It is interesting to note that such patients are brought in with a diagnosis of pseudo-angina and are said to be neurotic because they are Hebrews. They can have circulatory diseases. In women especially it is important to know the symptoms, to take the blood pressure, to examine the urine, etc., and work out the whole heart condition.

In most cases the condition means heart muscle failure. Still many cases of coronary disease go on for quite a long time before the heart muscle can be found involved. It is to be hoped the electrocardiagraph will reveal the muscle changes in time. So far I do not think we can be quite sure of the presence or absence of such changes in all cases.

The radiation of the pain as described by some of the speakers is not always quite as I see it. Although in a typical case the pain does go down the left arm, in a small proportion it radiates down the right arm or up into the head.

So far as keeping still or quiet is concerned, one of the most typical patients I had was a comparatively young man who had thrombosis of the anterior coronary. He had an ungovernable temper. When he had these anginal attacks he would go around the room swearing like a pirate.

One can do a great deal by giving a perfectly frank prognosis. Fortunately, most people with angina pectoris, especially with marked cases, are intelligent people, and one can tell them plainly if they have it. Give them the letters of Matthew Arnold and the letters and works of men like Sir William Gardiner, who describes his own case with heart block and heart pain. Give them Osler on angina pectoris and let them see what can be done. My own method for years has been to tell these patients plainly that they may die suddenly, to make their wills, and have no further responsibility requiring anything of that kind, so that no unusual loss will fall on their families.

In regard to treatment, I would differ with Dr. VanderHoof in regard to the use of digitalis. These patients ought to be put on a diet, to have their lives regulated, and do everything to get the circulation in the best possible condition. I believe if they need digitalis they are no longer angina cases. They are cases of heart failure of some kind.

Dr. Paulus (closing).—We can have an aortitis due to infection other than syphilis. It is these cases that often escape detection early in their course or are not given their proper emphasis because the Wassermann test is negative. Many of these cases will finally develop cardiac anginal attacks. Aortitis may develop in the course of various disease processes like a general streptococcic septicemia, and later these patients develop angina pectoris. Not all cases of angina will show gross pathologic lesions or even microscopic pathology in the myocardium or coronary arteries.

Some years ago Dr. LeCount of Chicago gave the post mortem findings in a series of angina pectoris cases or cases where anginal pains were the most marked symptoms. Some few cases showed very little definite pathology to account for the symptoms. This makes the pathologist skeptical at times of the proper ante mortem diagnosis. Nevertheless such cases exist. No doubt the angina must have been due to some spasm of the coronary vessel.

So far as the potential danger in these cases is concerned, as mentioned by Dr. Witherspoon, I may say frankly that I do not believe from our present knowledge of the condition we are ever able to tell definitely, that this man or that man will die in a short time. They are all potentially dangerous cases. You must be guarded in your prognosis. It is always a good policy to say angina pectoris is a danger signal, although this may not be necessarily so in a few weeks or a few months.

In the prolonged anginal attacks where we do not get relief by any of the means of medication we have at hand at present, it is a question of how soon the vagus inhibition or cardiac inefficiency or exhaustion will end in death. It would be well for us all to follow up these cases as much as possible from their earliest incipiency to the ultimate termination whether the patient lives in our immediate vicinity or at a distance, so that we can learn more about the results of our treatment and about the prognostic factors.

AN INTERESTING CASE OF PELLAGRA IN A YOUNG CHILD*

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In presenting this case to the Section this morning I am prompted by the belief that it demonstrates, in a striking way, the characteristics of the dermal manifestations of pellagra. First, the typical symmetry of the lesions is illustrated with almost mathematical exactness. Second, the well-defined and sharply circumscribed line of demarcation between the inflamed and healthy skin is clearly shown. It also affords me the opportunity to report the results of the injection of cerebrospinal fluid from this case into the frontal convolution of two Rhesus monkeys, which was done at my request by Dr. William H. Harris, of the Department of Pathology of Tulane University.

I wish first to invite your attention to the typical illustration of the "butterfly lesion" on the face. Here we have an almost perfectly symmetrical lesion extending over the bridge of the nose and spread over an equal area on each side

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