The nauseants (squills, senega, antimony, ipecac, etc.) may best be wholly discarded.

Preissnitz⁸ recommends hot, wet compresses to the throat and neck.

Of the depressants, codein, heroin, and finally, morphin, given in dry, tabloid form upset the alimentary tract, taken all in all, less than when in some syrup-like combination. To codein is given the preference, as it tends less to constipation.

In the terminal, hopeless stage, free use of morphin seems imperative. The general discomfort and suffering otherwise, is appalling. An excellent combination suggested by Dr. H. S. Patterson is this:

	gm. or c.c.		
Morph. sulph.	0.005		gr. $\frac{1}{12}$
Tinct. belladonnæ	30	or	℥ v
Ammon. chlorid.	30		gr. v
Aquæ dest. ad	4.00		ad 3i

M. Sig.—Such a dose every four hours, if necessary.

Or this of Dr. S. W. Lambert:

	gm. or c.c.		
Ext. opii			gr. ii
Ext. Belladonnæ	12		gr. ii
Chloroformi	13		℥ xx
Syrup. tolutani	30	or	3i
Aquæ dest.	120		ad 3iv

M. Sig.—A teaspoonful every four hours, if necessary.

For a short time heroin (grs. $\frac{1}{8}$ to $\frac{1}{2}$) seems to work well; but its efficiency is short-lived, and in the very advanced cases soon must give way to morphin, which at last is the sole means of comfort, scant at best.

16 Central Park West.

MENINGISMUS FROM ACUTE CERVICAL ADENITIS AND PERITONSILLAR INFILTRATION

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Some unusual features in this case, which so closely simulated some form of meningitis, make it of enough interest to report.

Patient.—A. L., a boy aged 4, was seen June 23, 1910.

Family History.—Father is living and well. Mother has pulmonary tuberculosis, now quiescent. The mother's tuberculosis was first diagnosed while she was nursing this child; she was fairly well advanced in the second stage at this time and undoubtedly had the disease when pregnant.

Personal History.—The patient was an only child and had always been well except for bowel upsets and slight tonsillitis in March. On May 17, a severe attack of coryza came on, and the boy was alternately better and worse for two weeks with more or less constant nasal discharge and slight cough. Then this trouble seemed to clear up and he was all right for a time. The mother had an attack of scarlet fever in May, and the child was exposed on May 6; the mother was promptly isolated. Three weeks after this exposure a slight transient erythema was noticed across the chest, of not more than two or three hours' duration. The boy felt perfectly well at this time. He had eaten fish for the first time in his life the day before this erythema was noticed. After the first week in June the cold which had been much better still persisted. On June 15, the cervical glands were swollen, bilaterally, more on the right than on the left. June 16, 17, 18, the glands were less swollen and the child seemed better at this time. June

19, there was stiffness of the neck on the right side. Temperature 99.6, the tongue coated and the throat clear.

Examination.—June 23, I first saw the boy. Examination showed him to be well developed and nourished. Examination of the heart and lungs revealed nothing abnormal. The throat showed chronically enlarged tonsils; it was perfectly clear, no membrane or exudate was visible. The teeth were good. There was bilateral cervical adenitis. The glands were the size of filberts and slightly larger, discreet, tender, not fluctuant; the skin over them was not reddened. Temperature was 101.2 F. The child felt languid.

Course of the Disease.—Next day, after a restless night, the temperature and pulse were normal. In the morning, the child was sleeping quietly and breathing easily. The glands were somewhat less tender. The condition gradually changed for the worse.

June 25: The child was more listless and weak. Examination showed the pupils equal and reacting to light. No Babinski or Kernig sign was present. Nothing abnormal was found in the examination of the lungs. Examination of the left ear showed the drum slightly reddened. Pulse was 120, temperature 100.2 F. The throat was clear; the tonsils were much enlarged, boggy and pale pink. Gradually the general condition grew much worse. The child's condition was much weaker despite stimulation with salt solution, whisky, caffeine and small doses of digitalis.

June 26: The child was apathetic and stupid. The pulse was markedly irregular and somewhat intermittent and would drop suddenly from 120 to 80. The child answered questions only when aroused. Stiffness of the back of the neck was noticed for the first time. At 2 a. m. the condition was alarming. The breathing was stertorous and the child was markedly apathetic, the pulse being weak and irregular. The cervical glands had markedly increased in size. The nose seemed obstructed and the clinical picture resembled that seen in the last stages of nasal obstruction in diphtheria. The child was given antitoxin, though careful and repeated examination of the throat had shown nothing. The result of the cultures taken the day before had not been heard from. Later these cultures showed staphylococcus and streptococcus growth. The child was stimulated with brandy and salt solution and rallied from the acute collapse. The breathing was not quite so obstructed. There was a leukocytosis about 30,000.

In the afternoon, the condition was as follows: General condition about the same as before collapse of early morning, cervical glands markedly swollen, head and neck absolutely rigid, moved with body as a whole, like an iron rod, knees rigid, Kernig sign more marked (a suspicion at a previous examination). Examination of the throat showed a marked bulging shelf over the left tonsil. There was no exudation. Digital examination of the throat was unsatisfactory.

Consultants' Opinions.—The child was seen in consultation by two specialists in children's diseases, one of whom thought, with me, that the condition was tuberculous meningitis. The other thought that there was a possibility of the symptoms being due to the infiltration around the left tonsil and the markedly enlarged cervical glands. These glands had at no time showed fluctuation or softening. It was thought possible that there was pus around the tonsil, but expectant treatment was decided on for a while.

Termination of Case.—That night the child was somewhat better. Next day the shelf over the left tonsil had disappeared; the throat was more easily inspected, the right tonsil was very much enlarged and a condition similar to the shelf-like projection on the left side was present, only not so marked. This quickly subsided. From this time on, the improvement was rapid. The pulse became regular, stiffness of the neck gradually disappeared and the cervical glands became smaller. When the rigidity of the head and neck had almost subsided it was possible to feel enlarged cervical glands as far back as the occiput. Save for a slight irritability of the heart, the boy convalesced quickly, and this irritability soon subsided.

Remarks.—Some weeks after the boy was up and around, there was peeling of the palms of the hands. Desquamation was not noted in any other part of the body. The treatment consisted of digitalis, whiskey, salt solution and caffeine. As

8. Preissnitz: Quoted by Cornell in Nothnagel's Practice: Tuberculosis, p. 609.

soon as possible the child was put out of doors for all day, with great benefit.

Two interesting points in regard to the case are: 1. Had the child recovered from a mild case of scarlet fever and were the glands sequelæ? None of those who saw the case believe this to be a fact. 2. The fact that the mother was tuberculous, and was undoubtedly so when pregnant with this child, influenced me to a great extent in arriving at a diagnosis of tuberculous meningitis. Dr. Hunter Dunn, one of the consultants, pointed out the possibility of the glands and throat being responsible for all the marked meningeal symptoms, which proved to be the case.

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GOOD AND BAD CORSETS

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In preparing a paper on "The Use and Abuse of Corsets" read in the Lane Course of Popular Lectures at Cooper Medical College Feb. 10, 1911, I had the following diagrams drawn. They represent the chief points which seem to me characteristic of the good as contrasted with the bad corset.

While the diagrams are in themselves sufficiently explanatory, and afford a formula for judging the good and bad points of any corset, it may not be amiss to add a few words on the subject in general.

Every practicing physician recognizes the evils resulting from improperly worn or improperly shaped corsets and yet few take pains to investigate a patient's habits in this regard. I venture to say that still fewer have any fixed ideas as to what constitutes a good corset.

FUNDAMENTAL PRINCIPLES

In considering the basic principles on which a corset should be built, the method of support is of first importance.

In that region of the body covered by the corset, the pelvic bones and spinal column afford the best opportunities for rigid fixing of the framework.

At the hips, the space between the crest of the ilium and the prominence of the trochanter extended as a zone about the body, lends itself admirably to tight lacing, without danger of injuring internal organs. Lacing here affords a means of holding the corset firmly in place.

Along the back, following the contour of the spine, we may run a more or less rigid piece forming the rear elevation of the structure.

The strength and supporting properties of the corset rest in this back piece and in the hip zone.

To complete the skeleton framework, a front piece less rigid than the back, but straight, should run up as high as the bust. The other main points are sufficiently explained by the diagrams.

LACING

A separate short lace string should be inserted at the hip zone and this part firmly laced first when adjusting the corset. The upper part should be more loosely laced by one or two strings. Whether the corset should be front-laced or back-laced is not of great importance. Each method has its advantages and disadvantages. The choice should be left to the corset-maker, as the situation of the lacing involves problems in the mechanical construction of the corset. The back lacing allows of the simplest construction.

The good corset is shown in Figure 1:

1. It is fixed by lacing about the hips and holds its place entirely independently of garters or straps.
2. It supports the lower abdomen and reduces the hips.
3. It has a straight front.

Fig. 1.

4. It is only form-fitting or loose about the waist and bust.
5. It diminishes the waist measure not more than one inch.
6. It laces from below upward by means of two or more lace strings.

Fig. 2.

The bad corset is shown in Figure 2:

1. It shows the zone of greatest compression about the waist.
2. It is loose about the hips.