gia, dysphonia, dyspnœa, cough and laryngorrhœa. One of the most frequent of these is pain on swallowing, which is often first noticed after taking fruit or anything of a sour character, such as vinegar, wine, salad dressing, etc. The pain may be very trifling at first, as the situation of the tubercular deposit decides its intensity and character. The laryngeal surface of the epiglottis, above the cushion, is one of the most frequent seats of deposit, but ulceration in that situation produces little pain. If, however, the ulceration is on the margin of the epiglottis, painful deglutition begins at once and is very severe. Two patients recently under my care illustrated these conditions very markedly. One of them, a Mr. T——, went to Florida early in January of this year; soon after his arrival, while eating an orange, he felt a slight pain each time he swallowed the juice. This continued during his stay of four months. He called on me the last of May, and stated the character of the pain, and that it was limited entirely to swallowing fruit. A laryngoscopic examination showed a large ulcer on the epiglottis just above the cushion. The drawing, which I pass around, shows the condition very well.

The second patient had a small ulcer in the right margin of the epiglottis and suffered great pain every time he partook of solids or liquids.

The continuous and usually progressive character of tubercular laryngeal pain is also diagnostic. Another suggestive symptom in pulmonary tuberculosis, of a coming laryngeal invasion, is excessive secretion of frothy, watery mucus. Increased cough of a laryngeal character, produced by a tickling or scratchy sensation, may be an early warning. Constant or intermittent hoarseness is also a primary symptom, although it is not always present. It depends on the implication of one of the vocal cords, inter-arytenoid space or arytenoid cartilages. It may also be present in other laryngeal affections. Whenever it occurs it always demands immediate attention. Laryngeal soreness and shortness of breath may also be present, but are not especially significant.

Objective symptoms are, anæmias, localized congestions, tumefactions, ulcerations and erosions. Marked anæmia of the soft palate, pharynx and larynx is usually present. Laryngoscopic examination becomes necessary for further observations. It seems unfortunate that so few medical colleges make the use of the laryngoscope compulsory for their graduates. Who can estimate how many cases of tubercular, syphilitic or malignant diseases of the larynx might be arrested if an early diagnosis were possible by every practitioner?

A tubercular affection of the larynx may present several different appearances when viewed with the laryngeal mirror, such as

(1) Infiltrations and hypertrophies.

(2) Ulceration with infiltrations and hypertrophies.

(3) Tubercular tumors or neoplasms.

Of these, infiltrations are the most frequent. Their favorite location is the interarytenoid space. At first they have a pearly-gray appearance, due to the presence of the tubercles immediately beneath the epithelium, and may be mistaken for adherent mucus. As time progresses, the infiltrations become more distinct and assume a fine granular appearance of a greyish-yellow color, and resemble shad roe. The water-color, which I have the pleasure of showing this Association, conveys these appearances very clearly, excepting that the infiltrations are on the pharynx. This was taken from a patient who consulted me about the middle of April, 1895. He had a serious laryngeal and pulmonary tubercular deposit. While under my care the uvula and posterior pillars of the pharynx began to enlarge and presented a grayish œdematous appearance. The uvula and soft palate also lost their usual soft elastic feeling and became firm and tense. Two days later small isolated yellow masses appeared in different parts of the soft palate, but were especially numerous on the uvula and posterior pillars. These masses were immediately beneath the epithelium, and when removed and examined by the microscope proved to be tubercular in character. Twenty-four hours later the epithelial covering of some broke down and left small superficial ulcers. Hypertrophies usually precede ulcerations in the larynx and may invade any part of it. When they occur in the arytenoid space they are usually multiple, and either papillary or ridge-like in appearance. The tips of the arytenoid cartilages and the aryepiglottic folds, are also favorite seats of invasion. The well-known club-shaped appearance of the former, and sausage-like formation of the latter, being considered pathognomonic of tubercular