type rather than calcareous. Indeed there was only one calcareous patch, 2 cm. across, at the beginning of the descending aorta and an atheromatous ulcer of small size, around the origin of the right renal artery. The fibroid hypertrophy was especially thick around the origin of the innominate, left subclavian and carotid, and there was great thickening also around the offset of the coeliac axis, associated here with not a little deformity of the aorta. 3.25 cm. above the coeliac axis was situated a large transverse rupture of the inner walls. (Vide fig. 1.) The rupture was situated, therefore, above the diaphragm, near to the point where the aorta begins the oblique course through that septum, the point corresponding to the body of the tenth dorsal vertebre. The rupture was 4.5 cm. across, and began 5 mm. to the left of the middle line behind, extending round the right side of the aorta to the middle line in front. The breadth of the aorta immediately above the rupture was 6.25 cm. This rupture which was unassociated with any evidence of atheromatous ulceration gave entrance into a long channel, extending both upwards and downwards. The upper channel was filled below with fairly firm adherent reddish-grey clot, which gave way to pale discoloured fibrin about the middle of the thoracic aorta, and from here a channel containing thin layers of fibrin and almost obliterated, continued upwards along the right side of the aorta as far as the middle part of the arch. In a downward direction the channel was relatively free from blood clot, what there was being soft, loose and recent. This channel was large, roughly triangular, and smooth-walled, passing along posteriorly somewhat to the right, and at the bifurcation it also bifurcated, passing along the common iliacs, and from them along the external iliacs. Here on the right side it opened again into the lumen of the right external iliac, close to its lower end, 4.3 cm. below the bifurcation of the common iliac, 9.5 cm. from the bifurcation of the aorta. On the left side it continued still further, opening in the first portion of the femoral artery, 7 cm. below the bifurcation of the left common iliac, 14.5 cm. from the aortic bifurcation. The channel ran along the inner aspect of the common iliac becoming posterior below.

Upon the right side a small dissecting channel continued down the posterior and outer side of the right internal iliac artery—for what distance I cannot say, the passage not having been noticed until some little time after the performance of the necropsy, and this artery having been cut near to its origin. Sections taken from the cut end indicated that it can at most have passed down for a few centimetres, the dissecting channel being separated from the intima by the merest trace of muscle tissue.