diastolic murmur and reduplication of the second pulmonary sound. There was poor expansion of the chest, with dulness over the left side and absence of breath sounds; expiration was prolonged. The abdomen was everywhere so tender on pressure, more especially over the epigastrium and in the left hypochondrium, that satisfactory palpation was impossible. The urine contained a small amount of albumen, with hyaline and granular casts and renal epithelium.

The chest was aspirated and 76 ounces of fluid were removed. With rest and digitalis the condition of the patient improved so much that he was discharged on February 3rd, there being still some fluid on the right side and a double murmur at the apex. The œdema had disappeared.

The patient was re-admitted upon February 29th, complaining of severe pain in the stomach and great thirst. Save for occasional attacks of dyspnœa he had been fairly comfortable since leaving the hospital, until two or three days prior to re-entrance, when he had been suddenly seized with agonizing pain in the right hypochondrium, extending well into the mid-axillary line. This was soon followed by severe pain in the umbilical and epigastric regions, as also in the back opposite to the level of the epigastrium. The pain was described as sharp and stabbing, present all the time and very much increased on movement or pressure; in fact the patient could not bear the slightest touch. Turpentine stupes had been applied to the abdomen, but the pain continued for twelve hours longer, when it ceased. Upon re-admission the pulse was found irregular in rate and force; there was inspiratory retraction of the basal intercostal spaces with poor expansion. The base of the right lung was dull, with here and there a friction rub. The patient suffered from severe paroxysms of abdominal pain, for which morphine was employed. There were also repeated paroxysms of dyspnœa.

Upon March the 28th the fluid in the right side of the chest having increased, 84 ounces were removed. He recovered well from the tapping, but some hours later he began to retch, and during the attack he died suddenly. The condition was diagnosed as one of chronic myocarditis, acute nephritis and pleurisy with effusion.

Besides the dissecting aneurysm and the associated arterial changes, the necropsy revealed well-marked hypertrophy and dilatation of the heart, emphysema and bronchitis with œdema of the lungs, and serous pleurisy of the right chest, adhesive pleurisy on the left side. The kidneys were sclerotic, of the small red granular type. The aorta presented an extreme condition of nodose arterio-sclerosis, the hypertrophy of the intima being very considerable and of a hyaline fibroid