(2) *Pyelo-cystitis.*—The amount of pus in the urine may be small; and what is not seldom the sole sign of the disease may thus be overlooked. Sudden rises of temperature, often accompanied by rigors, in old men, or in patients suffering from diseases of the nervous system, leading to sphincter troubles, frequently are due to infections of the urinary tract. By far the commonest microbe at work is *B. coli,* admitting of ready isolation from the urine.

(3) *Pyorrhœa Alveolaris.*—A close inspection of the teeth and gums should never be omitted in cases of fever of obscure origin. Long-continued and marked pyrexia may be due to oral sepsis. The form of the fever is apt to be periodic, with intermissions lasting from one to several days.

(4) *Perigastritis and Subphrenic Abscess.*—In these complications of gastric ulcer, physical signs are often delayed, perhaps for a fortnight or more. When signs do appear, pleural friction is apt to be the first. The same conditions may follow gastro-enterostomy, or the suture of a perforated gastric or duodenal ulcer. A rising leucocyte count may suggest the sequence of events.

(5) The subjects of *acute rheumatism* are prone to develop bouts of fever with little or no physical signs. Sodium salicylate may have no effect upon the fever. Probably some serous membrane is in a state of smouldering inflammation. But signs of inflammation may not be forthcoming for these reasons: the presence of old valvular disease makes the diagnosis of a recurrence of acute endocarditis impossible; pericardial adhesion, ofttimes universal, prevents the appearance of the physical sign of pericarditis; and of acute myocardial disease there is no physical sign. The undoubted possibility of rheumatic pleurisy and rheumatic peritonitis must not be overlooked. These cases of rheumatic pyrexia, not seldom considerably prolonged, are always a source of anxiety, which is increased in the presence of vulvar disease. For the transition from rheumatic to malignant endocarditis, in which streptococci play so important and so fatal a part, may be very gradual and may deceive even the elect. However, a careful search for the cardinal signs of infective endocarditis, which includes bacteriological cultivation of the blood, will generally be helpful. The concurrence of chorea, or of nodules, is much in favor of the non-infective variety of the disease, though neither event excludes streptococcal endocarditis.

(6) *Localized tuberculosis* is probably the commonest cause of fever with latent physical signs, or with signs difficult to elicit.