

is an ulcer 3 cm. in diameter, with an irregular base from which cauliflower-like masses project. Surrounding the oesophagus at this level is a firm mass about the size of a hen's egg. This growth extends to the left, and surrounds the left carotid and subclavian arteries, compressing these vessels and narrowing their channels. The growth is of very firm consistence, of whitish appearance, traversed by glistening bands, and exuding a cancerous juice. The adjacent lung is densely adherent and a gangrenous cavity about the size of a large apple is present at the apex of the lung, in close relation with the tumor. This cavity is filled with dark clotted blood, and a large division of the bronchus opens into it. There are several small cancerous nodules in the left lung, and small patches of broncho-pneumonia. On the wall of the subclavian artery 2 1-2 inches from its origin is a small circular perforation, 3 inches in diameter. This opening communicates with the gangrenous cavity in the lung.

The crico-artenoideus lateralis and posticus on the left side are markedly atrophied. Microscopical examination of the tissue from primary growth in oesophagus shows this to be composed mainly of fibrous tissue with extensive infiltration of epithelial cells, these being arranged in tubular and alveolar forms as in a carcinoma. The secondary nodules in the lung though of the same character, differ slightly in that the cellular elements of growth are more of an endothelial type.

*Anatomical Diagnosis.* Cancer of oesophagus, Gangrene of lung. Perforation of second portion of subclavian artery. Broncho-pneumonia and secondary growths in tissues of neck and epigastric glands. Cloudy swelling of organs. Perforative appendicitis and peri-appendicular abscess.

The diagnosis made during life was cancer of the oesophagus, followed by gangrene of the lung.

The presence of dysphagia in an elderly and somewhat emaciated man at once drew attention to the oesophagus; obstruction about 8 1-2 inches from the teeth, as found at the second examination, corresponded to about the bifurcation of the trachea, near which the stricture was ultimately found.

No obvious explanation was found for the fact that the sound first passed 13 1-2 down the oesophagus, and then was arrested. There was no stricture at this point, and there was possibly some error in observation.

In a case under the late Dr. Geo. Ross, one of us once passed an oesophageal sound into a large gangrenous cavity of the lung, and so failed to find obstruction in the oesophagus. At the autopsy some days later the communication with the lung had closed. It is needless to say that in the present case such a fallacy could not have occurred.

A feature of interest was the extreme narrowing of the oesophagus,