cerpitant râles and the tubal souffle. You were in presence of a central pneumonia which took four days in reaching the periphery of the lung. In these cases the diagnosis ought to be made at once, for in no other disease will you find a unique chill followed by pain in the side with a temperature of 39° (102·2° F.), and 40° (104° F.) at the second and third day.

Another case may present itself: it is that in which a patient, already attacked with unilateral pneumonia, will be taken with double pneumonia towards the fifth or sixth day of his illness. Let us suppose, for example, that we have a left pneumonia. All has proceeded regularly. Your patient is better, the temperature is falling, and nothing causes you to foresee a complication. The next day, that is, on the fifth, you take the temperature, and you are surprised at finding it still 39°, 39°5 (102·2°—103.°1 F.) You question the patient, who says he is getting better. There is no quickening of the pulse, nor increase of cough, nor pain in the side, the dyspnæa is not more pronounced. On auscultation you find always your crepitant râles and tubal souffle. In a word, the patient is better, the temperature alone does not satisfy you.

The next day, not only the thermometer still marks 39° (102·2° F.) but the evening before it had marked 39·8° (103 6° F.), and yet the patient feels always just as well. Be not deceived by what he tells you, seek—auscultate on the right, and most often you will find there the explanation of the maintenance of the temperature at 39° (102·2° F.) A *second pneumonia* (mark that I do not say secondary) will have declared itself. A single fact may put you on the track of this second pneumonia; put the same thermometer in the left axilla, the side in which existed the first pneumonia, then in the right axilla; if the two temperatures are sensibly equal, there will be a double pneumonia. It will happen even that the first pneumonia being on the way to resolution when the other begins, the temperature will be less elevated on the side of the first, than on the side of the second. These second pneumonias, which are shown in about one-fifth of the cases, are not grave, and in no way hinder the recovery of the patient: they are rather hyperæmic than frankly phlegmasic pneumonias.

A third variety of pneumonia may present itself, as to its situation: it is pneumonia of the apex, whose prognosis is so grave that Cruveilhier said it was always mortal, and he is right, in the majority of cases. Not, as some authors have pretended, that this gravity is due to the situation itself of the pneumonia, but to the constitution of the individuals in whom it declares itself. Professor Peter has conclusively demonstrated that, if pneumonia of the apex is dreaded, fatal, and often proceeds to suppuration, this is due to the individuals themselves, who are alcoholics, cachectics, debilitated by one cause or another, and in whom pneumonia is localized by preference in the apex of the lung: such is the veritable cause of its gravity, without being obliged to accuse the situation. In these patients the pain in the side will sometimes be wanting, the initial chill will be less marked, the expectoration itself may not be characteristic, and lastly, on auscultation, you will not find crepitant râles, if you have not in mind this variety of pneumonia. To discover the pneumonia centre, you ought to separate the arm from the trunk of the patient and apply the ear to the upper portion of the axillary space. It is there only that you will perceive the crepitant râles which will allow you to diagnose a pneumonia of the apex.

In addition to these varieties pertaining to the seat of the pneumonia, there exist others relative to the *age*. We will pass over pneumonia of the adult which we know, to speak only of that of the child, and of the aged.

Of the child, I will say only a word, for in it the disease is very rare, and when it is present it is without gravity; the pneumonia of the child is lobular pneumonia, of which I have spoken to you in my preceding lectures, and of which you know all the gravity.

Acute lobar pneumonia is very rare and benign in the child, it is unfortunately not the same in the aged in whom it is frequent, and takes a peculiarly grave character, which made Cruveilhier say that one-fourth at least of the aged died of pneumonia. How will you make your diagnosis? Here you are in the presence