isthmus of the fauces. She was subject to frequent attacks of catarrhal sore throat. On November 26th, 1887, she became seriously ill, with a temp. of 103.5° and noisy, difficult respiration. On examining the throat, there was observed on the left tonsil a grayish, gelatinoid-looking, raised patch, about the size of a ten cent piece, intimately adherent to the tonsil and surrounded by deeply inflamed membrane. Swallowing was painful, the left cervical glands slightly enlarged. The appearance of the patch differed materially from the fawn-colored, tough-looking, opaque patch of diphtheria. Moreover, it was slightly marked in a stellate manner; the markings became more distinct later on. The patch separated *en masse* in four days, leaving a raw, ulcerated surface that healed with fairly distinct cicatricial contraction, reducing somewhat the size of the tonsil. Until the patch separated the temperature continued elevated, with thirst, loss of appetite and considerable prostration. The breath only slightly offensive. Convalescence was slightly protracted, but there were no paralytic symptoms Isolation though advised was very imperfectly carried out. None of the other members of the family, which consisted of the grandmother, parents and a younger child, contracted the disease.

Case 2 differs considerably from the foregoing. Mrs. M., aged 50; from the country, visiting a sister whom she was nursing in confinement. She was a delicate woman, whose throat often gave her trouble; both tonsils were chronically quite large. I saw her first on February 25th, 1888. She complained of pain in the left side of the throat, and the left tonsil was found, on examination, to be completely covered with a whitey-gray membrane, intimately adherent and surrounded by a dark-red ball on the pillars of the fauces. The membrane was quite thin in several places and it terminated in a thin margin. It could not be stripped off, and the removal of a small piece left a bleeding surface. The left cervical glands were slightly enlarged. Temp. slightly sub-normal (97.3°), pulse 120, weak, no appetite. She had been in the city only two days, and thought there was some white deposit on the tonsil before she left home. She was carefully isolated for a few days, as besides the infant there were two other children in the house. Iron with chlorate of potash was given freely, and as much nourishment as possible taken. Temperature rose to normal next day and remained so throughout; pulse continued about 120, and weak with general prostration. No change occurring in the membrane after a few days, a solution of argent. nitr. (ʒss. ad ℥j.) was applied three times a day with a brush. With this application the membrane gradually became thinner. By March 10th the whole surface was still covered with membrane. I next saw her about the 20th of March on her leaving for home. Most of the slough had separated, and had extended down into the tonsil to its base, dividing it into two unequal, wedge-shaped parts, the anterior about half the size of the posterior part. Between these the slough had not yet completely separated; of what remained the superficial was semi-liquid, and the deep shreddy a. d adherent. Nearly one-half of the tonsil had been destroyed. The general health had improved considerably; there was now no pain in the throat.

The term, necrotic tonsillitis, for such cases, is used by Strümpell in his Text Book of Medicine, and is the most appropriate available; they are scarcely severe enough to be called gangrenous, and the term phlegmonous is associated with the idea of a more acute inflammation. There can be no doubt as to the propriety of calling Case 2 one of necrotic tonsillitis, its appearance and course were typical of such a condition. Nor do I think Case 1 can be described as anything else, though the inflammation was here much more acute, separating the slough in a very short time. It, however, bears a strong resemblance to diphtheria, but that it was not a case of that disease I believe for the following reasons: It must be rare for so large a deposit accompanied by such sharp localized inflammation, to remain so circumscribed, the uvula and soft palate were not affected, though in contact with the deposit. I have never seen one run such a course; the cervical glands would almost certainly have been much more seriously involved in so severe a case of diphtheria; no paralytic symptoms followed; there was no evidence of contagion; the appearance of the slough and of the ulcer resulting differed from those of diphtheria. Nevertheless, while all this is true, the fact remains that many cases of diphtheria cannot be diagnosticated from such cases of necrotic tonsillitis, and it becomes