dissection of the uterus and uterine vessels after death may still reveal no macroscopic signs of disease. The diagnosis may turn almost entirely upon blood-culture.

A bone injury in a child suffering from sudden fever must always receive critical examination; and the skeleton (especially the long bones) must be carefully examined if high fever, abrupt in origin, exists in a child without ascertained cause. Unfortunately, cases of infective osteomyelitis, due to *Staphylococcus aureus,* become pyæmic so rapidly that even the early detection of the focus and its prompt treatment rarely saves the patient; but probably some cases are saved by early diagnosis, and do not run this fulminating course. If incisions are made into doubtful areas of inflammation, cultures of the exuding fluid should be made, however innocent it appears to the naked eye. Now and again a drop of serum will yield a copious growth of staphylococci in the warm incubator within six to eight hours; this should at once lead to further surgical procedure, if no fall has taken place in the temperature or in the leucocyte count, and if no alleviation has occurred in the general condition of the patient as the result of the first incision.

(4) *Malta Fever.*—Unless the attention is called to the possibility of this infection, it may be overlooked. Residence in a Malta fever district may have been of short duration, and no obvious illness may have occurred there. The patient may come under observation for general weakness, neuralgic joint pains, or the fever, some months or even years afterwards, and may give no history suggesting his infection. The diagnosis is made either from a positive blood-culture (rarely possible in such a case), or from a combination of leucopenia with agglutination of a strain of the micrococcus by the diluted serum.

(5) In *malaria* the diagnosis rests upon the discovery of the parasite in the blood; leucopenia ("relative lymphocytosis") is almost invariable. A markedly intermittent character of the fever, however, must never bias the observer unduly in favor of this diagnosis, even in the face of a clear history of ague in the past; for many pyogenetic infections, local and general, are accompanied by this form of fever. The occurrence of rigors calls for the same caution. If the patient has never lived out of England, malaria may be excluded.

(6) *Cerebro-spinal fever* may be met with in its sporadic form. Occasionally there may be an absence of the signs for some days, or even weeks; no stiffness of the neck or retraction of the head, no change in the "reflexes" and, indeed, no signs