

mittent and not an enteric fever from the beginning in such a case.

7. Perhaps of all the differences between home and foreign enteric fever, the most apparent and the one longest observed in India is the marked departure from the typical temperature chart of the home variety. In India we do not find that gradual elevation of the temperature so common at home in the commencement of the attack, but on the contrary the thermometer registers 102° in the morning or 104° in the evening when first used. As the case progresses, too, we have peculiar upward starts of the temperature, often followed by corresponding depressions, and later on in the disease periods of apyrexia, or even of subnormal temperature, these again being followed by sudden exacerbations. In fact, the temperature chart of Indian enteric fever indicates it as a disease of sudden accession, irregular in its course and liable to change its character before its termination.

8. As an eighth peculiarity it may be stated that in India there is not that long apparent stage of incubation which occurs in Europe, during which the patient is said to "sicken for fever" for many days before he is attacked. In India I have rarely been able to make a soldier admit feeling ill or "off his feed" for more than two or three days before coming to hospital.

Now, if we admit all these peculiarities and divergences between home and foreign enteric fever, may not this lead to a correct recognition of that large group of febrile diseases now appearing in our returns as remittent fever, febricula, and many cases of the so-called simple continued fever? May it not become possible to relegate these complaints to their proper position in the nomenclature of diseases, remittent fever being merged in *ague plus* some complication, such as hepatitis, hepatic abscess,

dysentery, head affection, splenitis or phthisis pulmonalis, etc.? Then we could restrict simple continued to thermic fever, the initial stage of heat apoplexy. With regard to febricula it might also be possible to differentiate between its various forms, whether these be due to exposure to heat and fatigue (thermic febricula), abuse of alcohol (drink febricula), error in diet (food febricula), or enteroid fever.

Supposing it be true that foreign enteric fever manifests itself in every gradation of severity, from slight indisposition and febricula to the most severe type met with in Europe, and supposing this to be the rule and not the exception in India, we must then, I think, look for some explanation of this peculiarity to the etiology of the disease. The theory I would suggest to account for this is that the *materies morbi* of enteric fever exists in India in many gradations of intensity, and that the severity of any given case is in proportion rather to the strength and maturity of the poison entering the system than to the quantity.

Whilst in cold countries the poison appears to come to maturity more slowly, but more certainly capable of producing the disease in a virulent form with all its characteristic symptoms, in India this does not appear to hold good.

The explanation I would offer is that the source of enteric fever poison, namely contaminated water, undergoes the process of zymosis or fermentation more rapidly under the favouring influences of open drains, heat, and moisture in India; but that the microbe outruns its own growth as it were, and less often, in proportion to its immature production in India, attains the full degree of elaboration which a longer period, under less favouring influences, enables it to arrive at in the dark, cold, underground sewers of Europe.