point of fracture. A broad band is now passed around the body near the top of (and including) the long splints, and another broad band under the nates, leaving a hole for defæcation. The upper band keeps the child in the recumbent position, and supports his back when he is taken up; and the lower one supports the nates and thigh when he is taken up, and may be stitched on each side to the long splint. In most cases a soft and flat perineal band may also be applied with advantage; and it is of importance to look at the back splint daily, and maintain it in its place.

In this way the broken limb may be kept straight and quiet, and the patient can be removed at any moment, have his bed changed, or even be carried out of doors. In children of five or six, or older, extension by means of a pulley can be added if required—using about three pounds for a child of four, and one additional pound for each additional year. Fortunately these bones unite quickly (generally in three or four weeks); but it is prudent to keep on the apparatus five or six weeks, and not even then allow the child to walk. "If you follow my directions carefully, and take the proper pains, looking after your patient daily, you will always get straight legs, and in most cases there will be no perceptible shortening, what little that may occur never causing the slightest halt in the gait. This has been my uniform experience since I began to use this dressing, and I have used it now for more than twenty years."—*Med. Times and Gazette.*

PUERPERAL SCARLATINA.—C. M., AGED 28, primipara, was delivered of a living female child of ordinary dimensions on October 21st. The labour was tedious, lasting about thirty-six hours. The head presented; the placenta and membranes came away entire in twenty minutes, the uterus remaining firmly contracted. The mother did uninterruptedly well until 10 P.M. on the night of October 26th, when she complained of sore-throat and slight shivering, and vomited repeatedly. On October 27th, she was feverish, restless, delirious during the night; the vomiting continued; the lochia were very scanty and extremely offensive; there was total suppression of milk. Light-coloured offensive stools were passed two or three times during the day. Her mother, at 10 A.M., noticed her face and hands to be of bright scarlet colour, but omitted to examine her body. On October 28th, she had been very delirious the preceding night. Her medical attendant saw her at 11 A.M., for the first time after the morning of October 26th, and found her covered all over a well maked scarlatina rash. Temperature 103.2 deg.; pulse 128. At 7 P.M., the temperature was 104.6 deg. On October 29th, she was very restless and delirious in the night until 2 A.M., when she became quiet.

I saw her for the first time at 9.30 A.M., and found her lying on her back, with dilated pupils, face pinched, lips bluish, the tongue was dry and brown; the throat dusky red; the whole of her body, with the exception of the face, was covered with a scarlatinal rash of a dusky scarlet colour; there were purpuric spots about the extremities; the hands and legs were of a bluish colour; the muscles were very soft and flabby. There was no tenderness or distension of the abdomen. She was pulseless. Temperature 105.2 deg.; respirations 48, shallow, laboured, and sighing. She was conscious, and, when asked if she felt any pain, answered in the negative. At 11.45, she was unconscious, the whole of her body assuming a livid colour. Temperature 107.4 deg. She died at 12.20. No *post mortem* examination was allowed.

REMARKS.—It is an interesting case, inasmuch as the woman lived long enough for the scarlatina to fully develop itself. It bears out the opinions of Drs. Snow, Beck, Meadows, and others, "that scarlatina does not change and produce only 'malignant puerperal fever,' but it retains its specific characters in the parturient woman." (W. T. Haines, M.R.C.S., *London Lancet.*)

[A case almost exactly similar to the above occurred in this city a short time ago. The rash appeared on the first day after confinement and the patient died on the 7th day ———.]—ED. L.

DIAGNOSIS OF THROMBOTIC OCCLUSION OF ONE OF THE CORONARY ARTERIES.—Dr. A. Hammer, Professor of Surgery at St. Louis, at present at Vienna, publishes in the *Wiener Medezinische Wochenschrift* (February 2) an account of a case in which the above condition was diagnosed and verified by *post mortem* examination. The man, 34 years old, strongly built, had for the past year suffered from slight attacks of articular rheumatism, but no valvular affection of the heart had occurred. For four weeks previously to his being seen by Dr. Hammer, a very sharp attack of acute rheumatism had existed, but had gradually improved, and convalescence was proceeding. One day he got out of bed, and sat in an easy chair. In about an hour he suddenly collapsed, his pulse was 40, his lips pale and a little cyanotic; there was slight dyspnœa, but no pain. Five hours later his pulse beat only 23 to the minute, four hours later 16 to the minute; and when Dr. Hammer arrived (the previous observations having been made by the family medical attendant) the pulse was only 8 to the minute, a cardiac contraction occurring every eight seconds. There were no symptoms or signs of disease in the nervous or respiratory systems; percussion of the precordia showed no abnormal dulness. On auscultating the heart, the sounds were not accompanied or replaced by any murmur, but following them there was a tremor of the heart perceptible to the ear, conveying the idea of a clonic spasm, which lasted five seconds, the cardiac