been already affected. The only thing which will do this is careful nursing.

It is possible that many nurses who may read this paper have no recollection of what diphtheria was before the introduction of antitoxin, just about ten years ago, when local treatment of the throat—often very energetic—was freely used. It was, in truth, a disheartening disease to treat. Only the mildest cases got well at all, and in nearly all the severe ones the larynx was involved, and it was necessary to open the windpipe in order to prevent impending suffocation. Moreover, something like 70 per cent. of these tracheotomised cases died from extension of the membrane down the windpipe into the smallest recesses of the lungs. Now, this would no longer be a correct picture of the disease. For one thing, children do not, as a rule, die straight off in the acute stage from heart failure, or rather, heart poisoning; also, after antitoxin has been given, extension of the membrane from the tonsils to the larynx, or from the windpipe to the lungs is uncommon.

But the introduction of antitoxin has brought with it a danger that we may take the disease too lightly, that the nurse, in fact, may think that it is antitoxin, and not her own skill that will be responsible for the child's recovery; or that if it dies, it will be due to an insufficient dose of antitoxin having been given in the first place.

Now, this is not true. In point of fact, the nursing matters very much. One sees, especially in private practice and in hospitals where a "special nurse" has charge of the case, these little patients made worse by thoughtless, though well-meaning fussiness, and it is quite common to see a case in whom antitoxin has been given too late in the course of the illness for it to be any good, pulled through by the skill and patience of the nursing.

In what, then, does the nursing consist? Firstly, in sparing the patient's circulation as much as possible; and, secondly, in treating promptly any emergencies that may occur in the absence of the physician.

Complete rest is necessary in all cases of diphtheria. Almost all children require to be kept in bed for at least three weeks, and even then, after a careful examination of the heart, it is often impossible to feel sure that it will be safe to allow the patient to sit up. What this rest, however, means to the patient depends entirely on the nurse.

To come to details:—The first and most important point is that the rest shall include the stomach also, not merely the child's muscles. One of the most depressing things that can happen to the circulation of a patient who is suffering severely from diphtheria is vomiting, and I have repeatedly seen an attack of sickness change the aspect of a case in a few hours. Sometimes a child will die during the first act of vomiting, but if this does not occur, the circulation may receive a shock from which it may take weeks to recover.

This vomiting may be excited, and usually is, by the mischievous ignorance which has been described as a virtue by the phrase "getting in the quantity," or, in other words, attempting to force milk, or other food, or, worse still, nauseous mixtures of patent meat extracts and port wine down the throat of a child who does not want them, and who shows that it does not, by any means in its power. The food should be given, in practice, in small quantities, and the child should never be woken up to be fed. There is no danger in practice of his getting too little food for his requirements. To take an actual example, one pint of milk in the twenty-four hours is quite sufficient for the average child of four years. It will very soon ask for more of it can digest it, but, in practice, it will usually not emulate Oliver Twist in this respect.

Milk is not always the best food, as it sometimes disagrees, and may have to be supplanted by albumen water, with or without a little glucose. Often nasal feeding, if skilfully performed, is less tiring to the child that constantly swallowing small quantities of fluid. Incidentally, the time spent in learning by constant practice how to give a nasal feed without upsetting a child will never be regretted, though it may not, perhaps, be so interesting as watching someone else operate, and talking about it afterwards—a process which is occasionally described on the prospectus of the advertising nursing home as "skilled surgical nursing." The former, however, is infinitely more difficult, though it may be lacking in glamour.

The next point is to remember the effect of the position of the patient on the circulation. The ideal attitude is one in which the head is the lowest part of the body—that is to say, where the patient lies flat, with the foot of the bed raised some 3 or 4 in. But this position cannot be borne by some children, and it is then a great mistake to enforce it, as the worry and struggling is worse for the patient than the advantage gained by the lowering of the head. Some children will sit up, and they should be allowed to. A child should, incidentally, never be tied in a cot, or restrained by any mechanical contrivance.

If sudden fainting occurs, action should be prompt; one thing, and one thing only should be done. The child should be picked up by the heels, and held so with the head hanging straight downwards; merely lowering the head will not do. If this is ineffectual, someone else should apply a sponge or towel wrung out of hot water to the chest, over the region of the heart. All this should be done before and not after the doctor has been sent for. A mistake that is commonly made by the nurse is to give stimulants, either by the mouth or hypodermically; the disadvantage of this, in the case of heart failure from diphtheria, is that they are not absorbed in time for them to be of any use.

In convalescence, and especially when a child is

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