have used, in certain cases, goa powder or chrysophanic acid ointment, (thirty grains to the ounce is usually strong enough), and I have found it a very effective remedy, but there are great drawbacks to its general use. First, it stains everything with which it comes in contact, and in the second place, we are uncertain as to the amount of inflammation it may set up; some children bear it well, while in others it produces so much irritation, swelling and discoloration of the skin, as to alarm those who use it. It must, therefore, be used with caution, and patients should be warned of its properties; nevertheless, I repeat, it is a very effective remedy.

Your success in the treatment of ringworm will depend on you choosing your remedies with judgment, being guided in your choice by the circumstances of the case, and always bearing in mind that you have to steer, as it were, between setting up too much inflammation, on the one hand, and not using sufficient strong means on the other. Whatever treatment, however, you adopt, you will meet with a certain number of cases that defy your best efforts, and that get well only, perhaps, after years of tedious care. As a rule, shaving the head is quite unnecessary, but the hair should be kept quite short. Skull-caps are best avoided, as liable to propagate the disease. With regard to epilation, which is so largely used in France as a mode of treatment, I do not find that it is often necessary; it is, however, occasionally useful. Take, for example, the case of a boy anxious to return to school, who has a patch of chronic tinea tonsurans. In this case the extraction of the diseased hairs will shorten the treatment required, and enable him to return to school cured somewhat sooner than would otherwise be possible. Lastly, most observers agree that ringworm is often associated with a generally unhealthy condition of the skin, which is badly nourished. Under these circumstances, tonics, such as iron and arsenic, are often useful. This is quite in accordance with the fact that many strictly local affections are influenced by general treatment.

DISTINCTIONS BETWEEN CROUP AND DIPHTHERIA.—That croup and diphtheria are distinct diseases, Dr. W. H. Day (*Medical Press and Circular*) maintains, and he points out the following distinction :—

We constantly meet with genuine croup, of an acute and local inflammatory character, leading to the well known false membrane in the trachea and larynx, as described by the old-fashioned authorities. It seems impossible that we can mistake this true croup (which we have been in the habit of meeting with all our lives) for the peculiar membranous inflammation of the trachea, sometimes seen in diphtheria. It is well to glance at some remarkable points of difference in the two affections.

1. True croup is prone to attack the healthiest children, and in districts where diphtheria does not prevail.

2. True croup is apt to come on very suddenly, and in cases of recovery the general health is rapidly re-established, as compared with diphtheria.

3. In diphtheritic croup the disease is of a well-marked character, and is always accompanied by great depression and nervous symptoms.

4. Croup is a local disease; diphtheria is a constitutional affection, in which the kidneys and intestines may be involved. Croup is neither infectious nor contagious; diphtheria is both.

5. The cases that recover from diphtheritic croup are few, and the convalescence is not only very slow and tedious, but the throat affection is usually preceded by a characteristic membrane on the palate, and the prostration is always great. Partial loss of voice, fetid breath, swollen neck and glands, diminution of muscular power, paralysis of the muscles of deglutition, and albuminuria, are common in diphtheria; but they are not witnessed in inflammatory croup.

6. Between croup and diphtheria there is also another very important diagnostic difference; diphtheria generally begins in the pharynx, croup in the larynx. The false membrane found in the larynx in cases of genuine croup, is quite different from the leathery or yellowish gray exudation found on the tonsils, in the larynx and bronchial tubes, in cases of diphtheria. The pathological differences between croup and diphtheria are open to further contrast. In the early stage of croup there is an increase in the vascularity of the affected membrane, as in severe catarrh, with a trifling amount of inflammatory exudation. This is succeeded by fibrillation of the exuded lymph which, with the new formed cellular elements, becomes transformed into the characteristic *false membrane*. Its consistence varies, being in some cases tough, in others soft and amorphous, and easily removed from the mucous membrane beneath. In the larynx and upper part of the trachea, where the inflammation is most acute, the exudation is croupal or membranous, and is very characteristic of true croup, but in the lowest part of the trachea and diverging bronchi there may be nothing more than a scanty superficial layer of mucus.

"It is difficult in many cases to draw any line of demarcation between the histological changes occurring in diphtheria and those of croup. In diphtheria, however, the submucous tissue usually becomes more extensively involved, so that the false membrane is much less readily removed. The circulation also often becomes so much interfered with that portions of the tissue lose their vitality, and large ash colored sloughs are formed, which, after removal, leave a considerable loss of substance.