scanty muco-purulent expectoration, and vomiting, chiefly of curdled milk. He made no complaint of any pain. Temperature, 99°, rising to 104.6° at 10 p.m., with chill; pulse, 80; respirations, 20-24. Nutrition fairly good; face flushed; skin hot; mucous membranes of good color; a greyish fur on the tongue; no œdema.

Examination of the lungs showed enfeeblement of the breath sounds in the left lower axilla, with fine crepitus, and behind dulness from the middle of the scapula to the base, with feeble breath sounds and fine râles at the end of inspiration. The sputum contained no tubercle bacilli or pneumococci. The cardiac impulse was felt but not seen in the fourth intercostal space half an inch inside the mamillary line. Relative cardiac dulness vertically at the upper border of the third costal cartilage, and laterally from the left sternal border 3½ inches to the left. There was accentuation of the pulmonary second sound, but there were no murmurs. Pulse regular, of good volume, but compressible. No thickening of the radials. Spleen dulness increased, but the splenic border not palpable. Liver dulness 5½ inches from the fifth rib in the right mamillary line. Urine.—High colored, smoky; sp. gr., 1010; alkaline, albuminous, and containing blood, blood casts and epithelial casts.

principal points in the diary of the case are as follows:

From February 5th to February 10th there were vomiting and a daily rise of temperature to nearly 105° F., with chill followed by sweating occurring between 10 p.m. and 4 a.m. On February 7th exploratory puncture over the base of the left lung with a negative result, and on the 11th a similar result from exploratory puncture of the liver in front. A blood examination for the plasmodium malariæ was equally negative. On this day the vomiting was more frequent. The first sound of the heart was weak, and there was a distinct yellowish tint in the skin.

On February 14th I saw the patient for the first time. Since the 12th the temperature range had been lower and he had had no chills, but was still vomiting and felt very weak. The spleen was now distinctly palpable, the hepatic dulness within normal limits, and the first sound of the heart was very weak. I came to the conclusion from a study of the history of the case and by exclusion that the case was probably one of malignant endocarditis.

February 15th—Cultures were made from the blood drawn from a finger with a negative result.

February 17th—Vomiting less frequent. Tongue brown and dry. Temperature, 96-100·6. Cardiac dulness from the lower border of the second costal cartilage, and laterally from the left sternal border to