through the abdominal wall and firmly compressed for a few moments in order to reduce the swelling. Then the thighs are flexed on the abdomen, knees or legs grasped, and with a rapid up and down movement the lower part of the trunk is vigorously shaken for several seconds. The tumor is grasped again and compressed, and while pushed against any part of the posterior abdominal wall, the fingers push or strip the intussusciens out of the intussusceptum, the fingers at the same time making a trembling motion which assists in the reduction. After a few minutes of taxis the succussion is again resumed, and these efforts successively alternated. Sometimes, because of the mobility of the mass, taxis is not effective, and reliance must be placed entirely on the succussion or shaking. In all cases noted the tumors disappeared while the shaking was being done, although taxis had diminished the size of the swelling. There may be two reasons for this—either the loosening of adhesions by the sudden jarring, or preferably, that when a downward movement is suddenly arrested the resulting force is strongly outward, and if the invaginated mass is situated near the median line, the afferent and efferent parts of the intestine have a tendency to go away from the centre and thus pull the invagination apart. If the diagnosis of intussusception has been prompt, the method should be given two or three trials of fifteen minutes each, at intervals of two or three hours, before resorting to surgical treatment. However, the success of the new method of treatment is unlikely, if there is much swelling and local contraction. In the reports of three cases given, it is clearly demonstrated that succussion carefully used is a powerful means of reducing intussusception; but for the best results, this must be undertaken by one thoroughly practised in the technique.

The Blood Pressure in Cases of Acute Nephritis of Children.—LENNOX GORDON (*Archives of Pediatrics*, 1911, xxviii, 343) states that in cases of acute nephritis occurring in young children the blood pressure is raised, and often raised to a marked degree. This fact has apparently not been recognized by authorities on children's diseases. It is extremely difficult, in small children, to determine variations in pulse tension by digital compression, but with the sphygmomanometer any change which may occur is easily noted, and the fact that the sphygmomanometer has been very little used among children will explain why so little change in blood pressure has been found in nephritis. Before determining whether the blood pressure was raised or lowered, the normal pressure for children at different ages had to be determined. This was obtained by working out the averages on a series of 170 cases between the ages of a few months and twelve years. Observations were then made on 9 cases, 7 of which were cases of acute nephritis, and 2 were chronic, with acute symptoms superadded. From the results obtained in these cases the following conclusions were drawn, namely, that in children suffering from acute nephritis the blood pressure is raised, and that this rise may be very great. In 3 out of the 7 acute cases the hypertension was very marked. This fact is of diagnostic value, as in no other disease of childhood is there to be found the same high range of blood pressure. Those cases having the highest pressure were those in which only a trace of edema was noticeable, and also it was noted that in these same cases the quantity of blood in

the urine was very great; the explanation being, probably, that the greatly increased blood pressure had caused a rupture of the renal capillaries. It is difficult to explain the high tension and rapid drop which occurred in some of the cases, except by assuming a large degree of spasm due to some toxin acting on the arterial walls. The fact should be emphasized that in children it is only by means of the sphygmomanometer that changes in the blood pressure can be accurately ascertained.

OBSTETRICS

UNDER THE CHARGE OF

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Stroganoff's Treatment of Eclampsia.—ROTH (*Archiv f. Gynäkologie*, 1910, vol. xci, Part 2) has employed this treatment of eclampsia in 31 cases in the clinic at Dresden. It consists in giving morphine, chloralhydrate, and chloroform, by a definite routine, to prevent the development of convulsions. The patient is kept continuously partially narcotized and isolated in a dark room, with absolutely no disturbance. Whenever it is necessary to use the catheter, or to give an enema, a small quantity of chloroform is administered. This is also done before hypodermic injections are given. The chloral is usually combined with milk or broth, and the treatment is continued after the convulsions cease, the chloral being given in 20 grain doses, three times daily, often after the termination of pregnancy. So soon as the convulsions show a tendency to cease, labor is induced, and if the conditions are favorable the membranes are ruptured. Stroganoff reported 360 cases, with a mortality of 6.6 per cent. for the mother, and 21.6 per cent. for the child. In Roth's cases, in 23, convulsions appeared after the beginning of labor. These were immediately controlled by the treatment in 12 cases; after from one to three convulsions in 13; and after four or more in 6 cases. One mother died of empyema. Although the treatment could be carried out in the patient's home, it is better when done in a hospital, where complete control is more readily procured.

Twenty-five Cesarean Sections with no Fetal or Maternal Mortality.—HUMSTONE (*Amer. Jour. Obst.*, May, 1911) reports 25 cases of abdominal Cesarean section without fetal or maternal mortality. The indications were dystocia from ventral fixation in 5 cases, scar tissue in the vagina with funnel pelvis in 1 case, stenosis of the vagina in 1 case, impacted cyst in 1 case, contracted pelvis with prolapse of the cord in 3 cases, bony tumor of the pelvis in 1 case, generally contracted pelvis in 9 cases, funnel pelvis in 1 case, and flat rachitic pelvis in 3 cases. It is interesting to note that one-fifth of this series

were caused by previous ventrofixation; 3 of these cases followed operation by one man, who was accustomed to suture the fundus and posterior wall of the uterus firmly to the fascia, muscle, and the peritoneum just above the pubes. The other 2 cases were those of accidental fixation, where the operator intended to practise suspension. In 2 cases sterilization was accomplished by the removal of the tubes; and hysterectomy was done in 1 case because the vagina was so occluded that proper drainage could not be obtained. The operation was performed as rapidly as possible, and this was thought a valuable point in the technique. Two of the patients were operated upon a second time. A tendency to acute dilatation of the stomach was the most troublesome complication after operation, but was readily controlled by lavage. Three-fifths of the mothers nursed their children; the remainder were unable to do so. This series illustrates the extension of the operation in conditions other than contracted pelvis, and also the success of the operation when patients are taken in good condition.

Eclampsia and Anaphylactic Phenomena.—FELLANDER (*Zeitschrift f. Geburtshülfe und Gynäkologie*, 1911, Band lxviii, Heft 1) in a considerable number of experiments upon guinea-pigs found no reason to believe that eclampsia is an anaphylactic process. In his experiments he employed albuminoid material from the fetus, from the placenta, and from the amniotic liquid.

The Treatment of Children Apparently Stillborn.—AHLFELD (*Zeitschrift f. Geburtshülfe und Gynäkologie*, 1911, Band lxviii, Heft 1) considers the old division of cases of apparent failure in respiration, into livid and pallid asphyxia, to be illogical and misleading. After trying various forms of treatment, he believes that when a child does not show signs of life promptly after delivery, the umbilical cord should be immediately tied and cut. The child should be placed in a warm bath and the surface of the body cleansed as quickly as possible, fresh warm water being added to the bath at a temperature of 38° to 40° C. An effort should be made to determine what the exact condition present is, and whether the respiratory passages are occluded. One must remember that the heart may not beat at short intervals, and the child still be revived; and again that a child may be practically dead although the heart continues to beat. After the circulation of the skin has been stimulated by the warm bath, and the air passages have been cleansed from mucus and meconium, the child is suspended by the feet, the chest is compressed gently, and an effort made to force out the mucus which may have been inspired. If respiration does not occur, the child is wrapped in a warm towel, a catheter passed into the trachea, and suction exercised to remove the mucus. If the heart is beating the child will usually make a deep inspiration and the heartbeat become stronger and more rapid. The physician can usually determine by the presence or absence of reflexes in the mouth and throat whether or not the child is actually living. Ahlfeld lays great stress upon gentle but persistent counterirritation of the skin in stimulating respiration. He would have the child rubbed with warm towels, or again placed in a warm bath and then thoroughly dried. Schultze's method of swinging the child should not be used