sure difference measured between pulmonary artery to pulmonary artery-wedge by flow. A statistically significant rise in pulmonary arteriolar resistance due to norepinephrine was found in 16 normal subjects (p < 0.01: paired data analysis). A decreased response was noted in 3 subjects with diseased pulmonary vascular bed.

The rise in pulmonary arteriolar resistance in the presence of increased pulmonary vascular pressures strongly suggests active constriction of the pulmonary vascular bed.

**SUMMARIO IN INTERLINGUA**

Dece-octo subjectos normal e 3 patientes con vasculaturas pathologic esseva studiate. Mesuraciones simultanee de fluxo e pression esseva effectuate sub conditiones de controlo e post le administration de norepinephrina intravenose. Le doses del droga sufficeva a causar prolongate augmentos per 20 a 40 mm. de Hg in le pression systemic medie. Le resistencia pulmono-arteriolar esseva calculate per dividir le mesurate differentia inter le pression pulmono-arterial e le cuneate pression pulmono-arterial per le magnitude del fluxo. Statisticamente significative augmentos del resistencia pulmono-arteriolar como efecto de norepinephrina esseva constatate in 16 subjectos normal (p 0,01: analyse de datos appareate). Un reduceite responsa esseva notate in 3 subjectos con morbide vasculatura pulmonar.

Le augmento del resistencia pulmono-arteriolar in le presentia de augmentos del pression pulmono-vascular es un forte argumen pro le existentia de constriction active del vasculatura pulmonar.

**REFERENCES**


The critical sense and sceptical attitude of the Hippocratic school laid the foundation of modern medicine on broad lines, and we owe to it: first, the emancipation of medicine from the shackles of priestcraft and of caste; secondly, the conception of medicine as an art based on accurate observation, and as a science, an integral part of the science of man and of nature; thirdly, the high moral ideals expressed in that 'most memorable of human documents', the Hippocratic oath; and fourthly, the conception and realization of medicine as a profession of a cultivated gentleman.—WILLIAM OSLER.

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35. IVEMARK, B. J.: Case #10, q.v.

For true Philosophers, who are perfectly in love with truth and wisdom, never find themselves so wise, or full of wisdom, or so abundantly satisfied in their own knowledge, but that they give place to truth whencoever, or from whossoever it comes.—WILLIAM HARVEY. De Motu Cordis, 1628.

Medical Eponyms

By Robert W. Buck, M.D.

Moebius' Sign. The first mention of this sign was made by Moebius in a review of Pierre Marie's Contribution à l'étude et au diagnostic des formes frustes de la maladie de Basedow, Paris, 1883. The review appeared in Schmidt's Jahrbücher der Inneren und Ausländischen Gesamten Medicin 200: 100, 1883.

"Von Graefe has said that lessening or abolition of the synerge movement of the upper lids in raising and lowering the eyes is pathognostic. The reviewer has failed to find Graefe's symptom in a series of cases including some with and some without exophthalmos. He not only disbelieves in its pathognostic character, but considers it rather rare. On the other hand, the reviewer has recently observed a disturbance of convergence in two patients with Basedow's disease, both of whom had a moderate bilateral exophthalmos of equal degree. If the patient was asked to fix his vision upon the examiner's finger, both eyes looked to the right or to the left. That is, the patient fixed with one eye, and the external muscles of the other eye contracted consensually. On monocular examination, both internal recti functioned normally. In a third patient with exophthalmos, the symptom was absent. Whether the phenomenon is directly dependent upon the exophthalmus is uncertain."

The subject was again discussed, and observations in eight additional cases were reported in an article on "Convergence Insufficiency in Basedow's Disease" (Ueber Insufficienz der Convergenz bei Morbus Basedowii) which was published in the Centralblatt für Nervenheilkunde, Psychiatrie und gerichtliche Psychopathologie 9: 356-358 (June 15) 1886.
habeva entrate in le stenotic orificio pulmonar. Duo altere patientes manifesto solmente signos hemodynamic de que le catheter cardiac obstrueva le fluxo de sanguine a transverso le valvula pulmonar.

In nostro experientia, obstruction del valvula pulmonar ha occurrirte solmente quando sever grades de stenosis pulmonar esseva associate con un derivation dextro-sinistre. Omne le 8 patientes qui se presentava con symptomas clinic o evidentia hemodynamic de acute obstruction del valvula pulmonar habeva non-saturation arterial in stato de reposito e calculate areas de valvula pulmonar amontante a 0,15 cm² o minus.

Un declaration subite de disquietude, augmentos de cyanose, e tachycardia occurrente post que le catheter de exploration cardiac ha entrate in un stenotic orificio pulmonar es signos precoce de que le fluxo de sanguine pulmonar ha essite reducute.

Un continue vigilantia clinic, constante observationes del saturation arterial, e studios electrocardiographic es essential—specialmente in patientes con non-saturation arterial in stato de reposito—si le complica-
tiones de obstruction del valvula pulmonar durante catheterisation cardiac vole esser prevenite.

REFERENCES


The author presents an analysis of phlebograms recorded in various types of constrictive pericarditis. On the basis of the relative size of a and c waves, and the degree and the timing of systolic and diastolic collapse (x and y) waves, 4 different patterns can be distinguished that are attributable to predominant involvement of the right or left chambers by the constriction. The 4 basic patterns were found in particular in localized forms of pericardial constriction, while the more extensive processes cause combination patterns or curves modified by alterations attributable to venous congestion. Regression and recurrence of pericardial constriction is exemplified by serial phlebograms recorded in a patient with tuberculous pericarditis who temporarily was treated by cortisone.

Pick
Comparative Severity of Atherosclerosis


Seventy-eight cases of nonbacterial thrombotic endocarditis occurring over the past 22 years among 18,486 consecutive autopsies at the Mallory Institute of Pathology at the Boston City Hospital were analyzed. From a clinical standpoint, the patients were separated into 3 groups. The first group in which embolization of organs constituted the chief clinical picture may permit of antemortem diagnosis. In a patient with cardiac decompensation and evidence of embolization of several organs, the important differentiation is between nonbacterial thrombotic endocarditis, bacterial endocarditis, and mural thrombi of the cardiac chambers. In the second group, in which embolization is at least partially masked by a more primary disease, diagnosis is more difficult and may be considered when a patient in the elderly age group confined to bed develops symptoms consistent with embolization of organs which do not constitute a phase of the natural history of the primary disease. Diagnosis in the third group in which there is no embolization of organs and in which the valvular lesions constitute an incidental finding at autopsy is probably not possible. In 11 cases, emboli were found that were considered to have arisen from the valvular vegetations and to have caused or contributed to the patient's death. The organs principally involved were the brain, the spleen, and the kidneys. The most commonly associated diseases in this series were cancer (36 per cent), heart failure (39 per cent), and vascular thromboses (27 per cent). The pathogenesis of the vegetations is considered to be the occurrence of thrombi formed from blood within the cardiac chambers upon nonspecific areas of focal fibrocollagenous degeneration of valves. When embolization occurs, it is considered to be the result of a portion of adherent thrombus breaking off into the circulation. The main feature pathologically is the lack of cellular reaction in the involved valve in nonbacterial thrombotic endocarditis in contrast to the other types such as acute bacterial endocarditis, subacute bacterial endocarditis, healed bacterial endocarditis, healed rheumatic endocarditis, active rheumatic endocarditis, and the atypical verrucous endocarditis of Libman-Sacks.

These 2 enzymes (and transaminase as well) are widely distributed throughout body cells, the former participating in the citric acid cycle and the latter being concerned with glycolysis. Measurement of the plasma level of either enzyme is easy to carry out, although the result in the case of malic dehydrogenase may not be entirely specific. In 18 patients with acute myocardial infarction but not in shock, the plasma activity of all 3 enzymes was abnormally elevated, the peak level of each being reached at about 24 hours after onset of pain. In 14 patients with a variety of liver diseases the plasma activity of all 3 enzymes was elevated in 10 instances, that of 2 of the 3 enzymes was increased in 3 instances, and the activity of all 3 was normal in 1 patient (who had portal cirrhosis). The greatest activity of phosphohexose isomerase and of transaminase was found in patients with infectious hepatitis, whereas peak values of malic dehydrogenase were found in individuals having myocardial infarction. There was fair parallelism in the levels of activity of the 3 enzymes.

Rogers