but fifteen weeks existed, the endocarditis giving rise to no symptoms to announce its presence until almost two months subsequent to the stiffness in the knees. Furthermore, in many cases, the early diagnosis of endocarditis often presents considerable difficulty. When present, it is exceptional for the patient to escape pericarditis. In watching the progress of a case of pericarditis, one of the most striking features to be noted is the rapid increase in the area of cardiac dulness, which takes place even though the patient is kept in bed and carefully nursed and treated. This rapid increase is due, as a rule, not to pericardial effusion, but to dilatation of the heart. In severe cases the cardiac dilatation may rapidly become extreme and the patient succumb within a few days of the first appearance of the pericardial rub, from a syncopal attack, which is sometimes associated with severe vomiting. More commonly, especially in a second attack of pericarditis, the inflammatory process seems to assume a subacute form; the pericardial rub persisting over a varying area for some days or weeks, and the area of cardiac dulness remaining unaltered, and even increasing in extent. Eventually, according to the writer, within from six weeks to three months' time, one of three things may happen.

1. The area of cardiac dulness may decrease till it is nearly normal in extent, indicating that the heart has approximately regained its normal size, in which case a satisfactory recovery may be anticipated 2. The area of cardiac dulness may remain permanently enlarged, though the patient has become convalescent, in which case it is probable that universal adherence of the pericardium to the heart is taking place, and, though the patient recovers, the heart will be permanently crippled. 3. The area of cardiac dulness may still further increase, the liver becoming enlarged, and dropsy set in, and the patient die with all the symptoms of right-ventricle failure. As to prognosis, it seems probable that it depends in each case on the degree to which the myocardium is affected by the inflammatory process. There are certain danger-signals for which one should always be on the look-out in children or young adolescents when a suspicion of rheumatism is aroused, and one can thus recognise the subjects in whom repeated attacks of cardiac inflammation are likely to occur. These are rheumatic nodules, small fibrous growths commonly about the size of a split pea, but sometimes as large as an almond, or even larger. They are found in the neighborhood of joints, over the olecranon or condyles of the humerus, on the margins of the patella, over the malleoli, on the finger-joints, on the sheaths of tendons; sometimes on the scalp or vertebral column, and are attached by their bone to the fascia,