3. *Ulceration.*—The separation of the necrotic tissue—the sloughing—is gradually effected from the edges inward, and results in the formation of an ulcer, the size and extent of which are directly proportionate to the amount of necrosis. If this be superficial, the entire thickness of the mucosa may not be involved and the loss of substance may be small and shallow. More commonly the slough in separating exposes the submucosa and muscularis, particularly the latter, which forms the floor of a majority of all typhoid ulcers. It is not common for an entire Peyer's patch to slough away, and a perfectly ovoid ulcer opposite to the mesentery is rarely seen. Irregularly oval and rounded forms are most common. A large patch may present three or four ulcers divided by septa of mucous membrane. The terminal six or eight inches of the mucous membrane of the ileum may form a large ulcer, in which are here and there islands of mucosa. The edges of the ulcer are usually swollen, soft, sometimes congested, and often undermined. At a late period the ulcers near the valve may have very irregular sinuous borders. The base of a typhoid ulcer is smooth and clean, usually formed of the submucosa or of the muscularis.

There may be large ulcers near the valve and swollen hyperæmic patches of Peyer in the upper part of the ileum.

4. *Healing.*—This begins with the development of a thin granulation tissue which covers the base and gives to it a soft, shining appearance. The mucosa gradually extends from the edge, and a new growth of epithelium is formed. The glandular elements are reformed; the healed ulcer is somewhat depressed and is usually pigmented. Occasionally an appearance is seen as if an ulcer had healed in one place and was extending in another. In death during relapse healing ulcers may be seen in some patches with fresh ulcers in others.

We may say, indeed, that healing begins with the separation of the sloughs, as, when resolution is impossible, the removal of the necrosed part is the first step in the process of repair. Practically, in fatal cases, we seldom meet with evidences of cicatrization, as the majority of deaths occur before this stage is reached.

Large Intestine.—The cæcum and colon are affected in about one third of the cases (in nineteen of the sixty-four). Sometimes the solitary glands are greatly enlarged. The ulcers are usually larger in the cæcum than in the colon. Perforation of the cæcum is rare. The appendix may be involved. In my cases there was ulceration in two and perforation in one case. I dissected a case in Montreal in which the patient died three months after an attack of typhoid fever, and a localized abscess was found, due to perforation of the appendix. Death resulted from pylephlebitis.

Perforation of the Bowel.—In one hundred and fourteen cases of the two thousand Munich autopsies (5·7 per cent) and in fourteen instances in my series, the intestine was perforated and death caused by peritonitis. The perforation may occur in ulcers from which the sloughs have already