pital. 1000 units antitoxine were administered at 10 a. m., and patient passed a fairly comfortable day with frequent intervals of sleep lasting from 1-2 hour to 1 hour. Pulse remained weak and irregular, varying from 100 to 118, and respirations from 24-32 at different periods of the day.

Feb. 14. Received telephone message from hospital at 7 a. m. saying that patient had suddenly been attacked with violent fit of dyspnea and was not expected to survive was asked if Trachertomy should be performed. I left it to their discretion though it was not likely to be of benefit in view of the distance downward that the membrane had previously extended. On reaching hospital found that the operation had been performed by Dr. Lawrence and McKay, no anaesthetic was required as no pain was felt. She was still deeply cyanosed and it was evident the membrane had reformed and extended below the point of operation Administered hypodermic of 1-20 gr. strychnia. In a short time the dyspnea again began to increase until the respiratory efforts were so great that air was forced into the cellular tissue of the face, neck and chest, causing an emphysematous condition of these parts. Patient gradually growing worse and heart very weak and irregular, another hypodermic 1-20 gr. strychnia was administer about 1-2 hour after the first. This distressing condition continued for about an hour, when she began to improve slightly, but was still cyanosed at mid day with respirations shallow, 37, and beat still weak and irregular. During the early afternoon her condition improved, very little several small pieces of membrane and a quantity of mucus were coughed up through the Tracheotomy tube, necessitating frequent swabing out of the tube. At 3.30 patient's condition was improving and 1000 units antitoxine were again administered later. She coughed up a membraneous cast of a portion of the trachea abont 2 1-2 inches long, but only about 1-2 the thickness of previous specimen. In the evening she had a short sleep and took nourishment. Saw patient at 11 p. m. Tracheotomy tube had been drawn out a short time before while patient was sleeping. The opening into the Trachea had closed, and as she appeared to breath easier by the mouth, the tube was left out, wound dressed and allowed to heal by granulation.

Feb. 15th. Patient slept a little during the night and took nourishment well. During the day her condition improved slightly, heart more regular, but about same rate, respiration easier, no dyspnea continues to cough up small pieces of membrane at intervals, some of very small calibre. Temperature rose to 1.03 after last dose of antitoxine.

Feb. 16th. Patient cotinues to improve, emphysema has diminished in face and neck and to some extent in the chest; temperature steadily declining.

On the 17th urine was again examined and only slight amount of albumen found, this had disappeared at next examination on the 19th. Temperature continued to decline until the 19th, when patient had a few slight chills and a gradual rise took place reaching 104.5 on evening of 21st, but improved a few days after. Cough increased and a greenish, viscid mucus was expectorated for the next two weeks. Temperature did not remain normal for the whole 24 hours until March 1st.

March 7th left the hospital but was still very weak, unable to walk without support and with partial paralysis of lanyx, could not speak above a whisper This lasted for some weeks then gradually improved, but she did not regain her normal speech until four months after leaving the hospital.

The emphysema did not completely disappear from her chest until a few days before she left the hospital.

INTESTINAL PARASITIS.

Classification—

I.—Cestodd or flat worms.

1) Tenia Solium.
2) Tenia Saginata.
3) Tenia Echinococcus.
4) Bothriocephalus latus.

II.—Nematoda or round worms.

1) Ascaris Lumbricoides.
2) Oxiguris Vermicularis.
3) Tricephabus despar.
4) Ascaris Mystax.
5) Eustrangylus Gigas.