have usually no such effects. It seems clear then that it is correct to make an occasional count of the white blood-cells, as a routine practice in typhoid fever, and, if with the development of symptoms that lead to the suspicion of the occurrence of a perforation, the count should be repeated, and if leucocytosis is found present, and other typhoid complications can be excluded, this symptom would justify the assumption that a perforation has occurred. In some cases of profound typhoid toxæmia leucocytosis may not occur.

It would be well in suspected perforation to have a surgeon see the case with the attending physician, and it would be a good hospital practice to adopt Osler's suggestion that the house-surgeon should visit these cases in the wards with the house-physician.

The dangers of surgical interference are unquestionably very great. The following words of Wilson, written twelve years ago, state the question very clearly: "Granted that the chances of a successful issue are heavily against you, that the patient is in the midst or at the end of a long sickness, that his tissues are in the worst state to stand the injuries from the knife, that the lesions of the gut may be very extensive, that the vital forces are at the lowest ebb; no one has yet hesitated to perform a tracheotomy in the laryngeal complications of typhoid fever which requires it to save life, for these reasons. The operative treatment of purulent peritonitis has been performed many times successfully by the gynæcologist in conditions less promising. In point of fact, the objections that may be urged against laparotomy in intestinal perforation in enteric fever are no more forcible than those which would have been made use of at first against the same operation in gunshot wounds of the abdomen. The courage to perform it will come from the knowledge that the only alternative is the patient's death."

I am sorry that I can only count one recovery among my ten cases, and that one was not an ordinary perforation. I will allude to it again. Another of my cases lived over six weeks and ultimately died, subsequent to the occurrence of the third perforation. This young man did well for four weeks after I closed his first perforation. I regarded him as saved, when the second perforation occurred. The incision had not fully closed and the second perforation occurred *in situ*, and the contents of the intestines all escaped externally, and I think that had not a third perforation occurred within the abdomen on the forty-second day after operation, that he would have survived the first two. In one case I opened the abdomen and failed to find any evidence of perforation, only about two feet of completely collapsed bowel, from some cause undiscovered. This has occurred to other surgeons, and only recently a similar case occurred in the Johns Hopkins Hospital. My patient, as well as the one in Baltimore, recovered, the operation apparently having