CASE 1.—FIBRINOUS PLEURISY. Miss C. N., aged 46 ; feeble health always. Family history of rheumatism and tuberculosis. Called January 8, 1900. Patient suffering from severe chill, lancinating pain in region of right nipple extending over a surface as large as the hand. Dry cough, scant expectoration streaked with blood, dry rales, temp. following chill, 103 deg. F., pulse 120, resp. 50. Patient propped up in chair to relieve tension on pleura. Bronchial breathing; friction rub present; no exudate discernible. Diagnosis acute fibrinous pleurisy. Gave epsom salts, one ounce, to insure free purgation. Applied warm Antiphlogistine over the entire thoratic walls front and back. At 10 p.m. I found that the patient had had a copious evacuation. Removed Antiphlogistine and applied a fresh coat. Pain and dyspnœa were greatly relieved, temp. 101, pulse 95, and patient was able to resume the recumbent position. January 9th (9 a.m.), patient was free from pain, temp. 99, pulse 84, resp. 22. She was very comfortable. No untoward pleural symptoms. Applied Antiphlogistine daily for three days when recovery had so far progressed that further attendance was deemed unnecessary.

CASE 2.—PNEUMONIA AND PERICARDITIS. H. D., aged 60, hotel keeper, heavy eater and drinker. Contracted a well defined attack of unilateral pneumonia of left lower lobe, May 5th, 1900, severe chill, lasted over an hour. Temp. 105, pulse 104, resp. 38; tongue coated, foul-smelling breath, consolidation over posterior portion of left lobe. May 7th, cough and rusty sputum; other symptoms practically unchanged. Ordered rest, liquid diet, and in short, gave usual treatment for pneumonia. May 8th (5 a.m.), patient had another severe chill and pericarditis with effusion supervened with severe pain in left axillary region. Temp. 105, pulse 140, weak and intermittent. Dislocation of heart beat to right of sternum. Dyspnœa out of all proportion to extent of effusion. Patient delirious and tossing about in great mental and physical distress. Enveloped area, well over and around the site of pain and effusion with a coating an inch thick of warm Antiphlogistine. Placed patient on as dry diet as possible and gave a capsule containing strych. 1-20, glonoin 1-50, pilocarpine 1-10, every three hours. Changed Antiphlogistine every 8 hours for the first 48 hours, then every 24 hours for three days following. Watched symptoms closely, and under this line of treatment patient showed immediate and continuous improvement. May 10th, the symptoms had become so favourable that I considered the danger over. Pain was pretty well under control before second application began to dry. Pulse beats became slower, less intermittent and increased in volume. Temp. dropped 3 deg. in as many