cavities, and sooner or later the opposite lung may become affected either by the deposit of tubercles or by the formation of little patches of lobular pneumonia.

Here again the subject is full of complexities and we are in a little difficulty. Sometimes cases of caseous pneumonic phthisis are slow, subacute, almost chronic. But there is a certain section of these cases which is extremely rapid. There are those cases in which the fever rises and the deposit in the upper part of the lung breaks down rapidly, and within four, five or six weeks the patient dies with all the symptoms of phthisis. These may be called cases of acute caseous pneumonic phthisis, and answers to the true galloping consumption of our forefathers.

Now, passing from this caseous pneumonic phthisis, I will make the following additional statement: The usual rule with tubercular phthisis is death. I do not say there are no exceptions to this; perhaps cases of tubercular phthisis may get better, but they are few. It is in cases of pneumonic phthisis no doubt that the greatest number of recoveries take place, and they take place in one of several ways. Sometimes the exuded caseous pneumonic stuff undergoes fatty metamorphosis and is really absorbed. In other cases the caseous matter, not being quite melted and absorbed, a kind of fibroid change takes place in the lung. It gets hardened, perhaps the bronchial tubes are a little dilated, and the whole affair settles down into a hardened mass. Sometimes these cases of caseous pneumonic phthisis, whilst destruction is going on, yet develop secondary fibroid change, which does the same for these cases as for those of of tuberculous phthisis.

I have said that occasional cases of tubercular phthisis progress slowly, and in proportion to the amount of fibroid degeneration. So it is in caseous pneunomic phthisis; for, if it excites a secondary fibroid degeneration the progress is exceedingly slow.

Now we come to speak of the cases which I have classified as fibroid phthisis. The chief clinical characters of fibroid phthisis are these: First, it is, as a rule, a-febrile. The pulse is quiet, and the general health is but little disturbed. The second point is, that usually, not invariably, there is, just as in the case of croupous pneumonia, a history of some inflammation. It may be a pleurisy, very often it is so; it may be a pneumonia, which has been unabsorbed and converted into fibroid mass, or it may be an irreducible recurring bronchitis which has caused the development of fibroid tissue; and lastly, but rarely, it may be due to some constitutional disease, such as syphilis or cancer. But the main point is, that while it has such a history it is almost always unilateral, while tubercular phthisis is almost invariably bilateral sooner or later. Pneumonic phthisis may be or it may not be unilateral. Fibroid phthisis is in ninety-nine cases out of a hundred unilateral. The local signs of fibroid phthisis are extreme contraction, with pronounced friction sounds and displacement of the organs. With these few points I will narrate the history of one case of fibroid phthisis which will enable you to understand better what what you are to expect in these cases than you would from a mere description.

Here is an illustration of an interesting lung which was converted into a fibroid mass, was surrounded by an enormous thickening of pleura, and had upon its summit about an inch of fat, an appearance which I have never seen before or since, although I have examined over four thousand bodies. The subject from whom the lung was taken was my first patient in the London Hospital some three-and-twenty years ago. When he came to me he was a stout man, about fifteen or sixteen stone in weight, and complained of cough and spitting of blood. At that time I did not know much about lung diseases. I examined the man with the utmost care and found nothing. But from the history of the case I thought perhaps he might be suffering from some internal growth, such as aneurism, or something of that kind. I afterwards learned that he had been under the charge of the surgeon at the other end of the hospital for a fractured rib, from which he had recovered. I took an interest in the man, but months passed before I discovered anything. The first thing which I noticed was a little crepitation, and the next a little contraction of the right side. By and by he began to have violent paroxysms of cough, which often ended in retching and discharge of fœtid muco-pus from the lung. Then more and more progressively the right side of the chest contracted; the heart was now pulled from the left to the right side; next he began to fail, and a bluish condition of the skin made its appearance. I watched him, and from year to year I found the symptoms steadily increasing. It was, perhaps, at the end of ten years when I exhibited him to my colleagues. He complained that he had a paroxysmal cough, which ended in vomiting and the expulsion of muco-pus, which was sometimes fœtid and sometimes not. He had severe pain in the right side, and that beyond being a little weak and exhausted by the cough he had nothing else to complain of. The physical signs were these: The right arm was slightly swollen, and the fingers were slightly swollen and bluish. The heart was drawn considerably to the right side; there was dullness over the right side of the chest; there was bronchophony; there was an increase of vocal resonance, and a metallic crepitation accompanied them.

When I exhibited him to my colleagues, they were all of opinion that he had some growth in the right lung. Well, he went on, the heart becom-