thelium, a variety that does not usually tend to recur. The recovery of the normal voice is the exception rather than the rule after thyrotomy, from the risk of alteration of the relative position of the cords, and we may consider the patient fortunate in having recovered it after thirty months' disuse.

THE DEMONSTRATION OF MALARIAL ORGANISMS.

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HAVING seen something of the difficulties of applying the detection of the plasmodium malarie to practical diagnostic purposes, I should like to enter a plea for the examination of the blood for these bodies being made by staining them as more reliable than by examining the fresh blood, and more generally applicable. The difficulty is not with most men to find them, but to avoid mistaking for them the vacuolated corpuscles, common in a large class here, namely, the anemics. To avoid this Jaksch advises smearing the under surface of the slide with a solution of methylene blue, but this does not seem to give much help, and the general similarity of the two can be easily seen by comparing Jaksch plates of vacuolated corpuscles with some of Dr. Manson's diagrams.

If the intracorporeal bodies contain pigment there is, of course, no difficulty in distinguishing them, but unfortunately the commonest forms here contain either none or very finely divided pigment. Amoeboid movements would of course be a diagnostic point, but many men after examining a slide for half an hour or more (as recommended by Dr. Manson) with a $\frac{1}{4}$ th are very apt to make mistakes, particularly when dealing with bodies one-fourth to one-fifth the size of a red corpuscle, which is the commonest size here. As far as their occurrence in this Colony is concerned I have seen and demonstrated most of the forms in Dr. Manson's chart except B 10, 11, 12, C 12, D 11, 12, G 5, J 12, K 1, 2, 3, 4, 6, 11, 12, L 2, M 1, 9, 12, O 3, 6, P 6, 7, 11, Q 3, both in fresh blood and stained, and they are easier to find and more absolutely conclusive when seen stained.

Staining has the following advantages:

1. The bodies can be found with a $\frac{1}{4}$ th objective and recognised with ease and certainty with a $\frac{1}{8}$ th—no small advantage when the rapid deterioration of high objectives in moist tropical climates is considered.
2. Though extreme cleanliness is required, the absolute freedom from grease necessary to obtain the thin films required in fresh blood is not requisite. Cover glasses here become opaque in a very short time unless kept in some oil, from which it takes some time to absolutely free them.
3. The staining and examination can be done at one's own convenience. To examine fresh blood interferes with ordinary routine in a practice involving much travelling.
4. There are no other bodies in the blood, and no products or results of corpuscular degeneration with which they may be confused.

Hence we avoid what I believe to be common, mistaking anemic patients with vacuolated corpuscles for cases of malaria. Such cases are liable to pyrexia, either transient or irregular and intermittent, which does not yield to quinine, and in fatal cases shows no evidence of recent malaria.

Without adopting this method I believe we shall be unable to get sufficiently extensive reliable statistics to distinguish properly the non-malarial tropical pyrexias from true malarial fever.

The method of staining which I find gives the best results is that of staining with eosine and methylene blue separately, but I fully admit that I have often failed to get well-stained specimens.

If as detailed accounts of the best methods of staining these bodies as have been given for the examination of the fresh blood were published they would be largely used, and furnish much more reliable means of diagnosis for the mass of practitioners in our tropical colonies than the examination of fresh blood does.

NOTES ON AN OUTBREAK WHICH POSSESSED CHARACTERISTICS OF BOTH SCARLET FEVER AND DIPHTHERIA.

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AFTER reading the communication by Dr. Robert Lee on "Some Cases Resembling Scarlatina," in the BRITISH MEDICAL JOURNAL of February 16th, it struck me that the cases he referred to had a curious likeness to some which occurred in my practice about a year ago. In reply to a letter from me he wrote saying that he thought them like those he had described. Given as shortly as possible the facts were as follows: On February 8th, 1894, whilst I was attending the wife of a labourer who had been recently confined, I was asked to see her child, aged 9, who had been, as she considered, bilious; in reality the child presented no other symptoms beyond some slight fever and redness about the fauces and tonsils. Forty-eight hours after examining this child I commenced to be ill myself, and soon developed a sharp attack of follicular tonsillitis. On February 13th I received a note from my friend, Mr. R. C. Lyle, who had seen my patients for me on the previous day, saying that the child was suffering from scarlet fever. It seemed very probable therefore that I had contracted my "throat" from this case, and in the light of future events this seemed almost certain.

A sister of the child next went down with scarlet fever, then the child of a neighbour, and then two cousins, all of whom had been visiting the house. Following these closely were what my *locum tenens*, Dr. W. R. McKinnell, considered to be diphtheria, two in the neighbour's house in which there was already scarlet fever, and one in the house in which the cousins were suffering. Two of these were adults, male and female, aged 50 and 65, and the third was a boy aged 10. The male adult was the last case. I saw him about the second or third day of his illness, and on each tonsil there was a patch of dirty white membrane, not much raised from the surface; he complained of great weakness. The first three cases of scarlet fever were of moderate severity, but had marked throat symptoms. The next two, however, assumed a most malignant type, and ended fatally. These two children (girl and boy) were aged 9 and 16 respectively.

I was unable at the time to discover anything to account for the origin of these cases, but shortly afterwards I had a neighbour's child brought to me whose urine contained a large quantity of albumen, and who showed signs of having recently desquamated. This child had been attending school in a neighbouring parish in which there had been a good many cases of slight character, and she had probably contracted infection there. But how came the disease to assume so malignant a type in being carried from one parish to another? The cottages were in a perfectly sanitary condition, and there was nothing to account for the diphtheria, so called. Concurrently with the last cases of this outbreak there occurred in a hamlet three miles away another case of scarlet fever which had no direct connection with them, nor was it possible to discover from whence the infection had come. This child infected another, and both presented a copious rash and sore throat—in fact, they seemed to be typical examples of scarlet fever. I have used the expression "direct connection" because there was an indirect relationship between these and the other cases, which was curious if nothing else.

For several weeks previous to the occurrence of the first case of the outbreak I had been attending a confinement case in which the discharges had become septic, and, in spite of stringent antiseptic measures, the mother of the children first attacked (whom I have mentioned as being confined on January 30th) became affected to a slighter extent in the same way. In a third instance the same thing occurred, and this woman lived in the hamlet three miles away, in which the last cases of the scarlet fever occurred; the mother of the child first attacked nursed the lying-in woman, and the child used to visit the house. No one of the three affected women was ever dangerously ill, the temperature never rising beyond