

sterilizer. Dr. A. Caillé said that when he wished to examine a patient with diphtheria he never sat down in the sick-room. He had the child held in the lap of the nurse while he took up a position to one side. He used a spoon as a tongue depressor, and never carried a spatula. After cleansing his hands thoroughly he used some Labarraque's solution upon them, which he always carried with him. For intubations he wore an apron. The physician was not called upon to make himself pleasant. The cases were for the most part serious or desperate. There was no need of wasting time in dallying with the child, and so forth. After leaving the house, a walk of ten blocks would do a great deal towards disinfecting the clothing. The nurses should have long gowns with hoods, and the sleeves should be secure at the wrists by elastic bands. They should be provided with and directed to use the solution referred to and also Javelle water. The disinfection of the patient's naso-pharynx was of the utmost importance, and attention should be directed to insure constant cleanliness of the teeth. The nurses should also use gargles and insufflations.

Dr. Johnson said : Of all germ diseases probably none have been fraught with more terror and less been known about them than diphtheria and scarlet fever. Diphtheria is as old as civilization. Homer mentions it as attacking the armies of Ulysses. Hippocrates, the father of medicine, Celsus, Sydenham and others, from the dawn of medical history, have described it under many different names. In the Middle Ages it was known as the *Malum Egypticum*. The earliest medicinal records of this country describe it as the putrid sore throat of New England. Yet during all these ages that it has prevailed, no one has known its cause. Like the pestilence that walks in darkness, no one knows how it came or how to stop its ravages.

A mother attending her diphtheritic child, puts a blister on her chest, thinking she is going to have pneumonia. The raw surface becomes covered with the diph-

theritic exudation, and she dies from it—no false membrane having formed in the mouth or throat. A mother with cracked nipples nurses her diphtheritic baby, and has diphtheria of the breast. A patient, in the wards of a hospital where there is diphtheria, has leeches applied, and the diphtheritic membrane forms on the leech-bites.

The enormous number of cases like the above, which have been authenticated, produced the conviction that diphtheria was at first a local disease. Since the germ of diphtheria has been discovered, inoculation-experiments have been so frequently shown that it is first local and afterwards constitutional. It may be laid down as thoroughly established, that on whatever part of the body diphtheria starts, that is the focus of infection. From that part of the body the poison radiates through the body until, by a general blood-poisoning, it renders the organism incapable of life.

Why diphtheria should attack the tonsils and mucous membrane of the pharynx is easily understood. The germs of diphtheria dry up and float around in the air. As they are breathed in they lodge on the tongue. This furnishes the moisture necessary to revive them and the heat at which they most readily propagate. If physicians would only spend a few minutes every day in examining their own saliva, they would be amazed at the bacteriological laboratories they carry around with them. I shall never forget my own feelings the first time I made such an examination of my own saliva stained with aniline dyes.

Prof. Sternberg had demonstrated that pneumonia was caused by a disease-germ. A valued friend of mine had an attack of pneumonia that looked as though it would be inevitably fatal. I had been up all night with him, and toward morning he began to expectorate. When I left the patient I took the expectoration to see if I could find the germ of pneumonia myself. After making slide after slide of the sputa, I made a slide with the same care of