throughout, the highest count at any time being 10,000. The spleen was distinctly palpable, and it was thought possible that the case might be one of a typical typhoid fever. The Widal tests proved negative. The character of the fever suggested strongly an æstivo-autumnal malarial infection, but repeated examinations of the blood failed to show any malarial parasites.

On October 17th the patient was transferred to the medical service of the hospital, there being no further indication for isolation and it having been decided that the fever was not due to any pelvic complication. The physical examination of the patient, however, failed to throw any light on the obscure fever from which the patient had suffered. The patient was feeling much better in every way and, as the temperature was elevated only about one degree each day, she was discharged on October 21st, apparently practically well. There was no evidence of any skin eruption when the patient left the hospital. The provisional diagnosis was "intermittent fever of doubtful origin."

The subsequent history of the case was of great interest and clearly explained the cause of the obscure fever. On October 30th the patient returned with a definite macular and papular secondary syphilitic eruption, the digagnosis being confirmed by Dr. Gilchrist. On November 4th, when she again returned for observation, the face, shoulders and arms presented a definite macular eruption, and over the front and back of the chest there were scattered papules and an occasional pustule. There was general enlargement of the superficial lymph glands, the epitrochlear glands being the size of hickory-nuts.

Inquiry was now made into the venereal history of the patient's husband. He admitted exposure to infection on July 4, 1900. On August 11th he came to the Johns Hopkins Hospital Dispensary for treatment, and the records show that he then had a hard chancre on his penis. On August 27th he returned with a macular syphilitic eruption, and again, on September 15th, he was treated for a gonorrhœal urethral discharge.

On questioning the patient, she could give no history of the onset of the primary sore, nor were there any evidences of a chancre made out at the time of the operation, although it was not specially looked for.

The points of interest in this case are: (1) The impossibility of establishing a diagnosis until the secondary skin eruption became manifest; (2) the occurrence of chills and sweating and the close resemblance of the fever to that of æstivo-autumnal malaria; (3) the absence of any definite relationship between the fever and eruption which did not appear until practically four weeks after the onset of the fever; (4) the subsidence of the temperature to nearly normal a considerable time before the appearance of the skin eruption and without antisyphilitic treatment.