He was seen again at 11.30 p.m. and at 9 the next morning, and on neither occasion was there any change.

Dr. Mackinlay saw him at 3 p.m., when he was sleeping. At 5 p.m. he got out of bed to try to get relief, and was again seized with intense pain, starting in the abdomen and shooting through to the back and up the right side. He was seen again about 6 p.m., when he was moaning a good deal; and turning him over in bed to examine him at once aggravated the pain, which was then mainly over the base of the right lung. At 7.30 he was seen by Dr. Weeks. There was then marked dullness at the base of the right lung, with absence of breath sounds. There was marked pulsation in the epigastrium, but no murmur. Up to this point we were in favour of ruptured duodenal ulcer into the lesser sac, but the evidence was not sufficient. Dr. Weeks did at one time think of aneurysm as a diagnosis, but as the patient's condition was not improved he was removed to the infirmary, Middlesbrough, where he was seen by Mr. Dickie at 9 p.m. After examining the patient Mr. Dickie was unable to arrive at a diagnosis, except that it might be some early chest condition, and advised no operation. The patient gradually became weaker, and died at 7 a.m. on November 4th.

A *post-mortem* examination was made the same afternoon. The right pleural cavity was full of blood, which was pushing the lung upwards. The left lung was normal; the heart was enlarged and fatty; the arch of the aorta was dilated and covered with calcareous patches. At the point where the aorta passes through the crura of the diaphragm there was an aneurysmal dilatation on the posterior side the size of an orange. It had eroded the eleventh dorsal vertebra to the depth of half an inch and the circumference of a two-shilling piece. The walls were firm, and looked like normal arterial walls. On the anterior wall and to the right there was a large perforation into the right pleural cavity. There was marked extravasation into the cellular tissues up the spine and into the abdominal cavity extraperitoneally. The liver was enlarged and fatty. The gall bladder contained a number of large stones. All the other organs were normal.

A CASE OF SPONTANEOUS HAEMO-PNEUMOTHORAX.

BY

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J. P., aged 17 years, a junior clerk in a commercial firm, was admitted to the Northern Hospital on July 21st, 1913.

Onset.

On the morning of July 21st, while running to catch a boat, he suddenly felt giddy, his legs gave way, and he fell over; being unable to rise, he was conveyed by ambulance to the hospital.

Condition on Admission.

He was in a state of profound collapse, with rapid shallow respirations, barely perceptible pulse, pinched features, and cold extremities. The percussion note over the whole of the left side of the chest was absolutely dull, with the exception of Traube's area, which was resonant; the heart was displaced to the right of the sternum nearly to the right nipple line; the breath sounds on the left side were inaudible. The condition of the patient precluded any very searching examination.

The patient was of poor physique, and his mother informed us that she had always considered him delicate, but that he had had no special illnesses, and had not been troubled by any cough.

Course.

On the following day the physical signs were much the same, except that resonance over Traube's area was now abolished. The collapse had in great measure passed off.

The left pleura was explored, and a syringeful of blood withdrawn.

In the course of a week or two, while the heart remained displaced well to the right of the sternum, the dull percussion note over the front of the left side of the chest became gradually replaced by a tympanitic note, extending to the level of the fifth space in the mid-axillary line, passing abruptly into absolute dullness; the level of dullness passed round to the back to the level of the eighth dorsal spine. There was free shifting of the level of dullness, the tympany in front being replaced by dullness on the patient being turned towards his face, and the basal dullness becoming changed to over-resonance. The breath sounds over the resonant area were greatly diminished; at places distant amphoric breath sounds were heard. The *bruit d'airain* was not obtained.

Subsequently the fluid reaccumulated till the left pleural cavity was once again filled to its full capacity; he was tapped, and a pint of deeply blood-stained fluid was removed. From this time he made steady improvement. After a period during which the physical signs of pneumothorax predominated, breath sounds returned and the heart resumed its normal position. He was discharged from the hospital on October 29th, at which time no morbid signs were observed, with the exception of impaired percussion and feeble breath sounds at the extreme base of the left lung.

REMARKS.

There was some suspicion of his being of the haemorrhagic diathesis. This was supported by the fact that troublesome bleeding had occurred on the occasion of teeth extraction, and by his statement that he bled freely from small wounds; there was, however, no record of any other case in the family history, and the bleeding from the extraction of teeth did not appear to have been of any great severity.

The case was regarded as one of rupture of the lung, probably due to a small superficial cavity, with simultaneous laceration of a small vessel.

LITHOPAEDION.

BY

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TORONTO.

EARLY in the year 1870 a small, active woman, then aged 25 years, who had had three children, became pregnant for the fourth time. Matters progressed as usual for six months, then seemed to stand still; later the milk left the breasts, fetal movements lessened, and finally ceased. Her girth decreased, and in a few months only a firm mass was felt at the brim of the pelvis.

Anxious and puzzled, she consulted a doctor, who doubted that she had been pregnant, and advised leaving the mass alone as long as no serious inconvenience was felt. She followed his advice, and as time passed she had four more children; at each pregnancy the mass rose with the growth of the fetus, and returned to its old position after the birth of the child.

In January, 1912, she consulted me for long-continued costiveness, which she said was increasing. She did not then tell me of the events of 1870. I tried cathartics with only temporary relief; then suspecting obstruction, an examination showed more than one mass in the pelvis. I advised an operation. She entered the Victoria Hospital, Toronto, and with Dr. C. H. Thomas an operation was performed in March, 1912. Dr. J. E. Forfar gave the anaesthetic, and we found a lithopaedion at the brim of the pelvis; the head was easily movable, but the lower part of the body was almost surrounded by firm cartilaginous bands attached to the uterus, omentum, and intestines. The calcified placenta was found opposite the third sacral vertebra, and so bound down by adhesions that it was difficult to remove it. To make matters worse, a fibromyoma had formed in a loop of intestine where it touched the placenta; thus we had to resect over 3 in. of the intestine; the adhesions made this much more difficult.

The head was covered by a thin membrane containing some blood vessels; the antero-posterior circumference was $8\frac{3}{4}$ in. and the occipito-menti circumference $9\frac{1}{8}$ in.; the frontal, parietal, and occipital bones were well marked, and there was only a slight depression of the fontanelles; the eyes, nose, chin, and mouth were easily seen; the head was flexed and turned toward the left shoulder, and had a rough, stony feel. The legs and arms were flexed, with their outlines more visible on the right side;