hospital, I again examined her chest to find the presence of cavities distinctly indicated, and my patient soon to succumb to pulmonary disease. Here is a case where I have no doubt the onset of acute tuberculosis was mistaken for typhoid. I could invite your attention to other cases of tuberculosis where the tubercular disease has been attended by marked nervous symptoms, chronic meningitis with effusion, where the symptoms so closely resembled typhoid fever that it was impossible to distinguish the disease except by post-mortem examination.

I would lay stress upon the error made by so many in relying upon nocturnal exacerbation of temperature as an indication of typhoid. In talking over cases among ourselves, how we say, "I think the case is going to turn out typhoid, he had a rise of temperature last night, and his temperature is down this morning"; or, as a physician once said to me over a case where I held the diagnosis of typhoid in dispute, "Well, the temperature chart shows typhoid." Let me assert that no temperature chart *can* show typhoid. Look at the first twenty-one days of Alice Wilson. Look at Chart 3, which is that from a man who had acute pleuritis with effusion. Look at Chart 4, from a case of true typhoid, and forever disabuse your mind of the thought that there is any actual diagnosis value, so far as typhoid is concerned, in the temperature. Do not misunderstand me, gentlemen. I am not saying the clinical thermometer is useless in this disease. It can distinguish the difference between real and feigned disease; it can show you the degree of acuteness of your case; it can predict a hemorrhage as faithfully as the barometer can predict a storm, but it cannot write the diagnosis for you; it cannot supply brains.

I would say that sudden rises of temperature, followed by a sudden fall, would indicate in the system as it would out of the system, *rapid oxidation*. In the former case, the rapid oxidation of some morbid material which has entered the blood, or which has induced rapid oxidation of the normal elements of the blood and tissue, and I think this material will be found generally to be pus, or dead tissue element. What are the most reliable symptoms of typhoid fever? I assert, again, they are abdominal symptoms; they are tympanitis, pain in the right iliac fossa, gurgling diarrhœa, sometimes a rash; and, at the risk of appearing arbitrary, I will, with your permission, refer to some of these symptoms.

Tympanitis.—In this, I believe, we have the one symptom which is worthy the most special attention; it is not only of diagnostic value, but of the greatest value in prognosis. This tympanitis, in bad cases, comes on early in the attack, about the third or fourth day; the abdomen is then full, hard and tense, the recti muscles rigid, the percussion note drummy. Such cases run the worst course of any in typhoid; in these the prognosis is the gravest, and you can readily see the reason. I think you will admit that after you have passed the first ten days, the danger in typhoid is from one of three causes, viz., *hæmorrhage*, *perforation*, or *asthenia*. Now, if you have the bowel distended with gas, ad-maximum, you have clearly the most favorable condition possible for both hæmorrhage and perforation. The bowel can be paralyzed by distention, leaving its contents to irritate and aid the process of destructive inflammation. If the walls of the intestinal vessels have been weakened, they are more prone to rupture, because of the great distention of the bowel; and the ensuing hæmorrhage more severe from the same cause.

Regarding perforation, I believe the gas in the bowel is more often the cause than the process of ulceration. If you have seen many perforations from typhoid you will remember that most of them were perforations like pricks with a pin, or a trifle larger; the solitary gland had ulcerated away; the muscle had been irritated by the contents of the bowel remaining in a fermenting state in contact with it; the secretions had been suppressed, because of the same distention, and the point thinnest in the bowel gives way under the pressure. Now, is the gas always in the intestine? I think, in many cases, the peritoneal sac is enormously distended with gas. We see in cases of intestinal obstruction, enormous distention. In such cases we have no hæmorrhage, no perforation, and our patient dies, in their absence, presumably from distention. I am of the opinion that abdominal distention can cause death from mere pressure upon the sympathetic nervous system, reflexively slowing the heart's action.

Pain in the abdomen is pretty constant in typhoid, and its absence may be regarded as suspicious, the pain is often nearer the umbilicus than in