die; the rest will die or not, according to the care that is taken of them, the food they get, and the place where they live. But hardly any, until the time of their special liability is over, will escape attacks in which they will be pyrexic and waste, and show symptoms, cerebral and other, which are often absolutely indistinguishable from those that usher in a fatal meningitis.

Still more striking is the case of young adults who are tubercular. With these we know that the chief danger is not for the brain, but for the lungs; and we have strong hope that if we can tide them over the period of youth later manhood will give them comparative security. But how is it with them during this time of jeopardy? Much more than with the little children, it is apparent that they will live or not, according as their circumstances are ordered; that their life depends, that is to say, upon the conditions of living being made the easiest for them. A young man of tubercular tendencies (I am quoting from the fact) wastes, and sweats, and coughs, but with nothing discoverable in his chest beyond bronchial catarrh. Soon he is too weak to leave his room. He is advised to take a sea voyage, and to remain for a year or more in New Zealand. There he loses his cough and his weakness, puts on flesh, takes to an active out-door life as a sheep farmer, and presently, as is but natural, pining for his home and his old profession, and believing himself perfectly recovered, he returns to England. Again there are the wasting, the cough, and the depression; and this time the symptoms are so threatening that there is grave doubt whether he can be got on board ship, or whether in his extreme state a long journey is justifiable. But once more away from the country which is not liveable for him the threatening symptoms disappear, and his health returns.

Who then, I ask, will venture to say or to write in a book at what particular stage in the tubercular fever (so to call it) all expectation of recovery is cut off; or rather let me say, not so much expectation as possibility? It would of course be a grotesque misrepresentation of nature to pretend that such a case as ours in Burdett ward is not highly exceptional; or that with such symptoms any other result than death is to be looked for. But who is to draw the line between recoverability and irrecoverability? who is to say what particular phase or event in the clinical history represents the actual development of tubercle and seals the doom of the patient? We have ample justification, I contend, in laying down as true this proposition, in youth as well as in childhood threatened tuberculosis recovers. We can tell when such recovery is to be looked for; we can tell when it is highly improbable; we can hardly tell, certainly we cannot tell precisely, the point at which it becomes absolutely impossible.

But there is another point for consideration. Tubercular individuals, children at all events, will present the clinical symptoms of tubercular meningitis, and die in the usual way, but by post mortem neither tubercle nor inflammatory exudation will be discovered. We have to reckon, then, with the following facts, and to make out of them the best hypothesis we can. There is a certain set of symptoms by means of which acute tuberculosis is commonly recognised at the bedside. Such symptoms commonly end fatally, and after death grey granulations are found in certain situations. But to this rule there are two kinds of exceptions. One where the symptoms in question do not end fatally; the other where, although ending fatally, no trace of the grey granulations is to be found.

What, then, is the hypothesis—I mean the working provisional hypothesis, which best fits this state of facts? I think it is this: Acute tuberculosis regarded from the clinical point of view is to be distinguished from the actual deposition of tubercle regarded as an anatomical fact. The early symptoms of acute tuberculosis are those which precede the actual development of the grey granulations. This latter event, analogous in some respects to the eruption of a specific fever, is preceded by certain phenomena extending over a variable period of time, during which restitution is still possible. And while, on the other hand, the deposition of tubercle marks the termination of hope, on the other the stress of the premonitory fever which precedes that occurrence may of itself suffice to produce death.

But here the therapeutist steps in, and clearly there is a place for him. If his experience be large, it will furnish him with examples which will easily push aside the assertion that the acute tuberculosis which seems to recover is in fact not what it seems, but enteric fever, or something else. He has, then, only to appeal to the dogma that acute tuberculosis, pursuing its natural course, is necessarily fatal in order to reach the position he desires—the doctrine, namely, that the cure of this disease is accomplished through the agency of the hypophosphites of lime and soda. My own practice with reference to such drugs is this. In the belief that they are at least harmless, that they are commended for a class of affections very bare of remedies, and where some medicinal treatment or other is reasonably expected on behalf of those who are acutely and progressively ill. I have uniformly given the hypophosphites in every case of acute phthisis or acute pulmonary tuberculosis that has been under my care for many years. Without being at all struck with the effects of a remedy very highly commended in some quarters, I can certainly quote instances where the hypophosphites have been so far injurious that patients have improved on there being discontinued. In the present case ten grains of the hypophosphite of soda were given every four hours, commencing a week after the patient's admission. His worst and weakest time, you will remember, was the week succeeding. How far this is consistent with any curative power