could not be trusted to hold the tip of the child's tongue, small and slippery, with firmness. Perceiving that a darning-needle lay threaded on a pincushion, I thrust the needle through the tongue, and directed forcible traction to be made on the loop of thread, whilst artificial respiration was recommenced. Never do I recollect a case, of like character, where signs of animation appeared so quickly; which, since they vanished on relaxation of the tongue, and reappeared at once on the renewal of traction, were clearly due to that proceeding.

I venture to attach the greatest importance to forcible traction on the tongue, as a preliminary to artificial respiration in the newly born, not merely having tested the efficacy of the plan on subsequent occasions, but having read in an article in Holmes's *System of Surgery* (third edition) that Sir Joseph Lister considers it invaluable where life is jeopardised by inhalation of chloroform.

But a careful consideration of the arguments which this great surgeon adduces to prove his view that "the beneficial effect of this procedure cannot be explained mechanically, but must be developed in a reflex manner through the medium of the nervous system" (*op. cit.*, vol. iii, p. 604) fails, to my mind, to convey conviction of the stability of the theory, since it seems more probable that, in chloroform-poisoning and in the asphyxia of new-born babies, the laryngeal apparatus is flaccid, owing to paralysis of its muscular apparatus, caused in the former instance by the specific action of the anæsthetic, and, in the latter, due to previous disuse.

If this explanation be accepted, nothing is easier to understand than the frequent failures which follow artificial respiration, when the tongue has been previously withdrawn from the mouth, and the success which attends Silvester's method (the precaution having been adopted) as a means of resuscitating the newly born, or of preventing death from anæsthetic poisoning when solely threatened by laryngeal obstruction.

Should death appear imminent from causes other than laryngeal obstruction, only one method remains which can possibly avert dissolution—when the respiratory movements have ceased, when the circulation has stopped or is stopping, when galvanism has failed, and when the administration of diffusible stimuli, either in the form of inhalation or *per cutem*, would be useless—namely, the intravenous injection of fluid (medicated or otherwise), accompanied, under most circumstances, by simultaneous depletion. Five points would thus be gained; first, the re-establishment or the maintenance of the circulation; secondly, the removal of part of the poison, and dilution of the remainder; thirdly, where loss of blood had occurred, repletion of the vascular system; fourthly, the opportunity for administering a physiological antidote, e.g., in the case of chloroform, ammonia; and, fifthly, the employment of the most powerful cardiac stimulant with which we are acquainted.

It may be added, in support of this method, that last summer, when about to commence an experimental transfusion (*vide Lancet*, September 1st, 1883), by the kind permission of Dr. Pye-Smith, in his laboratory at Guy's Hospital, I noticed that one of the animals, deeply under the influence of mixed narcosis, seemed on the point of expiring, but re-animation speedily followed the performance of the operation.

The report of a fatal case of inhalation of ether, from St. George's Hospital, by Mr. Holmes (*BRITISH MEDICAL JOURNAL*, March 15th, 1884, p. 508) is my excuse for calling attention to this plan of treatment.

ENTERIC FEVER FROM CONTAGION.

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THE following notes on an outbreak of typhoid fever, which recently came under my notice, will, I think, be read with interest by those who are still gathering arguments in favour of the contagion-theory of the above disease. The village of Greendale, with a population of about one hundred all told, is about thirty miles from this city, and is situated partly in a valley, and partly on the sloping ground rising from one side of a watercourse which runs through the valley. This watercourse, in the dry season, is merely a chain of waterholes. The cottages are irregularly distributed, and every one is separated from its neighbour by a distance of from fifty to two hundred yards. The water-supply is chiefly from the creek, though some of the residents have wells; and a few collect their roof-water in iron or galvanised tin tanks. Only a few of the more important dwellings, such as the school-house, hotel, and store are provided with closets; and these are generally separate from the house, and are ordinary cess-pits, except at the school-house, where the excreta are received into

receptacles, which are emptied when necessary, and the contents buried. By the great majority of the inhabitants, the calls of nature are responded to in the most convenient spot in the vicinity of their dwellings, and household slops and refuse of all kinds are in most cases thrown out of the back door. There is thus every opportunity, during the summer, for noxious odours and vapours to rise around the dwellings, and, during the rainy season, for the fecal and other accumulations on the surface to be washed down to the creek, or to be carried directly, or by soakage through the soil, into the wells and water-holes at a lower level. Yet, in spite of all these unwholesome conditions, which have always existed, the schoolmaster informed me that to his certain knowledge there had been no case of typhoid fever for the last eight years, and, on inquiring for me amongst the oldest inhabitants, he could not find any record of a single case having ever occurred before.

The three nearest settlements are respectively six, seven, and seven miles distant.

The first case of the disease occurred in a girl named H., aged 22, who had been servant in a house in Melbourne where the complaint existed at the time she came home (March 14th). She became delirious; and took to bed seven days after arrival, and was over two weeks before showing any signs of improvement. Her mother sickened eighteen days, her sister (aged 19) sickened twenty-two days, and her brother (aged 23) twenty-seven days after her arrival, and all went through regular attacks of typhoid fever. They were all remarkably strong and healthy before. They lived in a small cottage on the slope of the hill; the pigstye was a few yards from the house; slops and refuse were thrown out at the back; excreta were also thrown out at the back during the time of sickness, and not covered with earth. Their water-supply was from the creek, but after the first member of the family became ill they got it from the school-house tank.

A child, P. (aged 4), living two hundred yards lower down the hill, took the fever six weeks after H.'s arrival from Melbourne. The P.'s got their water from a well close to their house, and their milk from the H.'s. The next attacked was Mrs. M., who used to go and nurse the eldest H. girl and her mother. After about three weeks of this self-appointed task, she complained of pain in the head and back, and shivering; and, though she did not lie up, she felt unwell, and suffered from diarrhoea. The M.'s lived on the slope of the same hill as the H.'s, but three hundred or four hundred yards on one side of them, and not much below the same level. Their water-supply was from a zinc roof, and collected into an iron tank; and their milk came from a dairy several miles away.

Mrs. M.'s little girl, aged 3 (the only child), sickened a few weeks after her mother gave up nursing the H.'s, and went through a rather severe attack of the fever. In fact, all the cases narrated were severe attacks except Mrs. M.'s.

Mrs. M.'s child was the last case of which I heard. The cessation of the disease I attribute to the fact of a heavy and continuous rainfall occurring just after she became ill, which flooded the surrounding country, and no doubt washed away the remaining germs of the disease.

CLINICAL MEMORANDA.

CASES OF FACIAL ERYSIPELAS WITH LOW TEMPERATURE.

DR. CAVAFY'S article, under the above title, in the *BRITISH MEDICAL JOURNAL* of March 29th, I have read with much interest, and especially because certain points discussed therein have recently engaged my attention in preparing a paper on the contagiousness of erysipelas, which appeared in the *Practitioner* of December last.

In that paper I stated my conviction—a conviction based upon some exceptional opportunities of observation—that "in cases of facial erysipelas, as they ordinarily present themselves in practice, whatever secondary varieties may exist, there are primarily two distinct forms to be dealt with, viz., the infective and the non-infective forms, or, as the distinction may otherwise be expressed, true genuine erysipelas and spurious or pseudo-erysipelas." I added, "Without venturing to indicate in what ratio these two forms stand to one another as to frequency of occurrence, I am quite sure that I have again and again seen and treated cases of the latter—cases in which the local affection has followed exposure to heat or cold, or other injurious influences, and the fever and general disturbance have been comparatively insignificant. Mr. Jonathan Hutchinson, in his paper 'On Certain Diseases Allied to Erysipelas,' clearly recognises their existence when he says, 'These forms of erysipelas, which are due to local irritation are, I think, almost always mild.' It is when the disease is due to contagion that it assumes its greatest severity."