There are some—perhaps not a few—who would object to this on the grounds—first, that apparently hopeless cases do sometimes recover; and, secondly, that death is sure to follow tracheotomy, either from an extension of the disease itself, or as the result of the operation, which has dangers of its own. Indeed, it is well known that some surgeons affirm the operation to be unjustifiable; while others, without going so far as this, deny the validity of any favorable arguments drawn from statistics, because, as they aver, the operation in the successful cases was performed so early that it cannot be said that recovery would not have occurred without it; or they dispute the nature of the disease, and declare that the successful cases were not membranous croup at all, but laryngitic or laryngo-tracheitis.

With regard to the first objection, it is pretty certain that whatever may be the case on the Continent, and especially in France, where the operation is performed at a much earlier stage in the disease than elsewhere, English practice is entirely against it; for, as the result of our own inquiries, it is clear that the operation is not often, if ever, had recourse to in this country until all hope of recovery without it has been abandoned.

The time at which the operation ought to be performed is when the voice is extinct, and the difficulty of respiration continues and increases, when the skin is becoming livid, the extremities are cold, and the anterior thoracic wall, especially the lower end of the sternum, sinks in on inspiration. It has been asserted by some of the advocates of tracheotomy that, in the absence or stridor, and when the chest-wall remains puffed out and the lungs seem full and distended, the operation is undesirable, as these signs, they say, indicate the extension of false membrane along the small bronchial tubes.

It may be questioned, however, whether these symptoms ought to contraindicate interference, for they may arise from an œdema or congestion of the lungs, the result of long-continued obstruction to respiration—a condition which, doubtless, impairs the chances of the operation, but does not render it useless, although it does suggest that the operation ought to have been earlier entertained. But the existence of congestion is no real contraindication; for its relief is facilitated by the increased freedom of breathing after tracheotomy.

Nor can the second objection be any longer supported, for many of the successful cases have occurred where undoubtedly there was false membrane present; and there are now numerous proofs that the false membrane can sometimes be removed by the surgeon, and sometimes expelled by the patient after tracheotomy has been performed. Indeed, it seems obvious, granting the presence of the membrane, that the best chance of getting it expelled is to open the windpipe—for is not this the recognized practice with other foreign bodies in the air-passages?

Some months ago we instituted an inquiry, by which we acquired sufficient information to show that there is a fair proportion of recoveries after the operation, whether we look to metropolitan or provincial, English or Scotch practice. We collected altogether from hospital and private practice eighty-nine cases of unmistakable croup and diphtheria, in all of which trache otomy was performed, and out of these thirty six recovered, and fifty-three died: which means that two patients out of every five operated upon recovered—a success by no means insignificant when it is remembered that the operation does not cure the disease for which it is done, but only affords a chance of life by postponing or averting death.

In several of these successful cases the true nature of the disease was shown by the escape or removal of false membrane. Last year we published (*Medical Times and Gazette*, July 17) a successful case by Dr. W. Richardson, of great value and importance, in which this occurred; quite recently another case, illustrating the same fact, was brought before the Medical Society of London; and in another column will be found the detailed reports of two similar cases, which have been recently under treatment in the Middlesex Hospital, in each of which tracheotomy was followed by the expulsion of false membrane and recovery.—*Medical Times and Gaz.*, Nov. 25, 1876.

ON SLEEPLESSNESS,

By Dr. J: Miller Fothergill, Assistant Physician to the West London Hospital;

[After reviewing the different forms of sleeplessness, Dr. Fothergill passes on to consider the chief forms of hypnotics in common use.]

To take opium first. Its use is rather indicated in conditions of insomnia which take their origin in pain. When there is vascular excitement present it is desirable to combine with it direct depressants of the circulation, as aconite or antimony. The subsequent cerebral anæmia induced by the resort to opium is not so pronounced as is that induced by chloral.

Hyoscyamus takes its place alongside of opium, and may be resorted to in cases where opium or morphia disagrees, as in cases of chronic renal disease. For this last class of patients the tincture of hop is often very serviceable, though now rarely prescribed; it is a very satisfactory agent in such cases.

Hydrate of chloral is comparatively valueless in sleeplessness due to pain, and is inferior, in this respect, it is said, to the croton-chloral-hydrate. It is, however, very useful in conditions of vascular excitement, either alone or in combination with opium. In the delirium of acute pyrexia in children it may be usefully combined with the bromide of