My eighth case, a patient of Dr. Britton's, a young woman aged twenty-three. I was called in the third day of illness. She was suffering from extreme dyspnœa; breathing very labored; general appearance cyanotic. On baring the chest and abdomen, there was very labored abdominal breathing; *chest walls stationary; no retraction; no movement of the larynx.*

The stethoscope revealed nothing more than a few coarse bronchial rales. *No respiratory murmur*, but little air entered the lungs. As the disease in the pharynx was of a malignant type, we had no hope of recovery under any circumstances; but as her dyspnœa was so painful and distressing I thought it wise to intubate, which I did, with immediate relief to the distressing dyspnœa. The stethoscope now reveals both coarse and fine rales throughout the lungs and bronchi, and a generally emphysematous condition. I think in those cases where the disease extends to the bronchi, the large plugs of mucous formed, and portions of exudation that become more easily detached in the bronchi, prove factors in developing rapidly an acute emphysema. This combination of conditions made the lungs too large for the space they had to occupy, and thus prevented the recession of the chest walls. This condition being also a cause of part of the dyspnœa, the extensive excursions of the larynx, so manifest where the dyspnœa is due to stenosis of the larynx alone, were consequently very much reduced.

I would emphasize these symptoms, as I have not seen them mentioned elsewhere in this connection, and I consider them diagonostic at a time when the stethoscope reveals nothing. When extreme dyspnœa is due to stenosis of the larynx, we find *movement* and *retraction* of chest walls and *extensive excursions of the larynx* up and down in the effort to get air.

If, therefore, in extreme dyspnœa the chest walls are more or less motionless and not retracted, and the larynx quiet, we may be sure of extensive exudation into, and engorgement of, the lungs, with possibly acute emphysema. If this symptom is of value, it is of the more value because the stethoscope in this extreme dyspnœa simply reveals nothing, as I have shown was exemplified in my fifth case.

Tracheotomy here would be worse than useless. Intubation would merely afford temporary relief.

My seventeenth case recovered. A boy, nine years old, had been ill four days with pharyngeal diphtheria, accompanied during this time with hoarseness and croupy cough. During the last thirty hours the croup gradually increased till it became alarming. I was called in for the purpose of intubating. The dyspnœa was extreme with all the accompanying symptoms of danger: marked recession of chest walls; extensive excursions of the larynx; pulling at the mouth to remove the offending matter for some time before, but now quiet, dull, semi-comatose and cyanotic. The stethoscope reveals no respiratory murmur, coarse rales only being detected. Drs. Spence and Hunter and myself retired for a moment to discuss the propriety of intubating; we decided in favor of it and returned to do so, but were surprised to find our patient to all appearance in *articulo mortis.* The mother said it was too late—"let him die in peace." And we all thought it was too late, but still urged the intubation, and against the wish of the mother I introduced the tube and obtained immediate relief; respiration became full, free, easy, and the child fell into a quiet sleep, from which, when he awoke, he had no knowledge whatever of anything having been done to his throat (which serves to show the degeee of coma). Auscultation now reveals a respiratory murmur full, free, soft, breezy and vesicular, accompanied, however, with coarse bronchial rales which gradually diminished and cleared up entirely during the next eight hours of easy and full respiration.

In about three-quarters of an hour after the tube was inserted the child awoke and coughed violently, bringing out a large quantity of mucous and false membrane; and to my amazement the silk thread attached to the tube, which I had not as yet removed, but had tied to the ear, had loosed from its moorings and vanished from sight. On examining with the laryngoscope I found the tube also was not, but had gone the way, if not of all flesh, at least of much flesh; it was coughed up and swallowed in my presence.

Because of the removal of the large amount of membrane with the expulsion of the tube, the respiration continued comparatively free, and we decided to leave him without double