

quently operated on by Mr. Pollard. The cavity was incised at the anterior extremity of the right second space, one inch from the sternum. Large quantities of gangrenous lung and putrid fluid were expelled through the wound. The cavity reached down to the sixth rib. A counter-opening was made in the sixth space, flanged tubes inserted, and a blue wool dressing applied. Next morning the child was much relieved, nearly free from cough, expectorating small quantities of frothy sputum almost free from odor, and practically free from pain, which had hitherto be enmost distressing symptom. The cavity was washed out daily once or twice as occasion required. At the end of a week the washings deposited a copious sediment of pus. The improvement, however, was not maintained. The temperature, pulse, and respirations remained high, fetor of breath re-appeared on the tenth day, and the patient sank rapidly three days later. A huge cavity occupied the anterior third of the right lung. It was lined for the most part with a thin layer of granulation-tissue. At the inner margin the necrotic process had invaded the pericardium and set up acute pericarditis. The œsophagus was firmly adherent to the right bronchus, and a narrow sinus, about three-quarters of an inch long, led from a minute valve-like opening in the œsophagus to a small ragged opening in one of the main divisions of the right bronchus. There were no signs of tubercle or of caseating or suppurating bronchial glands. The gangrene was undoubtedly due to the passage from the œsophagus into the lung of some irritative material (probably decomposing foodstuffs) along the sinus above mentioned. Whether this sinus was the remains of a glandular abscess or was caused by the passage of some pointed foreign body from the œsophagus was doubtful. The limitation of the gangrene of the anterior region of the lung, and the implication of all three lobes in a single cavity, were worthy of notice. Pericarditis appeared to be a rare complication of pulmonary gangrene. The indications for surgical interference were sufficiently clear,—viz., imperfect communication of the gangrenous area with the bronchi, failure of expectant treatment, and signs of a cavity in an accessible situation. The amount of repair which took place under unfavorable circumstances was very encouraging. An earlier operation might have saved the life of the patient.

Mr. Godlee mentioned a case of gangrenous cavity at the apex of one lung, which was opened and drained; the pleura was not adherent, necessitating the sewing of the pulmonary to the costal pleura before the abscess was opened. The child died in two days, and then it was found that another gangrenous cavity existed in the opposite lung.

Dr. Broadbent said he only saw in one case an attempt made to reach a gangrenous cavity in the base of the lung; but no relief followed.

Dr. Barlow related a case of gangrenous mediastinal abscess involving the lung by extension, and into which a sinus led from the gullet; probably the gangrene was secondary to perforation of the gullet by a foreign body. In cases of gangrene due to a discharge of a bronchial abscess into a bronchus, the œsophagus has not been in communication with the abscess cavity.—*Therap. Gaz.*

THE INFANT FOOD PROBLEM.

In the January issue is a very interesting and useful paper on this subject, taken from *The Sanitarian*. We now copy from the same source the following leading facts obtained in reply to questions on this subject, submitted to Dr. Eustace Smith, of London; Dr. J. Lewis Smith, of New York; Dr. Victor C. Vaughan, of Ann Arbor, Mich.; Dr. George H. Rohé, of Baltimore; Dr. F. Forchheimer, of Cincinnati; and others.

1. In the case of an infant, or a child under ten months of age, deprived of breast-milk, the artificial substitute provided should be made to correspond with human milk as closely as possible, both in its chemical constitution and in its physical characters.

2. Fresh, unadulterated cows' milk, when properly prepared, is an acceptable substitute for breast-milk. But since the casein of cows' milk coagulates in a heavy, dense mass, white breast-milk curd is light and flocculent, some expedient must be resorted to in order to make the former resemble the latter, so that the digestive powers of the infant shall not be unduly taxed. The casein of cows' milk, according to Dr. Eustace Smith, as the rule, traverses the infant's alimentary tract and may be found unchanged in the fecal discharges. It is therefore a constant source of irritation, and often gives rise to diarrhoea and entero-colitis. One of the most decided advances in dietetics in modern times, is the preparation of cows' milk with the aid of digestive agents, as in the method recommended by Professor Frankland. In this method the casein of a portion of the milk is first peptonized by fresh calves' rennet, and to this is added a portion of fresh milk, after heat has been applied to check the process and to prevent complete predigestion; some milk-sugar is finally added, and thus a mixture is obtained which closely approximates human milk in its chemical composition. It has, however, been found to serve as an efficient substitute, where the mother's milk is of poor quality, is inadequate in quantity, or is entirely wanting. The special feature of this method is the peptonizing of only a part of the casein, with the employment of heat at a certain stage to arrest the process so that the food shall not be completely digested. The addition of the carbo-hydrate (milk-sugar in this case) is necessary,