

cases of aortitis with dilatation of the vessel." Such cases as these, it seems, are exactly the conditions which we should expect in a large vessel the subject of a primary endarteritis which in a small vessel leads to obliteration, but in a trunk of the size of the aortic is followed by dilatation, from a weakening of the muscular and fibrous coats. Such a lesion may well be syphilitic, and is one which we should expect to be benefited by a course of the iodide. Nor is it at all strange, that the succulated aneurisms should pulsate less vigorously during the administration of the iodide. All the potassium salts are depressors of the heart's action, and when we take into consideration that the initial dose recommended by the promoters of this treatment is from 5 to 10 grains, to be increased until the patient is taking 90 to 400 grains a day, it is not at all surprising that the pulsation of the tumor should diminish, and as its nutrition is impaired with all the other tissues of the body, its size also.

Notwithstanding the adverse criticisms which have been made on the use of the iodide, as it can do no immediate harm, it ought still to be tried, if not in all cases, at least in those where there is even but a suspicion of syphilitic taint.

I pass on now to a consideration of the surgical treatment of those cases of aneurism, which, having resisted all medical treatment, are yet evidently rapidly advancing to that point where it is evident that they will carry the patient off from overwhelming hæmorrhage due to rupture of the sac. The first question, which it is fair to ask ourselves, with regard to such a case, may well be, whether we shall abandon the patient to his inevitable fate without making any effort to evert it? The final decision of such a question must, no doubt, rest with the patient himself. If we can only say to him, to assist his decision, that he is absolutely beyond our skill, and that any effort on our part, to give him relief by surgical means, will result only in a speedier death than that threatened by the disease, even though the patient asks for operation, we must refrain, for we have no right to assist him to commit suicide. Intense though the sufferings of the patient may be, to us has never yet been given the right to produce euthanasia. It may be a question in casuistry to decide just when it is ethical for us to advise such a sufferer to take a great immediate risk for the very remote hope of benefiting an otherwise irremediable condition. I myself think that if there is any hope whatever, however remote, under the conditions stated, it is right for the surgeon to make the statement clearly and fully to the patient, and then if he is willing, knowing all the risks of the procedure, to give him the benefit of a chance which may be but one-tenth of one per cent. His risk otherwise is total.

There is only one way by which we can expect

to benefit aortic aneurisms, and that is by inducing in some manner the formation of the hard, white clot, the so-called active clot, which alone can present an effective barrier to the hydrostatic pressure on the walls of the tumor. Some of the methods, which I shall briefly mention, have been deficient in just this particular, namely, that instead of favoring the deposition of the active clot, they have instead promoted the formation of the soft and soluble passive or red clot, which has soon been re-absorbed, or, breaking down, made its appearance elsewhere as an embolism. The method of injecting a coagulating fluid into the sac, was one of the first means that surgeons adopted against these tumors. I have already stated the objections to the method, which, in aneurisms of the arch, would be insuperable, because of the danger of embolism of the great blood vessels of the brain. Although the production of embolisms in the blood vessels of the extremities might be prevented for a time by compression of the abdominal aorta, the soft nature of the clot absolutely forbids us to expect anything but harm as a result of these injections. I believe that they are totally unjustifiable. The introduction of foreign bodies into the sac is a method which is comparatively recent, originating with the late Dr. Moore, of Middlesex, England. In 1864, he introduced into a thoracic aneurism twenty-six yards of fine silver wire through a fine canula. The patient died on the fifth day thereafter from inflammation of the sac, the surrounding parts and embolic infarcts in the kidneys. I can find no record of the findings as far as the condition of the sac is concerned, and the character of the clot, induced by so large a quantity of wire. The occurrence of an inflammation in the sac so intense as to extend to the surrounding parts certainly suggests that sepsis had more to do with the unfortunate result of this case than the mere introduction of the wire, and the infarctions in the kidneys increase this probability. This case cannot fairly be cited as unfavorable to the method. Many other similar cases are cited in the journals, in which this procedure was resorted to before the days of antiseptic surgery, and certainly no one can conceive of a more dangerous procedure than the introduction into an aneurismal sac of material of whatever nature, which was not itself entirely sterile; the most recent cases reported in this vicinity, in which this method was adopted, I find in the *Medical News* of April 9, 1887, both reported by Dr. Abbe, of New York. In the first case, seventy-five yards of No. 00 piano wire was used, and subsequently a current of electricity passed through the coil, as the reporter says. Result, death on the twenty-second day. In this case no autopsy was allowed, therefore it is impossible to say what was the condition of the clot within the sac, which is perhaps the most important question to be settled, if we are to come