an interest in so doing, and my list may be divided into four groups.

A. Cases in which death occurred in the first or second attack, or in connexion with a series of rapidly recurring attacks—the so-called *status anginosus*. We do not know how many instances of sudden death in the street or in bed at night are due to angina pectoris, but only three cases in my series died in the first attack. The mode of death is not always the same. In certain cases it is the most rapid we see—without warning, or after a few minutes of unpleasant substernal sensation, or possibly in some act, combining intense emotion with muscular effort, there is a rapid change, a sudden unconsciousness, a stony stare, a slight change in the facial expression, and then with two or three gasps all is over; no pulse is to be felt at the wrist; the respiration stops, but even when the patient is apparently dead a feeble heart impulse may be felt or faint heart sounds heard.

B. The patients have had a series of characteristic attacks ranging from two or three to scores during the course of a few months or a year or more, and in a severe paroxysm or in a series death occurs. The final event has not the same suddenness, nor is there the rapid loss of consciousness; the patient may indeed be moribund and quite conscious, though this is unusual. The mode of dying in these cases is very remarkable. In a number of instances I have made careful notes. Two are worth quoting:—

On Thursday, May 25th, 1899, while at work in the ward, Dr. Knox called me to see a patient in an attack of angina. I found a man, aged 41, who had been admitted the previous day complaining of pain in the heart. He had been a heavy worker, a large eater, had not had syphilis. Five years ago while rowing he had an attack of pain and shortness of breath, which lasted for a few minutes. On and off since then similar attacks have occurred, always brought on by exertion, now even by very slight effort. He had aortic insufficiency, and a very soft low tension pulse. About 9.30 A.M. his hands and feet had become cold and a little cyanosed, and he had a slight attack. It continued on and off all the morning. I saw him at five minutes past 12; he was propped up in bed moaning with pain, but was not sweating; the pulse was soft, regular, and feeble—100 to the minute, the left smaller than the right. Everywhere over the chest in front and back were medium-sized râles; the pulmonary resonance reached almost to the costal border on the right side, and the superficial cardiac flatness was completely obliterated; there was a soft apex systolic murmur, and a soft diastolic aortic heard along the sternal border. At 12.15 he had a sudden collapse, became pulseless, the features set, and he gave one or two gasping respirations, which recurred at intervals of about five minutes. No pulse could be felt in carotids or brachials. Remembering the remarkable case reported by Sloan, I performed cardio puncture, thrusting a long thin aspirator needle into the heart through the fourth right interspace. This was followed at once by one or two faint inspirations; the needle showed a cardiac impulse very plainly, beating 52 to the minute. At 12.25 the needle was moving much more slowly and more feebly—44 to the minute. A saline injection was made directly into a vein. At 12.28 the cardiac beats as shown by the needle were still regular—32 to the minute,