of the œsophagus. The hypothesis of pressure on the œsophagus by a mediastinal tumour was also entertained. On March 8, there was a severe attack of hæmatemesis; bright red blood was rejected without any effort of vomiting. Syncope followed and about an hour later a stool consisting of block clot was passed. Next day a similar attack of hæmatemesis proved fatal.

Necropsy.—The heart was greatly enlarged and the aortic valves were indurated. The thoracic aorta was uniformly dilated to a diameter of more than 5 cm. At the diaphragm was a spherical aneurysm of the size of the fist and intimately adherent to the œsophagus into which it had perforated. The lumen of the œsophagus was but little contracted by the aneurysm. The left pneumogastric nerve was involved in the adhesions between the œsophagus and the aneurysm, and was exposed in the communication between them. The walls of the aorta were thickened and of calcareous consistence. The stomach contained an enormous clot. The kidneys were slightly atrophied and the capsules were adherent. The abdominal aorta and the iliac arteries were a little sclerotic.

The case presents several points of interest. The patient complained only of digestive symptoms, œsophageal vomiting (regurgitation) and brief, but abundant, salivation after taking food. The latter appears to be an œsophago-salivary reflex. M. Antony has pointed out the existence of this reflex in cancer of the œsophagus. There were no signs of aneurysm. The survival of the patient after the first attack of hæmatemesis did not seem compatible with the hypothesis of rupture of an aneurysm into the œsophagus. But cases of survival after such hæmatemesis for days, weeks, and even for two months after more than a litre of blood has been lost, have been recorded. [See "Non-fatal Rupture of Aortic Aneurysm," "REVIEW," 1904, p. 703, and "Recurrent Copious Hæmoptysis" from an Aortic Aneurysm," "REVIEW," 1905, p. 367.] Rupture of an aortic aneurysm into the œsophagus is even compatible with a return to activity of the patient. The arrest of the hemorrhage has been explained as due to plugging of the opening with clot. Dysphagia is rare in aortic aneurysm. In this case there was no mechanical obstacle to deglutition. The selective character of the vomiting for liquids points to the absence of such obstruction and to spasm of the œsophagus as the cause. Evidently both the salivation and the vomiting were due to irritation of the exposed pneumogastric nerve during deglutition.

Rupture of an aortic aneurysm into the digestive tract is rare. In a period of seventy-two years 142 cases of ruptured aneurysm were reported to the Societe Anatomique of Paris. In