that while the morbid process has ended there is still a deep infiltration of the lung, which is probably associated with the constitutional taint. I have no doubt that by a continuance of the treatment which I have mentioned, particularly by the use of specific remedies, we shall secure the removal of this infiltration, but it is a warning to us that, although the temperature and pulse are normal, we should be careful how we allow these patients to expose themselves, until we are satisfied that the local conditions have entirely passed away.

We have all been taught, by sad experience, to be careful during the convalescence of certain specific diseases, notably typhoid fever, but I fear that we are not nearly so careful in the management of convalescence from local affections, particularly those of the chest. It is one thing for the temperature to fall to normal, the pulse to come down, and the breathing become easy, and quite an other thing for the local lesions to be entirely removed. Under such circumstances the patient, if allowed to expose himself, is in danger of a relapse. Even if a relapse does not take place, something which is worse may develop. If a slight trace of inflammatory process be overlooked and the patient be allowed to return to his ordinary occupation, it will remain and slowly take on a chronic degenerative change. The great majority of chronic troubles result from imperfectly cured local affections. This is pre-eminently true in regard to catarrhal pneumonia. It is true to a less degree as regards croupous pneumonia, and it is also true in regard to pleurisy. The criterion by which we are to judge when it is proper for the patient to rise, take exercise and expose himself, is solely the result of physical examination, showing that all trace of local disease has passed away. We cannot be governed by the general symptoms, for these may subside in a most satisfactory manner, and yet the patient be far from being entirely cured. The care which has been insisted on in the acute stage should never be relaxed until the physical examination shows that all local change has passed away, unless, after pursuing a judicious course, and keeping up this care for a reasonable time, we find that the patient, in consequence of some constitutional defect or peculiarity, is passing into a chronic stage. Under such circumstances further confinement, instead of being a benefit, would probably injure the constitution. The patient is then to be treated as one with a serious chronic disease, and although he is allowed to go about it is under a most rigid hygienic regimen.

The consideration of the treatment of pneumonia demands more time than we can devote to it to-day. This man was treated in a way in which I think that you will treat most cases of this disease. When he was admitted, the disease had passed beyond the stage where depletion would be admissable. When the case is seen early, it is often well to use quite positive depletion, even if it is only local. In this case, there was no need for cardiac sedatives, but in many instances, when the patient is seen early, you will secure admirable results in limiting the inflammation and curtailing the inflammatory process by the use of veratrum viride or aconite. In order to assist the liquefaction of the exudation and stimulate expectoration, I know of no remedy equal to the carbonate of ammonia, especially if there is considerable vital depression. I consider quinine an almost essential element of the treatment of pneumonia, not in immense doses except when there is hyperpyrexia, but in doses of from eight to sixteen grains per day, given by the mouth if the stomach is perfectly tolerant, or by the rectum if it is not so. The diet is to be nutritious and the food given in small quantities and at short intervals. We are to be governed in the use of stimulants by the same considerations which control their use in other diseases. Many cases of pneumonia do very well without stimulants, and they should not be used as a matter of routine. We should wait for the development of symptoms, and when they are used, their effect should be carefully watched to see if they are doing what we wish before we continue them or increase the dose.

THE TREATMENT OF CHOLERA.

Dr. Alexander Harkin thus writes in the *Lancet*' August 19, 1884:

The disease and its treatment naturally divide themselves into three stages: the pulmonary or diarrhœal; the stage of violent purging and, vomiting and cramps; and that of collapse.

For the diarrhœa nothing in my experience answers so well as dilute sulphuric acid, which should be administered every hour in doses of twenty to thirty drops in some agreeable menstrum, with mustard or turpentine epithems to the abdominal region and iced water when available *ad libitum*. Should the second stage supervene, it is necessary to take decisive steps, lest the third rapidly develop.

It is in the second stage that my peculiar experience becomes available. Physiologists teach that the phenomena of vomiting and purging depend altogether upon the nervous mechanism of the organs affected. According to Michael Foster, "the dilatation of the cardiac orifice is caused, in part at least, by efferent impulses descending the vagi, since, when these are cut, real vomiting with discharge of the gastritic contents is difficult through want of readiness in the dilatation. Since the vagus acts as an efferent nerve in causing the dilatation of the cardiac orifice so essential to the act of vomiting, it is difficult to eliminate the share taken by the vagus as an afferent nerve carrying up impulses from the stomach to the vomiting centre" (pages 275-6). The influence of the vagus is thus demonstrated in the act of vomiting, both as an afferent and an efferent conductor of nervous