

nected by a portal system, the thin-walled vessels on the pituitary stalk connecting capillary beds in the neural and glandular structures respectively. Neurones of the hypothalamus release their transmitter substances, and this is carried by the portal system to the secreting cells of the pituitary, causing them to release their hormones into the blood stream.

Electrical stimulation of the hypothalamus thus operates in two ways, so far as the pituitary is concerned. The neurosecretory supraoptic and paraventricular neurones release antidiuretic and oxytocic hormones into the posterior pituitary, causing them to release their hormones into the portal system that cause the anterior pituitary to secrete corticotrophin, thyrotrophic hormone, follicle-stimulating hormone, and so on.

Thus all too sketchily is it possible to indicate here the neural and hormonal mechanisms in which the hypothalamus plays a part. The review articles themselves are well worth reading and maintain the high standard we have come to expect from the *British Medical Bulletin*.

## Collapsed Middle Lobe

Back in 1937 R. C. (now Lord) Brock, R. J. Cann, and J. R. Dickinson<sup>1</sup> gave an excellent description of the effects of tuberculous mediastinal lymphadenitis on children's lungs. They suggested that the secondary changes were due to collapse as a result of pressure from enlarged caseous lymph nodes. "Epituberculosis" was the popular name given to the condition, but this term is no longer in general use. Like erythema nodosum, it was considered almost pathognomonic of tuberculosis, but both are now recognized as being non-specific. In his superb monograph on the anatomy of the bronchial tree Brock<sup>2</sup> devoted 24 pages to the middle lobe, saying that it was of great practical importance and deserved far more attention than it had hitherto received. This neglect he attributed to its being tucked away between the upper and lower lobes and alongside the heart, so that lesions of it were masked both clinically and radiologically.

The basic cause of obstruction to the middle lobe bronchus is enlargement of the lymph node occupying the very acute angle formed by the origin of the bronchus from the main stem. This node and the others disposed around the upper and inner surfaces render the bronchus peculiarly liable to compression as a result of their enlargement, especially if this is due to tuberculous infection. After collapse of the lobe, infection and bronchiectasis are common sequelae, as is ulceration of a node into the bronchus, leading to tuberculous bronchopneumonia. Brock commented on the importance of the selective incidence of post-tuberculous bronchostenosis on the middle lobe and that its recognition was becoming firmly established in everyday differential diagnosis and practice, adding that "it has even achieved the name 'middle lobe syndrome,' a term which really has little to commend it because, although it is most common in the middle lobe, it might affect any segment or segments in the lungs."

<sup>1</sup> Brock, R. C., Cann, R. J., and Dickinson, J. R., *Guy's Hosp. Rep.*, 1937, 87, 295.

<sup>2</sup> — *The Anatomy of the Bronchial Tree*, 2nd ed., 1954. Oxford University Press.

<sup>3</sup> Dees, S. C., and Spock, A., *J. Amer. med. Ass.*, 1966, 197, 8.

<sup>4</sup> Mandelbaum, I., and Battersby, J. S., *Ann. Surg.*, 1963, 158, 1066.

With the decline in the incidence of tuberculosis in childhood in recent years the syndrome is becoming comparatively rare in paediatric practice in Great Britain, but a recent report from the U.S.A. suggests that it may still be found, though now with a different aetiology. Susan C. Dees and A. Spock<sup>3</sup> record a series of 30 children presenting with cough, wheezing, and repeated attacks of pneumonia, all of whom showed complete or partial collapse of the middle lobe. The condition occurred twice as often in girls as in boys, with onset between 1 and 2 years of age, though the diagnosis was rarely made before the age of 6 years. Twenty-three of the children were "allergic," and the diagnosis on admission was asthma in 22 of the 30. Only one of the children had a positive Mantoux reaction. The allergic aetiology was based on the existence of eczema, asthma, and rhinitis (four cases), strongly positive skin tests to allergens (19 cases), and a family history of allergy in 18. Treatment was by lobectomy in 10 cases (all improved) and by conservative management in the remainder (condition controlled in 10, unimproved in eight, one died, and one not traced). Of the 10 children who had lobectomy, only one showed external compression of the bronchus by enlarged lymph nodes; the cause of the collapse was therefore presumed to be a combination of mucosal oedema and allergic and infectious secretions, although other possible causes considered were changes in surfactant and genetic factors.

In view of the high incidence of asthma in children in Britain it should not be difficult to find similar cases here. The authors' belief is that bronchograms should be taken on any allergic child who gets recurrent attacks of pneumonia, particularly if the same area is affected in each attack. Similar precautions might be taken even in non-allergic children. I. Mandelbaum and J. S. Battersby<sup>4</sup> reported on a girl aged 14 who had a chronic productive cough for a year after severe poliomyelitis which had necessitated tracheostomy. She had bronchiectasis of the lingula of the left upper lobe, which was completely collapsed as a result of compression of the segmental bronchus by enlarged lymph nodes. Lingulectomy effected a cure. This case reinforces Brock's criticism of the use of the term "middle lobe syndrome."

## Bathing the Baby without Soap

When an article on "A New Approach to Infant Bathing,"<sup>1</sup> by H. T. Calvert, H. A. H. Crowther, J. G. Davis, and N. P. Lisboa, appeared in the *Medical Officer* the popular press showed considerable interest and passed cynical comments. The authors suggest that the current method of bathing the baby has disadvantages. It takes too long; it makes the baby slippery (thus leading to anxiety and tension in the mother lest the baby should be dropped on his head); there is a risk that soap will get into the baby's eyes (thus turning him against all baths); and there is a scum on the bath due to

<sup>1</sup> Calvert, H. T., Crowther, H. A. H., Davis, J. G., and Lisboa, N. P., *Med. Offr.*, 1966, 115, 279.

<sup>2</sup> Farquharson, C. D., Penny, S. F., Edwards, H. E., and Barr, E., *Canad. med. Ass. J.*, 1952, 67, 247.

<sup>3</sup> Gluck, L., and Wood, H. F., *New Engl. J. Med.*, 1961, 265, 1177.

<sup>4</sup> American Academy of Pediatrics, *Standards and Recommendations for Hospital Care of Newborn Infants*, 1964. Committee on Fetus and Newborn, Evanston, Illinois.

<sup>5</sup> Parmelee, A. H., *Management of the Newborn*, 2nd ed., 1959. Year Book Publishers, Chicago.

<sup>6</sup> Bruce, L., *J. Obstet. Gynaec. Brit. Emp.*, 1956, 63, 735.