ditis; next, perhaps, chronic Bright's disease; next, in connection with either pleurisy or pneumonia, affecting the left side. It is in these three pathological connections that we most frequently meet with pericarditis. The instances in which it occurs otherwise, including, of course, traumatic cases, are very few. It is very apt to be overlooked in connection with pleurisy and pneumonia, because we diagnose the presence of those diseases and think we have enough to account for the symptoms, and perhaps, omit to examine with reference to pericarditis.

As to the physical signs, I need not, I suppose, dwell upon the friction murmur. That is evidence of pericarditis, and also of pleurisy in the first stage. It is not, however, always found, even in the first stages of pleurisy, whereas in pericarditis I think I am safe in saying it is always present before much effusion has taken place. The movements of the two serous surfaces upon each other are such as to give rise to a murmur if the conditions for it be present, namely, a fibrinous exudation.

In order to be able at once to recognize the murmur, we must bear its characters in mind. Let us repeat them. In the first place, the friction murmur is almost invariably double; this is, it accompanies the two sounds of the heart, although it has not a fixed and uniform relation to them. They are, so to speak, in discord with the sounds of the heart, but there are two for each revolution. They convey to the mind the idea of friction. This in itself should not be relied upon in the diagnosis, for endocardial murmurs sometimes have that character. They seem to come from a superficial situation, right under the ear, or under the surface. They are increased in intensity when pressure is made over the præcordia with the ear or stethoscope. They are not conducted beyond the præcordía much, if at all, and are frequently heard only within a certain portion of the præcordia. These are characteristics of the pericardial friction murmur, as contrasted with an endocardial murmur. Endocardial murmurs, in order to be confounded with a pericardial friction murmur must be double, since the pericardial murmur is double, and the only instance in which this error can be committed holds with relation to the aortic direct and the aortic regurgitant The diagnosis can be made in that murmurs. case by paying attention to the qualities of the endocardial murmurs, the conduction of the aortic direct up into the great vessels, etc.

After the effusion has been poured out into the pericardial sac, as in this case at present, the murmur disappears, and if we see the case for the first time at this stage, we have to depend upon other signs for diagnosis. Removal of the heart from contact with the thoracic wall, by the presence of fluid in its investing membrane, alters the first sound, diminishes its intensity, and divests it of its booming quality. It becomes valvular, in that respect being like the second sound, and frequently being more feeble. This change is a very striking one, and was illustrated in the following case. Some years ago, when again about to commence my visiting service in the wards of the hospital, and while passing through, one of the assistants said, regarding a certain patient, that it was a case of rheumatism, a light attack ; but, as a matter of curiosity, more than anything else, I put the stethoscope over his heart, and at once recognized the fact that the first sound was like the second, being valvular in quality. A further examination proved the presence of pericarditis with effusion, which had entirely escaped attention, because there was no pain or other symptoms pointing to it.

If the apex beat be above the normal position it is a diagnostic point in favor of pericarditis with effusion. Sometimes it can only be felt by requiring the patient to lean forward, so that the apex may come in contact with the thoracic parietes. In this patient, the apex beat is in the fourth intercostal space, instead of in the fifth, which is indicative of some of the effusion still remaining within the pericardium. The presence of the effusion is further determined by percussion and auscultation, the former showing an increased area of dulness, and the latter an increased area over which there is absence of respiratory murmur. Increased area of dulness in the præcordial region, caused by pericardial effusion, is diagnosed from that caused by enlargement of the heart in this manner. In the latter the increased area of dulness extends more downward and to the left, while in the former the area of dulness is increased laterally, nearly equally on the two sides, and upward, and the triangular form of the area of dulness, corresponding with the form of the pericardium, isevident on percussion and auscultation. Theapex beat, instead of being lowered, as in enlargement of the heart, is higher up than normal, in effusion into the pericardium.

The treatment of pericarditis varies considerably according to the amount of the effusion and the intensity of the inflammation, as denoted by the general and local symptoms. I have already spoken of the importance of quiet, which is an essential point in the treatment. If the patient suffer from a considerable amount of effusion, it is proper to treat it as we would effusion into the pleura, viz : we may give hydragogues ; but always remember that this must not be carried to the extent of producing any considerable general debility. We may give diuretics. Sometimes Sometimes. blisters over the præcordia have a beneficial effect. I do not know that we can explain how it is done, but facts show the vesication of the skin lying over serous membranes aids in producing absorption of the contained effusion. I suppose a certain amount of benefit pertains to the application of the tincture of iodine externally. The patient, of course, is to be sustained by measures which do not excite the action of the heart, but which improve the constitutional power. If pain be a.

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