support; two of their patients showed considerable improvement after some years. There is nothing to be expected from an operation.

Etiology and Treatment of Congenital Inspiratory Stridor.—L. BALLIN (*Jahr. f. Kinderheilk.*, 1906, lxii, 808) includes among cases of stridor inspiratorius congenitus only those which answer to the following description: The condition must begin at birth or, at the latest, a few weeks after; at inspiration the child produces an intense noise, the point of origin of which is to be found in the larynx or below it; the noise may be produced with each inspiration or only during moments of excitement. The condition disappears toward the end of the first year, leaving no disturbance whatsoever of the general health. It never produces dyspnoea, and if this is present a complication may be assumed to exist. Some authors believe the condition to be due to abnormalities in the larynx, chiefly a bending of the epiglottis and an abnormal approximation of the arytenoepiglottic folds. Others believe it to be due to abnormal softness and yielding on the part of the infantile larynx, and the above mentioned changes to be secondary results; some speak of spasm of the glottis and of inco-ordinated breathing, resembling the stuttering of the speech; the latest theory, defended chiefly by Hochsinger, explains the condition with hypertrophy of the thymus body. Ballin has observed five cases, in two of which autopsy was performed, and two others were examined by Röntgen rays. In only one could enlargement of the thymus be noted; this condition could, therefore, be excluded. Which of the other two theories is correct could not be determined even though serial sections of the tissues were made. The larynx in both fatal cases was found to be smaller than in the cases of normal children, a point in favor of the developmental abnormality. Respiratory disturbances in such patients should be carefully guarded against and even slight disturbances energetically treated.

Pleuritic Effusion Treated with Adrenalin by the Preliminary Intraserous Injection Method.—W. EWART and F. MURRAY (*Brit. Med. Journ.*, 1906, i, 973) report the case of a boy, aged ten years, suffering with pleuritic effusion. They performed paracentesis because of orthopnoea; the siphonage method was employed, filtered air being allowed to enter by thoracic suction. Less air was introduced than fluid removed; 54 ounces of fluid were withdrawn and 477 c.c. of air admitted. The pneumothorax was well borne, but the fluid reaccumulated. In a space of ten days, five intraserous injections of 10 minims of adrenalin solution (1 to 1000) were made; it was intended eventually to perform thoracentesis, but this was not necessary as the fluid underwent complete absorption. Improvement in physical signs was noted after the second injection, and on discharge there was but slight impairment of resonance, Grocco's triangle had entirely disappeared, and the heart had returned to its normal position. The author calls attention to the harmlessness of the filtered-air pneumothorax, the respiratory advantage of the pneumothorax over the hydrothorax, as the lung was able to re-expand before the heart returned to its position, and the re-accumulation of the fluid in spite of the early production of the pneumothorax. Adrenalin thus administered is harmless if care is taken to inject it into the pleural cavity and not into the lung; re-absorption of fluid was induced by it. They advise adrenalin injections a day or two prior to the performance of paracentesis.