Purpuric rash.
Tense fontanelle (bulging in babies)
Kernig's signs.
L-P. indicates any > intrathecal pressure $\frac{\uparrow}{\text{normal}}$ $\frac{\uparrow\uparrow}{\text{severe}}$.
+ all accompanying srs of acute toxaemia.

Early diagnosis imps. – confirmed by L.P. – Turbidity of C.S.F, pressure culture & microscopy for causative org. & cell count – WBC's in CSF
Meningococcal & Infl. M. may occur in epidemics, others sporadically.

Tt (active, intensive, immediate!)
Simultaneous intensive Tt. of 1. PENICILLIN (given in L.P. & Str.) I.M. – maximum doses – 50,000 u Intrathecally daily? or 30,000 – 40,000 u I.M 3 hrly.
2. Adequate SULPHA's – S/d, aureomycin & negathrine.
3. STREPT. – intrathecally as req.

Details of Tt. – dosages, etc., vary slightly acc. to spec. caus. org.

Intrathecal inj. given to get at seat of inf. at time of diagnostic L.P.
Daily unnecessary trauma,

Prognosis + sequelae revolutionised since advent of Penicillin + Sulphas. Nearly
high incidence of complete cures in 2-3 weeks + sequelae almost nil.

Records of some cases ~~can~~ into penalty when to. with Abipt.

PAEDIATRICS – Meningitis (cont.)

Routine nursing of a fever – eg. hydrotherapy, fluid diet, charts – TPR, BP, FBC, vomit, twitch, discharges, etc, etc, + so forth.
Special care of skin surface – p. points, mouth toilet, eye toilet (child lies with eyes open) condition abates – to gen. improvement + for complete recovery in 2-3 weeks.
Persist ℞ tr. until sts clear.
Convalescence continue in quiet room ℅ careful, full nursing, augmenting ℅ suitable diet – varies ℅ age of child, etc.
Complic's ℅ should be observed include – > intracranial pressure, ℅ drowsiness, < pulse rate, + slow, laboured resp.'s; Arthritis, Ot. Med., deafness, conjunctivitis + blindness, various paresis

Specific Types of Meningitis

Influenzal Meningitis: More difficult to control. As well as P+S's as above, may need Strept. – must be given ℅ greatest care, esp. if given intrathecally, as may have powerful reactions, dangerous to life (eg. poor colour, twitching, body rigidity, severe convulsions persistent deafness, etc.)
Must have Haemolytic influenzal Serum – as soon as culture is proved positive – DOSAGE – 60–90 c.c.'s in 1 or 2 doses in first 2 days.
HEPARIN may incidentally be used – anti-coag, to break down or prevent adhesions in the brain tissue and spinal cord.
Instillation of O_2 under pressure into the spinal cord, may also prevent adhesions.

Tuberculous Meningitis – Most TB inf.'s localize in the pul. org's, bones or abdominal viscera, but occasionally a primary TB lesion in infant localizes in the meninges, instead of any groups of glands – thorax, abdo, etc. Rarely occurs before 6 months – usually attacks healthy, well-nourished babies.
Before Strept. – 100% mortality. Onset latent + gradual, child just vaguely ill in first week – fretful anorexia, restless, etc.
2nd week unmistakable signs of cerebral irritation
vomiting – not related to food.
drowsiness, irritable when roused.
neck stiffness, head retraction.
obvious loss of weight, constip. + +, mild pyrexia only

To meningitis Diag. confirmed by L.P. – CSF not turbid, but under pressure, & tubercle may be cultured; very high cell count + high chloride content.

3rd week drowsiness progressive.
Posture to Opisthotonus, convulsions.
Terrific wasting atony + maybe paresis.
Excessive vomiting and constipation.

All symptoms are aggravated; and may be in constant coma with a terminal rise in T to 105° – 109° Sudden death may occur.

Tr. Intensive comprehensive tr. as for other varieties of meningitis, including Strept. – Sometimes to brain ventricles.

Convalescence – long, temporary compls. treated as they occur.

INFECTIOUS DISEASES.

MEASLES – to all ages & sexes. – 6-12mths – not unusual – one attack per person.

Begins as coryza ("cold.), rhinitis + runny eyes.
cough, becoming worse – laryngitis in older children.
Fever ish – 103-104°
Excessive lachrymation + conjunctivitis.
Anorexia, vomiting sick + sorry.
4-5 days after rash appears.

Koplik's Spots (in mouth – sometimes days before rash appears) Opposite second molar – white raised spots, also rash on soft palate + uvula – tiny, discreet red spots about the same time as rash appears on body. Rash appears first behind ears – "discreet" spots on face then body. Normal skin between spots (Sc. F. – red all over) exanthematous. Usually not itchy. When rash out T° declines – still cough – nose + eyes run, etc. 5-7 days rash gone – T° OK (if rises – some complication)

Tr. inf. Dis. – Barrier nursed. Free fluids. Care of skin + eyes – P. or S. drops. Put cot with cot to back to light – so as not to hurt eyes – but do not darken the room. Rapid return to F.W.D. when feels like it. Antibiotics cover – P or Sulph. – resp. inf. – prevents secondary broncho-pneumonia.

Compls. Bronchitis.
Otitis Media.
Conjunctivitis
Post-measles encephalitis rare.

Whooping Cough. Resp. Inf. - pertussis bacillus. - potent killer, esp. in babies & can occur in first weeks of life. Begins i cough for fortnight or so - nothing unusual. - cough catarrhal. 2nd week worse at night - becomes spasmodic & worse No T. & bright & happy - cough not marked in daytime. Sometimes vomiting after cough. Whoops at third week. May be brought on by meals. 6th week stage of decline, less & less then stop.

Whoop may re-occur later with a cold. Caused by plug of mucus in lower end of trachea - vomited up, then spasm stops. Potentially serious in babies. - have peculiar muscular turns - cyanosed, as have no coughing reflex Struggling & may develop small cough after some days. Kills by suffocation. Liable to broncho-pneumonia. Terramycin given.

Complis. - respiratory - broncho-pneumonia (Terramycin)
cerebral Haemorrhage rare.

Tr. O neat & Resuscitation.
Sucker for mucus.
Watch carefully - hold when coughs.
Terramycin best "cover" - for three weeks.
Full bord. diet given + vitamins.

SCARLET FEVER. - sore throat & pain on swallowing, high T usually - 102 - 104° - caused by Strept. headache, vomiting - sore glands, and pain in back of neck.
2-3 days after - typical scarlet rash on chest then over body - advancing from day to day. Discreet papula spots - generalised, erythematous rash - very irritating. As spots decline T° becomes O.K.

Tr. Primarily P. & S/d.
- T° rapidly subsides - not hospitalised.

Comps: ducto throat inf. - adenitis, otitis media, nephritis (may occur in first week after original inf. & may have macroscopic blood, oedema of ankles & neck, eyes, etc. diminished output - scarlatina Rheumatism over

SCARLETINA RHEUMATISM. Joints, miserable sick - tr. as for Rheumatic Fever. Occurs as comp. of Sc. F. at end of 3rd week.

Mulberry tongue - furred Raspberry Tongue red & raw 2-3 days after fur wears off. Circum-oral pallor & rash. Rash lasts a week.

Desquamation if dis. has been intense.

Comp's: minimal if tr. effectively & early, otherwise as above.

Barrier nursed. Transf. books & toys - Still infectious if desquamating & nephritis or running ears.

DIPHTHERIA. Immunisation has effectively dealt with it. ~~Tonsilitis~~ Throat infection due to Klebs Loffler Bacillus. May also occur in wounds, noses, etc. Not as acute as Scarlet Fever - T° 99-100 - not feeling unwell, but intensely inflamed throat and tonsils covered with membrane: Insidious onset tendency for membrane to spread to larynx, nose

Tr. Diphtheric Anti-toxin + P+++ and other antibiotics. Careful nursing.

Peculiar smell - sickly-putrid odour. Swabs taken.

Cardio-Vascular poison - K.L.B. Systolic murmur - myocarditis, rapid pulse, soft flabby heart muscle & dilated.

Acute Paralysis. Circulatory Failure - Get squint - paralysis eye muscles & paralysis of palate (curious intonation of voice) - no movement in muscles when say ah. - water comes through nose when drink water - no control of palate.

also Foot Drop. - R.I.P. for 3 weeks & tonics, then grad. rec.

Primarily laryngeal diphth. - characterised by croup. Light sedation given, steam tent, P. for catarrhal, but diphtheric becomes worse 100,000 x 6 hours after. Anti-Diphtheric Toxin. Tracheotomy perf. allow obstruction if prions enough. Left until membrane disappears and normal breathing resumed.

POLIOMYELITIS.

Rhesus monkey supplies material for Salk vaccine – only animals to which they can transfer the disease.

Occurs in epidemics, but some odd cases – usually in late summer & autumn. All ages susceptible – not usual under 4–5 months, but most common from 2 yrs. on. – 20 yrs. decline. Recurrence in individual rare – confers life-long immunity – More common in country areas. Disease transmitted by direct contact. Adenoidectomy raises possibility of infection. Modes of contact: Direct
: Faeces-contamination of soil in unsewered areas

Sts. Initial catarrhal stage – off colour – naso-pharyngeal symptoms – rhinitis
Headache – dopey & drowsy – indef. sick for 3–4 days.
Then 2nd stage – Invasion into CNS – headache.
stiffness of neck & head retraction
sore spine & back – aversion to flexion
Intense hyperaesthesia pain
usually lower limbs – if occurs – prob. subseq. paresis. ←
Glazed look pre-paralytic
Suddenly alert & apprehensive if approached – fear of moving.

Dx. Diagnostic L.P. C.S.F. usually under slightly >'d pressure. – clear, proteins elevated, >'d polymorph's then lymphocytes. Chlorides & sugars unchanged.
No specific antidote or cure.
R.I.B. fever nursing – make as comfy as possible.
Paralysis a job of years. Progress usually improvement.
Initial onset the worst. Muscle atrophy may occur.
Physiotherapy & Orthopaedics important.

BULBAR POLIOMYELITIS. Sts. usual for polio. Paralysis affects vital centres – breathing muscles of diaphragm, resp. centre, etc. P. gradually strangulated, but fully conscious. Slowly becomes paralysed, and breathing an effort. Voluntary – having to lift chest, become tired with effort. Nursed in Respirators. Nearly always fatal, but some recover.

Salk Vaccine – safe (a killed vaccine) 3 inj. 1 – 1m. later, then 1 yr. later.
Incubation period roughly 7 – 21 days.

CHICKEN POX Virus, no dramatic S.+S. – mild – sore throat + follicles on palate. Vaguely and indefinately sick, then rash or eruption – red papular raised spots – become vesicular. Troublesome in hair + scalp.

Pain on micturition, sometimes ∓ flames.

Bodily cleanliness essential – weak Dettol bath soothing.

Keep vesicles dry + prevent being infected – calamine, etc.

Comp's. encephalitis – rare.

MUMPS sore throats, glands, rise in temp., off colour.

Maybe pain, locally, bi-lat. parotids.

Seat in comp.'s in adults – orchitis or ovaries – may cause sterility.

Intensive X-P. therapy. R.I.B. until swelling goes.

Poss. encephalitis

Mouth toilet, light diet, 14 days.

HERPES ZOSTER (Shingles) in epidemics – pain in chest, etc.

2–3 days infection on face – follow superficial nerve.

Chloramphenicol. Red + angry vesicles then dry.

Clear up in 14 days.

DATE	HISTORY, NOTES, ETC.		TREATMENT
TR. ANTIGEN.	Commence at 2 months old	1st	
	then 1 month later	2nd	
	then 1 month later	3rd	
	then at 15-18 months old	BOOSTER.	
CDT.	at 4-5 years of age	Booster	
TET. TOX.	thereafter every 5 years		
SABIN	Commence at 3 months old	1st	
	Then at 5 months old.	2nd	
	at 7 months old.	3rd	
	If the child has not had any TA. immunisation —		
CDT.	Commence with 1st dose from 2 years old.		
	Then 2nd dose 6-12 weeks later.		
	Then 3rd dose 6-12 months later. Then continue with TET. TOX as above		
	If any adult has not had any. TA., CDT., TET. TOX.,		Give:—
TET. TOX.	Commence with 1st dose,		
	Then 2nd dose 6-12 weeks later.		
	3rd dose 6-12 ~~weeks~~ months later.		
	Then every 5 years.		

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