

the aural clinic was established) for adenoids where none existed, and the catarrhal or septic lesion was kept active by chronic nasal catarrh from the causes mentioned above.

The routine was therefore established that all children were seen by the school medical officer, referred to the aural clinic, and from there sent to the proper departments for the respective treatment—i.e., for adenoids, for cauterisation, turbinectomy, or septal resection, as the case required. Before return to school the children were always seen by the aurist and kept under his supervision by the S.M.O. for the necessary after-treatment. It struck me forcibly that the inspection of school children for adenoids and for ear conditions generally, and for otorrhoea especially, should be undertaken at an earlier age in the infants' class, before irrevocable damage was done, which only came to the notice of the aural surgeon when the infant had passed into the age for routine inspection. A few early cases came from the maternity and child welfare clinic, but these were a very small proportion of the whole of the small sufferers.

I need not dwell on the type of treatment, as this has been discussed already, except that I found the collosol preparations of great value in the earlier cases; and a point, not noted so far in the discussion, is the rapidity and ease with which the early cases of otorrhoea (after the acute stage was over) cleared up with daily ionisation with zinc or with iodine, this treatment being only of use in the older patient who is manageable.

\* The incidence of otorrhoea in this town is undoubtedly partly due to a prevailing south-westerly wind and, which is of more importance, to the daily irritation of the nasal and post-nasal mucous membranes by the almost constant presence of coal-dust. It is quite impossible for the school medical officer adequately to cope with all the ear cases and the conditions leading up to their causation. He is, as a rule, sufficiently burdened with a whole host of inspections and reports and clinics to be able to give any time for anything but a cursory examination of these cases, even though he may have the knowledge and the penchant for such work; and the pay of these officers does not tend to make a special study of such work worth the while.

There can be no doubt that the appointment of a whole-time aurist, or, at least, a part-time officer with adequate remuneration for efficient services, would repay any town that has the welfare of its citizens at heart, since a deaf person is extremely limited in his choice of work and appointment to a job in these competitive days alongside his more fortunate brethren who do not carry the cotton-wool emblem of the chronic septic aural discharge.

I am, Sir, yours faithfully,

R. ECCLES SMITH, O.B.E., F.R.C.S.

Barry, Glam., June 9th, 1922.

#### YARROW CONVALESCENT HOME, BROADSTAIRS.

*To the Editor of THE LANCET.*

SIR,—The special feature of the Yarrow Convalescent Home at Broadstairs is not sufficiently known. It is intended for the children of the educated class of limited means, and it is common knowledge that there are an exceptional number at the present time of such families, their financial difficulties having been brought about as the result of the war and the high cost of living. Facing the sea there are extensive balconies upon which the children lie out and get the benefit of the fresh air. There are also extensive playing grounds. There is a dairy attached to the Home, from which only Grade A milk is obtained, and there is practically no limit to the amount of milk which the children are allowed to take. All the cows are periodically tested against tubercle.

No letters or introductions are necessary: all that is needed to gain admission is, that the children are

recovering from operations or illnesses, and require a helping hand in the shape of good food and fresh air to secure final recovery. The charge of 10s. a week is made as it is the desire of the Committee of Management that the parents should contribute to the cost of their children's recovery. The fees, however, are somewhat elastic, and those who can afford to pay more than 10s. are expected to do so.

With regard to the length of stay at the Home, there is no limit; it is determined by Dr. Moon, and if he considers a lengthened stay is necessary to put the children in a good state of health, it is not curtailed. It is the desire of the Management, instead of temporarily benefiting large numbers of children, permanently to put a reduced number in the best of health.

The Management prefers to be dependent on the medical profession for recommending suitable cases, but it must be clearly understood that in no case will a child be admitted when there is any suspicion of an intention to use the Home as a holiday resort. The Home has been established solely to help the children of the educated class so to recover their health as to fit them for life's battle.

I am, Sir, yours faithfully,

June 12th, 1922.

ETHEL DAWSON OF PENN.

#### PULMONARY BASAL PHYSICAL SIGNS IN RHEUMATIC PERICARDITIS.

*To the Editor of THE LANCET.*

SIR,—Once more I venture to trespass upon your valuable space in connexion with pathological conditions relating to the heart. Dr. Robert Hutchison, in his paper in your issue of June 3rd upon Acute Carditis in Childhood, refers to Bamberger's sign and seems inclined to attribute it to "pneumonic subacute consolidation." From that opinion my own post-mortem and clinical experience would lead me to differ. For example, I was in a ward on one occasion when a physician, after examining a case of acute rheumatic pericarditis in a child, stated that he noted the presence of pneumonia of the lower lobe of the left lung. Cases seen after death led me to suggest that the presence of bronchial breathing heard near the inferior angle of the scapula had misled the physician regarding the presence of pneumonia. On the following day we were able to prove in the post-mortem room that such had been the case. No trace of any consolidation of the lung was present.

While I agree that a "pneumonic subacute consolidation" occasionally occurs in cases of rheumatic pericarditis, or that a triangular strip of collapse of the lower lobe may sometimes be present on the left side, and also occasionally on the right, it does not seem to me that these conditions account for the bronchial breathing which may be heard near the inferior angle of the scapula in cases where an enlarged heart is consequent upon the presence of rheumatic pericarditis. The sum of my post-mortem experience relating to bronchial breathing near the inferior angle of the scapula led me to the following conclusion. Any abnormal condition within the chest which aids the conduction of tracheal sounds, yet the abnormal condition does not reach the chest wall, may lead to the tracheal sounds—i.e., bronchial breathing—being heard near the inferior angle of the scapula. For example, in a case of pneumonia of the posterior half of the left upper lobe, in which the consolidation did not reach the axilla, bronchial breathing was heard only near the inferior angle of the scapula. Bronchial breathing, as is well known, may be heard in this area in cases of dilatation of the bronchial tubes, and a cavity has more than once been wrongly diagnosed at this spot in consequence. The enlarged heart pressing upwards against the bifurcation of the trachea acts like the patch of pneumonia or the dilated bronchial tubes as a conductor of the tracheal sounds. But, it may be asked, why should the bronchial breathing be best heard over an area near