areas of collapsed lung tissue. Many of the small cavities are in connection with bronchi, but they are not all bronchiectatic. Right lung crepitant, except at apex, where there is a small cavity and a few cheesy nodules.

Nothing of note in other organs.

Remarks.—There are only a few points in this case on which I wish to make a few remarks.

1st, The situation of the tumor. 2nd, The character of the cough. 3rd, The communicated tracheal pulsation. 4th, The influence of treatment.

The situation of the tumor is unusual. Its orifice of communication with the lumen of the aorta is beyond the last of the great vessels springing from the arch. Considerable evidence of atheromatous change was found in the lining membrane of the ascending and transverse portions, and, under these circumstances, one would rather expect to find that this part had at some portion given way, owing to its feeling the full impact of the blood-current. Probably the softening changes advanced most rapidly at this spot, and thus permitted of the dilatation taking place. The growth from its situation necessarily pressed backwards, and produced pressure both on the bifurcation of the trachea and on the left bronchus. That both these conditions were present was clearly made out during life. The former by the peculiar character of the cough, and the latter by the airlessness of the left lung.

The character of the cough was peculiar. It had a deep, gruff, hoarse tone that clearly was not of a laryngeal nature at all. This peculiar cough, which is not so easily described, but can readily be recognized when heard, is, I think, never produced except by pressure upon the trachea. At the very first examination of this patient, the sound of the cough made me suspect and look for an aneurism.

It was shortly after having been consulted by this patient that I noticed in one of the Medical Journals that attention was drawn by an army surgeon to his frequent observation of pulsation from thoracic aneurisms communicated through the trachea in the way