

The Midwife.

ACUTE POLIOMYELITIS.

The *Lancet* publishes an interesting paper on "Acute Poliomyelitis and Allied Conditions," read by Dr. E. Farquhar Buzzard, F.R.C.P., before the Harveian Society of London, which he considers should be classed among the acute specific fevers rather than among the diseases of the nervous system. As it is a disease which attacks infants and young children, it is one concerning which midwives should unquestionably be informed.

Dr. Buzzard writes in part:—

I may be asked, What good would such a change in classification effect? In my opinion it would be of the greatest possible service in an indirect way. At the present time I do not believe that one case of poliomyelitis in fifty is diagnosed correctly within a few days of its onset. I will go further, and say that the idea of such a possibility does not enter the medical attendant's mind. He is asked to see a child who has some rise of temperature, is seedy, perhaps complains of headache, may vomit, may even have a slight convulsion. He examines the child all over, looks for rashes, inspects the throat, and, finding nothing, says that it may develop into something, perhaps measles or chicken-pox, or hints that it may only be influenza. The idea of acute poliomyelitis never enters his head, and why? Simply because acute poliomyelitis is not among the acute specific fevers in his text-book, but is found in that most shunned of all sections, the section on diseases of the nervous system.

AN ACUTE SPECIFIC FEVER.

Let me now recount my reasons for placing poliomyelitis with the other acute specific fevers.

1. *Age Incidence.*—This resembles that of several specific fevers. The large majority of cases occur in the first five years of life, after which the liability gradually diminishes. Instances of the disease after 40 are quite rare, although they occur in severe epidemics.

2. *Seasonal Exacerbations.*—The disease is most common in the months from July to October, but it is not extinct at any time of year.

3. *Endemic and Epidemic Manifestations.*—While cases are fairly common from year to year and widely distributed all over the world,

epidemics have been recognised with increasing frequency in many countries, as well as in the British Isles. . . . In all probability many endemic cases in infants are rapidly fatal, and are diagnosed as cases of tubercular meningitis or teething convulsions, &c. There are no reliable grounds on which to base the statement that the mortality rate is greater among the epidemic than the endemic cases.

4. *Immunity from Second Attacks.*—There can be no doubt that a second attack of poliomyelitis is extremely rare, and its occasional occurrence finds its counterpart in the other specific fevers.

5. *The Virus.*—The obscurity surrounding the nature of the virus is shared by many of the specific fevers, notably variola, varicella, and measles. Recently, however, the specificity of the disease has been abundantly proved by the experimental work of Levaditi, Flexner, and other observers.

6. *The Onset and Course of Poliomyelitis* simulate those of other fevers in many ways. Healthy children are suddenly attacked with a febrile illness associated with headache, anorexia, vomiting, perhaps convulsions, and this condition runs a rapid course of a few days. The disease is soon over, the temperature drops, and if the patient survives there are only the effects of the morbid process left.

7. *Contagion.*—That the disease is contagious is now hardly open to doubt, but the actual path of contagion and the factors influencing it have still to be discovered.

It will be agreed that poliomyelitis has a strong family likeness to the acute specific fevers of childhood, but it differs from most in one important particular. The inflammatory eruption—the rash, in fact—is not visible on the surface, but lies deep in the central nervous system. Its presence can only be assumed during life by the secondary changes it produces in the function and structure of the skeletal muscles—that is to say, in the muscular paralysis and atrophy.

I do not wish to minimise the difficulties of diagnosis, especially in the case of infants and young children. In these small patients the disease is ushered in by constitutional disturbances, such as fever, anorexia, fretfulness, restlessness, perhaps vomiting, sometimes catarrh, and occasionally convulsions. Within a few hours there may be evidence of muscular weakness, which is only detected by close

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