of the faucial cavity and is exceptional. Should a white exudation be observed in even small quantity any where in the fauces it is to be carefully examined. It is likely to be attended by more, and in a more dangerous locality, farther down. How are we to distinguish the croupous from the white exudation in other inflammations? Observe how adherent it is. This is the test, even *post mortem*, relied upon in our largest dead-houses, whether it is or is not croupous. The croupous exudation is attached firmly, and detached with great difficulty, being rooted into the follicles. Other exudations are detached readily. In case the exudation seen is not white, and especially if it be of a dirty dark color, the presumption is that it is croupous, this appearance being regular and expected if the exudations have been out a day or two. Other exudations are so easily detached by the motions of breathing and swallowing as not to remain long enough to be anything else than white. In case the dirty dark exudation is removed with difficulty, but more easily than when fresh, it is croupous. More recent exudation of curdy white color will probably be observed elsewhere, if it is looked for. It is in these cases in which there is exudation high up, and which may fairly be denominated diphtheritic, that we are apt to have most marked laryngeal paralysis, because the mucous membrane of the pharynx forms the covering of the posterior crico-arytenoid muscles which in normal inspiration when healthy enlarge the glottis and the mucous membrane is so swollen as to impede muscular action. If physical examination show enlarged glands, the inflammation is of higher type than the catarrhal.

Should physical examination be negative, or out of the question, we can then rely on a comparison of the rational signs only. This is here done in tabular form. The reasons for most of the signs will be apparent if the pathology is kept in view. Otherwise it is chiefly matter of memory—always treacherous when most wanted:

IN FALSE CROUP.	IN TRUE CROUP.
1. The invasion is sudden.	Begins slowly.
2. No adherent pharyngeal exudation.	May be such.
3. Little fever.	Considerable.
4. Symptoms alarming from the first.	Early symptoms mild, but become slowly and steadily more severe.
5. Morning remissions and evening exacerbations always.	Not so, but gradually and insidiously increasing.
6. Dyspnœa intermits.	Dyspnœa remits only.
7. Aphonia is never complete.	May be complete.
8. May have alarming symptoms developed suddenly without any serious lesion in the lungs.	When alarming symptoms develop during its course we will find something to account for it in the lungs or throat.
9. Voice between attacks is natural	Voice is more or less changed.
10. Night attacks, seldom in day.	Progressive impediment to breathing.
11. No barking cough.	Begins with a barking cough
12. Always begins with a whispering cough.	Aphonia is developed after several days.
13. No false membrane ejected.	False membrane coughed up or vomited.

CASE OF INTESTINAL OBSTRUCTION.—LEFT LUMBAR COLOTOMY—RECOVERY.

BY PETER MANSON, M.D., GOLD HILL, NEVADA.

James Cook, æt 41, a Scotchman; came into my office about eight o'clock on the evening of the 27th of Sept., 1878, having travelled during that day by stage coach from Bodie, California, a distance of 130 miles, over a rough mountain road nearly all the way.

He said that his present illness commenced about six weeks previous, and that he had been under the care of the doctors of Bodie for intestinal obstruction. When first taken ill he went about three weeks without an action of his bowels, and was treated during that time with large doses of castor oil and other purgatives. His bowels were greatly distended, tongue dry and cracked, and suffered intensely from wind colic. One of the doctors of Bodie diagnosed the case typho-malarial fever. After three weeks treatment his bowels began moving freely, and continued so for eight or ten days, thin watery discharges. As soon as the stools assumed a little more consistency, the evacuations again stopped, excepting an occasional small stool. The above was his own account of his case during his six weeks' illness in Bodie.

On examination I found the bowels moderately distended with gas; pulse normal, no fever, tongue moist, and slightly coated. He seemed to think that if he could only get rid of the wind he would feel all right. In the region of the cæcum there was a round distention of gas; on pressing over this it would suddenly start, and fly around the colon to the region of the sigmoid flexure, abruptly stopping there; on pressing over the sigmoid flexure, the gas would again fly back to the ileo-cæcal valve. This led me to suspect an obstruction in the region of the sigmoid flexure. The patient said that he had been troubled a great deal with flatus for some months before he was taken down. He thought that his stools had been more narrow and ribbon-shaped than normal. On introducing my finger into the rectum I found a small quantity of fæces. There had been no evacuation of the bowels for five days previous. High up in the rectum opposite the left sacro-iliac symphysis I could feel a slight ridge along one