and under the sterno-mastoid muscle. All Schmitz's cases were less than two years old; thirteen of them less than one year old.

The symptoms are quite peculiar. Respiration is laboured, carried on through the half open mouth, and attended by a loud snoring noise. The noise made by breathing is unlike that observed in croup, and very much like that in enlarged tonsils. The neck is stretched out; the head somewhat bent backwards. There is a sense of fulness, or even actual swelling, in the neighbourhood of the angle of the lower jaw. Milk returns through the nose and month. Inspection of the throat is not easy; when the tongue is depressed by a spatula, the infant chokes, and the fauces become filled by regurgitated milk or mucus. Under favourable conditions, a prominence can be seen in the posterior pharyngeal wall. Palpation, by means of a finger passed into the fauces, is much more decisive; in a few seconds the presence, position, and size of the abscess can be made out. In every case of dyspnœa in an infant, without obvious cause, the possibility of retropharyngeal abscess should be considered.

The result in the sixteen cases was as follows: thirteen recovered perfectly, one was lost sight of, two died. One death was sudden, and attributable to œdema glottidis (the abscess having been opened); the other child was neglected by its mother, and died of marasmus.

Spontaneous bursting of the abscess is usually fatal from the pus entering the larynx. Resolution never occurs.

The treatment consists in opening the abscess by the knife. Whether the opening be made in the pharynx, or in the neck, or in both, depends upon circumstances. An opening in the neck should be avoided if possible. Seven times Schmitz made the opening in the pharynx only, thrice in the neck only, and five times in both places. He uses a conveniently guarded knife, the blade of which is uncovered at the very time it is wanted, and then covered again; so that all possibility of accident in introducing or withdrawing the knife is avoided. At the moment when the knife enters the abscess, the tip of the left forefinger is used to depress the epiglottis and shut the larynx.

CASE OF ACUTE BRIGHT'S DISEASE WITH URÆMIA.

By Dr, Loomis, New York.

The following history shows the effects of a hypodermic of morphine in uræmic intoxication, coming on during the acute stage of parenchymatous nephritis:—

J. B., a young man, 23 years of age, of temperate habits, free from hereditary or acquired tendency to disease, early in February, 1869, came under my care with acute Bright's disease. Three weeks previous he had been thoroughly chilled after an exposure of two or three hours on one of the docks on a damp, chilly day.

From that time he did not feel well, suffered more or less from headache, loss of appetite and nausea. Ten days before I first saw him, he had noticed his face swollen on rising; at the same time he noticed that his urine was scanty and darker than usual. He had sent for me to relieve the pain in his head, which he described as terrible.

On examination I found his feet and legs, as well as his face, slightly œdematous; his pulse was 110, and irritable in character; skin hot and dry. He said that he had passed no urine since the previous night, but at my request voided about four ounces of smoky-looking urine which was highly albuminous; it was not examined microscopically. I ordered him to be dry-cupped over the lumbar region, a hot-air bath, and a large saline cathartic.

When I next visited him, twenty-four hours after, all his previous symptoms were aggravated. The œdema was increased; he had passed little urine, none for ten or twelve hours, and his bladder was empty; pulse 120, headache still severe, vision imperfect, was restless and at times delirious; dyspnœa not severe.

As the hot-air bath had produced very little diaphoresis, and his bowels had not moved, I ordered him one grain of elaterium, to be followed by an enema in four hours, and half an ounce of the infusion of digitalis every two hours.

At four o'clock the next morning, six hours after, I was summoned to him with the statement that he was in a convulsion. When I reached him he was semi-comatose; his friends said his convulsion lasted twenty minutes. His bowels had not been moved. I immediately administered a large enema of spirits of turpentine and oil, which was soon returned without any fæcal discharge. His muscles began to twitch, he became restless, his skin was dry and hot; pulse 130 and small. Fearing another convulsion, I administered hypodermically fifteen drops Mag. sol. morphine. Gradually the muscular twitchings ceased, he became quiet, and passed into a heavy sleep. I remained with him. In about two hours after the administration of the hypodermic, his surface was covered with a profuse perspiration, and his breathing became more natural. He could be aroused, and would swallow when fluid was placed in his mouth; four hours after with a catheter I drew off five or six ounces of highly albuminous urine, which contained blood and granular casts. Six hours after, I commenced the administration of the infusion of digitalis, a tablespoonful every two hours; he was sleeping quietly, perspiring freely, could be easily aroused. I then left him.

At my next visit, ten hours after the administration of the hypodermic, I found him sleeping, skin moist, pulse 100, could be easily aroused and drank freely of milk. At my request he passed six or eight ounces of urine; his bowels had moved freely twice.

From this time, under the daily administration of digitalis and mur. tinct. ferri, and a milk diet, he went on to complete convalescence.

This was a somewhat rare case of acute parenchymatous nephritis occurring independent of any known blood-poison.

It shows in a striking manner how difficult it is to get the action of diaphoretics, diuretics, and cathartics, when the symptoms of *acute uræmia* are present in such cases, as well as their failure to prevent the occurrence of convulsions. The administration of a full dose of morphine, at apparently the most unpromising period in the history of the case, not only seemed to prevent an impending convulsion, but aided in the establishment of a saving diaphoresis and diuresis.

THE SOURCES OF ERYSIPELAS.

Mr. Howse, in a recent clinical lecture (*Guy's Hospital Gazette*), discusses the source of the poison of erysipelas. In a large number of cases in the wards of a hospital the poison was no doubt absorbed from the wound made on the patient by a surgical operation. Mr. Howse thought that most of the cases might be prevented by the adoption of the antiseptic treatment at the time of the operation and afterwards. He had had scarcely any cases since he had applied it, now about three years ago, and in those cases in which he had had it, either the antiseptic treatment had not been used, or the cases were such that it was not possible to apply it effectually. For example, he had amputated a finger at the Out Patients' a few weeks ago; the spray was out of order, so it was done without; the patient caught erysipelas, and was at present in the hospital with it. Then, again, it was universally recognised by those who adopted antiseptic surgery, that cases of necrosis in which long sinuses ran in to the interior of bone quite out of reach, were such that it was very difficult, if not quite impossible, to apply the antiseptic properly. He had had one case of this kind last year. It was well-known to most of them, that we were at present passing through an epidemic of this disease. He was glad to be able to say that, with the exception mentioned above and one other case (an amputation in Cornelius Ward, in which the carbolic dressings had been left off ten days because the stump was nearly well), he had literally had not one single case of the disease. And this, although his patients had been lying next to affected patients, and his dressers having the care of Erysipelas Ward, passed frequently from the one to the other. Such facts, he thought, spoke volumes for antiseptic treatment. Country hospitals were not entirely free from erysipelas. Mr. Howse had lately visited a new hospital in a provincial town, and though it had not been open more than a few months, there were a great many cases of erysipelas in the wards. He was very much inclined to question the value of statistics published regarding the number of cases of pyæmia in many country hospitals, because owing to the fact that many patients were buried without any *post mortem* examination having been made, the disease was often overlooked.

GYNÆCOLOGY.

FRENCH PRACTICE IN THE TREATMENT OF VARIOUS UTERINE DISEASES.

1. *Ulcerations of the Neck of the Uterus.*—M. Lucas-Championnière states that at the Bureau Central des Hôpitaux, where consultations take place twice a week on a large number of women, he has had the opportunity of hearing some of the clinical remarks of M. de Saint-Germain. As a general rule this physician rarely employs