over-dosing is to be avoided because it leads to inhibition of the action of the drug; the dose for clinical purposes should be the same as that of diuretin; (7) the coagulability of the blood is diminished by thephorin. It is thus seen that in thephorin we have a new preparation which, from its composition and from the result of experiments on animals, would appear to be well suited for clinical purposes, but how far it will replace older diuretics can only be judged from clinical observation.—*British Medical Journal.*

Oesophageal Symptoms in Aortic Aneurysm. E. Hirtz and H. Lemaire (Bulletins de la Soc. Med. des Hospitaux.)

and H. Lemaire (Bulletins de la Soc. Med. des Hospitaux.

A man, aged 55, was admitted into hospital on March 3, 1905. For four months he had been losing health and strength. For two months vomiting had followed nearly every meal. At first the vomiting occurred about an hour after meals, then it occurred earlier, and finally it took the form of regurgitation. After taking a few mouthfuls of food the patient had to get up in order to reject what he had swallowed. This always occurred in the case of liquids, but solids were often retained. Deglutition was not painful and did not appear to be difficult. The patient had not been obliged to diminish the size of the mouthfuls.

He looked cachectic and the conjunctivæ and face had a subicteric tinge. There was myosis without inequality of pupils. In the upper part of the epigastrium some deep and painful lumps were felt. On taking a glass of milk the patient vomited it after some seconds and in the meantime abundant salivation occurred. The urine was increased in quantity and contained a trace of albumin. The area of cardiac dulness was increased, especially to the left. The apex beat was in the fifth space outside the nipple line. There were a "*bruit de galop*" on the left side and a resounding second sound at the base. The arteries were atheromatous; the radial and femoral pulses were equal. Abundant salivation always followed the taking of food, but occurred at no other time. The patient complained of great thirst which he could not quench. The existence of painless œsophageal vomiting with abundant salivation caused stricture of the œsophagus to be diagnosed. The lump felt in the epigastrium seemed to point to malignant disease of the cardia. But the facts that the regurgitation followed closer and closer upon deglutition, and that the patient was not compelled to diminish more and more the size of the bolus, and that the regurgitation was almost selective for liquids, were not in accord with the existence of a progressive malignant stricture of the lower end