than soreness. As the plant increases aud becomes scattered over a larger area, the movements of the pharynx become restrained, the muscles slightly stiffened, and partial dysphagia may result. A slight irritable cough may be produced. The fungus grows most luxuriant between the crypts of the faucial tonsils, next on the base of the tongue and lingual tonsil; then on the pharyngeal walls and last upon the pharyngeal tonsil itself.

Mycosis presents small creamy-white opaque masses projecting above the mucous membrane. They are soft and moist in appearance, but are not easily removed. They will stand a large amount of friction without separating their attachment. Usually a number of the plants are scattered over the area affected, varying in size from a pin's head to a millet seed or larger. There is no inflammatory areola around them. Sometimes they exist for years, presenting few symptoms of a distressing or injurious character.

Upon a hurried or casual examination, it might possibly be mistaken for diphtheria in its first stage. This could only be so when the nests are massed together; but even then the fact that it is non-febrile, undergoes no change, and is intensely chronic, should at once remove all doubt.

From sebaceous accumulations in the crypts of the tonsils it is easily distinguished, by the fact that the former only occur at the mouths of the crypts and are easily pressed out, while the leptothrix growth occurs indiscriminately independent of the position of the lacunæ; and can barely be removed by any amount of legitimate pressure.

There was little or no difficulty in making a diagnosis between this disease and tonsilitis. In pharyngeal mycosis there is nothing dangerous to life; and, as a rule, if left to itself, might last through a lifetime. It is quite probable that its long continuance might depress the vital forces and render the subject more susceptible to the influences of other diseases.

The treatment is the eradication of the plant. In a few recorded cases this has been done with facility; but in the majority careful and vigorous treatment has been required, and this has had to be persisted in in many cases for a long time before complete cure can be obtained. The tincture of iodine, silver nitrate, bichloride of mercury, calomel insufflations, have all been used with more or less efficacy. Chromic acid cauterization has its advocates. Curettement has also been recommended. None of these have met with as good results as the use of the galvano-cautery needle. It should be inserted directly into the fungoid deposit, and a number should be