

Systolic murmurs at the pulmonary region are of a frequent occurrence; although soft and blowing they are occasionally harsh and loud, and may even have a character closely resembling pericardial friction. They are often heard up to the sternoclavicular joint and are occasionally transmitted to the aorta and heard down to the apex. Although more frequently found in chlorotic girls than in other conditions, still it is important to remember that they are occasionally found as a temporary phenomenon in healthy well-nourished men. They are frequent in neurotic hearts, in the latter stages of febrile affections, and in a variety of debilitating conditions, but as these have no special bearing on the present subject they need not be further referred to. When the heart and vessels are free from disease, when there is an absence of cardiac enlargement, of arterial sclerosis and of a history of conditions leading to cardiac disease, the prognosis must be based rather on the general condition of the applicant than on the presence of the murmur, and if we can feel fully satisfied that it is of a functional character it may be disregarded.

Another murmur which is frequently heard is that in the subclavian arteries. It is systolic in rhythm, often rather harsh, more common on the left than on the right side and not infrequently present below and to the outer side of the clavicle. This murmur often occurs in strong, healthy men and has been attributed to the pressure of large muscles on some part of the subclavian artery altering its calibre at certain parts of its course. In the absence of pulmonary disease I believe it may be disregarded as of any special significance, although it has occasionally led to a suspicion of aneurism.

The cardio-pulmonary murmur is heard at the apex or just outside it, or sometimes along the left border of the heart and even along the right side of the sternum. It is soft, systolic, short and puffing, and its most important character is due to its being distinctly influenced by respiration, being heard best at the end of inspiration and dying away with expiration. It is, however, sometimes heard all through the respiratory phase, becoming extremely faint during expiration. If careful observation shows that it has these characters and if other evidence of cardiac disease is lacking it may be disregarded.

In all forms of cardiac lesions, after compensation has once definitely broken down, the tenure of life is insecure and uncertain. Although cases are occasionally met which survive for a period of ten or fifteen years after suffering from general anasarca, yet these are too exceptional to allow of their being taken into account. According to N. S. Davis, the average period of duration of life after compensation began to fail varied from 2.6 years in mitral regurgitation to 3.8 years in aortic