erated ductus was plainly seen as a small ligament about .25 cm. long and extending from the base of a depression at the bifurcation of the aorta just beyond the subclavian where its insertion was marked by deep puckering and by a patch of atheroma. The left ventricle was markedly hypertrophied, its wall measuring 18 cm. in thickness, but was only slightly dilated, a simply hypertrophy existing. The aortic orifice was very narrow measuring 4.5 cm. in circumference. The aorta itself widened slightly at its origin, but was abruptly narrowed at the point of insertion to the left subclavian artery to a circumference of 3 cm., widening shortly below this to 4 cm. Several patches of atheroma were scattered over the arch and thoracic aorta.

Case II.

Large Patent Foramen Ovale with Calcified lower Border, Fenestrated Annulus Ovalis and Anomalous Septum in right Auricle, Anomalous Pocket on Wall of Left Auricle, Aneurismal Dilatation of Coronary Sinus and of Right Auricle, Dilatation of the Pulmonary Artery. Slight Hypoplasia and Coarctation of the Aorta.

Clinical History. Mrs. B., aged 38. Admitted to R. V. H. in August, 1912, in an advanced state of failing compensation, marked ascites, anasarca and orthopnoea. Menstruation set in at the age of 21 and disappeared at 28. Had one child who died early. Acute rheumatism at the age of 14, and since then had symptoms of myocarditis with exacerbation in 1902 and 1903, asthma and chronic bronchitis; in 1904 right hemiplegia with aphasia and a slight degree of recovery. Failing compensation with severe dyspnoea in 1906, right sided pneumonia in 1908, dysentery in 1909, pneumonia and jaundice in 1911.

Condition on admission. A pale, emaciated woman, with marked ascites and generalized oedema, dyspnoea and orthopnoea and precordial pain, the right arm and leg paretic, of good intelligence, nervous system normal, the liver much enlarged, a trace of albumin in the urine but no casts.

Examination of the heart showed great irregularity (auricular fibrillation), marked venous pulsation (positive venous pulse) in the neck, very diffuse impulse, increased pear-shaped cardiac dulness, a presystolic murmur at the mitral area with accentuated second sound. Examination by Dr. Martin on two occasions *showed a faint thrill and presystolic murmur localized towards the middle of the precordium in the fourth left interspace.* The symptoms of failing compensation increased gradually, bronchi-