

of the desks to the pupils, and the whole is less scrupulously clean than it might be. These defects cannot be all due to lack of means, for poor Florence can do much better in antiquated palaces. Some of the disadvantages of overcrowding might be mitigated easily by simple measures for regular aeration during class. The impression received is that defects exist because they are not realised. To the credit side, however, may be placed the excellent supply of midday food, the summer colonies, and the large provision for taking charge of young children from the early age of two years (nowhere else attempted) till they enter the primary school.

Such are the impressions received during a visit to representative elementary schools of five European countries. In conclusion, a word of grateful recognition should be said of the uniform courtesy extended in every case, alike by authorities and school *personnel*, to an unexpected and unknown visitor.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

THREE CASES OF IMPERFORATE ANUS AND RECTUM.

BY JAMES LAURIE, M.B., C.M. GLASG.,

VISITING SURGEON TO THE GREENOCK INFIRMARY; ASSISTANT SURGEON TO THE THROAT, NOSE, AND EAR DEPARTMENT OF THE GREENOCK EYE INFIRMARY; AND SURGEON TO HIS MAJESTY'S PRISON, GREENOCK.

THE relative infrequency of congenital defects of the rectum and anus prompts me to report the following cases which came under my observation and treatment in 1895. Keating, quoting Ball, says: "In a joint collection of 66,654 deliveries in Vienna and Dublin lying-in hospitals there were only three cases of imperforate rectum."

CASE 1.—I was called at 11 o'clock one night to see an infant (a female), aged 24 hours, and on my arrival at the house I found a midwife busy giving the child injections of soap-and-water, but "still she could get no passage." There was a well-formed anus, and on passing my finger three-quarters of an inch into it I found a very dense membrane occluding the passage. I opened it by a crucial incision, much to the relief of the child, and instructed the mother and the nurse how to keep it dilated by passing the finger, well-oiled, into the part. I saw the child some time afterwards and she was doing well.

CASE 2.—In the second case there was a very fine and delicate membrane closing the external aperture of the anus. The child had been born the evening before and no fæces had passed. The membrane was easily torn by a pair of dressing forceps and the mother was instructed to keep it dilated.

CASE 3.—I was sent for to see this child one forenoon and was informed by the nurse that the infant had been born 16 hours previously and had no anus. On examining the perineum there were a well-marked raphé and considerable bulging when the child strained or cried, but no indication of an anus. Under chloroform, which was administered by Dr. A. G. Newell, I made an incision from the centre of the raphé to the coccyx and felt the rectum bulging downwards. By a blunt dissection for an inch through cellular tissue I found the rectum ending in a blind pouch. Gently pulling it down I incised it by transfixion antero-posteriorly and sutured the ends of the skin. The sutures held. The child made a good recovery and had full control over his bowels.

The infants were all well nourished and were doing well when I heard of them last.

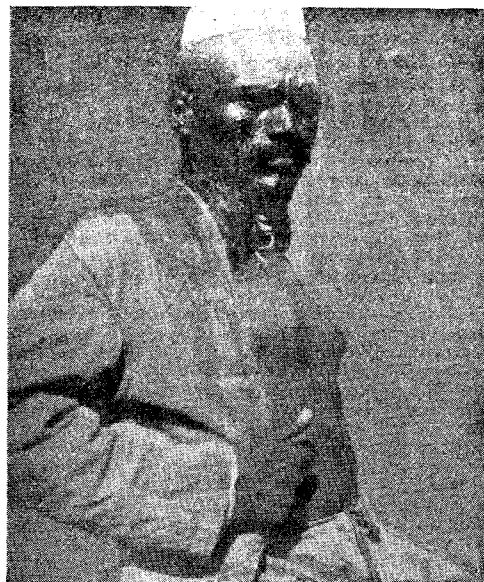
Greenock.

NOTE ON A CASE OF FIBROMA IN THE MALE BREAST.

BY A. WEBB JONES, F.R.C.S. ENG.

CONSIDERING how rarely one meets with new growths of the male breast I have thought the following case of pure fibroma perhaps worth recording.

The patient, an Egyptian soldier, aged 35 years, came to hospital complaining of a gradually increasing swelling of the left breast which he first noticed four months previously. Latterly he had also been troubled with slight pain. On



Showing patient before operation.

examination the left breast was uniformly enlarged to about twice the size of the right. The outline stood out in marked contrast to the opposite side, but retained its general shape. On palpation the mass felt soft and elastic, but no indication of lobulation—as in a lipoma—could be obtained. It was freely moveable on the chest wall.

The breast was removed without difficulty by Thomas's incision. Microscopically the growth proved to be a pure fibroma.

Wadi Halfa.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

PADDINGTON GREEN CHILDREN'S HOSPITAL.

A CASE OF TUBERCULOUS PERITONITIS WITH OBSTRUCTION;
LAPAROTOMY AND SHORT-CIRCUITING OF THE
SMALL INTESTINE; RECOVERY.

(Under the care of Dr. G. A. SUTHERLAND and Mr.
W. WATSON CHEYNE.)

A FEMALE child, aged three years, was admitted into the Paddington Green Children's Hospital in September, 1899. For three months the abdomen had been increasing in size and she had suffered from attacks of vomiting and constipation. There had never been diarrhoea or abdominal pain. In the family history there was nothing to be noted save that one brother had died from pulmonary phthisis. The child's previous health had been good. On admission she was found to be well nourished but markedly rachitic. The abdomen was much enlarged and tense, with dilated superficial veins. Fluctuation could be made out over the greater part, the fluid apparently being free in the peritoneal cavity. The liver was not enlarged and the spleen could not be felt. Deep palpation of the abdominal contents was impossible owing to the amount of distension present. Rectal examination showed the presence of ballooning. The heart and lungs presented no evidences of disease and the urine was small in amount, but otherwise normal. Mercurial inunction over the abdomen was ordered and a mixture of cod-liver