Editorial Comment

The Prevention of Tuberculosis in Children

AUTHORITIES AGREE that children are born free from tuberculosis and that infection, if it takes place at all, occurs after the child is born. It is likewise known that infants and young children are very easily infected by close association with active cases of tuberculosis. To prevent infection, then, in the very young, the first principle to follow would obviously be, to keep the child away from persons who have active tuberculosis. This is simple enough in an ordinary home where there are no tuberculous individuals, while the child is still young. However, as the child grows up and is not kept so closely at home, is allowed to play about, visit in other people’s homes and later on enter public or private schools, from this time on exposure to infection sooner or later takes place.

The likelihood of infection at this time will depend upon the condition of the child. If a child has been reared in hygienic surroundings at home, has been fed pasteurized or certified milk and has been reared according to the instructions of children’s specialists, the condition of the child will then be such as will protect it from ordinary exposure.

Children today receive much better care during early life than ever before; specialists are teaching the mother how to care for and feed her children. Tuberculosis occurring in children whose parents do not have tuberculosis is becoming more rare each year.

Many of the diseases of children, such as measles, whooping cough and scarlet fever, have been regarded too lightly by everyone in all walks of life. Many cases of tuberculosis in children follow one of these diseases; therefore, we should regard them as pre-disposing causes of tuberculosis and such cases should be followed up very closely by the medical attendant.

Tuberculosis in children occurs most frequently in families where tuberculosis already exists and this presents one of the gravest public health problems. In some cities and communities there is an ordinance which provides as follows:

When a child is born in a home where there is a tuberculous individual, either the child or the individual is taken from the home. From a scientific as well as a true humanitarian standpoint this is an ideal procedure; however, it often brings a great deal of grief to the home. Personally, I do not feel that any father or mother could seriously object if they were made to understand that they are sparing their child the danger of infection. It may be of interest to know that this ordinance is rigidly enforced in the city of Chicago.

In communities where this ordinance is not enforced or does not exist, when a child is born in a home where tuberculosis exists, certain rules must be followed. If the father has active tuberculosis he should be rigidly instructed as to the dangers of infecting his child, or better still be sent to a sanatorium. In case the

“The most important factor in diagnosis in the majority of cases of pulmonary tuberculosis is keeping the disease in mind.”
Lawrason Brown, M. D.
mother has tuberculosis she should not be permitted to nurse her child or to have the care of the child; preferably she should be sent to an institution. If this cannot be done the physician must explain in great detail the grave danger of the child becoming infected.

Prevention of tuberculosis in children then depends on following out a few general principles.

1. Keep the child from contact with tuberculous people.

2. Insist that children be cared for and fed according to the latest instructions laid down in pediatrics.

3. Always regard any disease of childhood as one that will lower the resistance to tuberculosis and see that the child has made a complete recovery before it is allowed to be up and around.

4. Advise all children to play in the open and to have sun baths.

C. M. H.

The Mop-Up

Physicians working in other lines of medicine and surgery are standing by in a state of perplexity awaiting the final decision of phthisiologists as to whether the treatment of tuberculosis is to remain in the jurisdiction of the internist or whether it is to be placed in the hands of the surgeon.

James Alexander Miller, speaking in the clinic of Chicago's great chest surgeon, the late Carl Hedblom, only a few weeks before Dr. Hedblom's untimely death, said that no longer did sufferers from tuberculosis travel long distances to desert or mountains but now seek relief from the surgeon in our centers of population like Chicago and New York.

We have been so zealous for the millennium in tuberculosis that we have gone to dizzy heights of enthusiasm with every great discovery that appeared promising in the treatment of this malady. Koch was sure his tuberculin would prove the cure of tuberculosis. With the several refinements of tuberculin came waves of popularity for tuberculin treatment only to recede into the calm of unpopularity that must follow faddishness. Far swinging of the pendulum, first to, then fro, followed the advent of Rollier's heliotherapy, sanacrysin, B-C-G vaccination, etcetera.

These splendid and useful contributions have had to fall by the wayside because of the reaction to a fling in the limelight. Doctors as well as patients have fallen victims to enthusiasm and faddishness for the new things in tuberculosis.

Let us analyze more soberly that great contribution—surgery in tuberculosis. Let us give it dignified consideration that it may not suffer the devastating reaction that has come to other great contributions to the fight on tuberculosis.

Rest and rest alone has stood the test of time and is today as always the classical treatment of tuberculosis. In the infiltrative stages of pulmonary tuberculosis and before ulceration is extensive, rest, either relative or profound, is indicated, first, that resolution may be obtained and finally, restoration of function. Disciplined bed rest gives the desired relative rest; artificial pneumothorax, the profound.

Whether through diagnostic failure or inadequate treatment the stage of ulceration, excavation and fibrosis has been attained, a vastly different problem presents. Resolution has taken place through ulceration and destruction. A wreck of cavitation and scar remains, parenchyma is destroyed, restoration of function is obviously impossible. The patient is struggling to overcome the insult of this wreck of proliferation and necrosis.

Surgery offers us the only solution of this problem—mechanics for a mechanical problem. The permanent collapse of this mass of cavitated fibrosis and granulation is imperative. Surgery removes the rigid bony cage, renders toneless the powerful diaphragm and allows collapse of the wreck.

Here we should ponder over the fact that surgery in tuberculosis is unlike other surgery. This insulting infected mass is not amputated; it is only collapsed.