What we can do, however, is to keep the fauces clean by washing away the toxin-laden secretions from time to time, and we use for this purpose a douche can—not, incidentally, that abominable and septic instrument the enema syringe—and either normal saline solution or tap water at a temperature of 100 degrees or a little less. We irrigate not only the throat, but the nose also, about every four or six hours until the throat has apparently healed, and afterwards night and morning until the patient is free from infection. We also encourage the elimination of toxins by allowing the patient to drink copiously of water or barley water, and by keeping the bowels open with suitable aperients.

It is necessary also to pay particular attention to the skin, bearing in mind that when desquamation occurs the skin is not doing its proper share of excretion, and is therefore throwing extra work on the kidneys. For this purpose we give daily tepid baths, which are followed by anointing of the whole surface of the skin with olive oil, which may contain a small percentage of eucalyptus or other antiseptic oil to keep it from becoming rancid.

It is as well to point out for the benefit of those who have to attend a case of scarlet fever in a private house that the drinking of cold water and the warm bath are often regarded as deadly heresies by the laity, and a considerable amount of tact may be necessary to overcome the objections which may be raised by the patient's relatives.

Another point that is often discussed is the length of time that a patient suffering from scarlet fever should be kept in bed in the acute stage. Formerly it was the custom to insist on a three weeks' confinement to bed, in the belief that any tendency to subsequent nephritis was thereby diminished, but this has long been abandoned, and it is usual nowadays to allow the average patient to begin to leave his bed about five days after the temperature has fallen to the normal, provided, of course, that there is no special reason for prolonging the period in any particular case.

We come now to the treatment of the toxic or so-called malignant cases, where streptococci are present in the blood from the first. As a matter of fact, about 95 per cent. of these patients die in the absence of any specific treatment, but the mortality can be lowered to about 75 per cent. by the use of injections of normal saline solution under the skin. It is a debatable point whether antistreptococcic serum is of service in these cases, inasmuch as a clear line has not been drawn between the use of this remedy with and without saline injections also. My own experience is (and it is in conformity with what we should expect to happen in theory) that when the serum is added to about three pints of normal salt solution it is very useful indeed, but that it often fails completely when given alone. Whatever else we do in these cases, we usually give stimulants very freely. At the best, however, we lose the great majority of the patients.

The treatment of the septic cases is on a different footing altogether, and here there can be no doubt that active disinfection of the fauces is very useful, but it is essential not only that the antiseptic employed should be capable of killing germs when it comes into adequate contact with them—and there are many so-called antiseptics that are not—but that it should be applied properly.

We are no longer attempting merely to take away the organisms that are lying loosely on the surface of the fauces, so it will not suffice to use a gargle alone. A gargle, incidentally, is practically merely another name for a mouth-wash, as it neither penetrates beneath the surface nor does it reach the lower part of the tonsils; a mouth-wash, however, is even more useful in the septic cases than in the ordinary cases, but it is not sufficient in itself. A spray, too, is useless, as it merely deposits a fine cloud of antiseptic on the top of the faucial mucus, and it has the further disadvantage that it is very unpleasant, and often frightens children out of their wits.

In practice the best way is to apply some powerful non-toxic antiseptic—I myself use Izal—with a swab once or twice in the twenty-four hours until the ulcerated surfaces show signs of healing, using the douche of saline solution freely in the intervals.

If there is much prostration, saline injections subcutaneously are of great value, but antistreptococcic serum is quite useless.

The treatment of the otitis need not be described in detail here, as it has already been discussed in a former article in this series, but it may be summed up in the free use of the douche, using normal saline solution in the acute stage, and later on astringent drops, a close watch being kept by the nurse for any sign of swelling or tenderness behind the ear, which would render a mastoid operation necessary. If the otitis should show no signs of abating after careful treatment, it may be necessary to perform a radical mastoid operation in order to save the patient from the risk of extension of the inflammation to the brain, or veins in the neck.

We come now to the management of the patient's surroundings with the view of pre-

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