A 53-year-old woman was admitted to the hospital as an acute emergency because of sudden onset of left hemiplegia and coma. There was no past history of diabetes, hypertension, or cardiac insufficiency. The blood pressure ranged from 130/90 to 90/68. An electrocardiogram revealed changes consistent with acute anterior transmural myocardial infarction. The patient expired within 36 hours after the electrocardiogram without regaining consciousness.
While it is well known that acute cerebral injury and subarachnoid hemorrhage can cause gross alterations of the T-wave in the electrocardiogram, we believe that the pattern of acute infarction, as illustrated, is distinctly unusual. Postmortem examination revealed the cause of death as extensive subarachnoid hemorrhage from a berry aneurysm of the right anterior cerebral artery. The heart weighed 350 grams with reddish-brown resilient myocardium which microscopically was entirely normal. The left ventricle measured 1.6 cm. The right 0.3 cm. There was minimal evidence of intimal coronary arteriosclerosis with no areas of narrowing or thrombosis.

One must consider the possibility that the patient expired too soon for anatomic myocardial changes to have taken place, but the absence of coronary narrowing or thrombosis and the time interval of 36 hours make this possibility unlikely.

THE P-R INDEX

The P-R index (A-V conduction interval) was studied before and after surgical closure of the interatrial septal defect in 35 cases of widely patent foramen ovale types. In 20 per cent of the cases, this index was found above 1.00, that is, first degree A-V block. In 60 per cent, a preoperative index above 0.81 was found. In the immediate postoperative period, the A-V block disappeared in 100 per cent of the cases and there was a general decrease of the P-R index in cases "without block." This fact proved to have a significant statistical value when it was analyzed.

No apparent relation was found between the area of the septal defect, the level of the pulmonary arterial pressure and the degree of diastolic overloading with the delay in the A-V conduction. Because the A-V conduction improved, it is thought that the delay of it has no relation to anatomic alterations of the conduction system, but rather that its immediate disappearance in the postoperative period practically simultaneous with the elimination of abnormal hemodynamic conditions: diastolic overloading of the interauricular septal defect, leads us to suggest that these disturbances are somehow related to the diastolic overloading of the right cardiac chambers.


RHEUMATIC FEVER IN THYROIDITIS WITH HYPERTHYROIDISM

Six cases of rheumatic fever with rheumatic heart disease were studied during an episode of thyroiditis with hyperthyroidism. In two cases in whom thyroid biopsy was done, this study showed signs of "chronic nonspecific thyroiditis." Antithyroglobulin antibodies were found in the serum of every case. These antibodies were not found in the serum of 20 control subjects without thyroiditis, with or without rheumatic fever. The cases with some manifestations of heart failure and auricular fibrillation responded better to the treatment with antithyroid drugs than to digitalis.


UNUSUAL MANIFESTATIONS OF SYPHILITIC CARDIOVASCULAR DISEASE

A case of syphilitic cardiovascular disease associated with extensive myocardial scarring and widespread myxomatous degeneration of the heart and large arteries is presented. It is assumed that cardiac myxomatous degeneration progressing to scar tissue formation in the myocardium was a major cause of chronic left and right heart failure, as well as of rupture of the mitral chordae tendineae. Cardiovascular myxomatous degeneration might represent a form of connective tissue damage due to a hypersensitivity reaction elicited by an antigen developing in the course of the syphilitic infection.