frequent small doses of calomel, and directed the patient to be put under a steam tent.

On Sunday morning I saw the patient again, and found him much worse. He stubbornly refused to remain under the tent. The dyspnœa had greatly increased; the cough about the same; cyanosis was very marked, and the heart failing. I again examined the throat and still found no exudation on fauces or tonsils, and no sign of exudation in the larynx. Recommended intubation or tracheotomy, but paterfamilias very decidedly objected. The child died on Sunday night. I reported the cause of death to be croup. Although no precautions have been used, none of the members of the family have had any symptoms of diphtheria although nearly four weeks have elapsed since the death of this child.

Now, this case is an example of a class of cases which occurs in the practice of every physician. Some call them membranous croup; some diphtheritic croup (whatever that means); and some call all these cases diphtheria. The sole object of this short paper is to elicit discussion, and find out the opinion of the society on this vexed question.

A microscopic examination is regarded by most as the diagnostic test. If it were not for the theory now prevalent of the presence of a specific bacillus in all these cases, authority would still maintain the existence of true croup. A microscopic examination, however, is not possible in the country. Even in the city it is not always available in time to establish a diagnosis, even if it were infallible.

Professor Shuttleworth, who, by the by, holds that all these cases are diphtheria, showed me a few days ago a record of a case—a very severe one—where the first swabs from the throat revealed only staphylococci and streptococci, but no Klebs-Lœffler bacilli, and it was only when the patient was made to cough forcibly, while the swab was held in situ, that the specific bacilli of diphtheria were found.

In regard to the contagiousness of pseudo-membranous affections of the larynx, I am strongly inclined to think that it is overestimated. How frequently in private practice do we find just a single case in a family! My own experience of twenty-four years in country practice, during which I must have had one hundred cases of what I diagnosed as membranous croup, is that so far as my recollection goes I cannot recall a single case which I could attribute to contagion, or from which contagion spread. Practically, they were sporadic and generally prevailed in winter and spring, and in certain localities, nearly always in children (I never met a case in an adult), and these cases do not