BRITISH SOCIETY for the HISTORY of PAEDIATRICS and CHILD HEALTH

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AUTUMN MEETING 2021

Friday 3rd to Saturday 4th September

Sarum College

Salisbury

BSHPCH Meeting Salisbury 3-4 September 2021

Programme

Friday 3rd September

12.30	**Lunch**	
Chair	**Professor Mike Dillon**	
14.00	**Professor Lewis Spitz**	History of the separation of Conjoined twins
14.40	**Mr Richard Spicer**	Bristol Children's Hospital and Oesophageal Atresia
15.10	Dr **Tony Hulse**	The Language of Hypothyroidism
15.40	Dr **Doug Addy**	History of the Salpêtrière Hospital; Louis XIV, Pinel, Duchenne, Charcot, Gilles de la Tourette and Babinski
16.10	**Tea break**	
Chair	**Dr Jonathan Dossetor**	
16.30	Dr **James Taylor**	The first 50 years of Paediatric Cardiology at Great Ormond Street
17.10	**Dr Robert Scott-Jupp**	Peter Dunn and neonatal hip dysplasia
17.40	**Professor Brent Taylor**	Peter Dunn, pioneer of perinatal medicine and founder of the BSHPCH
18.10	**AGM of the Society**	
19.00	**Drinks reception**	
19.45	**Dinner**	

Saturday 4th September

Chair	**Mr Nick Baldwin**	
09.00	Dr **Mike Inman**	The British Medical Team, Saigon Children's Hospital, 1966-71
09.40	**Professor Mike Dillon**	Sir Archibald Garrod: Pioneer of inborn errors of metabolism
10.10	**Professor Anne Green**	The first treatment for PKU – the pioneers, Birmingham 1951
10.40	**Professor Lawrence Weaver**	Human Milk and the Physiology of Transmutation
11.10	**Coffee break**	
Chair	**Dr Robert Scott-Jupp**	
11.30	**Dr Cameron Morrice**	Coping strategies in children displaced by modern conflict
12.00	**Dr Philip Mortimer**	Raw milk
12.30	**Dr Mary Clare Martin**	Smallpox, childhood and youth: hospital, home and workhouse, 1721-1800
13.00	**Dr Colin Michie**	A silent pandemic in Scotland: did neonatal tetanus generate a pattern of 'misinformation'?
13.30- 14.30	**Lunch**	
14.30		Visit to George Frederic Still's grave and tour of Cathedral

Abstracts

Mr Richard D Spicer
Retired Paediatric Surgeon, Bristol

Bristol Children's Hospital and Oesophageal Atresia. A personal perspective

The Children's' Hospital in Bristol started life in 1857 and occupied a neo-Gothic building near the University from 1885 to 2001 when it moved to a new building near the other city-centre hospitals.

When the hospital opened in 1885 one of the founding members of staff was Charles Steele FRCS, one of two surgeons appointed. He was the first surgeon in the world to attempt an operation on a neonate with oesophageal atresia in 1888. Surgeons elsewhere made further attempts by different approaches over the next 53 years. Cameron Haight in the USA was the first to achieve complete correction and a long-term survivor in 1941.From that time on increasing numbers of successful operations were done in several countries with progressively declining mortality.

In Bristol primitive operations were done by an adult surgeon until 1976 when Bristol's first paediatric surgeon, Helen Noblett, was appointed. Her outcomes were as good as anywhere in the world and she ran an excellent department of paediatric surgery single-handed until 1982 when a second surgeon was appointed. The department has since gone from strength to strength.

I will tell the story of oesophageal atresia from a local, a national, and an international perspective, including the contribution of advances in other fields such as neonatology, and will conclude with reflections on medical politics in Bristol and current advances in oesophageal atresia being pioneered by Bristol paediatric surgeons.

Dr Tony Hulse
The Evelina London Children's Hospital

The Language of Hypothyroidism

Cretin! Idiot! Terms of abuse but actually they have very specific scientific meanings. The early literature confused treatable hypothyroidism with a number of other causes of mental retardation but was there really a confusion between hypothyroidism and 'mongolism' later to be known as Down syndrome, as is sometimes stated?

And when was the distinction between 'endemic cretinism' and sporadic hypothyroidism fully understood?

In this paper I will explore the language surrounding hypothyroidism, the fascinating references in literature, including Shakespeare, to these various related disorders and how they evolved as our understanding of the pathophysiology of thyroid disorders gradually developed.

Dr Doug Addy

The History of the Salpêtrière Hospital: Louis XIV, Pinel, Duchenne, Charcot, Gilles de la Tourette, and Babinski.

A journey from tyranny and horror to caring and renown.

The Salpêtrière Hospital in Paris is one of the great hospitals of the world. This paper will describe the dramatic history of the hospital and give brief biographical details of Duchenne de Boulogne, Charcot, Gilles de la Tourette, Babinski, and others, concentrating on their contributions to paediatrics but including some of their contributions to medicine in general.
It began with Louis X1V of France in 1666 and was initially essentially a detention centre for aberrant women. It became a despised rat-infested prison/pseudo hospital and was plundered during the French revolution. In the late 18th and early 19th centuries it was mainly a mental hospital. Philippe Pinel was chief physician and is remembered as one of the first psychiatrists and, in particular, for freeing the mentally ill from their chains. In the later 19th century it became a world-renowned centre for neurology with Charcot as very much the main figure. It is now a busy teaching hospital, housing the medical school of the Sorbonne.

Duchenne (Duchenne's muscular dystrophy and Erb - Duchenne palsy), Charcot and Marie (Charcot – Marie – Tooth disease), Gilles de la Tourette (Tourette's syndrome), and Babinski (Babinski's sign) are the names associated with the hospital that will be most familiar to paediatricians.

The magnificent 17th century buildings still exist alongside the new buildings of the modern hospital.

Dr Robert Scott-Jupp

Peter Dunn and neonatal hip dysplasia

Developmental Dysplasia of the Hip (previously known as Congenital Dislocation of the Hip) has been recognised since ancient times. Prof Peter Dunn devoted much of his life to researching and improving the management of this common condition. He wrote a detailed historical account in 2006 for the Bristol Medico-Historical Society.

This presentation will draw on this resource, to describe changing perceptions of aetiology, attitudes to management, methods of diagnosis and, latterly, screening, from pre-history to the present day.

Dr Mike Inman

The British Medical Team, Saigon, 1966-71

In 1965, President Johnstone asked our Prime Minister, Harold Wilson, for military assistance in Vietnam. To his credit, he refused to send military help, but offered to send a humanitarian medical team to assist the Ministry of Health of South Vietnam. A team to work in the Saigon Children's Hospital had been suggested by a British doctor working for USAID. This talk will describe the team of four doctors and six nurses, which was sent in August 1966, and what we found when we arrived at the hospital, and what we were able to achieve at that time, and some of the difficulties of working there. The members of the team changed over the years, but the team remained for the five years at Nhi Dong hospital, and then departed, as the political situation had changed considerably.

Professor Michael Dillon

Sir Archibald Garrod: Pioneer of Inborn Errors of Metabolism

Garrod can justifiably be considered the founder of biochemical and molecular genetics and the father of inborn errors of metabolism. This remarkable physician scientist was responsible for laying some of the most important groundwork for the revolution in molecular pathology that would transform medicine in the 20th century.

Born into an eminent medical family in 1857 he rose through the ranks of the London medical establishment to consultant posts at GOS and Bart's. Although a competent physician it was the science underpinning medicine that consumed most of his life.

His interest in chemical pathology and the role of urine pigments as markers of systemic disease led to a detailed study of alkaptonuria showing that it was innate, not due to intestinal infection as currently proposed, was recessively inherited and caused by an enzyme deficiency. He also studied albinism, cystinuria and pentosuria which, with alkaptonuria, were known as "Garrod's Tetrad" and came to similar conclusions. He presented these data in his RCP Croonian Lectures in 1908 on "Inborn Errors of Metabolism".

He subsequently served with distinction in WW1 as an Army Physician, became Medical Unit Director at Bart's post war and finally succeeded Osler as Regius Professor of Medicine at Oxford. He died in Cambridge in 1936.

His revolutionary views were not initially taken seriously by the scientific and medical community and it was not until the mid-1950s that the brilliance of Garrod was eventually recognized.

Professor Anne Green

The First Treatment for PKU – The Pioneers, Birmingham 1951

Prior to the introduction of newborn screening, Phenylketonuria (PKU) was a devastating disorder with affected individuals usually committed to a life in care in large mental institutions. Newborn screening only began after it was shown that those with PKU could be treated effectively with a modified diet and could subsequently lead normal lives. The first production of a diet and the demonstration of its effectiveness was thus a key milestone in the history of both PKU and newborn screening, and took place in Birmingham, UK in 1951. The pioneers were a two-year old girl Sheila Jones, her mother Mary, and three dedicated professionals at Birmingham Children's Hospital: Evelyn Hickmans, John Gerrard and Horst Bickel. Together they changed the course of PKU for those across the world. This presentation summarises the history and achievements of this team who opened the door to PKU treatment and the introduction of newborn screening.

Professor Lawrence Weaver, University of Glasgow

Human Milk and the Physiology of Transmutation

In the ancient Graeco-Roman world human milk was thought to be mother's blood diverted to her womb during pregnancy, where it first formed, and then nourished, the fetus. At birth blood was diverted to her breasts, where it was whitened, vivified and transmuted into milk to feed her young. Mother's milk transferred to her baby not just nourishment but also vitality and features of her temperament and character.

This view endured until well into the eighteenth century even as its origin, nature and properties were revised according to successive conceptions of milk, from a humoral fluid, to a mixture of curds and whey, a corpuscular substance, and a chemical emulsion of 'combustible, plastic and oily parts'.

Hippocratic, Galenic, alchemical, chemical, hydro-pneumatic and mechanical theories of transmutation, underpinned by anatomical dissection and vivisection, ingeniously explained the synthesis, metabolism and growth-promoting properties of this vital fluid. Human milk was generally regarded as the proper food for babies and 'improper feeding' the cause of many of their complaints.

Changing theories of the processes of gestation, lactation and the digestion of milk offer insights not just into the history of physiology, but also into how disorders of infant feeding, such as diarrhoea, were treated in accordance with therapies that reflected the anatomical and physiological thinking of their times.

Dr Cameron Morrice

Coping strategies in children displaced by modern conflict

World War II saw the displacement of children both here in the UK as well as in Occupied Europe. Children of differing ages were affected differently, but there were patterns to the way they processed their trauma. In this talk we will look at how research into these patterns is guiding interventions to help children displaced by modern conflict.

Dr Philip Mortimer

Raw milk

The isolation of *Mycobacterium tuberculosis* by Robert Koch in 1882 brought the germ theory of disease to bear on two of the mortal infections of the Victorian era, 'consumption' of the lungs in adults, and tuberculosis affecting the abdominal organs, bones , joints and, acutely, the meninges in children.

At the time, examination of carcasses in abattoirs, and from the turn of the century the tuberculin testing of cattle indicated that up to half of UK milking herds were infected with M. tuberculosis in its '*bovis'* form. The country was slow to address the dangers of consuming milk from these cows, a problem magnified by the use of railways and tanker-lorries to deliver pooled milk to large urban populations. This threat to children from bovine tuberculosis only receded when in the 1920s big milk suppliers such as the Co-Op, United and Express, and other dairies, began to pasteurise their milk.

By the 1950s pasteurisation was almost universal, but recent decades have shown that Tb in cattle and some wild animal species is almost ineradicable and there has been resurgent interest in drinking raw milk for its supposed nutritional benefits. In England it remains legal to sell raw milk at the farm gate and to deliver it to households.

Paediatricians should be aware of the dangers of drinking raw milk. It may occasionally contain microbial contaminants associated with Tb and other resistant infectious diseases.

Dr Mary Clare Martin
Institute of Lifecourse Development, University of Greenwich

Smallpox, childhood and youth: hospital, home and workhouse, 1721-1800

Smallpox, the only life-threatening disease to have been eradicated from the planet, was ubiquitous in eighteenth-century England. Despite the introduction of inoculation in 1721, and its adoption by the Foundling hospital and poor law authorities from the 1740s and especially the 1760s, many people escaped or did not have access to the procedure, which in any case was not always effective. While there has been extensive research on poor law and medical provision, little is known about how children experienced inoculation, particularly in social groups outside the aristocracy.

This paper will focus on provision for children to be inoculated, and their accounts of how they experienced this, by, for example, Charlotte Papendiek and William Hickey. Successful cases will be compared with the experiences of families who took other protective measures, such as sending them away from infected areas: with families in which children "took it the natural way", or those who experienced serious illness and death. The paper will also consider the punitive public health measures taken to 'protect' the population in general from infected poor children and families, such as sending them over the county boundary or removing them from the workhouse. In this anniversary year, this study thus facilitates greater understanding of the complex social processes and human relationships involved in disease prevention and treatment.

Dr Colin Michie

A silent pandemic in Scotland: did neonatal tetanus generate a pattern of 'misinformation'?

Survival of our infants has been the most challenging period of life through the millenia. Infant mortality is multifactorial; infections and malnutrition are usually the largest contributors. The universal pathogen, *Clostridium tetani*, has contributed to this. Infant tetanus is almost always fatal, typically causing weakness, jaw-clenching and seizures with death early in the second week of life.

Methods

Scottish Statistical Accounts were compiled and submitted by clergymen in 1791-1799 and again 1842; these were reviewed together with contemporaneous medical and newspaper reports. Search terms employed included 'infant tetanus', 'lockjaw' and 'trisumus neonatorum'. This search has been complemented by reading on a wider basis of materials relating to infant mortality among enslaved populations from the Caribbean and the southern states of antebellum America.

Results

Infant tetanus was positively identified in many Scottish communities, urban and rural. The nosology was complex: different chronological names were often used, including fifth-, eighth- or ninth-day disease; pleurisy and seizure were probably also applied. 'Infant tetanus' was not employed until late in the nineteenth century. In some communities infant tetanus killed large numbers of infants, in others no mentions were recorded. Observers on Lewis and St Kilda associated the illness with unsanitary housing conditions. Similar accounts and patterns of varied nomenclature were published in Scandinavian countries. Strategies to inform midwifery provision or training, or describe optimal methods of infant and umbilical hygiene were not shared, although various treatments were proposed. No references linking these problems were made with reports from centres with expertise in infant health were found. Finally extensive searches have failed to identify burial grounds for these infants.

Conclusions

Neonatal tetanus was pandemic in nineteenth century Scotland. Underreporting, varied names and differing beliefs in its causation persisted in the lay press into the twentieth century when anti-toxin treatments were in use elsewhere. Perhaps this fearful condition engendered its own peculiar misinformation.