Even medicine can be made palatable by assistance from sweets or fruit to forget the nasty taste.

There is no better education for an ailing child than the care of something weaker than himself—a kitten, a little dog, or chickens, who have to be fed at special times, and whose eggs have to be collected, and the date marked on each; a 'bird's larder,' so easy to fix and keep in order in front of the window where he spends most of the day, is a wonderful fund of amusement, and 'tits' and 'finches' so soon lose their first panic and become friendly. Then there is 'flower lore,' their habits, names, peculiarities, and many a dreary hour in the winter can be filled by going through the flower book, where all the blossoms of each month are pressed and named."

PURULENT BRONCHITIS: ITS INFLUENZAL AND PNEUMOCOCCAL BACTERIOLOGY.

Doctors Adolphe Abrahams, Norman F. Hallows, J. W. H. Eyre, and Herbert French present, in an instructive paper in the *Lancet*, new facts on a definite type of disease of the respiratory system which they have observed, whilst they have been engaged in military practice in the Aldershot Command, to which they apply the designation of "purulent bronchitis," on account of the characteristic nature of the expectoration. The affection has a very high mortality, very much higher than that of lobar pneumonia, and there are features and circumstances which suggest an epidemic nature.

A Typical Case of Purulent Bronchitis.

A typical case is as follows. The onset is usually acute; the early symptoms are those of a "cold in the head." The temperature may be 101° or 102° F., but there are no features to distinguish the condition from acute "coryza" or febricula, so that in the majority of cases the patient does not report sick for two or three days, by which time he is sent to hospital. At this stage two features attract particular attention. First, the character of the expectoration: this consists of thick pale yellow dollops of almost pure pus, not the frothy expectoration familiar in ordinary bronchitis; it has no particular odour, and it becomes increasingly abundant until in a day or two it may amount to several ounces in the 24 hours. Secondly, the rapidity of the patient's breathing: this may be so evident that pneumonia suggests itself, yet on examining the chest the only physical signs consist of few or many rhonchi scattered widely, but most marked at the bases of the lungs behind, associated with wheezy vesicular murmur; resonance everywhere is unimpaired and bronchial breathing is absent. The characters of the temperature, pulse-rate, and respiration-rate are exemplified below. A little later a third point attracts notice: a peculiar dusky heliotrope type of cyanosis of the face, lips, and ears, so characteristic as to hall-mark the nature of the patient's malady even on superficial inspection. By this time dyspnœa is very pronounced; respiration consists of short, shallow movements, which in bad cases amount almost to gasps, reminiscent of the effects of gas-poisoning. Recovery at this stage may occur, but by the time the cyanosis has become at all pronounced the prognosis is extremely bad, though the number of days the patient may still live in spite of the severity of his distress is often surprising. The character of the sputum remains the same throughout, though sometimes it is blood-tinged, or actual blood may be expectorated instead of, or in addition to, the more typical pale yellow pus. In the later stages of the illness areas of impaired note or of actual dullness may be found, particularly over the posterior aspects of the lungs, associated with bronchial breathing and crepitant râles. These may be due to the progression of the purulent bronchitis into hypostatic pneumonia, or into actual broncho-pneumonia at the bases; or, on the other hand, they may be due to massive collapse of the lungs secondary to the bronchitis and obstruction of the bronchioles by pus. In a few cases, not necessarily the most serious, a frank lobar pneumonia has developed later, and has been followed by an empyema from which 15-30 ounces of thin pneumococcal pus has been aspirated—in one case alone was resection of a rib unavoidable. The condition, however, is not primarily a lobar or a broncho-pneumonia, but a bronchitis, and although a small amount of basal broncho-pneumonia has been present in one or two of our post-mortem examinations, in other fatal cases there has been no broncho-pneumonia at all, not even the smallest portions of either lung being found to sink in water.

The observers have no doubt that the condition is primarily an affection of the bronchi and bronchioles, and not of the alveoli, though the alveoli may be affected later if the patient survives long enough. In a typical post-mortem examination it would be difficult, or almost impossible, to define the actual cause of