

It will be observed from these two tables that the percentage of post-scarlatinal diphtheria at the London Fever Hospital has been uniformly lower than that at the hospitals of the Asylums Board. In both tables, however, a conspicuous increase in the percentage of post-scarlatinal diphtheria appears in 1895. Whereas, however, in the Asylums Board hospitals this percentage continues to increase in 1896 and 1897, in the London Fever Hospital table it suddenly falls in 1896, and continues to diminish, until in 1898 no case occurs. This difference is rendered more conspicuous when it is pointed out that of the 3 cases in 1896, 2 occurred before the month of March, when our record commences.

Since that date but 2 cases of post-scarlatinal diphtheria have occurred among 1,332 scarlet fever patients admitted, in spite of the admission of 150 cases of diphtheria. Of these 2 cases 1 was isolated on account of rhinorrhoea accompanied by the presence of diphtheria bacilli in the nose. In an adjoining room was a case of diphtheria with scarlet fever. It is possible that the mild attack of faucial diphtheria which supervened six weeks after admission was contracted from this source. On the other hand, the throat may have been infected from the nose. For the second case no cause could be assigned. In neither of them were bacilli found on admission. Both made good recovery.

The first of these two patients was included in a series of 51 cases of post-scarlatinal rhinitis described by Todd,<sup>5</sup> his observations covering a part of the period included in our report. The leading characteristics of this complaint were as follows: It attacked children only, causing external rhinitis with slight watery discharge. It caused no constitutional disturbances. It was definitely contagious, spreading as rhinitis from child to child, but it did not give rise to faucial or laryngeal diphtheria. A bacillus was isolated by Todd from the noses of these patients, which by all available tests, including that of pathogenicity, was the true diphtheria bacillus, yet he failed in nearly every case to discover any such bacillus in their throats. Were these cases of nasal diphtheria? If so, why did they give rise to rhinitis only and not to faucial diphtheria, and why did not the disease spread beyond the nose? Whatever the explanation, the fact remains that post-scarlatinal faucial diphtheria did not arise. Nevertheless it appears to us that such cases of rhinitis might be the starting point of faucial diphtheria, and that in future they will require careful supervision.

#### GENERAL CONCLUSIONS.

We believe that post-scarlatinal diphtheria is due to the introduction of unrecognized cases of diphtheria into the scarlet fever wards, and that this can only be obviated by systematic bacteriological examinations of all cases on admission, and by separation of those in whose throats diphtheria bacilli are found. If Hoffman's bacillus, which we believe to have no direct causal connection with