

1-6 to $\frac{1}{2}$ grain—of calomel may be placed on the tongue as often as every hour or half hour.

In some cases it becomes necessary to guard against diarrhoea, by the use of Dover's powder. Probably a systemic effect can be secured in this way quite as speedily as by inunction or subcutaneous injection. After a day or two of this frequent dosing, we may properly conclude that something of its constitutional effect has been secured. I would then suspend it for a time, or give it much less frequently.

In all instances where the croup is secondary to or a concomitant of, other diseases, and in feeble children, I think it safer not to give mercury at all. Prof. J. Lewis Smith, in his most excellent work on children's diseases, advises a mixture of chlorate of potassium and muriate of ammonium for these cases, and gives us the following formula :

Grammes.

R _x . Potassii Chlorate.....	4	3 j.
Ammonii Muriat.....	2.6	℥ij.
Syrupi Simp.....	fl. 30	$\frac{1}{2}$ j.
Aquæ.....	fl. 60	$\frac{3}{4}$ ij.

Misce.

R. A teaspoonful or two every half hour or hour.

While you are attending assiduously to the details of medical treatment, you will give some thought to the nourishment of your patient. If, in any acute disorder, support is necessary, it is so here. Probably there is little or no appetite, but the fever creates thirst, which should be assuaged, in part, by milk. Beef-tea and other fluid foods may be given, if desired, but milk is of more value than any of these.

Then as to stimulants, I advise an early resort to them. The labored breathing, the restlessness, and the enforced wakefulness, are so rapidly exhaustive, that they may properly be given from first to last. Do not think that the violence of the laryngo-tracheal inflammation contraindicates their use; on the contrary, it creates a demand for them. Some of the authors tell you that when the heart shows signs of failure, *then* resort to stimulants. But why wait for exhaustion? Why not try to prevent it? If stimulants are adequate to rally from a low condition, may they not, if given in time, forestall that condition? I believe it is proper to begin their use as soon as you feel certain that you have to deal with true croup. They may be given at first in small quantity and at infrequent intervals, but when the disease is as its height and the labor of breathing is great, you may use them with unsparing hand. The disease creates a tolerance of them. A child of from two to four years may take daily anywhere from fifteen to ninety fluid grammes, or from one-half to three ounces, of brandy or whiskey with only benefit.

But statistics are heavily against us in this disease, and it is more than possible that, in spite of our efforts, the condition becomes increasingly unfavorable. It is apparent at length that, without the intervention of surgery, the child must die.

The question of a resort to tracheotomy then presents itself and must be promptly decided.

Tracheotomy does not cure croup; it simply admits air to the windpipe below the point of obstruction. With time thus gained, the laryngeal inflammation *may* subside and the patient recover.

The death-rate having been high, the operation has never been a popular one, but it should be remembered that the mortality has been in spite of the operation, not because of it. As it is never entered upon until death seems to be inevitable without it, and as its performance under ether or chloroform is painless, I think we might well resort to it more frequently than we do.

Reports from some public institutions are quite in its favor. Of ninety tracheotomies in the children's hospital at Prague, nearly thirty-five per cent. were followed by recovery. This is a better showing, however, than most other institutions make, and far more favorable than statistics from private practice.

Age has its bearing on the success of the operation. The older the child, the better is its chance, because, mainly, the trachea and larynx are more developed. Under two years of age failure is the rule, though, like many rules in medicine, subject to exceptions.

There is a proper time in the progress of the disease for operating. You will be in little danger of resorting to surgery while there are still hopes of success through medical means. There is more danger of procrastinating until the patient is moribund. This mistake, has, I think, been sometimes made. As soon as lividity of the lips and fingertips shows that the blood is becoming surcharged with carbonic acid, then, and not much later, is the time for tracheotomy.

The probabilities of recovery after the operation are much lessened if there is coexistent bronchitis or pneumonitis; and, unhappily, one or the other is often present. Not only that; these diseases are often consecutive to the tracheotomy, and, in case of death, are prime factors in its causation.

To prevent the occurrence of these pulmonary troubles after the operation, attention must be given to the temperature and humidity of the air to be inspired. Since it is no longer warmed by passing through the nose and mouth, it should be warmed artificially from 85° to 93° Fahr.

A competent nurse should be constantly at hand, by night as well as by day, to regulate the temperature, to give necessary attention to the tube, and to administer proper nourishment at proper times. The difficulty of obtaining such help at an hour's notice constitutes one reason why tracheotomy in private practice compares unfavorably with the same operation in public institutions.—*Phil. Med. News.*

QUININE ENEMATA.

In a lecture on the treatment of malarial fever, published in the *Detroit Lancet*, Dr. Alonzo