applies to high tension and sclerosis following renal disease, and does not imply that there may not be a reverse process, with high tension and sclerosis, prior to the renal disease. Batty Shaw has obtained a renal extract which causes high tension when injected into the blood of an animal. Schæfer, Oliver, Shaw and Barr have shown that there is a powerful pressor agent in the posterior lobes of the pituitary body. Whether it plays any part in the etiology of arteriosclerosis or not is not yet settled.

As to the varieties of the disease, different writers have given us different classifications. John M. Cowan, of Glasgow, divides the condition into the focal or nodular and the diffuse. Clifford Allbutt speaks of the toxic, the hyperpietic, and the involutionary. Alfred Stengel gives us the presenile, which he divides into the acute and the chronic forms, and the senile. Joseph McFarland treats of the condition under the terms acute and chronic. Osler contents himself with the simple division into the nodular, diffuse and senile, while Edwards makes two forms, the nodular and diffuse.

On the morbid anatomy I shall say but little. Of the focal form of the disease I would call your attention to two types. The first is that of endarteritis obliterans. This form affects the smaller arteries, and is very frequently of syphilitic origin. The nodule may completely close the lumen of the vessel and in this way prove of extreme importance, shutting off the blood supply from the area of distribution. The key note to the changes in this form is to be found in the words cell proliferation, with subsequent degeneration, though gross fatty and calcareous deposits of atheroma do not occur. Various infections, other than syphilis, as scarlatina, smallpox, enteric, etc., may cause this form, and it has been held that it may be caused by trauma. Thoma's theories suit this form only, if at all any form. The second type of the local form is what is called atheroma, or endarteritis nodosa or deformans. These atheromatous patches are usually present in the elderly, though their size and number vary very greatly. They vary from that of a pin's head to plaques as large as a quarter of a dollar. They are usually of a greyish or yellowish color, but if calcified are whitish. Sometimes they are soft or translucent, often opaque and firm. Ulceration is not uncommon, from which may arise trombé. The aorta suffers most frequently from this form of the disease. The coronary, cerebral and peripheral arteries are affected oftener than those of the viscera, the pulmonary circulation being least liable. In advanced cases all the coats are involved. The intima is always thickened. In the early stage, spindle, stellate, and round cells are scattered between the laminæ, while the lining endothelium remains intact. In the later stages, hyaline, fatty, granular, mucoid, or calcareous changes may be found. The elastic