two. The morphological changes are the same, but there are important clinical differences in the diseases which have given rise to these morbid changes. So, I say, we have for the present a structural argument; but I place the argument for distinction upon a much higher ground, and I repeat that the true criterion of difference between the pathological changes is to be found much more certainly in their life histories than in their final anatomical expressions. Before leaving this question, I will make another observation in regard to structural characters, namely, that the characteristic anatomical element of tubercle is the lymphoid cell; that the distinguishing character of fibroid degeneration is a fibroid mass with fibro-cellular elements in it. Now, the question arises whether such mere pathological curiosities which can be distinctly recognized in the dead-house can find adequate expression in the wards of the hospital. If that were so, I should be content to leave them where they are, but I think these distinctions are not merely pathological curiosities, for if I follow them into the wards there can be recognized much more distinctly than in the dead-house, these three groups of phthisis which have been anatomically characterized. The better to illustrate what I have said, I will sketch the history of a case from each group.

First, I will give a representative case of tubercular phthisis, that form of phthisis in which the dominant anatomical element is tubercle, plus the secondary consequences in some form of pneumonia and some kind of fibroid tissue. We shall suppose the disease occurs in a girl about eighteen years of age. She has large pearly conjunctivæ, flushing cheek, and early symptoms of exhaustion. When the doctor finds her in this condition he makes a physical examination of the chest, and finds nothing which will account for the phenomena and constitutional disturbance. By and by, she begins to have fever in the evening, and as yet no evidence of lung trouble can be found. Perhaps six months after the beginning of this the physician discovers simply a crepitation at the summit of one lung, and he now knows definitely that the case is one of tubercular phthisis. Then begins cough, expectoration, and irregular fever.

The extension of the disease is steady, but the constitutional symptoms take the lead of local signs. The patient goes on, the disease gradually progressing, and probably within four years, at most, the case comes to an end. Now, before leaving that class of cases, let me make an observation—that the slowness or rapidity with which the case progresses, depends upon the secondary complication. I think it is almost an axiom that tubercle *per se* does not kill. If by any means we can keep the patient from having a further increase of tubercles, and what is more frequently possible, from further pneumonic or fibroid complications, the patient may live for many years.

It is according to the character of the secondary complications that the future of a case of pulmonary phthisis is determined. If the secondary complication is fibroid, the progress of the case is slow, and the patient may enjoy comparatively good health for a long time. If, on the other hand, the secondary complication is pneumonic, then there are developed in the lungs little pneumonias which produce fever and wasting, and the case is one which always progresses more or less rapidly.

In tubercular phthisis with secondary fibroid complication, the prognosis may be very good indeed. It is in such cases that some people think by drinking whiskey that a secondary fibroid complication takes place, and the life of the patient is prolonged beyond the average.

The peculiar clinical feature, however, of tubercular phthisis, is that at first there are but few local signs with profound constitutional disturbance.

Now we come to the clinical character of cases of pneumonic phthisis. The two kinds of pneumonia which we have taken into consideration are the ordinary croupous pneumonia and the cheesy pneumonia. Now I will represent croupous pneumonic phthisis by giving a specimen case. It is typical, and will answer for many cases. Here is the lung of a patient who was well known in the London Hospital; his name was MacIntosh; he came into the hospital with all the usual signs of pneumonia. The pneumonia, however, had some features which were exceptional, and which led me to give the prognosis in the case which I did. He had the usual symptoms of pneumonia, with this qualification; dulness over the seat of the disease was more complete than usual. There was diminished tactile vocal fremitus instead of increased. Instead of bronchial breathing there was feeble breathing, and, in short, there were present symptoms almost like those present with pleuritic effusion. There was no tubular breathing. There was diminished vocal resonance; and the dullness was considerable, but as there was no displacement of organs, no projecting of intercostal spaces, and there were profound constitutional symptoms. I had no difficulty in arriving at the conclusion that the case was one of pneumonia. I then predicted that we were certain to have trouble with this case, for I had observed that when there remained diminished tactile fremitus, and such physical signs as have been enumerated, the lungs were unable to fulfill their function, and so it was with MacIntosh. He expressed himself as feeling quite well, but the physical sounds remaining were diminished breath sounds, and diminished vocal resonance. He got quite well and went out of the hospital, but had this solid mass in the right lung. He was not long out, say about two months when he returned. I then watched him for twenty, two months. The course of the case was simply that of ordinary pneumonia, in which the pneumonic exudation was unabsorbed, probably from