sclerosed. The pulse was somewhat collapsing, of good tension, regular rhythm and volume. There was visible pulsation of the vessels of the neck; the carotids springing forward in systole. Palpation revealed a diffuse precordial pulsation with a prolonged diastolic thrill palpable on the right as far as the nipple line. The thrill was also palpable in the suprasternal notch, but its maximum intensity was about the third and fourth cartilages to the left of the sternum. The apex of the heart showed some displacement to the left, being located in the fifth interspace one inch outside the nipple. The transverse dulness encroached upon the left edge of the sternum. The sounds at the apex were decidedly weaker than normal; at the base one could not discover any accentuation of the second sound either pulmonary or aortic. At the apex a faint diastolic murmur and a systolic murmur were audible. In addition to these one could hear a musical murmur, diastolic in rhythm, widely propagated over the chest, having its point of maximum intensity, however, at the third left interspace. This murmur was of rather high pitch and was audible to the patient. It could be distinctly heard at a distance of from 18 to 24 inches from the chest wall, and on one occasion in a quiet room the murmur was audible at a distance of fully five feet, the patient dressed and sitting in a chair. The diagnosis of aortic and mitral regurgitation was made. Various speculations, however, were made concerning the origin of the murmur just described.

The patient was discharged, and for several months he passed from under our observation. He returned in May of 1898. About sixteen months of pretty active life with freedom from distress had been enjoyed, but in April he became very short of breath and his sleep was greatly disturbed by hideous dreams and attacks of dyspnœa. The complaints made on this occasion of admission to the hospital differed with those at first noted. Precordial pain was the prominent feature of the case at first; now he complained of sleeplessness and dyspnœa,—dyspnœa even when at rest, and sometimes amounting to orthopnœa.

Along with these allied complaints one found on examining the heart that the cardiac dulness had increased. The apex was now in the sixth space, the transverse dulness 1½ to 2 inches greater. There was epigastric pulsation. A thrill was uncertain. The musical diastolic murmur heard so widely was of a lower pitch, yet retaining its musical quality, but was no longer audible away from the chest wall. A "to-and-fro" murmur was heard at the xiphoid cartilage.

The patient wished to go home and was discharged on the first of June. He remained in bed until October 6th, when he was finally readmitted to the hospital, where he died on the 31st of the same month. The course of the case during the summer months was marked by hæmoptysis with signs of dulness (infarct) over the right lung at the