the left lung. The râles are some sonorous and some sibilant, formed in the larger tubes, and indicating a process of bronchitis of these tubes. With this there are heard, in a number of points over the front and back, coarse sub-crepitant râles. Very careful percussion shows that at several points in the left lung resonance is not perfect as compared with the resonance of the points immediately around them; not that it could be called flat, but simply less resonant than over the unaffected lung.

The patient is ordered home and to bed. The disease passes on through a stage, attended by a moderate degree of fever of rather a remittent type, with a rise in the evening to 102° or 103° and a fall in the morning to about 101°; never entirely disappearing. This is attended with a good deal of perspiration; the skin is relaxed, the cheek of the affected side is flushed, and the patient loses flesh very rapidly; he becomes extremely anæmic; the tongue is foul and coated, but the appetite is pretty well preserved; the secretions are scanty, as in all inflammatory or febrile affections; the urine scanty and high coloured, and the bowels are constipated. The cough is troublesome, and is attended with considerable expectoration, at first of clear mucus, not rusty coloured, but soon becoming streaked with yellow lines, and gradually more solid and purulent in character.

The physical signs remain as I have described them, except that the râles gradually become larger and more moist, and are heard over the whole of the left lung, back and front. With this there is scarcely any dulness on percussion over the lung, and it is only by very careful examination that you will find four or five points of limited size, where there is distinct relative impairment of resonance. You would be surprised at the great disproportion between the numerous râles and the amount of dulness and the absence of pure bronchial breathing.

As the case advanced, the lower portion of the lung cleared up, the râles gradually diminished, and the respiratory murmur returned; but at the apex there remained râles, which became larger and larger, until they finally became almost bubbling in character, the respiratory murmur slowly became more blowing in character; diffused, hollow, blowing breathing.

Now, what has been the course of the disease in the lung? We have had originally a catarrh affecting the bronchial tubes. This has extended along the left bronchial tube until it has reached and involved the alveolar structure, and thus set on foot a broncho-pneumonia of the left lung. Such changes are very insidious in their course, and the disease may exist for a long time before being discovered.

Catarrhal pneumonia is to be distinguished from bronchitis by its unilateral character, the presence of sub-crepitant râles, the detection of small areas of dulness, by careful percussion, and by the degree of febrile action. The exudation is not of a croupous but of a catarrhal character; the walls of the alveoli have been attacked so that the cells are no longer able to rapidly get rid of the exudation. It takes a long time to accomplish this, so that at the end of six or eight weeks râles may still continue at the apex of the lung. A portion of the exudation undergoes cheesy degeneration, breaks down, and is discharged slowly.

Will it ever be removed, or will it pass into a state of catarrhal phthisis? This will depend upon the violence of the attack and the tendency of the individual. Every one is liable to an attack of catarrhal pneumonia, and in any one, owing to the causes before referred to, it may set on foot catarrhal phthisis. Of course, in a person who has a weak state of constitution, particularly if he has an inherited weakness and tendency to lung disease, or if his health has been broken down by any of the debilitating causes of which I have spoken, an attack of less severity will be able to start a catarrhal phthisis in his lung. We may have this disease running a very rapid course, and terminating in from six weeks to four or five months, with all the evidences of a catarrhal pneumonia, passing into a chronic form, with marked fever, night sweats, and breaking down of the lung tissue, and the patient slowly sinking, and finally dying. These are cases of galloping consumption, or acute catarrhal phthisis. There are one or two symptoms occurring during its course to which I shall allude more particularly toward the end of the hour.

In the more common form the disease is not usually so severe or general from the beginning;