ing them blow out hard after each inspiration during the inhalation.

VII. The patient is, as a rule, anæsthetised and ready for the operation to be commenced when unconscious winking is no longer produced by touching the surface of the eye with the tip of the finger. The anæsthetic should never under any circumstances be pushed till the respiration stops; but when once the cornea is insensitive, the patient should be kept gently under by occasional inhalations, and, not be allowed to come out and renew the stage of struggling and resistence.

VIII. As a rule, no operation should be commenced until the patient is fully under the influence of the anæsthetic, so as to avoid all chance of death from surgical shock or fright.

IX. The administrator should be guided as to the effect entirely by the respiration. His only object, while producing anæsthesia, is to see that the respiration is not interfered with.

X. If possible, the patient's chest and abdomen should be exposed during chloroform inhalation, so that the respiratory movements can be seen by the administrator. If anything interferes with the respiration in any way, however slightly, even if this occurs at the very commencement of the administration, if breath is held, or if there is stertor, the inhalation should be stopped until the breathing is natural again. This may sometimes create delay and inconvenience with inexperienced administrators, but experience will make any administrator so familiar with the respiratory functions under chloroform that he will in a short time know almost by intuition whether anything is going wrong, and be able to put it right without delay before any danger arises.

XI. If the breathing becomes embarrassed, the lower jaw should be pulled, or pushed from behind the angles, forward, so that the lower teeth protrude in front of the upper. This raises the epiglottis and frees the larynx. At the same time it is well to assist the respiration artificially until the embarrassment passes off.

XII. If by any accident the respiration stops, artificial respiration should be commenced at once, while an assistant lowers the head and draws forward the tongue with catchforceps, by Howard's method, assisted by compression and relaxation of the thoracic walls. Artificial respiration should be continued until there is no doubt whatever that natural respiration is completely re-established.

XIII. A small dose of morphia may be injected subcutaneously before chloroform inhalation, as it helps to keep the patient in a state of anæsthesia in prolonged operations. There is nothing to show that atropine does any good in connection with the administration of chloroform, and it may do a very great deal of harm.

XIV. Alcohol may be given with advantage before operations under chloroform, provided it does not cause excitement, and merely has the effect of giving a patient confidence and steadying the circulation.

25. The Commission has no doubt whatever that, if the above rules be followed, chloroform may be given in any case requiring an operation with perfect ease and absolute safety so as to do good without the risk of evil.

EDWARD LAWRIE, (President),
T. LAUDER BRUNTON, G. BOMFORD, RUSTOMJI D. HAKIM, } Members.
EDWARD LAWRIE, Surgeon-Major.

Hyderabad, December 18th, 1889.

(True copy.)

A DISCUSSION ON FOODS FOR INVALIDS AND INFANTS.

In accepting the invitation you were so good as to address to me, that I should open a discussion in this important Section on the subject of foods for invalids and infants, I felt that you had asked me to deal with an unusually wide and comprehensive, although undoubtedly a most interesting and practical subject, and one which is very intimately associated with recent progress in therapeutics.

The subject is, however, so large, and extends over such a very wide field, both of observation and experiment, that I must ask you to allow me to remain strictly within my *rôle* of "introducer," and to content myself with pointing out a few topics which appear to me to be especially suitable for discussion in this Section, adding here and there a few observations of my own with the view of stimulating or provoking further expressions of opinion from those who may be able to throw more light on the questions involved than I am.

The connection between invalids and infants may not appear to some minds to be a very close one, and if I had had my own choice in this matter, I might perhaps have been disposed to "drop the infant," for my acquaintance with infancy is entirely uninterested and impartial, and is not complicated by claims of ownership. But if I cannot claim that direct and intimate association with the state of infancy which so many of you are, no doubt, able to do, I may, perhaps, for that very reason, be able to take a more calm and dispassionate view of its wants and its weaknesses.

There is, however, this very important connection between invalids and infants—namely, that they are commonly dependent on others for the provision or selection of their food, and it is for this reason, I presume, that we are invited to consider their food wants together.

And, first, with regard to the feeding of inva-