very severe attack of dyspnœa, which lasted about half an hour. Pulse was 120; temp. 100°.

He continued to suffer from dyspnœa and pain in the chest, which he could not localize, until June 12th, when he died after a prolonged attack of orthopnœa.

Autopsy, 30 hours after death:

Body that of a medium-sized man; rather emaciated.

On opening the abdomen, intestines appear normal.

Thorax.—Lower lobe of right lung adherent at lower part by soft recent adhesions. Further up there is a plastic lymph, non-adherent, and beyond this, intense congestion of the pleura; the surface of the upper half of the upper lobe alone is healthy. The upper part of the lung is compressed by about one pint of turbid serous effusion. The lower part of right lung, especially at the margins, and for a space of three or four inches, is in a state of pneumonic consolidation—red hepatisation; a small part of it has advanced to the stage of grey hepatisation. On the anterior surface there is an abscess about the size of a filbert, apparently arising from a previous broncho-pneumonia. Upper part of lung fairly healthy.

Left Lung—Non-adherent; anterior surface healthy; posteriorly hypostatic congestion; apex on section appears acutely congested—crepitant; on pressure, exudes a large amount of frothy serum.

Heart—Weighs 330 grammes; substance apparently healthy, also valves, except aortic, which appears to be slightly incompetent. The arch of the aorta is dilated and lengthened so as to form a large fusiform aneurism, involving, chiefly, the transverse portion of the arch.

The innominate artery is dilated throughout its whole length so as to form an independent aneurism which sits upon that formed by the arch. The right subclavian and carotid are given off from this sac, but are of normal size and appearance from their origin. The recurrent laryngeal nerves were not observed in the dissection, but it seems probable that the right was in some way interfered with by the innominate portion of the aneurism.