extensive disease at the apex of the lung. It seems to me plausible that the influences which favor the growth of the bacillus at the apex of the lung also favor its growth in the apex of the lower lobe. The vulnerability of this portion of the lung is based upon abundant evidence both clinically and in post-mortem examinations. Consequently, if we are unanimous in saying that signs of disease at the apex of the lung are of great diagnostic importance, the discovery of the vulnerability of this part of the lower lobe must materially strengthen our diagnosis. As first localized by Fowler, this secondary lesion is situated about one and a half inches below the upper and posterior extremity of the lower lobe, and about the same distance from its posterior border; which he found to correspond on the chest-wall to a point situated midway between the fifth dorsal spine and the border of the scapula; from this focus the disease spreads along the interlobar septum. A rough surface marking of this line of invasion is obtained by making the patient place his hand upon the opposite shoulder, when the vertebral border of the scapula in its new position will indicate approximately the line of the disease. The importance in the physical examination of the chest of the early appearance, in phthisis, of this secondary lesion in this portion of the lung cannot be over-rated. It has proved of much satisfaction to me as an aid to diagnosis in some of the cases I have examined. Having examined the apex of the lung, and not being convinced of the physical signs there, we should next examine the apex of the lower lobe at the point indicated, and if signs are manifest, it should at once satisfy us as to the diagnosis. The disease in the lower lobe next progresses towards the base in a manner somewhat similar to that at the upper lobe. We have the appearance of new foci with healthy lung between, the disease advancing in a more or less racimose manner. The extreme base of the lung escapes altogether.

We have so far traced out the localization of the primary lesion in the apex, then the early appearance and localization of the secondary lesion in the apex of the lower lobe, and the progress of the disease from these centres. True to the same law