tions, provided the infection remains pure, leucopenia is apt to occur. But a mixed infection, especially with the pneumococcus, is the rule in influenzal pneumonia, whether lobar or lobular, and a high leucocyte count is therefore by no means uncommon. Despite some earlier statements, it seems that in uncomplicated influenza the microbe is rarely, if ever, demonstrable in the blood.

(2) *Typhoid fever* is the most frequent and the most important cause of fever of longer duration than five days in Great Britain, physical signs being absent. As a possible cause of any case of obscure pyrexia, it must be perpetually borne in mind. Neither a sudden onset, nor absence of headache, nor the form of the temperature chart must prevent this. Diarrhœa is no longer regarded as an almost constant symptom. The manifestations of the disease are so protean that safety lies only in regarding every patient suffering from fever of undetermined cause as a suspect. In one case the first symptom was acute delirium, which continued during the first fortnight; there was no headache at any time. Both in this case and in another case of typhoid fever with marked delirium during the invasion period, there was a marked neuropathic family history. Before the immunity of any district from typhoid be accepted as evidence against the disease, it must be shown that the patient was continuously in that district during the two weeks preceding the illness; for the infection may have occurred during a sojourn elsewhere.

In the pathological investigation, sufficient importance is often not attached to the leucocyte count. The agglutination test should always receive this support, for the association of leucopenia with even an incomplete Widal reaction is a valuable indication of typhoid fever. A complete Widal reaction with leucopenia is diagnostic. If the agglutination reaction is not present, as it may not be during the first week, the diagnosis may often be established by blood-culture. Allied to typhoid fever, and often undistinguishable from it clinically, is "paratyphoid fever." These cases are even more liable than cases of true typhoid to present no physical signs. The diagnosis can be made only by isolation of the microbe from the blood-stream, urine or fæces.

(3) Certain cases of *septicæmia*, and especially septicæmia in the puerperium, may lead to marked fever without other signs. The most careful obstetrician may fail to discover aught amiss with the pelvic viscera; indeed, in fatal cases a careful