while in England a medical man is able to pronounce with tolerable certainty that his patient is "in for typhoid," experience teaches us in India to be more guarded, for although to have the courage of our opinions is a good thing, it will not improve our reputation with our patients to declare at the outset a case to be "typhoid" which may recover within a week.

And we may here discuss the point —Are these transient febrile complaints, lasting a week or ten days, which are so common in India, allied to enteric fever? They appear to be so for the following reasons: 1, They occur at the same time as acknowledged cases of that disease; 2, they are most prevalent in the hot and dry months, April, May and June, at a time when ague is at its minimum; 3, they are readily distinguishable from ague, and are usually called remittent fever; 4, they are frequently associated with the recognized concomitants of enteric fever, such as sore throat, etc.; 5, they do not present the complications of ague, such as hepatitis, jaundice, dysentery, or melæna; 6, they may develop all the pathognomonic symptoms of enteric fever, or they may run on for months without doing so, or without developing any complication to account for their continuance; 7, quinine does not check their progress; 8, they attack young soldiers in particular, like enteric fever; 9, they are indistinguishable from the commencement of enteric fever; 10, relapse is infrequent.

3. The next peculiarity of foreign enteric fever is the frequent existence of constipation, or of alternate constipation and looseness of the bowels.

4. Often associated with this peculiarity is faintness and fewness of the characteristic lenticular rose spots.

5. The abdominal lesions are less marked, Peyer's patches less infracted, ulcerations are less numerous and smaller. In India we often find that perforation takes place in the most unexpected manner when all abdominal symptoms were absent, and we find, on *post-mortem* examination, merely a small punched-out aperture, with finely eroded edges, whereas, in England the ulcer is commonly large, and has eaten through a thick mass of infiltrated glands, and presents a soft, shreddy appearance.

6. Another marked peculiarity of foreign enteric fever is its great tendency to relapse or to be followed by secondary fever. In nine cases out of ten this has occurred in my experience; the reverse is the case in Europe. Moreover, when relapse does take place in Europe, the symptoms of enteric fever are all repeated over again. In India relapse is usually a nondescript secondary fever, of a remittent type, with a tendency to run on indefinitely, the temperature falling in the morning to near, and sometimes even below, the normal point. In some cases distinct intervals of apyrexia occur, and in those cases, if closely looked for, an allied condition may be observable about mid-day. The patient becomes restless, his face paler, and he draws the bedclothes round him. To what extent this secondary fever is really agucish, that is, malarious, appears to me uncertain, for it is not accompanied by the complications of ague and persists unchecked by quinine. It is as common among those who have not previously suffered from malaria as in those who have. I have found it persistent in the hills, where there was not a case of disease due to malaria in the station. Whether this frequent relapse, or secondary fever, as I prefer to call it, be due to malaria or to other causes, this peculiarity must have gone far in the past, and still goes far, to satisfy the minds of those who believe in the existence of a specific bilious remittent fever in India, and that they have had to do with a malarious re-