and rheumaticus, or as Streptococcus brevis and longus. It is true that streptococci do cause at times well marked clinical pictures, and do vary in the length of the chain found, but are these essential differences on which to base a definite classification and to state a streptococcus which produces erysipelas will not also produce rheumatic lesions? The following case will illustrate the fallacy of such a contention.

R. E., aet 17, single, laborer, white, entered the Presbyterian Hospital under the service of Dr. Gilman Thompson, to whom I wish to express my thanks for permission to report the clinical history.

Family History:—One sister has chorea.

Personal History:—Frequent "sore throat," acute rheumatic fever, with cardiac disease, in 1905.

Present Illness:—In October, 1907, he began to have cough and dyspnoea, which became worse, and he had to stop work in the latter part of November, 1907. About December 25, 1907, he began to have epigastric pain, anorexia and vomiting, which continued until his entrance to the hospital, on December 30, 1907.

Physical Examination on Entrance:—Well developed young man, dyspnoeic, orthopnoeic and cyanotic, praecardium bulging, with a diffuse pulsation. Heart was enlarged to the left and right. There was a long murmur, occupying the entire systole, heard best at the apex and transmitted to the back. Second pulmonic sound was short and sharp. Faint presystole thrill was present. There was passive congestion of both lungs. Liver was tender and extended 6 cm. below the costal border. Some ascites was present. Slight oedema found over shins. Temp. 98°, pulse 108, respirations 30.

Jan. 4.—Jaundice present.

Jan. 6—Heart and liver slightly smaller. Temp. 101½°.

Jan. 11.—To and fro friction sound over the pericardium. Temperature 102°.

Jan. 12.—Signs of fluid in pericardium. Temp. 101½°.

Jan. 13.—Cardiac dulness steadily increasing, friction rub less apparent.

Jan. 14.—Paracentesis of pericardium unsuccessful.

Jan. 15.—Swelling of left arm and signs of consolidation of the apex of the lower lobe of the left lung.

Jan. 20.—Cardiac dulness had diminished and patient was improving; signs of consolidation in left lung much less, but there were signs of fluid over the left apex. Temp. 100° to 102½°.

Jan. 23.—Erysipelas of the face developed. Temp. 104°.

Jan. 25.—Condition remained about the same, and patient died suddenly. Temp. 103°.

An autopsy was performed 7 hours post mortem, and the anatomical diagnosis was as follows: 1, Facial Erysipelas; 2, Acute