ly distresses the bystanding and sorrowing relatives.

CASE II.—A lady, sixty years of age, fell head-foremost down stairs, and was taken up unconscious. She had complained much of head-discomfort in the morning, but nevertheless had been out for a short walk. The weather was thundery. On my arrival, immediately after the fall, there was considerable ecchymosis at the outer angle of the left orbit; but there was no bleeding from the ears, nose or mouth; nor was there any extravasation between the ocular conjunctivæ. I found her wholly unconscious, breathing stertorously, and vomiting. The right pupil was dilated and fixed; the left very sluggish. When she was turned on her side the stertor ceased; the aspect of the face became almost natural; and she moved her left arm and leg, and remained like a person quietly asleep for twenty-four hours. At this time, *nasal* stertor commenced, and gradually increased in intensity; and *pari passu*, the face became congested and turgid, the veins of the temple stood out in bold relief, and in about an hour she died.

Dr. Monckton saw this case with me in consultation; and I was able to demonstrate to him how stertor and its consequences instantly recommenced in this poor lady's case when she was placed in the supine position, and also how easily nasal stertor could be removed either by pressing the tip of the nose upwards, or by dilating the nares with the handle of a salt-spoon.

There is yet one other form—the puffing out and flapping of the cheeks and lips—which may be fairly dignified with the title of *buccal* stertor. Now, although this last does not give rise to any respiratory difficulty, it is nevertheless, like nasal stertor, of importance in prognosis, and useful for purposes of definition. Like nasal stertor, it is dependent on paralysis of the portio dura, and therefore, indicates the approach of the intracranial mischief towards that part of the brain which governs the functions of organic life, or (which is a very important alternative that both it and nasal stertor may arise simply from venous engorgement at the base of the brain, in consequence of the suffocative stertors damming the jugulars.

Authors have always looked upon this symptom as an extremely dangerous one; and so no doubt it is, in the combined conditions of apoplexy and suffocation; but, as I have observed both it and nasal stertor, in a modified degree, in the snoring sleeper, and as cases of suffocative apoplexy, in which it has been most marked, sometimes make a rapid recovery, I withhold my opinion for the present.

Indeed, it is almost impossible, from the writings of the past, to arrive at any conclusion as to the value of any symptom of apoplexy. We must now observe from a new point of view (apoplexy without suffocation), and draw our conclusions in the future. The following short case is a happy illustration of some of these remarks. I am indebted to Dr. Lewis, of Folkestone, for the notes.

CASE III.—A lady, sixty-seven years of age, was found in her bed in an apoplectic condition. There was total loss of consciousness; the pupils were of about the usual size, but fixed; there was slight reflex action on touching the eyeball, and an occasional involuntary movement of the arms. The face was turgid, and there was both *pharyngeal* and *buccal* stertor. On being placed on her side, the stertor instantly ceased, and she gradually improved. In twelve hours, she had perfectly recovered consciousness; the respiration was normal; the face very pale, and the pulse quick and feeble; and there was no paralysis.

Surely no case could have looked more unpromising than this, when the age is taken into consideration.

*Nasal* stertor is unaffected by the position of the body, but may always be relieved by mechanical means.

*Palatine* stertor is usually of the least consequence; *i. e.*, it obstructs the breathing only very partially, and cannot always be removed by changing the position of the body. It is affected by the size of the tongue, the length of the uvula, the position of the chin, and other incidental conditions, all of which may be obviated if the obstruction to the breathing be sufficient to render it worth the doing.

*Pharyngeal* stertor is the most common, in severe cases of apoplexy, when patients are recumbent. This may always be obviated by