inces provide for free serological investigations and free drugs.

Organized and co-operative teaching of syphilis in medical schools is of the greatest importance. A few theoretical lectures presenting the basic principles combined with practical work in syphilis clinics, would be of the greatest value in making the young practitioner of the future familiar with all phases of this disease; its detection, management, treatment and prevention. Postgraduate courses would keep the practitioner informed of new developments in chemotherapy and public health measures.

Teaching hospitals could fulfill an important function by establishing diagnostic clinics to which the practitioner might send complicated and obscure cases for complete examination and diagnosis and for suggestions regarding future treatment and management.

While the control and the ultimate eradication of syphilis is necessarily a slow and complicated process, congenital syphilis represents a fairly simple problem. It is first and foremost a preventable disease which, if detected early enough and sufficiently treated, could be stamped out now. The means of prevention have been at our disposal for years, all that remains is to make use of them. With the continuing progress in medical science and especially in view of the encouraging results obtained from the use of penicillin, therapeutic problems in the treatment of syphilis are gradually becoming more simplified. Of the venereal disease problem as a whole, which is a matter of such profound concern to every thinking person in this country at the present time, prevention of congenital syphilis is one aspect which offers a comparatively quick and easy solution. If we have not yet reached a point where the effects of syphilis can be prevented in later life, at least children need no longer be born with it.

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RÉSUMÉ

L'ignorance des mères syphilitiques, la négligence de certains médecins, le laisser-aller de beaucoup de contaminés sont les causes de la persistance d'un mal dont la disparition est indûment retardée. Le praticien a déjà beaucoup de facilités dans les voies du diagnostic et du traitement; il faudra cependant, maintenir sa curiosité scientifique et le tenir au courant des nouvelles méthodes d'investigation et de traitement. Les hôpitaux devront aider le praticien dans les cas compliqués de sa clientèle. La syphilis congénitale, dans ces conditions ne devrait plus exister. JEAN SAUCIER

Case Reports

REPAIR OF CONGENITAL DIAPHRAGMATIC HERNIA IN AN INFANT

By Anna Wilson, B.A., M.D. and K. R. Trueman, B.A., M.D., M.Sc.(Minn.)

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Diaphragmatic hernia in infants is rare. When present, however, it is a dangerous condition and according to Hedbloom, 75% of such cases die before the first month of life has elapsed. Many cases doubtless pass unnoticed and the condition continues to be compatible with life and normal living. However, in infants persistent cyanosis, unusual dyspnœa and perhaps vomiting and feeding difficulties should suggest the possibility of diaphragmatic hernia interfering with the physiology of the cardiac, respiratory, and digestive systems. The suspicion should be heightened if physical examination or a roentgenogram of the chest reveals a displacement of the heart to the right. A special x-ray examination for hernia is then indicated.

The treatment for diaphragmatic hernia in the newborn is early surgery. Where there is fear that the infant will not tolerate such a procedure, and where there is no progressive deterioration, it is reasonable to carry it over a critical interval with careful nursing until it is better prepared. Nevertheless the danger of strangulation of the bowel, of acute pulmonary failure, occurring in the presence of impaired respirations, etc., make the case an uneasy one to watch placidly. Surgery undoubtedly carries a high risk of mortality in this type of case, and surgeons may be deterred by a previous failure or by an unsuccessful case heard of elsewhere. Such a failure may depend upon the condition found at operation. Very large defects in the diaphragm are sometimes present, defying closure even when the most skilful and elaborate plastic procedures are employed. On the other hand, a defect may be encountered quite amenable to repair and then a simple operation is all that is necessary for a cure. The following case illustrates this point:

Baby P., male, was born on February 2, 1944, of a primiparous mother following a Cæsarean section performed by one of us (A.W.). The mother had had pre-eclamptic toxæmia, necessitating hospitalization on two occasions. She went into labour several days

before term. The reason for intervention was fetal distress after 24 hours of labour, as revealed by irregularity of the fetal heart sounds. Immediately after birth the infant's condition was satisfactory. When it was placed in the nursery, however, it became blue and dyspnœic and the administration of oxygen was necessary. Feeding difficulties were soon encountered, the baby refusing to eat and regurgitating what was introduced into the stomach by means of a catheter. On the sixth day, the fear of aspiration of fluid at feeding time led to a more careful examination, together with a chest film. This revealed that the heart was displaced markedly to the right and the lower half of the left lung was replaced by what appeared to be either an unusually high diaphragm or a diaphragmatic hernia.

A barium meal on the eighth day revealed the stomach and duodenum to be in the abdomen, but the small bowel was seen to be occupying a large part of the left side of the thorax (Fig. 1).

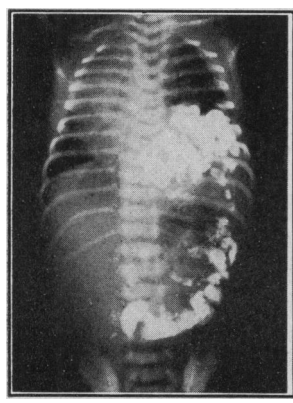

Fig. 1

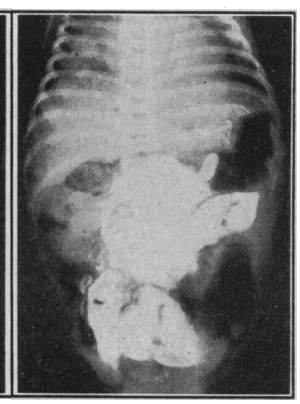

Fig. 2

Despite periods of rapid and often laboured respirations the general condition of the infant remained satisfactory. After an initial weight loss of five ounces it began to gain and by March was restored to its original weight. A month after birth its condition was considered satisfactory for operation.

On March 3, a preliminary left phrenicotomy was performed in order to immobilize the diaphragm on that side. The object of this procedure was to simplify the reduction of the hernia at the later second stage. Also the immobility gave more assurance of good healing when the diaphragmatic defect should be closed. The phrenic nerve was found through the usual supraclavicular approach. After crushing the nerve a fluoroscopic examination of the chest revealed the left diaphragm to be paralyzed. There was no substantial change in the patient's condition following this operation.

A week later a laparotomy was undertaken through an upper left rectus incision, using ether anæsthesia. As was already known, the stomach was entirely below the diaphragm. In the dome of the left side of the diaphragm, and somewhat posteriorly was an opening about two inches in diameter. Through it the whole of the small bowel and the greater part of the large bowel, excluding the cæcum and the sigmoid, had reached the thorax. In addition, the spleen was found above the diaphragm. A most difficult organ to identify above the diaphragm was the left kidney, which it is expected has rarely been found in the chest, and no satisfactory explanation as to its unusual position is available.

As soon as the chest was emptied of its abdominal contents the aperture in the diaphragm was closed. As is the rule in this type of case, there was no hernial sac to remove. The repair was effected by the application of four interrupted heavy silk sutures. Prior to tying the last suture of the closure an effort to reduce the left-sided pneumothorax by aspirating the air was made. As no intratracheal tube had been used, the lung could not be inflated as would otherwise be possible. The closure of the abdomen was made somewhat difficult by the unaccustomed presence of the viscera in that cavity.

The postoperative course was uneventful. The heart had occupied its normal position a few days after the operation and a chest plate revealed the left lung had expanded. Feedings were taken well and a satisfactory weight gain resulted. Dismissal from the hospital was three and a half weeks after the operation at which time the weight was eight pounds, one ounce. A barium meal recently revealed the small bowel to be within the abdominal cavity. The left diaphragm had regained its function (Fig. 2).

MEDIASTINAL ABSCESS*

By J. Carl Sutton, M.D., C.M., D.A.B.S.

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Mediastinal abscess is a pathological condition which is not frequently encountered. It is accompanied by very distressing symptoms, which are primarily respiratory distress associated with dysphagia. The condition is often of short duration and death frequently results from delay in recognition and, as in this case, possibly from improper choice of anæsthetic.

Whilst mediastinal infections are more common than one suspects, according to Neuhof,[1] they still are relatively infrequent. In 113,098 admissions at the Montreal General Hospital from 1933 to 1943 there were 21 cases of mediastinal infections from all causes. Even presuming that a goodly proportion were diagnosed improperly, there were only 15 cases in 2,908 autopsies during this period, in spite of their high death rate and our high percentage of autopsies (60%).

The most common sources as reported by Neuhof[1] were infections of the neck and traumatic perforations of the cervical and thoracic œsophagus. A peri-œsophageal abscess appears to be the first phase after perforation of the œsophagus.

INDICATIONS FOR OPERATION

It seems to be the consensus that in any perforation of the œsophagus from instrumentation

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