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THE DIAGNOSIS OF LOBULAR PNEUMONIA (ACUTE AND CHRONIC) FROM TUBERCULOSIS.

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Broncho-pneumonia, the name now generally used by recent writers, is an inflammation of the bronchi and adjacent parenchymatons tissue of the lung.

It is common under five years of age. During the period of dentition it occurs with greatest frequency and is attended with the greatest fatality. After this age the lungs in children develop and begin to assume the adult type, and are then less subject to this form of pneumonia. It frequently follows bronchitis and the infectious diseases of childhood, particularly measles and whooping-cough. Other favoring causes are sudden changes of temperature and ill-nourished and poorly clad children living in badly ventilated houses. It often occurs, however, in healthy children. Briefly, it may be said if following a bronchitis, measles or whooping-cough, a child has an accession of high fever, with cough, rapid pulse and rapid breathing, with râles and blowing, breathing heard at the bases, and with or without limited areas of dulness, the diagnosis may safely indicate acute broncho-pneumonia.

If instead of resolution and a return to health the symptoms and physical signs continue for a few weeks the disease merges into a chronic condition, and the diagnosis as to whether the pneumonia is tuberculous or non-tuberculous in character is beset with many difficulties. I am not aware that the differential diagnosis has received much attention from the profession until recently, perhaps because tuberculosis in children beginning as an inflammation, was thought to be comparatively infrequent.

Of 500 autopsies in children reported last year from Munich Pathological Institute, in 150 tuberculosis was present, and in 92 per cent. of these cases the lungs were involved.

In an analysis of 247 cases of pulmonary tuberculosis in children, one was two weeks old, one six, one seven, fifteen from two to three months, seventeen from three to six months, forty from six to twelve months, sixty-six from one to two years, eighty-two from two to four years, thirty-nine from four to six years, forty-six from six to ten years, and twenty-two from ten to fourteen years.

Tuberculosis in children is more frequent than is generally supposed. A couple of years ago, I attended an infant aged two months in which I made a diagnosis of acute broncho-pneumonia. Later, the extreme emaciation, the persistency of the disease and the general appearance of the child, in connection with the family history, led me to regard the case as tuberculous. Death took place at the age of three months and four days. At that time one uncle and aunt were dead from phthisis. The child's grandmother died (from same cause) one month after its birth and the child's own mother and another uncle and aunt have since died from the same cause.

It seems highly probable that many such cases often diagnosed capillary bronchitis, or catarrhal pneumonia, would, with a careful enquiry into the antecedents and environments, be regarded as tuberculous. The source of infection is full of interest. In the Johns Hopkins Hospital Bulletin for last year a case is reported of a healthy infant nine weeks old with excellent family history, having been moved into a house where a phthisical patient, whose sputum was known to contain bacilli, had been living. The infant died, aged four months, and the post-mortem showed extensive tuberculous broncho-pneumonia with suppurative and caseous focci in the bronchial glands. In this instance it was thought highly probable that the child became infected in the house, where the phthisical patient had been living.

A study of the clinical type of the disease will be necessary in order that a correct diagnosis may be reached.

Jacobi in the Encyclopœdia of Diseases for Children gives three varieties:

I. Acute miliary tuberculosis of the lung.