properly arranging the position of the patient; allowing the paralysed mass—the tongue—to gravitate to one side, rather than against the back of the pharynx.

Mucous stertor, when unconnected with lung-engorgement, the consequence of suffocation from stertor, only occurs in very serious cases, depending upon interference with the nutritive processes of the lung-tissues—probably arising from accident to, or pressure upon, the medulla oblongata. This can always be satisfactorily removed by proper attention to the position of the body.

These principles apply not merely to apoplexy but also to all apoplectic conditions. Especially I would mention drowning, epilepsy, convulsions in children, meningitis with effusion, death-rattles, fracture of the skull, concussion, bronchitis, (especially that of old people) sudden œdema of the lungs, large hæmorrhage from the lungs, great exhaustion, chloroform-poisoning, drunkenness, opium-poisoning, and all conditions in which mucous or fluid exists in the lungs; and also all conditions allied to the apoplectic, whether there be mucous or not.

I have seen and treated all these conditions, and invariably with a similar result—an unfailing relief to the distressing symptoms and their consequences; and in many instances, both in my own as well as in the practice of my friends, ultimate recovery has occurred in cases which must, we believe, have terminated fatally if the obstruction to the breathing had been allowed to continue unrelieved.—*The British Medical Journal.*

Cholera Infantum.

℞ Argenti nitrat.....gr. j.
Acid. nitric. dil.....*m* viij.
Tinct. opii deodorat .....*m* viij.
Mucil. acaciæ ..... ℥ ss.
Syr. simplicis ..... ℥ ss.
Aq. cinnamomi..... ℥ j.

M. Sig.—A teaspoonful every three, four, or six hours to a child one year old.—Bartholow.

This combination is remarkably beneficial after the acute symptoms have subsided.—*Michigan Medical News.*

VARIETIES OF ACUTE LOBAR PNEUMONIA.

M. DIEULAFOY.

If lobar pneumonia always presented itself to you with the frankly acute character, it is very certain that errors in diagnosis would not be produced, and the disease could never be mistaken.

Unfortunately, it is not so in practice, and this phlegmasia, so frank, and so clear, which I have just described to you, affects certain varieties which you ought to know.

We can immediately arrange these varieties in three great classes which we will afterwards subdivide.

Varieties according to the *situation* of the phlegmasia, according to the *age* of the subject, and lastly, according to the medical constitution of the period.

To the first of these varieties belong the *central* pneumonias, double pneumonias, and those of the apex. In these different forms you will find all the phases of lobar pneumonia frankly acute: the anatomical lesions will be quite the same: but the patient not re-acting in the same manner, will offer to you a train of symptoms which might deceive you if you were not forewarned.

In *central* pneumonia, the patient will present himself to us saying that he has had a single internal chill with a consecutive stitch in the side. You will observe a very pronounced dyspnœa, the pulse is large, the countenance empurpled: everything confirms you in the idea of a pneumonia, and as your patient has been suffering for from twenty-four to thirty-six hours, you auscultate him with the certainty of finding crepitant râles, but you hear nothing: you make your patient cough, always with the same result. You ask to see the sputa, there is none, or it has been thrown away. In presence of these facts, you are truly perplexed. The onset is certainly that of pneumonia, the temperature is equally conformable to what you know, 39 degrees (102·2° F.), but there are no crepitant râles! Are you to conclude from this that there is no pneumonia?

No, wait until the morrow, and you will have the rusty sputa, but it will often be only on the fourth day that you will perceive the