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CO-EXISTENCE OF INFECTIOUS DISEASES IN THE SAME INDIVIDUAL.—Edward Carmichael, M.D., M.R.C.P., Edin., cites the following interesting case in the *Lancet* of May 19th, 1894:

The patient, a boy six years of age, had been ill for four days before I saw him, suffering from sore throat, vomiting, and a slight rash. I suspected it might prove to be a case of scarlet fever. The boy was still feverish, although no rash was to be seen, and accordingly I looked for desquamation. This soon appeared and confirmed the diagnosis. What puzzled me was the temperature still remaining high. Diarrhœa set in, then splenic enlargement, but there were no spots on the abdomen. The enlargement of the spleen became so marked and the anæmia so profound that I began to fear I had to do with an acute case of leucocythæmia. Dr. Claud Muirhead kindly saw the boy in consultation with me, and after examination was inclined to think it might be leucocythæmia, but thought I should still keep typhoid fever in view seeing the microscopic examination of the blood showed no very marked increase of leucocytes. After a prolonged illness the spleen began to diminish, the diarrhœa to cease, and a slow but steady recovery ensued, thus putting leucocythæmia out of the question. The interesting and, as I have said, unique point was that this boy infected his sister, whom we had to keep in the house, with a distinct and typical scarlet fever which set in about ten days after my visits began; and some weeks after the father, while helping to nourish the boy, went through a typical typhoid fever, with the usual temperature curve, rash, and diarrhœa, so that my diagnosis was that the boy had both scarlet fever and typhoid fever, that he gave the one to his sister and the other to his father. All three patients recovered. No defective drainage or water or milk supply could be traced, but I found that a day or to before the illness began the boy had let a key fall through a grating of the street gutter, to recover which he lifted the grating, lay down and scraped among the *débris*.

THE FORMS OF PERITONITIS, THEIR RELATION TO APPENDICITIS, AND THE ETIOLOGY OF EACH.—Roswell Park, A.M., M.D., *Medical Age*, January 25, 1894, considers that failure of diagnosing the lesion of appendicitis is best explained upon the following grounds:

1. To the very common and early diffusion of pain with which many of these cases begin, even those where the phenomena subsequently become strongly localized. This is not always due to ignorance on the part of the patient, for many intelligent people are unable to indicate the place where they first feel the pain of which they so bitterly complain.

2. To the frequent insidiousness of the disease itself, and especially in many of those cases in which pus forms.

3. To carelessness in the first examination, and to failure to appreciate the real nature of the lesion in true appendicitis. This is purely a matter of ignorance, and concerns mainly those men—their number very rapidly diminishing—who diagnosticate all these cases as inflammation of the bowels.

4. To failure to recognize the induration or tumor in the right ileo-cæcal region, which failure may sometimes be well excused because of the distention of the abdomen, the acute sensibility of the part, and the pain which the slightest manipulation produces; in other words, to the impossibility of proper examination.

5. To the fact that some of these cases present, almost from the outset, common signs and symptoms of primary obstruction of the bowels, and that the diagnosis once made by the attendant is not altered to suit the other aspects of the case as they develop. This surgeon thinks that we must have charity for those who make this mistake, because to his knowledge it has been made by good and competent general practitioners.

Dr. Park has learned to believe that,—

1. There is no such thing as idiopathic peritonitis. Every so-called case has a definite origin, which, however, it may not be always possible easily to determine.