the writer has seen the operation done the day after birth, but as a matter of practical Nursing, she should advise its postponement until after the shedding of the cord, which is our baby's first trouble, and it is best to take them *one* at a time. The opposite surfaces of the notch are sometimes brought together by simple suture of surgical silk, or by needles and silver wire. As far as a limited experience goes, I have seen better results from the former, and it seems less irritating to the infant. There is always slight loss of blood, and some of it gets into the mouth and is swallowed, and passes through the bowels, so Nurses must be prepared for that contingency. After the operation, baby's arm will have to be fastened down to prevent the hands from reaching the wound, and this slight though necessary restraint always appears to be trying to our little patient, for, when awake, his arms are in continual motion, generally in the direction of his mouth, and any attempt to interfere with these doubtless salutary movements, results in "cries"—the baby has yet to be born who likes having his arms "pinned down," but in this case, unfortunately, we must not regard his wishes, for we have to secure the arms. There are two ways of doing this, either by fastening them *straight* down the sides of the body with a bandage or a silk handkerchief, or to tie them behind the back, which in my judgment is preferable, it can be done in this wise :—Take a yard and a half of tape or sarsanet ribbon—you can cut it shorter if necessary—not *less* than an inch wide, cut the ribbon in half, *double* each length and make a slip-knot on each, pass the loop over the hand and outside the sleeves of the bed-gown to just above the elbow, and drawing upon the two open ends of the ribbon, tighten the loops in such a way that it does not *close upon the arm*, nor can it possibly slip off, when you have tied the four ends of the ribbon in a bow behind the back, just sufficiently tight to prevent the arms being raised to the mouth, but allowing of a certain amount of movement in the forearms and hands.

Our next care is the feeding of our little patient; this will have to be done from the breast, or with a spoon, for the hard disc of the feeding bottle presses upon the wound, but the *nipple* can be grasped between the gums, and the *point d'appui* for the tongue being the nipple which is *inside* the lip, suckling can be gone on with, and if the mother does not suckle, a wet Nurse should be procured, for this and similar operations of a severer kind, in the interests of the baby. Spoon feeding is of course more troublesome, and less satisfactory. I have told you, in previous papers, how to spoon-feed the newly-born, so need not repeat the directions.

We have touched upon the simplest form of hare-lip, but the malformation sometimes is intensified into what is called the double hare-shorn lip, the fissures extend close into the nostril, the gums show between the rent, and at the time of birth *appear* to be attached to the nose; this peculiar effect adds greatly to the disfigurement caused by the lesion, and this again can be complicated with another and more serious malformation, *cleft palate*, when a communication is formed between the oval and nasal cavities, and this greatly adds to the anxiety and trouble of the Nursing duties. As regards the palate, nothing can be done by surgery during infancy, nor, in fact, until adult life, with good results, but the lip can be rectified. We may have cleft-palate without hare-lip, hence no external disfigurement. I have mentioned in an early paper, that when you wash out the infant's mouth at birth, you should pass the bulb of your little finger up to the roof if there is a cleft you discover it at once; failing this, it is only found out by the milk returning through the nose when the infant is put to the breast or bottle. Occasionally the *soft* palate is the seat of the lesion, and it can only be detected by examining the mouth ; and now increased difficulties in feeding arise, and the milk runs out of the mouth instead of down the throat ; in rarer cases still, the cleft extends through the *soft and hard* palate, and the risk of choking adds to the troubles of feeding—the lesion to the soft palate is not amenable to surgical treatment, and, as a rule, infants so afflicted are rarely reared, as far as the writer's experience goes ; eight to ten weeks is the span of their lives—as the infant gets older you cannot get sufficient food into the stomach to support life, and the little victim dies of slow starvation. By what I have just brought before their notice my young Nursing readers can see that altogether cleft palate is more serious to deal with than hare-lip, even in its severe form. It also affects the articulation for life. Speech is due to the vibration of the vocal cords, but the normal palate which should be *high* vaulted may be likened to a sounding board, giving resonance and *clear* articulation to the voice.

There is another point to bear in mind with regard to our little patient in cases requiring operation—the effect of shock. Speaking generally, we may say that operations are detrimental to infantile well doing, and whilst sparing no efforts to minimise the evil, we must bear it in mind ; these remarks apply more to the home than the Hospital, because, in a surgical sense, the operation *per se* is successful and complete, but the writer has known many instances where the infants did not permanently overcome these troubles, and hence have not been reared.

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