without any tremor in the interval, such as might be given by fibrillation. At 12.37 the excursion of the needle was a little stronger. No heart sounds could be heard; no pulsation in the veins of the neck. At 12.44 I injected a tenth of a grain of strychnine directly into the wall of the left ventricle. The needle in the right fourth interspace continued to show definite movements, gradually getting feebler, and stopped at five minutes past one, 50 minutes from the onset of the collapse, and exactly 45 minutes from the last inspiratory gasp.

Nov. 4th, 1901.—I was sent for hurriedly this morning to see a stout, healthy-looking man, aged 57, whom I had known for some years, and had seen at intervals. As I entered the room at 8.15 the patient apparently was *in articulo mortis*; indeed, I thought he was dead. The eyes were fixed, the pupils dilated, the face of an ashy colour, and he was not breathing. Seeing my startled look, Dr. Atkinson, who was just preparing a hypodermic injection of ether, said: "It is all right; he will come to; he has had four such attacks in the night." There was no pulse in either radial, but listening over the heart one could hear feeble distant heart sounds. In about a minute (it seemed to me longer) the patient began to breathe; inspiration and expiration were somewhat noisy and deep, and accompanied everywhere with loud bronchial râles. He did not recover consciousness. He became more livid in the hands and face, and the pupils became contracted. The pulse could be felt, small at first, but it then became of much better volume and ranged from 56 to 68. In the course of ten minutes the breathing became less laboured; his colour improved and lost the ashy look, but he did not regain consciousness. The heart sounds could be well heard; the pulse was full and soft, 62. At 11.15 the patient died in another attack. He had not regained consciousness. He had had his first attack of angina on Nov. 2nd.

C. A chronic form, represented in my series by 10 cases, all of which were characterised by frequent recurring attacks over a period of more than 10 years. John Hunter, you remember, had had his first seizure in 1773, 20 years before his death, and he had many in the intervals. One special feature of this form is the frequency with which certain special actions are associated with the attacks. A patient may be perfectly comfortable and remain free if he leads a tranquil life with little or no muscular effort: a slight hill, the act of dressing himself, may be sufficient to bring on an attack; or in another patient an indiscretion in diet. This is a form with which the patient may feel comfortable for a great many years. I have had several friends, two of them medical men, who have managed very comfortably for more than 10 years, in spite of the liability to attacks. On the other hand, they may be among the most distressing cases we see. A Mr. D. of Wilmington lived a life of martyrdom for more than 10 years; emotion, cold, exercise, eating, would bring on the attacks, and his existence was a burden—not a week passed without an attack. He was thought to be neurotic and hysterical, though a man of 60. He had remarkable quivering of the fingers in the attacks, and on several occasions became unconscious. He threw himself about and was in intense distress during the paroxysm. I saw him in an attack and felt sure the condition was serious. The left radial pulse became very much smaller than the right. He died suddenly after nearly 11 years of suffering. Both coronary arteries were calcified.