THE MODERN TREATMENT OF DIPHTHERIA IN PRIVATE PRACTICE.—By W. A. Walker, M. D., New York. On the evening of September 14th, a little girl called at my office with a request that I should visit her sick brother. The public schools opened their doors on that day, and Johnny McD., although complaining of feeling sick was sent to mingle with the hundreds of other school children.

An inspection of the case showed all the clinical symptoms of diphtheria, with a muco-purulent discharge from the nostrils so fetid that the odor filled the room. The examination completed, the mother anxiously inquired: "What is it?" "It is a case of diphtheria," I said; and her face blanched, her voice trembled, as she said quietly: "I know what that means—I have buried two children with that."

On the 19th the father called at the office to say that Johnny could not be kept in bed, and they thought he was well.

In a skeleton way this illustrates the results of treatment with antidiphtheritic serum, and stands in bold contrast with the drug treatment with the bottles of medicine, the cruel swab, the sleeepless nights, the futile attempt to force food and medicine, the onset of secondary infection, and death or a tardy convalescence.

The uniform success which I have observed, and had in my own practice, has convinced me that the treatment of diphtheria with antitoxin is a great advance in therapeutics, and it is my impression that critics who have condemned this treatment have in most instances either observed only hospital patients, or have not persisted in the treatment or perhaps have not had a fresh and reliable serum, or have not used it early enough.

From the standpoint of a general practitioner I confidently expect to cure any case of diphtheria in private practice, seen within forty-eight hours of the onset of the disease.

Take, for instance, a typical case; a previously healthy child, six years of age. The family physician is called in and finds the following conditions: general depression, face pale, pulse accelerated, temperature about 101° F. Inspection of throat shows general diffuse redness, with the characteristic deposit on one or both tonsils. This peculiar deposit once seen is not readily forgotten; the high fever, flushed face, and rapid pulse usually seen in pseudo-membranous tonsillitis are absent; the margin of the inflammatory process is usually sharply defined in diphtheria and not in tonsillitis. In follicular tonsillitis the leading symptoms