Above case was neither phthisical nor a hæmophilic. There is strong evidence to prove that the disease was conveyed through the milk-supply coming from an infected house where there were four cases of typhoid fever. The milk was not boiled before use, and a second inmate of the patient's house also contracted enteric fever. Some others to whom the milk had been supplied were protected by previous attacks; in other cases the milk was regularly boiled. In these latter no bad results have appeared as yet, a point in favour of the advisability of boiling milk.

Ookiep, Cape Colony.

THE MORTALITY FROM EMPYEMA IN CHILDHOOD.

By J. P. WIGHTMAN, M.R.C.S. ENG., L.R.C.P. LOND.,
LATE SENIOR HOUSE SURGEON, INFIRMARY FOR CHILDREN, LIVERPOOL.

IN this condition, a serious and not uncommon one, a favourable prognosis may be given, providing that the diagnosis is made in the early stages. What can be more sad than a mother bringing her child, worn out by prolonged hectic due to a discharging empyema, for advice? The rapidity of convalescence, averaging from six to eight weeks, and the usual cure, no trace of the disease remaining, add a special attraction to a condition which, if left alone, must almost always produce a fatal result. The subject of this disease and its treatment has been brought forward in the various medical journals, this paper being in part a *résumé* of the various views and methods of treatment.

Signs of a recent attack of scarlet fever (desquamation &c.) are by no means uncommon in patients seeking relief at a children's hospital. With regard to this, it is remarkable that among 1008 cases of scarlet fever, mostly in children, recorded in THE LANCET during the year 1891 empyema is not even mentioned as a complication; nor is this the case in a paper on Scarlet Fever published in Vol. XXI. of the St. Thomas's Hospital Reports. This naturally leads one to infer that empyema is most likely to occur if a case of scarlet fever is neglected. Various statistics of mortality are on record. The younger the patient the greater the risk of a fatal termination. The sooner the purulent effusion is removed the quicker the recovery. Rupture of an empyema through the chest wall or into the lung is a grave complication, though the latter occasionally leads to spontaneous cure. Apart from the above, danger to life is chiefly threatened by the onset of complications—viz.: (1) pericarditis (among 29 fatal cases at the Liverpool Children's Infirmary¹ pericarditis occurred 12 times, in 10 it was of the suppurative form); (2) peritonitis; and (3) septicæmia.

As regards the effect that different methods of treatment have, taken as a whole, I do not think resection of rib renders the chance of cure either greater or less, except in certain cases. At the Hospital for Sick Children, Great Ormond-street, from 1880 to 1892, 214 cases were treated. Of these, 85 were treated during the earlier period by incision, with 16 deaths, and 129 afterwards by resection of rib, with 23 deaths, the mortality, as will be seen, being nearly the same in each case.² Mr. Godlee published in 1886 the result of 36 cases. The majority (19) were treated by resection, the remainder by incision or aspiration. Of these cases only 1 was fatal. In THE LANCET of May 5th, 1894, I published the results of 118 cases, classifying all treatments together, with 23 deaths. In the same journal³ Dr. F. E. Batten of London published the results at the Hospital for Sick Children, Great Ormond-street, for the year 1893-94. Of 43 cases treated by resection, 5 were fatal. In THE LANCET also he asserts strongly that resection is the only treatment for empyema, a statement which I think cannot be accepted without much reserve. Dr. E. Cautley of London, at a meeting of the London Medical Society,⁴ in a paper based upon a series of 86 cases treated by various methods, gave a mortality of 16.6 per cent. The rate of mortality was the same after resection as after incision, with the exception that 5 out of 6 cases under two years old, treated by resection, were fatal. His opinion was

that resection ought only to be had recourse to in cases in which the tube could not be inserted without, when drainage was imperfect, or for the cure of an old sinus. Dr. Morison of Hartlepool (34 cases, 2 deaths) upholds incision.⁵ By the courtesy of Mr. Jordan Lloyd of Birmingham I am able to publish the treatment and results at the Birmingham and Midland Children's Hospital for the last five years. The total number of cases treated was 123; of these, 99 were cured, 20 were fatal, and of 4 there are no records. Among children of three years of age and under there were 43 cases; of these, 18 ended fatally. In the 99 cases cured the average stay in hospital was seven weeks and a half, the shortest stay eleven days, and the longest 164 days. Resection of rib was performed in 6 cases. I am indebted to Mr. H. G. Davis, house surgeon of the hospital, for taking much trouble in the preparation of the hospital statistics.

The routine treatment is incision and drainage as soon as pus is determined. Resection of rib is exceptional as a primary procedure.

If the above figures are put together they number 656 cases of empyema in children, with 104 deaths, giving a death-rate of 16 per cent.

The extreme gravity of empyema in a young child may be seen by the following:—

Mortality from Empyema in Children three years old and under.

	Cases.	Deaths.
Dr. Goodhart (Guy's Hospital Reports)...	29	19
Birmingham Children's Hospital ...	43	18
Liverpool Children's Hospital ...	33	18

These figures give a death-rate of a little over 50 per cent.

Rawdon, Leeds.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ROYAL FREE HOSPITAL.

CHRONIC RIGHT-SIDED PLEURISY WITH CONSTRICTION OF THE SUPERIOR VENA CAVA SIMULATING INTRA-THORACIC TUMOUR; REMARKS.

(Under the care of Dr. H. SAINSBURY.)

THE symptoms to which malignant growths of the chest give rise are very variable, depending upon the starting-point of the disease, whether pleura, bronchial tubes, or lung tissue. As these symptoms may be for a long time only those of a simple inflammation of the part attacked, this difficulty in diagnosis will be readily appreciated. The results which inflammation in its several stages and manifold incidence may bring about constitute an almost infinite variety of combinations. Here is an instance in which the diagnosis of intra-thoracic tumour, probably new growth, was made with some confidence, and yet the result of the post-mortem examination proved this to have been a mistake. The changes produced by the inflammation were unusual and extensive, but they were in no way the result of tumour formation.

A woman aged sixty-two was admitted into the Royal Free Hospital on Nov. 22nd, 1894, suffering from dyspnoea (of the variety orthopnoea), with much cyanosis and cough. She stated that she had suffered from winter cough for some years, that her present cough had been worse since the taking of a chill some six weeks before admission, and that her breath had become very short, especially of late. Two weeks before entering the hospital she said that she had noticed some blood mixed with the expectoration. Since the chill—i.e., during a period of six weeks—she was conscious of having wasted and lost strength. On examination the evidence of fluid in the right pleura was found; but though the chest on the right side was dull and

¹ THE LANCET, May 5th, 1894.

² Mr. Bernard Pitts: THE LANCET, Sept. 9th, 16th, 23rd, and 30th, and Oct. 14th, 1893.

³ THE LANCET, June 2nd, 1894.

⁴ THE LANCET, Feb. 2nd, 1895.

⁵ THE LANCET, Sept. 29th, 1894.