

nal wall. No adequate proof has yet been offered to show that the influence of the round ligaments, when anchored to the cervix, enters as a factor, in the slightest degree, in maintaining the normal position of the cervix nor in restoring a displaced cervix to normal. Prolapse of the cervix does not and cannot occur after supravaginal hysterectomy, if previous to the operation the fascial diaphragm is uninjured and the cervix is in normal position.

Renal Hematuria as a Symptom of a Perinephritic Condition of the Kidneys.—YOUNG (*Surg., Gynec. and Obst.*, 1920, xxxi, 478) says that of 1300 cases treated in the house service of the Genito-urinary Department of the Massachusetts General Hospital, 40 per cent. had a history of gross hematuria at some time or other in the history of the disease. The cause of renal hematuria can be demonstrated in all but a very small proportion of cases. Kidney bleeding of unknown origin has been known to be enough to threaten life and require nephrectomy. A horseshoe kidney, a slightly movable kidney, a varix of a renal papilla may occasionally exist without the possibility of positive pre-operative diagnosis. In a few instances the split function may show considerable damage on the bleeding side and the pyelogram a considerable deviation from the normal, a combination which should require exploration; but these cases are very rare and operation as a routine exploratory procedure in cases of hematuria of unknown origin is unwise, as there is no assurance that it will have any effect on the progress of the bleeding. In a fair number of these cases a nephritis has been proved to be the cause of trouble. It is reasonable to believe that in a majority of these cases there is an early unrecognized nephritis or a perinephritic condition which can be, and probably often is, the cause of hematuria, and that this condition may or may not go on to a progressive damage of the kidney, depending on conditions which we do not as yet understand. In certain of these cases the primary focus of damage can be recognized, and when eliminated will prevent the later development of the disease.

Blastomycosis.—MOORE (*Surg., Gynec. and Obst.*, 1920, xxxi, 590) reports a case of cranial blastomycotic infection. Little is to be found in our modern text-books on the systemic involvement of various organs of the body by this infection. Moore's case received the infection through a puncture wound as many of the cases do. The infection in this case was probably introduced through the mouth from the splinters habitually carried in the mouth. The treatment of the case was hardly radical enough in destroying the various recurring foci of the disease. The eye should have been sacrificed earlier, and radium used in the orbit as the roentgen ray was apparently the best agent used in the treating of the lesions on the face and neck. The disease remained more or less local for a long time notwithstanding its tendency to spread through the lymphatics and become systemic. No organisms were obtained either from the urine or sputum, nor did we succeed in getting a culture from the blood. The infection of the brain was possibly through the ophthalmic vein or through the veins of the scalp

and emissary vein through the skull. The study of the organisms in the different lesions and tissues showed a considerable variation in their size; those from the abscesses of the face, neck, and orbit, showing the large forms, while no large forms could be found either in the pus or the tissue from the brain. There are many budding forms of the organisms, but no evidence of endosporulation, as in coccidiodes.

PEDIATRICS

UNDER THE CHARGE OF

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A Clinical Classification of Diarrheas.—ROYSTER (*Arch. Ped.* September, 1920) classifies the diarrheas of early life as follows: Food injury (acute) from overloading the digestive tract, particularly the stomach, with proper food; the accidental administration of an excess of one or more food elements in a bottle baby's formula, either fat, carbohydrate or protein nervous diarrhea from sudden overheating or sudden chilling, excitement or fear, improper or indigestible food; food injury (chronic) from the habitual administration of too large quantities of one or more of the normal and proper food elements or mixtures too strong in all elements; fermental diarrhea; infectious diarrheas due to the dysentery group of organisms, the gas bacillus or other organisms. An effort was made to ascertain what relation existed between the onset of summer diarrhea and the temperature and humidity. Last summer the warm weather was late, its onset not having been well established before June 12, which was two or three weeks later than usual. The incidence of diarrhea was correspondingly late in its appearance. The mean of the observations of the local weather was taken as the only practical record. The temperature was averaged each day from the highest to the lowest. The relative humidity was observed at 8 A.M. and 8 P.M., and an average taken. The incidence of cases exactly followed these curves. It was of great interest to note the height of the incidence on the day following the height of the temperature.

Effort Syndrome in Children.—KERLEY (*Arch. Ped.*, August, 1920) reports several cases which are given as illustrations of the condition to which this name is applied. As the most prominent symptoms involve the circulatory and nervous systems, it has also been called "neurocirculatory asthenia" or "neurocirculatory myasthenia." The chief cause has been found to be infections from the tonsils, teeth and other foci. The child who may later become a member of this group presents a typical history, which tells of absence of capacity for sus-