beginning to sit up, the utmost vigilance is necessary; the slightest paleness of the face or blueness of the lips should be regarded as a danger signal, and the patient should be promptly inverted for a few minutes, and then put back to bed. In hospital practice, incidentally, a careful nurse will feel the pulses of all the convalescent patients at least three times a day, conveniently just before each meal.

Patients who have had tracheotomy performed demand some special mention, firstly because it is especially necessary that they should have complete rest, and also because emergencies requiring prompt treatment sometimes occur. The usual tendency is to worry these patients by unnecessarily changing the inner tube. In reality, provided that the tube is sufficiently large, the inner portion of it only requires changing sufficiently often to prevent its sticking to the outer part, and this will be but seldom if the secretion is sufficiently free and the cough vigorous. Especially when a "special" nurse has been in charge, I have known the inner tube changed whenever the child coughed. It should hardly, nowadays, be necessary to say that a feather should never be pushed down the tube to clear it; the usual result of the use of this septic irritant is broncho-pneumonia. After tracheotomy, most children attempt to make up arrears of sleep, and it is most important that they should not be hindered by undue fussiness on the part of the nurse.

The after treatment of these cases may then almost be summed up in the aphorism, "Don't interfere," but occasionally emergencies will arise, and then the "interference" should be prompt.

The chief of these is obstruction of the tube by a piece of membrane, or thickened secretion. In the first place, provided that the tube is of adequate size, this very rarely occurs. When it does, however, there cannot for one minute, be any doubt as to what has happened; the child is making convulsive efforts to breathe, and has all the appearances of suffocation, but no air is either entering or leaving the tube. This can be ascertained by holding the palm of the hand, moistened, if necessary, just over the orifice of the tube.

When this occurs, the first thing to do, obviously, is to take out the inner tube. In most instances, the obstructing mass will come out with it. Should this not have any effect, however, it is clear that the outer tube is blocked also, and then the nurse should, without hesitation, cut the tape, and take out the outer tube also. She should then gently attempt to hold the margins of the wound in the windpipe apart with a tracheal dilator, or if this is not handy, with the loop end of a hair pin. Even if she does not succeed, the child will be able to go on breathing, to a certain extent, through the undilated slit, but it cannot obtain any air at all through a blocked tracheotomy tube.

Nowadays steam tents are not usually employed after tracheotomy, but should one be ordered, it will be as well to remember that the object of the steam is to moisten the air that the child breathes, not the bedclothes. Only a very small jet of steam should be used, and that should be as near the tube as possible, though in this case care should be taken that the child's skin is not scalded. It is very difficult, however, to ensure these ideal conditions, and, in practice, what usually happens is that the child dislikes the steam, and is therefore restless, and its clothes often become saturated with moisture.

When a steam tent is not used, the air may be warmed and moistened by keeping a sponge wrung out of hot water over the mouth of the tube if the secretion is inclined to be sticky, but usually the best method is to lay a pad made simply of four folds of antiseptic gauze over the tube; the ends can be loosely tucked into the tapes that hold the tube in position.

When the tube is taken out the child will probably be nervous, and it is important that this nervousness should not be apparent in the nurse also; and here again, much harm is done by fussiness. In nine cases out of ten it is best for the nurse to go out of sight of the child, but not out of earshot. She will very soon know when things are going wrong by the alteration in the child's breathing, but the constant presence of a fussy nurse is, I am sure, often responsible for an attack of laryngeal spasm, that makes it difficult for the child to do without the tracheotomy tube.

Much can also be done by the nurse when the tube has been out for some days in teaching the child to use its voice again. In this some children are very obstinate, and a great deal of patience and tact is necessary.

So it will be seen that the nursing of a case of diphtheria is a very simple matter in theory. I do not mean to suggest, however, that it is so in practice. I have only indicated the lines on which it should run, and the art is certainly not to be learnt by "doing fevers" for six months or a year at a fever hospital. In practice it is always harder to hold one's hand than to use it, but it is just this "masterly inactivity" that makes for success. And the success is worth having, for it does not mean merely the patching up of someone with a chronic ailment, but the complete restoration to health of a child, with a life of possible usefulness before it.

QUEEN ALEXANDRA'S IMPERIAL MILITARY NURSING SERVICE.

The undermentioned Staff Nurses to be Sisters:—Miss A. R. F. Auchmuty, Miss S. K. Bills, Miss B. N. Daker, Miss G. Knowles, Miss C. Mackay, Miss W. G. Massey, Miss B. Rennie, Miss M. Worthington.

The undermentioned Staff Nurses are confirmed in their appointments:—Miss G. M. Allen, Miss K. M. Bulman, Miss E. Foster, Miss M. E. M. Grierson, Miss A. M. Orchard.

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