

other depressants, which not only retard the resolution of the morbid phenomena, but to which I largely attribute the subsequent debility and protracted convalescence which characterise so many cases of this ailment.

INFLUENZA IN AN INFANT, COMPLICATED WITH HYPERPYREXIA.

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I was asked to see baby P., aged 4 months, on March 18th. He had been ailing for two days with a slight cough, which evidently gave him pain; he was restless and peevish, and "his skin was hot." The temperature was 101°; the pulse good at 98; there was good deal of coryza, and he was evidently tender generally over the body as he cried when handled; the bowels were a trifle over-active and the motions curdy; examination of the chest revealed moderate bronchial catarrh. The mother and another child were suffering from influenza of a mild kind, with symptoms akin to those of he baby.

Confinement to one room, a simple sedative diaphoretic mixture, and careful regulation of the diet were ordered, and everything seemed to progress favourably until the evening of March 20th, when violent general convulsions supervened at 8 P.M. As I live some distance away, a doctor living quite close was called in in the emergency. He treated the baby skilfully and with success, the convulsions being subdued in two hours. However, they returned again at 2 A.M. on March 21st, and I was sent for. I arrived at 3 A.M. and found the baby generally convulsed. I gave a whiff or two of chloroform and 5 grains of bromide of soda, the former bringing relief for a time, but the convulsions returned as its effect wore off. The temperature in the rectum was 107.6°. To make sure I took it again with another thermometer, and the same point was reached. Here, then, we evidently had the cause of the convulsions; and now the question arose, how was this temperature to be brought down?

A bath was got ready, the water being comfortably warm to the hand (I regret there was not a bath thermometer in the house), and the child, completely stripped, was put in, the water covering him almost entirely. At this time his respirations were 90 per minute, and pulse about 200. By the addition of cold water the bath was now somewhat quickly lowered until a point was reached at which it felt decidedly "cool." Gradually the child ceased to twitch, the respirations fell to 35, and the pulse to 110 a minute, at the same time becoming fuller and better. The following is the record of the temperature:

4. 5 A.M. temperature in the rectum ...	107.6° F.
4.10 A.M. " " " " ...	105.0° F.
4.15 A.M. " " " " ...	103.2° F.
4.20 A.M. " " " " ...	101.0° F.
4.30 A.M. " " " " ...	99.0° F.

At this point he was taken out, and he immediately fell into a sound sleep, in which I left him.

I visited him again at 11.30 A.M., when I was informed he had slept soundly for four hours or so, but since he awoke had gradually become restless and hot. The temperature had risen again to 105.6°, the respirations to 90, and the pulse to 180, so I again had recourse to the cold bath.

11.30 A.M. temperature in the rectum ...	105.6° F.
11.35 A.M. " " " " ...	105.0° F.
11.40 A.M. " " " " ...	104.5° F.
11.50 A.M. " " " " ...	102.8° F.
12. 5 P.M. " " " " ...	101.6° F.

As he was getting pinched-looking at this point he was taken out, and while he was evidently relieved of all his urgent symptoms to a considerable extent, the effect of the bath was not so marked as on the previous occasion; he slept for two hours and then relapsed into much the same state as before. I saw him again the same evening at 9.45, and as his temperature at this time was 106°, I repeated the cold bath, with the following results:

9.50 P.M. temperature in the rectum ...	106.0° F.
10. 0 P.M. " " " " ...	104.6° F.
10.10 P.M. " " " " ...	102.8° F.
10.20 P.M. " " " " ...	101.0° F.

was now obliged to take him out as he was getting

pinched-looking and cold. I saw him the following morning; he had a restless night, and was now evidently weaker. The temperature was 104.6° and the pulse 180. Careful examination of the chest revealed nothing but moderate bronchial trouble, there being no evidence of pneumonia to be found. He became gradually weaker and died the same evening, quietly and without any return of convulsions. With the exception of the convulsions brain symptoms were absent throughout. After the first bath 1-grain doses of quinine hydrobromate and phenacetin were given every three hours, but without effect on the temperature.

ON THE REMOVAL OF ADENOID VEGETATIONS IN THE NASO-PHARYNX,

WITH A DESCRIPTION OF A NEW FORM OF SCRAPER.

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That most excellent early form of scraper suggested by Dr. Hartmann, of Berlin, I have employed since its invention some years ago, but it now seems to me to require some modification. Hartmann's scraper is stirrup-shaped and triangular in form; the double semi-sharpened edge being set at somewhat less than a right angle to the shaft, pointing towards the posterior nares.

It frequently happens that vegetations exist in such a position in the naso-pharynx that the non-scraping portion of the instrument is presented to them, and it is only by awkward manoeuvring that the scraping edge can be brought to bear on the vegetations lying behind, and in some cases below, the scraper when *in situ* behind the soft palate.

I have tried to design a scraper which would be quite blunt towards the soft palate, and set at an obtuse angle on the shaft. It presents a semicircular scraping double

edge, which can by an alteration of pressure be made to scrape with its presenting curve upwards, backwards, and even downwards, attacking adenoids even occupying the pharynx at the same introduction of the instrument. I have used it now frequently, and find it quite comes up to my expectation. In some instances I have removed with it large pendulous vegetations, for the removal of which I have previously invariably employed Loewenberg's forceps. Whatever form of scraper we use, these forceps must continue to be required in removing some of the growths effectively.

I believe that to remove post-nasal adenoid vegetations effectively an anæsthetic must be used, and, after some years of trial, I have come to the conclusion that ether, skilfully administered by means of Clover's inhaler, is the best and the safest. I never allow the patient to be put deeply under its influence, and certainly never get rid of the cough reflex. It is wise to recollect that frequently these conditions are associated with nasal stenosis and confirmed mouth breathing, and that greater care than usual is needed in the administration of the anæsthetic.

I used to operate with the patient's head hanging back over the end of the operation table; but I found that there was a danger of asphyxia from bending of the trachea over the cervical vertebrae in persons with long necks; in fact, I observed in some cases that the patients ceased to breathe when the head was thrown back over the end of the operation couch in the position chosen by some operators. I find that a safe and convenient position is to remove all pillows on a level couch and allow the head of the patient to roll over

towards the operator to the right, so that the right hand of the operator may be used whilst his left steadies the head.

The instrument I have suggested is readily introduced behind the soft palate, and, used as I have described, a few rapid and well-directed lateral movements suffice to scrape

