

second attack of what was presumably diphtheria about three weeks later; it is true that the patient was not under observation during this second attack, but cultures made only a week later showed the diphtheria bacillus to be present in the throat. During this second attack no antitoxine was used, and yet a third attack occurred thirty-seven days after the beginning of the second. In this case, then, the period over which active immunity lasted would seem to be about thirty-seven days, whilst that over which passive (antitoxine) immunity lasted was only twenty-one days.

It seems highly probable that auto-infection occurs in most cases of croupous pneumonia and in many of streptococcus throat; it is also known that virulent diphtheria bacilli are occasionally found in the throats of healthy people. This case would seem to prove definitely that auto-infection does occur in diphtheria, as it was shown that the diphtheria bacilli were constantly present in the throat between the second and third attacks, the throat all this time presenting a perfectly normal appearance. It is only fair to conclude that when the immunity was worn out the individual became affected by the bacilli then present.

Although the patient was not under constant observation from January 7th, when the first attack began, until April 10th, when the diphtheria bacilli finally disappeared from the throat, yet cultures were made frequently enough to warrant the assumption that the bacilli were continuously present over the period between the dates specified. In an observation recorded in the *British Medical Journal* of which Sevestre speaks, the bacilli were obtained from the throat seven months after the disappearance of the membrane; but in this case the cultures were few and far between. The question of the survival of the diphtheria bacilli after the disappearance of the membrane is an important one from a prophylactic point of view, for we must admit the possibility if not the probability of individuals such as our patient transmitting the disease to others. Such a possibility once being established, the isolation of diphtheria cases would not be subject to any fixed law, but would depend on the demonstration of the presence or absence of the bacillus in the throat.—*Johns Hopkins Hosp. Bulletin*.

ETHMOID DISEASE.—Dr. Thrasher, of Cincinnati, considers that the middle turbinate bone is more frequently the seat of disease in so-called catarrhal cases than any other part of the nose and from its anatomical situation in the upper part of the nasal fossa, from pressure when in a swollen condition may cause all sorts of reflex phenomena. He advocates removal of the enlarged tissue with the cold snare, warning against the use of the cautery in this situation (with which

the editor agrees). He describes the principal symptoms as follows:

"1. Pain, generally referred to the infra or supra-orbital nerve, sometimes to the eye or orbit (more especially when the ethmoid cells are also involved), and occasionally to the ear. I have no doubt but some of the severe facial neuralgias for which exsection of the nerve has been performed would have been better relieved by exsection of a diseased middle turbinate.

"2. Nasal discharge, sometimes of exceedingly unpleasant character. The discharge from the cells themselves often irritates the membrane in front, giving rise to a sore and red nasal extremity.

"3. Obstruction to breathing and anosmia; but frequently the breathing channel is not impeded even in severe inflammation of the middle turbinate.

"4. Obstruction of the natural openings of the accessory cavities, notably the antral, frontal, and anterior ethmoid, occasioning in each case its own train of symptoms.

"5. External deformity of the nose only, and when the ethmoid cells are involved the eye is often misplaced by orbital swellings.

"6. Various reflex nervous phenomena."

GNORRHOËAL PLEURISY.—In a recent article Fautout reviews all the reported cases of this nature. As a result of this review he finds that, though a good many cases are reported, very few present sufficient evidence to be classed as gonorrhœal pleurisy. One case, however, reported by Bordoni-Uffreduzzi, seems to definitely prove that gonorrhœal pleurisy can occur. The case was one of a young girl, aged eleven years, who was assaulted by an individual with gonorrhœa. Some days afterward she was attacked with severe polyarthritis and later a double pleurisy developed. She also showed symptoms of endo- and pericarditis. Dr. Mazza, on examination of cover-slips from the pleural exudate, found numerous organisms morphologically resembling gonococci within the leucocytes. Furthermore, he was able by Wertheim's method to cultivate the organism and show that he was dealing with a pure culture of Neisser's coccus. The author comments on the need of further bacteriological investigation on this subject.—*Gazette Médicale de Paris*, October 5, 1895.

DR. STEELE, of Plaistow, reporting a case of erysipelas neonatorum successfully treated by anti-streptococcic serum remarks:—In the practice of the Plaistow Maternity Charity I have seen a fair number of cases of erysipelas neonatorum, but I have never seen one recover when the disease was so far advanced as in this case. I am convinced that the child's recovery is due to the anti-streptococcic serum. No other treatment of any kind was adopted.—*Brit. Med. Jour.*