found amenable to early operation with removal. The relative infrequency of infection of the pleural blood is remarkable. I have personally seen only two cases of gas infection of the pleural blood, both of which recovered. A number of other infections by large bacilli, which might have been gas bacilli, but were not certainly so, have been treated as empyema and drained, and so far as we know, with recovery in all cases.

2. *Continued Fevers, or P.U.O. Cases.*

In a winter such as 1916-17 has been, there has been an enormous prevalence of infection of the respiratory tract, including pneumonia, but it is remarkable how little prevalent lobar pneumonia has been. Severe cases of bronchitis, tracheitis and laryngitis are common, and loss of the speaking voice is very often seen. It is difficult to distinguish mild broncho-pneumonia from severe cases of bronchitis, and the presence of pneumococcus is in no sense diagnostic, as most cases show it to be present. The diagnosis has to be made on clinical grounds, and most frequently a high degree of physical disturbance, continued high fever, and the presence of blood streaks, blood or rose color in the sputum is used to determine the diagnosis in favor of broncho-pneumonia.

A tendency to extension of the disease from one part of the lung to another at different times in the course of the malady is remarkable, so that sometimes patients are ill for weeks, with apparent extensions of the disease; the final chart of such a patient looks like a typhoid fever chart; so true is this, that in many cases we have been compelled to make agglutination tests for typhoid and para-typhoid fever, with almost constantly negative results. The absence of sunny, clear weather in winter in the northern parts of France seems to be responsible for the slow convalescence of many patients suffering from disease of the respiratory tract.

Considering the cases of continued fever coming to the hospital, it becomes necessary to divide them into the constituent diseases, viz., typhoid and para-typhoid fevers, so called trench fever, and other less specific infections. Since the whole army is inoculated, the clinician is no longer able to determine on clinical grounds whether a case of continued fever be typhoid, para-typhoid, or another. The classical signs of enlarged palpable spleen, rose spots, etc., are too often absent. A dirty tongue implies gastro-intestinal disturbance, but is in no wise specific. The old-fashioned Widal test is useless because it is positive by reason of inoculation. It therefore becomes necessary to make a quantitative agglutination test, which is done in series; this is done at intervals of not less than four days, and the positive diagnosis of typhoid or para-typhoid "A" or "B" may be possible by observing that there is an ag-