fever, render the prognosis most unfavorable. The same is true of copious intestinal hemorrhages coming on after the third week of the fever, as well as of all those glandular changes which are a part of the natural history of the fever, and which I have already described.

Any of these changes may lead to complications which endanger the life of the patient, and consequently when they occur, necessitate a guarded, if not an unfavorable prognosis.

Some of the prominent accidental complications which may occur in the course of typhoid fever, but which do not belong to its regular history, have their seat in the respiratory organs. Slight bronchial catarrh is present in nearly every case, and can hardly be regarded as a complication. It is so much a part of the clinical history of the disease, that some have named this fever bronchial typhus. There is another much more serious bronchial complication, namely, catarrh of the smaller bronchi, or capillary bronchitis. This usually comes on during the second or third week of the disease, and, if extensive, greatly endangers the life of the patient. If then during this period of the fever you have sub-crepitant rôles suddenly developed over the whole of both lungs, accompanied by great dyspnœa and an abundant expectoration of stringy mucus, you are warranted in giving an unfavorable prognosis.

Extensive œdema of the lungs occurring with, or independent of, capillary bronchitis and pulmonary congestion, sometimes comes on suddenly during the third week of typhoid fever, and indicates great failure of heart-power. The slightest indication of its occurrence should always be regarded with suspicion. It is not unfrequently accompanied by more or less extensive hemorrhagic infarctions of the lungs; these depend on embolism of some of the branches of the pulmonary artery, due to fragments of clots which have formed in the right side of the heart, the result of the cardiac weakness. They often lead to gangrene of the lung. It is sometimes impossible to diagnosticate their existence during life.

Pneumonia, when it complicates typhoid fever, is generally latent. It comes on very insidiously, and, unless you are on the watch for its development, and make frequent and careful physical examinations, it will pass unrecognized. It is more frequently developed during the third and fourth week of the fever, and usually is catarrhal rather than croupous in character. At first only single lobules are involved, but after a time an entire lobe becomes consolidated. When irregular variations in temperature occur during convalescence, or during the third or fourth week of the fever, there is reason to suspect the development of pneumonia. In the majority of cases the characteristic pneumonic cough and expectoration are absent. Whenever an extensive pneumonia complicates typhoid fever, the prognosis is especially unfavorable.

Pleurisy does not occur so frequently as a complication of typhoid fever, as does pneumonia or bronchitis. When it does occur, pus is almost invariably the product of the inflammatory process. Usually it comes on late in the disease, comes on insidiously, and is quite likely to pass unrecognized unless frequent physical examinations of the chest are made. In many instances it is really a sequela of the fever, not developing until three or four weeks after the fever has run its course. Its occurrence must always be regarded as unfavorable; for a year or even longer time must elapse before recovery can take place, and even then recovery is doubtful.

Occasionally, laryngitis is a serious complication of this fever. It generally occurs in those cases where the fever has been very protracted, and there is great prostration. Its presence is marked by sudden and very intense inflammation of the mucous membrane of the glottis, which is liable to become œdematous, when death may suddenly occur. It may lead to ulceration of the mucous membrane. Whenever, during any stage of a typhoid fever, the characteristic symptoms of laryngeal obstruction occur, remember the danger of œdema glottidis and of extensive laryngeal ulceration, and promptly resort to those means which shall relieve the unpleasant symptoms, and avert the danger which threatens your patient.

Pyæmia may be met with as a complication during convalescence from typhoid fever, but it is not of as frequent occurrence as septicæmia. Whenever we have septic poisoning developed, with extensive sloughs in the intestines, the prognosis is exceedingly unfavorable.

Acute gastric catarrh is another complication of this fever, the possible occurrence of which must enter into your prognosis. A patient may have reached his fourth week, and be rapidly convalescing, his desire for food returning; you endeavor to hasten his recovery by increasing the quantity of food taken, or by allowing him to partake freely of such articles of food as are difficult of digestion. The result of this overcrowding, or of imprudence in diet, is irritation and inflammation of the enfeebled gastric mucous membrane. Vomiting of a stringy mucus occurs, which, by its prostrating effects, endangers or destroys the life of your already enfeebled patient. I would impress you with the importance of exercising the greatest care in regard to the diet of patients convalescing from typhoid fever. They should be restricted to milk and nutritious broths in moderate quantity until all danger from this complication shall have passed.

Disturbances of nerve function have been considered under the head of symptoms, but, not unfrequently, certain brain and nerve