information concerning the child, and the general appearance, gait, and pose of the head may be observed at a glance, and the presence of the adenoid facies, rickets, or deformities should also be noticed. Before the examination of the chest is proceeded with the child should be spoken to and encouraged to speak and to become used to the stethoscope which, with a little suggestion, may be regarded as a new kind of toy. Not a few children are inclined to look upon the stethoscope with distrust, but their aversion may be very readily overcome by asking them to hold the chest-piece to the ear in order to "hear the bird sing," and whilst the piece is held to the ear a sibilant whistle may be produced, the tip of the tongue being placed behind the upper incisor teeth, approximating to its position in the act of hissing. The lips should not be used in the production of this sound, which is the best test of a child's hearing, and with a little experience the intensity can be varied so that a standard for normal hearing can be obtained. The fact that the little bird is heard to whistle must be ascertained not by questioning but by observing the child's face, for the resulting smile is not only almost invariable but is the most valuable affirmation to be obtained. During this performance, which need not take more than 30 seconds, the school nurse should be loosening the infant's clothing, and the child should by this time be interested enough to place the stethoscope on its chest when asked to do so, and it will be an advantage to allow the little hand to remain on the end of the stethoscope whilst it is moved to different parts of the chest.

The weighing and measuring of the child may now be undertaken, after which the manual examination for the submaxillary and cervical glands should be done. For this the child must bend the head downwards in order to relax the cervical muscles, and this opportunity is favourable for the inspection of the condition of the scalp and head at the crown; in the same way the sides of the head may be inspected whilst the examination for external ear disease is proceeding. The infant is less likely to be frightened by this part of the examination, but it is well to retain the child's interest by talking, and, indeed, it is a golden rule that throughout the examination the child should not be too conscious of the fact that it is being examined. The examination of the mouth and throat is left until late because it disturbs the child most, and in this connexion the shape and material of the spatula are not unimportant. Vulcanite is to be preferred to metal, the coldness of which makes it uncomfortable for the child; when the instrument is disinfected by means of biniodide or other compound of mercury, metal of course cannot be used. Here also reference may be made to the question of the advisability of giving sweets to the child. It is true that the school medical officer should rely on his tact and manner to win for him the infant's confidence, but there are not a few cases in which the appeal to "cupboard love" is necessary, and in which the giving of a small sweet will make the difference between an examination of a crying, struggling child and one which is done quietly, pleasantly, and successfully. Particularly useful is the giving of a sweet in the examination of the mouth and throat, for however reluctant the little one is to allow its mouth and throat to be examined, it will almost invariably allow the doctor to "see if the sweet is finished," and the whole process of the examination will be regarded as part of a game, and even the last slight pressure of the spatula on the tongue which is necessary to reveal the tonsils will not interfere with the smile which comes when the examination is finished.

Thus it will be seen that by methods which the above remarks indicate in a cursory manner the infant may be not only interested in the examination but may be made to enter into it as a game; and such methods will be found to be particularly useful in the case of timid and nervous infants who, if frightened, would be found to be difficult and even impossible to examine fully without physical force. Too much attention should not be paid to quiet crying in an infant, and it has at least one advantage that the occasional long-drawn inspiration gives one a good opportunity of listening to the lung sounds. But even gentle crying should be a rare occurrence, and by tact and kindness and the use of suitable methods the confidence of the most timid infants of four and five years may be won by the true lover of children.

Newport, Mon.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF SEPTIC PLEURISY AND PERICARDITIS RUNNING AN AFEBRILE COURSE; DEATH WITHIN SIX DAYS OF ONSET OF SYMPTOMS.

BY C. W. WINDSOR, M.A., M.D. CANTAB.

THE patient was a thoroughly healthy man, aged 40 years, living in a country village, occupying himself with farming for a living and shooting for sport. The only previous illness of consequence was a severe attack of pleurisy 16 years ago; but ten weeks before the onset of the illness to be described below he had a very sharp attack of shingles which pulled him down somewhat. On each of the three days before the beginning of the fatal illness he had been out shooting, and beyond being a little fagged was in apparently good health. On Sept. 28th at tea he complained of his throat being stiff and full but did not make much fuss about it. This condition became much worse during the night, so that a medical man was sent for early next morning, when the uvula was found to be much swollen, almost blocking the fauces and interfering considerably with breathing. His temperature was 99° F. Later in the day this oedematous swelling was freely scarified, to the patient's relief; his temperature rose in the evening to 102°. Next morning, Sept. 30th, the swelling of the uvula and soft palate had subsided but the patient looked ill with rather a cyanosed complexion; his temperature was 101°, his breathing was quick and shallow, his voice had almost gone, and swallowing was difficult, the symptoms pointing to some oedema of the glottis; the pulse was rapid. During the night he complained of very severe pain in the upper part of the abdomen, especially over the liver. On examination of the chest friction sounds were heard over the lower part of the right lung, the axilla, and also at the left base behind; while over the cardiac area there were abundant soft crepitations but no pericardial friction. There was no expectoration. The temperature was 99°, the respirations were 40, and the pulse was 120. The heart sounds were clear. The urine and abdominal viscera were normal. The uvula and mouth were healthy. The skin was perspiring freely. The feet were cold. There was cyanosis of the face. This condition of things quickly developed into well-marked pleurisy at each base, with some consolidation of the underlying lung tissue. Expectoration was slightly rusty coloured. The temperature remained normal but the pulse-rate varied between 140 and 160 and respirations were from 40 to 50. There was a constant desire to sit up in a chair, as he could not rest in bed. The face was a bad colour and the patient was greatly exhausted and suffered from sleeplessness. His mind was quite clear. In this condition the patient was seen in consultation by Dr. Laurence Humphry. Without development of further physical signs the condition became rapidly worse and the patient died on Oct. 5th after six days' illness.

Nothing special beyond pneumococci was found on bacteriological examination of sputum. Treatment was on ordinary lines with a view to promote sleep, to relieve pain, and to maintain strength. Antistreptococcic serum was injected, oxygen and hypodermics of strychnine were freely used. At the post-mortem examination there was very intense pleurisy on each side with membrane a quarter of an inch on both surfaces of the pleura, also consolidation of the lung in each lower lobe. The whole pericardium was lined with a similar thick membrane, showing a reticulated surface and resembling uncooked tripe. There was some congestion of the larynx. There was considerable enlargement of the spleen. Cultivation growths from the affected viscera showed staphylococci and streptococci, pneumococci, and also a large bacillus resembling bacillus anthracis but which proved to be a putrefactive organism. The interest of this case lies more in the speculation as to its origin than in the actual lesions. The oedematous swelling of the uvula and soft palate was

attributed to the sting of a wasp or other insect, possibly occurring while taking tea, at which the patient ate some strawberry jam. The patient, however, disclaimed any knowledge of having been stung or bitten. There had been no exposure to cold or wet. The bad prognosis given was based upon the afreble course of the illness, the extremely rapid pulse, the cyanosis and cold sweats with rapid exhaustion. The case was apparently one of septic infection resulting from some cause unknown, unless the hypothetical sting be looked upon as the point of entrance of some infective organism. Inquiry was made as to the possibility of infection from any diseased animals or farm stock with a negative result.

Royston, Herts.

INDUCTION OF LABOUR V. MORPHINE IN ECLAMPSIA.

BY W. BOXER MAYNE, M.R.C.S. ENG., L.R.C.P. LOND.

THE following is a report on a severe case of eclampsia showing the relative value of hypodermic injections of morphine and induction of labour as treatment.

I was called about 7 A.M. to see a young woman whose husband informed me that she was eight months pregnant and that she had just had a fit. On arrival at the house I found that the patient, a primipara, 20 years of age, had had in the meantime a second fit, the first having occurred about 6 A.M. and the second about 7 A.M. On inquiry I found further that she had complained for a day or two of violent headache and also of pains in the back. She was very puffed about the face, her feet and ankles being very oedematous. Though strange and excitable in her manner she nevertheless allowed, after a little persuasion, a vaginal examination; the os was of about the size of a shilling and the vertex was presenting. Having found morphine a great success in other cases I resolved to give the same treatment further trial and, as before, to commence with a hypodermic injection of half a grain. Whilst getting the injection ready the patient had a third severe fit. In addition to the morphine I placed two minims of croton oil with a little butter on her tongue and had her wrapped in a hot pack. At 10 A.M. she had a fourth fit, a nurse in attendance administering, by my instruction, a further hypodermic injection of a quarter of a grain of morphine, which was repeated by myself about 12.30 A.M., the patient being then in a semi-conscious state. I had no sooner gone than the patient had a fifth fit; and at 3 P.M. a sixth, when the nurse gave her a third hypodermic injection of a quarter of a grain of morphine. Seeing the patient again at 4.30 and finding that she had had the two fits since my previous visit and that she was in a comatose condition, I determined to postpone no longer the last resource, viz., induction of labour. Administering chloroform, I managed to dilate the os sufficiently to enable me to perform version; accelerating matters by traction I presently delivered a living child. As a precaution I gave a hypodermic injection of four tabloids of ergotinine citrate, each 1-200th grain, and one of strychnine, 1-30th grain. From this time nothing untoward occurred; the patient spent a quiet night and was able to recognise me the following morning, though still dazed and heavy. During the day she passed a little urine with her motions, and the day following, under the influence of diuretics, &c., a fair amount; this, the first I had been able to examine, presented about one-third albumin. The progress of the patient since has been uninterrupted.

Swindon.

A CASE OF PLASTIC RESECTION OF THE BREAST AND ITS BEARING ON THE ROUTINE PRELIMINARY INCISION OF BREAST TUMOURS.

BY C. HAMILTON WHITEFORD, M.R.C.S. ENG., L.R.C.P. LOND.

THE patient, aged 24 years, married, one child 19 months old, was operated upon on Nov. 10th, 1907, and was shown at a meeting of the Plymouth Medical Society on Feb. 19th last. For the past four months she had noticed in the centre of the upper and inner quadrant of the left breast a

tender thickened area of the size of half-a-crown. This tender area, after treatment by local applications for four months, was still a source of discomfort to the patient who, having to be anæsthetised for operation on an anal fistula, decided to have the breast dealt with at the same time. The breast was treated by Collins-Warren's modification of Thomas's operation. The skin incision, nine inches in length, exposing the fibres of the greater pectoral muscle, commenced in the nipple line in the fold below the breast, was prolonged upwards along the lower and outer margin of the breast and was further extended along the under surface of the anterior axillary fold. The breast was then dissected upwards and inwards off the greater pectoral muscle until the deep surface of the upper and inner quadrant was exposed. The mass was incised on its deep surface and the diagnosis of chronic mastitis was confirmed. The segment of breast tissue containing the tumour was excised. This wedge-shaped area included the whole thickness of the breast, but stopped short at the subcutaneous fat, which was not disturbed. The base of the wedge measured three inches; the apex of the wedge was situated one inch above and one inch to the inner side of the nipple. The breast was reconstructed by closing the wedge-shaped gap and fixed in its normal position. This was done by four layers of catgut sutures. The first layer, including the subcutaneous fat, approximated the superficial portions of divided breast tissue. The second layer approximated the deep portions of cut breast surface. The third layer, the breast having been turned down into its natural position, attached the breast to the edge of the greater pectoral muscle. The fourth layer approximated the connective tissue immediately beneath the skin incision, which was sutured as advised by Warren without drainage. In spite of many ligatures and firm pressure by dressings a hæmatoma developed between the breast and the greater pectoral muscle. This hæmatoma became infected and was drained through the skin incision.

When seen four months after the operation the breast was in its natural position, the skin over the resected area was normal, showed no depression, with only a suspicion of flattening, and admitted of the wearing of a low evening dress. It is interesting to note that this satisfactory result ensued in spite of the unfortunate incident of the hæmatoma. The long skin incision and freeing of the breast by cutting off the nerve-supply rendered the lower portion of the breast at first almost completely anæsthetic. At the present time this anæsthesia has nearly disappeared. In view of the extensive area involved in the dissection it is probably safer to drain for 24 hours the retro-mammary tissues by a tube passed from the lowest part of the skin incision to the deep surface of the sutured breast area.

The above method has an important bearing on the best position for the preliminary incision, which should be made into every breast tumour as a preliminary to radical treatment. The surgeon who, in performing a radical operation for supposed malignant disease of the breast, neglects the elementary precaution of incising the tumour, as a means of either confirming or disproving the diagnosis, runs the risk of finding himself in the unenviable position of having performed Halsted's, or some equally extensive operation, for a simple tumour such as an adenoma or abscess. An incision made into the tumour directly through the overlying skin in the event of the tumour proving non-malignant and needing only local removal, results to a certainty in a scar and probably in a depression. This scar, or scar plus depression, if situated in the upper half of the breast, interferes with the wearing of a low-necked dress. By employing Warren's skin incision, followed by incision of the tumour on its deep surface, such disfigurement can be avoided. If the tumour is found to be innocent it can be treated as in the case recorded above. If the tumour proves to be malignant, in order to minimise risk of dissemination of cancer cells its cut surface is cauterised and a pad of gauze is packed between the breast and the greater pectoral muscle. The breast is turned outwards and downwards so as to occupy its normal position and is fixed to the greater pectoral muscle by a continuous suture. After discarding all instruments, gloves, &c., used for the exploratory incision, a fresh supply is employed in the performance of the radical operation.

Adoption of the above method (which, while not unknown, is certainly not in general use) as a routine preliminary to