but the combination of this with alternating pressure gave results which were in some instances much larger than, and in the others very nearly, if not quite, as large as, the amount of tidal air. The marked effect of pressure in assisting the output and subsequent elastic intake of air was particularly well seen in the case of the younger subjects, and this was doubtless due to the greater mobility in them of the thoracic walls. It further appeared that the prone position was advantageous in assisting the effects of pressure, probably because pressure applied to the back became more evenly distributed over the thorax and abdomen. It appeared to the committee that both this method and the even more simple method of rhythmic pressure upon the back with the subject placed in the prone position, should occupy a prominent place in all recommendations made with the view of the resuscitation of the apparently drowned. One of the most striking results shown in the series of experiments on dogs drowned in fresh water was that of the complete disappearance of the water which was taken into the lungs, even in cases in which artificial respiration was not followed by recovery. The actual amounts which were absorbed had been found to be very variable (from 75 to 690 cubic centimetres). This no doubt depended somewhat upon the size of the dog used, but it probably depended more upon the character of the respirations, especially those at the beginning of the immersion. Another striking fact which came out in these experiments was the great length of time during which immersion might last and yet be followed, with efficient artificial respiration, by complete recovery. Several of the experiments illustrated this point. In one case the immersion lasted nearly eight minutes without a fatal result. In other instances a much shorter immersion was followed by death in spite of artificial respiration, and even in two instances in spite of the fact that the natural respirations were recovered. The reason for the failure of recovery—when it was not due, as seemed to be the case in certain instances, to early complete failure of the heart—appeared to have been due to deficient aeration of the blood by the respiratory movements. The results with sea-water were, on the whole, similar in character to those with fresh water, but there were certain points of difference. So far as these experiments went it would seem that there was, as a rule, less absorption of water by the lungs. This was, of course, to be expected, seeing that the osmotic force of sea-water was higher than that of the blood. Indeed, in one experiment this showed itself by the fact that a larger amount of fluid was returned from the air passages than had been taken in and the excess must have come either from the blood or from other fluids of the animal body. Since one of the most marked physiological symptoms of death by asphyxia from drowning—as in other forms of asphyxia—was the extreme lowering of blood pressure owing to paralysis of the vaso-motor system, it was hoped that such a drug as suprarenal extract might, by antagonising this symptom, produce, in association with artificial respiration, rapid recovery; the more so because this drug was known also to increase the force and rate of the heart's action. But it was obvious that it would only act if there were some sort of circulation going on to promote its absorption and to carry it to the peripheral vessels; and even then it could only produce permanent benefit if the artificial respirations were efficiently promoting the aeration of the blood, since as long as the venous condition of the blood continued the paralysis of the vessels and heart could not be more than quite temporarily relieved. This was, in fact, what was found to occur, for in cases in which, owing to froth in the bronchi, the diffusion of the oxygen of the inspired air into the alveoli was interfered with, or in which, from any other cause, the artificial respiration was inefficient, the result of intrapulmonary or intracardiac injection of adrenalin had only a quite temporary effect—the blood pressure rising and the pulse improving for a short time—to give place again to paralysis of vessels and heart and at the best only deferring the fatal result for a brief period.

Dr. H. R. SILVESTER said that he should confine his remarks to discussing the most convenient and efficient mode of carrying out artificial respiration. He regretted that the committee of inquiry had not used the same method for estimating the amount of air that could be introduced into the lungs as the committee of 1862, for he considered that no satisfactory results could be obtained by estimating the amount of air passing through the upper air passages, for some portion of the air would tend to find its way into the stomach and thus prevent any accurate comparison. Another serious objection to the face mask method was that air from the stomach was liable to pass into the spirometer. He thought that the rolling method had the additional disadvantage that the contents of the stomach were liable to get discharged into the pharynx and so into the air passages. Dr. Silvester pointed out the importance while using traction to have the body on an inclined plane and even in some cases to tie the feet. He considered that the conclusions of the present committee were based on insufficient evidence.

Dr. R. L. BOWLES said that the report of the present committee confirmed the report of the committee of 1862, which showed that sufficient air for the maintenance of life could be introduced by alternate compression and relaxation of the chest wall and by means of movements of the arms. The present committee had experienced the same difficulty in estimating the amount of air capable of being taken in and driven out of the thorax by artificial respiration in carrying out the experiments on the dead body as the committee of 1862, but by well working the muscles the rigor mortis of the body might be overcome and the chest could be rendered more or less elastic before beginning the experiment. He considered that the falling back of the tongue and the collection of mucus in the pharynx were the greatest hindrances to artificial respiration and that while the body was in the supine position these difficulties could not easily be overcome, whereas if the body were in the prone position neither of these difficulties could occur. He thought that it was important that the simplest and most efficient method of resuscitation of the apparently drowned should be given to the public and therefore he strongly urged that the prone and not the supine position should be used. He doubted if experiments on dogs were of much value, for the conditions present in the dog with regard to habits and position differed so entirely from those of man that the conditions could hardly be made comparable. The condition of the lungs found in the dogs drowned experimentally did not correspond with that which was found in man drowned, for in the latter case a considerable amount of water was usually found in the lungs. He thought that the danger of rupture of the liver was a real one and was another reason for not employing pressure during artificial respiration. In conclusion he said that both the Marshall Hall and Silvester methods had been shown to be capable of introducing air into the lungs, but that the public should be taught to use only one and that the Marshall Hall method.

Lieutenant-Colonel C. R. WOODS said that the first thing to do in resuscitating the apparently drowned was to get rid of the water from the lungs and this was most effectively done by turning the patient into the prone position. He thought that with a heavy body the rolling method had some advantage but that the Silvester method could be more readily carried out. He thought that too little pressure was often employed in expelling the air from the chest.

Dr. F. W. HEWITT called attention to the fact that there was often a considerable amount of muscular spasm of the upper air passages during the administration of an anæsthetic which might produce asphyxia and this was not removed even when the trachea was opened. He thought that the method of inflation of the lungs was of great service and that the method might be elaborated.

Dr. M. S. PEMBREY said that it did not seem to him that the absolute quantity of air made to enter the chest during artificial respiration was of much importance, for a few extra respirations made up for any deficiency in the actual amount at each inflation. The influence of the nervous system was a matter of great importance in man. The amount of water which the lungs would rapidly absorb was very considerable. Dr. Pembrey suggested that the method of absorption might be traced by colouring the water with carmine.

Professor SCHÄFER replied.

CLINICAL SOCIETY OF LONDON.

Ileo-cæcal Invagination by a Meckel's Diverticulum.—Sequel to a Case previously shown as one of Congenital Morbus Cordis.—A Case of Great Dilatation of the Heart.—Election of Officers

A MEETING of this society was held on May 22nd, Mr. HOWARD MARSH, the President, being in the chair.

Dr. J. P. ZUM BUSCH read a paper on a case of Ileo-cæcal Invagination by a Meckel's Diverticulum. The patient was a man, aged 21 years, an acrobat by occupation. He had

suffered for several years from abdominal symptoms pointing to an intestinal growth. The condition became suddenly worse after a heavy strain during muscular exertion. Sickness and vomiting, the passage of blood by the anus, and the appearance of a quickly growing swelling in the ileo-cæcal region led to the diagnosis of invagination produced by intestinal polypus and necessitated an immediate operation. The abdomen having been opened, an ileo-cæcal invagination was found and with great difficulty reduced. This invagination was, however, only secondary to a primary invagination of a Meckel's diverticulum into the ileum. Extensive gangrene of the intestine rendered the excision of the whole invaginated portion (about three feet) necessary. Side-to-side anastomosis was performed and an uneventful recovery ensued. The condition described was a very rare one, as only 15 cases of invagination of a Meckel's diverticulum had been published; in 12 of these a secondary invagination of ileum into ileum or ileum into cæcum occurred. The prognosis of this condition seemed to be exceedingly bad, as in only one case had the patient recovered after excision of the gangrenous intestine. In that case, which was published by Brunner, it was not absolutely certain whether the inverted part was really a Meckel's diverticulum or whether it was an invagination produced by an accessory pancreas.—Mr. W. G. SPENCER referred to the small lipomata found in the pancreas which, he remarked, frequently formed the starting-point of cæcal invaginations.—Mr. E M. CORNER described the two ways in which Meckel's diverticulum became invaginated. In some cases the invagination might start at the apex of the diverticulum and these mostly ran a chronic course. But in other cases the diverticulum became invaginated and the small intestine contracted upon it; the symptoms in these circumstances became acute.—Dr. ZUM BUSCH replied.

Dr. PERCY KIDD narrated the sequel to a case previously exhibited before the society as one of Congenital Cardiac Disease. The patient was a girl, aged 23 years, who was shown before the society in February, 1901.[1] The case was regarded by nearly all those who saw it at that time as one of congenital morbus cordis. There were marked dilatation and hypertrophy of the right side of the heart and a loud second sound more marked over the pulmonary area. The patient died six months later and very extensive endarteritis was found to involve the pulmonary artery and its branches, though the pulmonary valves themselves were healthy. The lungs were engorged and the right side of the heart was much enlarged in consequence of the disease of the pulmonary artery. The history suggested that the arterial disease originated during intra uterine life. —Dr. P. HORTON-SMITH had made the macroscopic and microscopic examination of this case. There was extensive and advanced chronic endarteritis in the pulmonary artery and its branches but limited to the pulmonary system of vessels. There was no emphysema of the lungs. The cause was very obscure; there was no history of gout, lead, or alcohol.—Dr. H. BATTY SHAW remarked on the occurrence of a diastolic murmur on the right side of the sternum in this case. Such murmurs occurred in association with mitral disease, but it was probably generally due to leakage of the pulmonary valves. Dr. Kidd's case helped to substantiate this view.—Mr. SPENCER discussed the occlusion of the duct of Botalli and the hypogastric arteries in relation to lesions of the kind under discussion.—Dr. F. PARKES WEBER, referring to the diastolic murmur, asked whether there was any relative dilatation of the right auricle, because relative tricuspid stenosis might produce a diastolic murmur.—Sir HUGH R. BEEVOR referred to a case in which both pericarditis and aortic disease were suspected but dilatation of the right heart alone was found after death.—Dr. W. EWART regarded diastolic murmurs such as that in this case as of mitral regurgitant origin and not arising in the pulmonary valve. He could hardly believe that the lesion, which was evidently a progressive one, in Dr. Kidd's case was of congenital origin though its cause was evidently very obscure.—Dr. KIDD, in replying, thought that the lesion must have arisen in intra-uterine life and it was undoubtedly progressive in its nature.

Dr. J. PORTER PARKINSON related the further history of a case of unusually Great Dilatation of the Heart. The patient had been shown to the society in January, 1901,[2] when the physical signs showed the heart to extend almost completely across the chest. There was a systolic and presystolic murmur both at the apex and in the region of the right nipple. There were remarkably few symptoms, dropsy only appearing during the last few weeks of life. He died in December, 1902. At the necropsy the heart was seen to be immensely enlarged and the pericardium was universally adherent. All the chambers were enlarged but especially the auricles and the right ventricle. The mitral orifice was exceedingly stenosed; the tricuspid valve was thickened and the orifice was somewhat stenosed. The heart weighed 30 ounces when empty of blood. The specimen was shown with the object of demonstrating that the systolic pulsation in the region of the right nipple was produced by the right auricle and not by the left auricle which, though much enlarged, lay at a distance from the surface.—Dr. EWART remarked on the interest of the case as bearing on the causation of pulsation over the right auricular area.—Dr. C. W. CHAPMAN referred to a somewhat similar case in which practically no symptoms existed.—Dr. PARKINSON, in replying to Dr. W. PASTEUR, stated that the pulsation over the auricular area was synchronous with the apex beat

The annual meeting of the society was then held. The report of the council and the treasurer's statement of accounts were duly submitted and the usual votes of thanks to the retiring officers and council were proposed and adopted with acclamation. The scrutineers' report showed that the following gentlemen had been elected for the session 1903-04:—President: Dr. Frederick Taylor. Vice-presidents: Dr. D. B. Lees, Dr. H. A. Lediard, Sir William R Gowers, Mr. H. H. Clutton, Mr. Henry Morris, and Mr. C. H. Golding-Bird. Treasurer: Mr. G. H. Makins. Council: Mr. J. Kingston Barton, Dr. F. E. Batten, Dr. J. Mitchell Bruce, Dr. J. Walter Carr, Dr. W. S. Colman, Dr. Lee Dickinson, Dr. S. H. Habershon, Dr. F. H. Hawkins, Dr. Kidd, Dr. Hector Mackenzie, Mr. F. W. Strugnell, Mr. Herbert W. Allingham, Mr. Leonard A. Bidwell, Mr. Walter Edmunds, Mr. J. Hutchinson, Jun., Mr. T. H. Kellock, Mr. H. Betham Robinson, Mr. Charters J Symonds, Dr. C. S. Wallace, and Mr. F. C. Wallis. Honorary secretaries: Mr. Anthony A. Bowlby and Dr. W. Pasteur.

SOCIETY FOR THE STUDY OF DISEASE IN CHILDREN.—A meeting of this society was held on May 15th, Dr. Frederick Taylor being in the chair.—Dr J. Porter Parkinson showed a specimen of Colloid Cancer of the Peritoneum removed from a girl, aged 12 years. During life the abdomen was distended with free fluid and she was thought to be suffering from tuberculous peritonitis. On removal of the fluid large cells filled with colloid deposit were found in the detritus. An irregular hard swelling was then palpable in the hepatic area and some scattered nodules could be felt elsewhere. An abdominal section was subsequently made and the peritoneum was found to be sown with small masses of growth of a sodden semi-transparent appearance which microscopically were colloid cancer. Subsequently the abdomen became completely filled with irregular masses of growth which surrounded all the contained organs. The primary seat of the growth was thought to have been in the rectum.—Dr. A. E. Sansom thought that by reason of the patient's early age the case was probably a record one.—Dr. A. A. H. Partridge showed a boy, aged ten and a half years, the subject of Interstitial Keratitis who simultaneously developed an affection of the hands. He said that the cause to which the joint changes were due was an interesting question. The joints looked like those of osteo-arthritis but he supposed that they must be considered due to the general condition. An interesting point about the case was that the left hand became affected after the left eye and the right later—this happened in November, 1901; the right eye failed in January, 1903. —Dr. Edmund Cautley said that the disease did not seem to him to be a syphilitic affection of the joints; he was much more inclined to consider it a case of osteo-arthritis arising in a child the subject of inherited syphilis.—Dr. G. A. Sutherland said that he thought that the joint changes were probably syphilitic in origin.—Dr. George Carpenter agreed as to the striking resemblance between the child's condition and osteo-arthritis. He thought that there was periosteal thickening of the heads of the metacarpal bones and that the condition of the knuckles could not be distinguished from syphilitic epiphysitis.—Dr. F. Parkes Weber said that he had examined the case very

[1] THE LANCET, March 2nd, 1901, p. 626.
[2] THE LANCET, Feb. 2nd, 1901, p. 325.

carefully and the evidence was very strong in favour of the state of the joints being due to congenital syphilis. Unlike osteo-arthritis there was a complete absence of tenderness and the movement in the joints was almost perfect. The changes were almost entirely confined to the bones and the periosteum. Certainly there was just the slightest effusion into one or two of the joints. He regarded the case as one of phalangitis of syphilitic origin.—Dr. Cautley showed the Stomach and Œsophagus of an infant, aged 18 months, who had died from Diphtheria. The child was admitted into hospital for constipation and anuria and ten days later developed bacilluria, the variety being the bacillus coli. Subsequently the patient became feverish, profoundly asthenic, and died in 12 days from the onset of the fever. The œsophagus contained membrane in the upper third. One third of the mucous membrane of the stomach towards the pyloric end was covered with yellowish-grey membrane. —Dr. Watson said that he had obtained a pure culture of the Klebs-Löffler bacillus from the mucous membrane of the stomach and also in sections of the stomach wall.—Dr. Parkinson showed a case of Enlarged Bronchial Glands in a child, aged four and a half years, which was associated with a paroxysmal cough like whooping-cough. The associated signs were those of bronchitis with breath sounds weaker on the right side and in places somewhat bronchial in quality. There was much sputum which was free from tubercle bacilli. The fingers and toes were clubbed. He thought that there were enlarged mediastinal glands pressing on the right bronchus with secondary dilatation of the tubes and that the "whoop" was occasioned by irritation of the vagus nerve. The very continuous whoop was so distinct that the child was not allowed by the mother's friends to associate with their children and had been sent out of hospital on several occasions as a case of whooping cough.—Dr. Taylor showed a case of Athetosis in a girl suffering from mitral disease. She was suddenly attacked with right-sided hemiplegia during sleep and some twitchings of the right arm and leg were noticed at the onset. Involuntary movements commenced in the right hand and foot two days after the hemiplegia began. The condition was probably embolic and permanent.—Dr. Sansom said that there was no question as to the embolic plugging of the left middle cerebral artery. Plugging in a purely rheumatic case of heart disease was not quite so common as was sometimes thought.—Dr. Sutherland said that the case seemed to be one of chorea from the nature of the movements. The movements were very rapid for athetosis and there was also the fact of the rapidity of their onset, and there was the association of endocarditis which was a strong point in favour of chorea and he did not think that the absence of facial movements absolutely excluded chorea.—Dr. Taylor also showed a case of Acute Anterior Poliomyelitis involving the abdominal muscles as well as the legs and lumbar muscles. He said that the more he saw of cases of infantile paralysis the more he found that the abdominal muscles were involved and he thought that the lesions were as much primary there as in the limbs.—Dr. E. C. Williams (Bristol) read a paper on a case of Infantilism in a child, aged ten years, who had not grown since four years old. Her weight was 26 pounds and her height was three feet. She was awkward to manage and rather dirty in her habits. She could read her letters and count and answer simple questions fairly intelligently. There was no heart disease; she was free from congenital syphilis and rickets and she lost weight under thyroid treatment.—Dr. Carpenter drew attention to the association of infantilism in congenital syphilis with atrophied testicles. He suggested that Dr. Williams should make a rectal and bimanual exploration of the pelvic viscera and report upon the condition of the uterus and the Fallopian tubes and ovaries, as it would make the case more complete if that were done.—Dr. John McCaw (Belfast) read a paper on a case of Splenic Leukæmia in a child, aged 18 months. There was no history of syphilis and the patient was not rickety. The accessible lymphatic glands were enlarged. The spleen reached to the umbilicus and the liver also. The urine was loaded with oxalates and contained a trace of albumin. There was intense leucocytosis; the lymphocytes reached 99 2 per cent. of the leucocyte count. The red corpuscles were diminished by more than half and a few nucleated corpuscles were seen. The hæmoglobin was 39 per cent. She subsequently developed purpura and died soon afterwards. The spleen diminished in size very considerably before death and was not nearly so hard as it was previously to the touch. The swelling of the lymphatic glands disappeared to a large extent and they were not so hard.

ILFORD MEDICAL SOCIETY.—A meeting of this society was held on May 7th.—Mr. C. W. Mansell Moullin read a paper on the Treatment of Fractures into Joints and Sprains at the present day compared with that which was in vogue a few years ago. Formerly a Pott's fracture was put up in splints or in plaster-of-Paris for four or five weeks without being moved or touched in any way and as a result when the limb was taken down and the patient was assured that the fracture had united the limb was quite useless. It was cold, heavy, and stiff, all the muscles were wasted, the tendons were glued down to their sheaths, the joint could not be moved, and if the limb were used at all or allowed to hang down it became swollen and painful at once. It often took longer for the patient to recover from the effects of the treatment than it did for the fractured bones to unite. In Colles's fracture the results were even worse. Not only the wrist but the fingers were left stiff and painful so that the hand was helpless and useless. The knee, if the patella were broken, was more fortunate, for owing to the wide gap left between the fragments stiffness was not so common unless, as occasionally happened, the upper fragment became glued to the lower end of the femur by adhesions. In sprains, when, for instance, the internal semilunar cartilage became displaced or torn, the effect was just the same. The knee became cold and stiff as a result of the treatment. It had to be massaged and douched for weeks before it regained anything like its full range of movement and sometimes it never did so, especially in a hysterical girl. Rest was undoubtedly necessary for broken bones or torn ligaments to unite, but absolute rest, combined with uniform pressure, uninterrupted for weeks together, was thoroughly bad for every other structure in the limb—thoroughly bad even when there had been no injury, and worse still when there was a large amount of extravasated blood and effused lymph filling up all the interstices and matting everything together. In the treatment of a fracture leading into a joint the object was to replace the fragments in their natural relation and to keep them there until they were joined. But the extravasation of blood and the effusion of lymph must be checked as soon as possible. All that had been poured out already must be absorbed and driven into the lymphatics as soon as it could be. The muscles must be prevented from wasting. The joints must not be allowed to become stiff and the nutrition, the blood-supply, of every structure and tissue in the limb must have as much attention paid to it as the union of the broken bone. This could only be accomplished by systematic massage, begun very quietly and gently the day after the accident and continued every day, doing a little more each time until the swelling had entirely gone and the joint could be moved by the manipulation through almost its full range. There were some cases in which the injury was too grave or the patient was too violent, but these were very few; and even in them the line of treatment must be the same although it could not be carried so far. The limb must be placed upon a splint so contrived that it could be exposed thoroughly by removing a bandage without risk of displacement. In a Pott's fracture this could be readily done by means of a back splint with a moveable foot-piece. In a Colles's fracture a Carr's or a Griffith's splint answered in the vast majority of cases provided that the fragments had once been got into good position, but in many only a guttapercha wristlet was required. A fracture of the patella, on the other hand, required wiring. Mr. Mansell Moullin stated that for many years past he had wired every case of fractured patella and had never had a moment's uneasiness about them. No splint at all was necessary. The knee was bandaged after wiring and the patient was placed in bed and encouraged to move it about. At the end of eight or nine weeks patients treated in this way were able to walk, to run, to kneel, or even to kick with the injured leg. The massage might be carried out by an experienced nurse but as a rule, at first at any rate, the surgeon should do it himself.

BRITISH GYNÆCOLOGICAL SOCIETY.—A meeting of this society was held on May 14th, Dr. Heywood Smith, the President, being in the chair.—Dr. H. Macnaughton-Jones, using the epidiascope, showed Sections of Ovaries removed from patients who had for years been sufferers from incurable dysmenorrhœa. The sections (prepared by Mr. G. L. Eastes) showed a condition of cirrhosis and cystic degeneration throughout the entire substance of the ovary, the capsule being considerably thickened and the cellular elements

being almost indistinguishable in parts.—Dr. Macnaughton-Jones also showed a Uterus with the Adnexa removed by Professor Bumm's method. A carcinomatous mass occupied the fundus but the cervix was quite free from disease. The advantage of the operation (which Dr. Macnaughton-Jones had already described in the Journal of the society bearing date February, 1902) consisted in the rapidity with which it could be performed and its absolutely bloodless nature. Also there was no danger of wounding the ureters and the vault of the vagina could be dealt with according to circumstances. The operation was suitable to such a case as the present or comparatively small myomata or certain forms of malignant endometritis or deciduoma.—Mr. Charles Ryall confirmed Dr. Macnaughton-Jones's statements as to the bloodlessness and rapidity of the operation.—Mr. F. Bowreman Jessett, Dr. William Duncan, Dr. Mansell Moullin, and the President, while expressing their interest in Professor Bumm's method, concurred in the opinion that the uterus could be removed as quickly and with as little loss of blood by ligaturing the broad ligaments without forceps and they thought that the presence of such a number of the latter must be a disadvantage.—Dr. Bedford Fenwick showed two Enlarged Ovaries which had been adherent to a fibromatous uterus extending nearly to the ensiform cartilage and had therefore been removed with it. In a large number of hysterectomies he had found more or less gross disease of nearly every ovary and tube and if that were the case generally he thought it would be a grave error not to remove the ovaries with a diseased uterus.—Dr. Herbert Snow said that pain, though mainly due to tension of the capsule, might also arise from peritonitis or pressure.—Mr. Jessett, Dr. C. H. F. Routh, Dr. F. A. Purcell, and Dr. Duncan, while agreeing that the amount of disease shown in the sections quite justified the removal of the ovaries, spoke strongly in favour of conservative measures and of the importance of preserving a portion of even one ovary.—Mr. Jessett opened the discussion of his paper on Intestinal Obstruction, a rare complication of Ectopic Gestation, which was read at the last meeting. He said that owing to the pain being entirely above the umbilicus the case had been diagnosed as one of diaphragmatic pleuritis. The patient when he saw her had all the symptoms of intestinal obstruction. She had not been pregnant for nine years and her menstruation had been regular until, five days previously, she was suddenly seized with pain between the umbilicus and ensiform cartilage and became collapsed. An operation was performed but death ensued the same night.—Dr. Mansell Moullin said that he had met with two somewhat similar cases.—The meeting concluded with some further demonstrations from the epidiascope.

BRISTOL MEDICO-CHIRURGICAL SOCIETY.—The eighth meeting of the session was held in the Medical Library, University College, Bristol, on May 20th, Mr. G. Munro Smith being in the chair.—Mr. John Chiene, professor of surgery, University of Edinburgh, gave an address on Movement, laying special stress on the importance of voluntary movements in the treatment of fractures and sprains.

Reviews and Notices of Books.

Therapeutics of Infancy and Childhood. By A. JACOBI, M.D., LL.D. Third edition. London and Philadelphia: J. B. Lippincott Company. 1903. Pp. 560. Price 18*s.* net.

IT is probable that the first edition of Dr. Jacobi's "Therapeutics," which was published in 1895, was not extensively read in this country except by those who make a special study of the diseases of children. Times change, however, and the industry of American authors and publishers has introduced so many excellent medical text books to the notice of our own students that it has become a fashion among us to rely on American publications for much of the information which is necessary for our professional education. In no department of medicine is this confidence in American books better justified than in those which are concerned with the diseases of children. Dr. Jacobi may fairly be regarded as the father of pediatrics, and although he is better known to fame as a clinician than as a writer, owing to the respect with which everything which he has to say on the subject of treatment is received in this country, it may safely be assumed that the present edition of his "Therapeutics" will be far more widely read than was the case with the former editions. The volume under review is a systematic and complete treatise on the therapeutics of childhood and it is by no means confined to medical subjects but includes the treatment of a number of conditions which more usually come within the province of the surgeon. For instance, anatomical deformities, congenital luxations, fractures of bones, hernias, and hydrocele all receive the attention of the author. Although the various conditions are seldom illustrated by cases, nevertheless, without this popular method of making a work on therapeutics interesting, the author contrives to hold the reader's attention by the vigour and directness of his style.

Dr. Jacobi, as is well known, is no great believer in drug treatment and much of his advice depends on the application of prophylactic measures and dietetic and hygienic management. He appears, however, to have faith in the administration of arsenic and phosphorus in the treatment of cases which depend on constitutional dyscrasias and neurasthenic states. Dr. Jacobi, in common with many other experienced clinicians, has certain prejudices in treatment. For instance, his confidence in decoctions of cereals and dextrinised flours in the routine feeding of infants appears to us to be put on a higher pedestal than it genuinely deserves. We do not imagine that there are many authors who would contest with him his right of priority in the usage of these diluents, nor do we regard the question as of sufficient importance to make it a ground for dividing the medical world into two classes, the faithful and the unfaithful, those who believe in cereal decoctions and those who do not. The truth is that in experienced hands success in the feeding of infants can be achieved either with or without the assistance of any diluents other than water. Another matter with which we have greater sympathy is the free administration of water to infants and children as a routine practice. This is a humane and scientific precaution which is too often neglected. Another point which Dr. Jacobi urges is the superiority of cane sugar as opposed to milk sugar and he adduces arguments in favour of the former which we do not consider to be convincing. On the subject of cream the author's views do not agree with those which are generally held. He minimises the troubles of nutrition which may arise from a deficiency of this element and we cannot help thinking that he exaggerates the dangers which are likely to accrue from excess. For instance, he apparently regards the production of rickets as almost independent of starvation as regards fat. He considers over-alimentation as at least as dangerous as under-alimentation in the production of this nutritional disorder and in this latter contention we are disposed to agree with him, although this view is not generally held.

In discussing the question of difficult dentition we notice the statement that "dentition is a physiological process" and that "the long period of dentition is also the time of many disorders and diseases which are not easily diagnosticated and may tempt the practitioner to suggest or accept a diagnosis of difficult teething," and further he says, with an undercurrent of sarcasm, that "there are, fortunately, practitioners who prefer making a diagnosis of the real condition of the ailing baby, and that and its improvement or cure comprise the main treatment I recommend for *difficult dentition.*" The aphorism that dentition is a physiological process is a meaningless truism which has crept into one text-book after another until practitioners almost hesitate to ascribe any of the conditions