and sometimes impossible. A patient may have a sore throat, with diphtheria bacilli present, and yet no membrane forms. If exposure to diphtheria is known to have occurred, it is better to regard the case as one of mild diphtheria and treat it accordingly.

There are certain mild exudative inflammations of the throat in which it is quite impossible to say whether we have diphtheria or pseudo-diphtheria to deal with. They look exactly alike, and the symptoms and duration are the same. Indeed, so much alike are they that if we were called in and told that one case was diphtheria and another pseudo-diphtheria we should be quite unable to say which one was the diphtheria. Should we wait for a bacteriological report and risk fatal poisoning and involvement of the larynx? No! We should inject antitoxin and make it a practical certainty that our patient will recover.

A fatal source of error is to confound catarrhal laryngitis or the old-fashioned inflammatory croup with diphtheria of the larynx. When there is even the smallest patch of membrane in the pharynx the diagnosis is clear, but unfortunately there are many cases of primary laryngeal diphtheria. We cannot be sure whether the laryngeal stenosis is inflammatory or membranous, and the only safe treatment is to inject antitoxin at once. Should subsequent events show the case to be one of diphtheria we have probably saved a life, and if not we have done no harm. I cannot be too emphatic on this point. Every case in which there is even a suspicion of laryngeal diphtheria should be promptly treated with antitoxin. Many years ago, in the pre-antitoxin days, I reported a series of cases treated with calomel fumigations with excellent results. Time and further experience have but confirmed the favorable opinion I then formed of this plan of of treatment.

For the past ten years I have treated all my cases of laryngeal diphtheria as follows:

1. Inject antitoxin, full doses.
2. Fume calomel under a tent (30 grs. an hour) until stenosis is relieved.
3. Intubate early if symptoms demand.

I regret that I have not a full record of my cases, but the results have been marvellously good. Every case I have seen and diagnosed early has recovered.

The early diagnosis from scarlet fever has in some instances puzzled me very much. The diseases often co-exist in the same patient, and in some malignant cases of scarlet fever there is a very imperfect developement of the rash—indeed the patient sometimes dies before the rash is due to appear. In three of my cases there was so much doubt that I injected