Thymus Death.—FALLS (*Surg., Gynec. and Obst.*, June, 1916) reports the case of a primipara with normal labor at full term ending in thirty-six hours. Two hours after delivery the child breathed badly and was cyanotic. Two hours later the symptoms increasing, the child died without convulsions. The heart sounds before and after birth were normal; just before death the pulse fell to 30 per minute. Autopsy was made five hours after death, the body kept upon ice in the interval. On examination the left lung was compressed and pushed to one side by a large thymus, a heart-shaped organ situated slightly to the left of the median line extending from the lower border of the thyroid above, to the fourth rib below. The left innominate vein crossed the thymus and had compressed it somewhat. There was no evidence of thrombosis in the veins in this region. The heart was apparently normal, but both lungs were markedly edematous. There was no lesion of the intracranial organs, but on opening the trachea it was markedly compressed by the thymus, and its compression and its effects had evidently caused fetal death.

Brachial Birth Palsy.—THOMAS (*Am. Jour. Obst.*, April, 1916) contributes a paper upon this subject reporting 11 cases with illustrations and describing his treatment. The writer has had experience with 24 palsied arms in 23 patients, and finds that there is no displacement in the shoulder-joint, and perfect recovery will be obtained from exercise alone. When a case of birth palsy is seen with the typical internal rotation of the limb and the characteristic limitation of abduction, and external rotation in a child as old as two or three, a posterior subluxation of the shoulder-joint is almost invariably present. This may be recognized by remembering the important relations at the shoulder, which are those at the upper end of the humerus to the margin of the acromion. The examining finger on making pressure finds a depression under the posterior margin of the acromion. The relation of the humerus to the anterior and posterior borders of the acromion are the important points in the diagnosis. If this dislocation can be recognized at birth, it is comparatively easy to reduce it. That this condition is the result of traumatism is shown by the bending downward and forward of the anterior portion of the acromion. This is caused by the same pressure which pushed the head of the humerus back during delivery. This the roentgen ray does not always show because the bones may be too young to give the usual shadow. Ossification in the acromion does not begin until about fifteen years of age. In many patients it is well to examine them under partial etherization, and when the diagnosis is made, to put the head of the humerus in good position and retain it by a light cast. The writer has operated upon the shoulder in 9 cases, and the elbow in 1; the incision is so planned as to give a free exposure. After this the obstructing portion of the acromion is removed. Then the effort is made to force the arm into external rotation and abduction, and to put the head of the humerus as nearly as possible into its normal anterior position. After the operation is complete, a light plaster cast is applied fixing the arm in abduction and external rotation for about six weeks. The writer has had good results from his operative treatment of these cases.