tion that I have made pathologically? in short, is there a distinctive life history for the so-called tubercular phthisis, pneumonic phthisis and fibroid phthisis, and if there is, can it be so set forth that he who runs may read? Is it a pathological curiosity or is it easily recognizable? Now I venture to think within certain limits that it is so. There are, however, to be met with at the very starting certain difficulties. The first of these difficulties arises from this fact, which every practical man will recognise at once, that the symptoms due to diseased lungs are much more distinctly referable to impairment to the function of the lung than to the anatomical agent which is destroying or impairing the function. Recognition is sometimes difficult, but in the early stages with great care it can be done. Then there is a second difficulty which we meet with, and which is partly pathological, and that is with regard to terminology. There is no difficulty in understanding what is meant by a tubercular phthisis. We agree in this case; a suppurative destruction of the lung, where the anatomical element is tubercle, we will agree to call it tubercular phthisis, and if we wish to define a little further we call it a pneumonic phthisis or fibroid phthisis. When we come to pneumonic phthisis we at once meet with a considerable amount of complexity, not only the nature of the thing itself, but of the nature of the terminology which has been adopted. I do not pretend to make this quite plain, or to that maintenance or accuracy of knowledge on this subject which would enable me to speak on the subject with the same confidence as the other subjects.

There are three forms of pneumonia which we will readily recognize; there is the common inflammation which attacks the base of the lung and with a little pain or uneasiness at the side, and is followed by crepitation and tubular breathing, which usually terminates by resolution on the 5th, or 6th, or 7th day. That is the first and the most common form of pneumonia. Then there is a second form altogether different to this, which affects the upper part of the lung, which, instead of beginning abruptly, by fever—sometimes begins insidiously and continues to march downward. The characteristic of this disease is a kind of cheesy stuff like that found in the ripe scrofulous gland, that of common pneumonia being a granite red. The anatomical element of the cheesy pneumonia being a sort of link between these two, connecting them together. There is a third form of pneumonia that is called the catarrhal or lobular pneumonia. This sort of pneumonia is common in children, resulting from capillary bronchitis and surrounding the smaller bronchii. There are these three forms of pneumonia, and every one of them, although with different degrees of liability, is capable of developing phthisis; that is to say, every one of these forms of pneumonia is capable of giving rise to exudations, and which, when not absorbed and undergoing suppurative destruction, comes immediately within the pale of phthisis. The common pneumonia may do this, although rarely. The cheesy and pneumonic does it commonly. The catarrhal with an intermediate degree of frequency. We have thus much complexity in enquiring into the definitions of these groups of phthisis. I will not venture to intrude too closely on this ground at present, because it would occupy too much time, and blur the outlines of a picture I wish to keep clear. I will confine my illustrations to cases arising out of croupous and cheesy pneumonic phthisis. Are we justified in distinguishing these three groups of phthisis? First of all there is a tubercular phthisis—the phthisis produced by the destructive agency of tubercles, and the consequence of tubercles in the lungs. My belief in chronic phthisis is that mere tubercle never kill. If one could keep them quiet from producing a secondary change they could keep the patient alive, and also from fever complications, I see no reason why they cannot live as well as anybody else. With regard to the 1st group the most distinguishing point is that, whilst the tubercular matters are at the beginning few and slight, the constitutional symptoms are many and profound.

Take a typical case in a girl. Here is a girl perhaps with the history of phthisis in the female portion of the family. She is about eighteen, has large eyes, blushes easily, and for some time has been getting out of health. The Doctor is called in, and, no matter how minute the examination is, he simply finds the temperature a little elevated, the breathing quick, and that is all. He has before him a case where the constitution is gravely distressed and in which there is nothing local to cause it. The experienced physician immediately suspects tubercular phthisis. The patient gets thinner, and a cough begins, bye-and-bye a little dulness is found, and the chest gets flattened; then the usual symptom of phthisis set in, and, although there is improvement from time to time, the main progress is nearly always downward, and, in from two to three or four years, the case terminates, as a rule, with death.

It is marked, as I have said, in the early stages by