

large statistical data which must have accumulated in the United Kingdom office would make a full disclosure, they would certainly produce a result not of merely statistical interest, but also of great public value.

ABORTIVE TREATMENT OF PNEUMONIA—The indications for treatment are exactly the same here that they are in an inflammation in any of the extremities. We must stop the engorgement and prevent the exudation; if that is impossible we must limit it to its lowest possible extent. We have, through the agency of some force the nature of which is not considered in this paper, a weakening or possibly a total suspension of vaso-motor control over the calibre of the small vessels in the lungs, and the result is congestion, then inflammation. This force must be met and overcome. We can strike directly at the cause and abort acute lobar pneumonia with as much certainty as we do the rigors of ague. If we can see the cause while the crepitant r le can be detected, in other words, while the exudation is taking place, we can stop it right then and there by the administration of ergot.

Give me Squibb's fluid extract of ergot, an oiled silk jacket and a mustard plaster, and I will treat successfully and in most cases abort more pneumonias than can be saved by the entire balance of the *materia medica*. I do not offer this treatment as something new or novel. The action of ergot upon unstriped muscular fibre, has been well understood for years. It has been used to control h morrhages in all parts of the body, where bleeding was due to relaxation of the arterial tone, with the most gratifying success. It has been found invaluable in h morrhages from the bowels, in fact it is the most universal and potent internal h mostatic known, the happiest results being produced in h moptysis by the hypodermic injection even when due to purpura h morrhagica. But, gratifying as these results have been, they cannot compare with the glorious results obtained by its timely and fearless administration in pneumonia. I mean by the term "fearless," a deliberate, conservative attempt to poison the patient with ergot. I have done this repeatedly, and long before the first symptom of ergotism appeared, the pneumonic inflammation has faded away like snow before the sun of June.—F. W. Epley, in *N. W. Lancet*.

INTUBATION v. TRACHEOTOMY.—Dr. Jerome Anderson, of California (*Occidental Medical Times*), says intubation of the larynx is a simple, easily performed operation. The head should be held erect, and strongly lifted, the epiglottis will then be elevated, and prevented from approximating too closely to the glottis. In this way one of the chief obstacles to rapid intubation will be overcome. The fear that the aperture may be too

small to permit the introduction of the tube is a pure chimera; long before this stage is reached a child dies. The danger of pushing loose membrane into the trachea need not be taken into account, because, if the child has reached the exfoliative stage without fatal asphyxia, it will hardly require intubation afterwards; and, in any case, nothing but awkwardness or the use of unwarrantable force could detach or push membrane before the tube. The proper after-treatment depends entirely on the recognition of the dual nature of the disease. Diphtheria of the larynx usually invades this organ some days after its appearance in the fauces, and after the first systemic fever, due to its ptomaines affecting the nervous centres, has partially subsided. Membranous croup is due to reflexion outwardly upon the larynx of a profound impression upon the nervous centres by a common "cold." The treatment of diphtheritic croup after intubation is simply that of diphtheria; the one absolute essential in the treatment of membranous croup in steam. As to the comparative merits of intubation and tracheotomy, Dr. Anderson, says there is absolutely nothing that the cutting operation does which will not be accomplished by intubation better and more surely. A table of 27 cases is given; 14 cases of croup, with 11 recoveries, and 13 of diphtheritic croup, with three recoveries. One case is recorded in which the intubation tube was swallowed, and remained in the intestinal tract fifteen days before being passed *per rectum*.—*Br. Med. Jour.*

DENTITION AS A FACTOR IN THE CAUSATION OF DISEASES IN CHILDREN.—Dr. A. Brothers publishes a paper on this subject in the *Archives of Pediatrics* for June, and makes the following observations:—Having kept carefully compiled records of about five hundred teething infants in private and dispensary practice, he believes that dentition is rarely, if ever, the direct cause of disease; moreover, precocious or retarded dentition may occur in otherwise healthy children of an entire family, but the period of protrusion of the first teeth occurs in healthy breast-fed children at six months and a half in the vast majority of the cases. Further, he concludes as follows:—The first dentition is usually complete from the thirteenth to the thirty-sixth month; dentition is distinctly retarded in the first as well as in the late teeth of children brought up on a mixed or artificial diet; congenital diseases, as syphilis, seem to have a retarding influence on dentition. Rickets has a very pronounced retarding influence on the whole course of dentition. Struma seems to hasten the eruption of the first teeth, but does not affect the later teeth. In cases of undeveloped brain there is marked retardation during the entire period of dentition. Chronic diseases have a retarding effect upon the first teeth, but do not seem to influence