subsequent cancer, if the neoplastic development becomes manifest within a few days or weeks after the injury. The existence of a not recognized precancerous or cancerous condition at the site of the injury at the time of the accident becomes under such circumstances a matter of strong suspicion and probability. The proper consideration of the size of the tumor at the time of its discovery, its histological type, permitting an estimate of its approximate normal growth rate, and the presence or absence of metastases may be of distinct help and value in the analysis of such cases.

6. The symptoms characterizing the primary traumatic period may be connected by the so-called bridging symptoms (continuity of pain, swelling, functional disablement, suppuration, and ulceration), observed during the preparatory period, with the symptoms of neoplastic origin, found during the manifestation period of the neoplasm. The presence of bridging symptoms is not an essential feature for the establishment of a causal relationship between trauma and cancer. There may even occur pseudo-bridging-symptoms, which actually represent an indication that the trauma affected a site containing a preexisting, unsuspected cancer. This conclusion is suggested, if the symptoms elicited by the trauma appear to be out of proportion to its intensity, and lead over without any appreciable reduction into those manifestly produced by the neoplasm.

The claim, frequently made, that traumatic sarcomas require a shorter latency period than carcinomas, is scarcely tenable considering that the distinction between these two types of malignant tumors is to a large extent an artificial one, based upon morphological criteria and not upon biological or embryological-histiogenetic ones (Hueper). The data given, concerning this matter by various investigators, are, therefore, without significance from a medicolegal viewpoint (Thiem: sarcomas: 8 days to 1 year; carcinomas: 3 weeks to 3 years; and gliomas: 1 month to 10 years or more). The latency periods vary obviously in part with the average growth rate of a particular type of neoplasm (Fraenkel; Pick; and Ewing).

7. The diagnosis of a neoplasm and its type must be established definitely by proper and adequate means and by competent physicians. It must be based on clinical and roentgenological evidence, confirmed and supplemented, wherever possible, by histological evidence. The histological examination of tissue removed from the suspected lesion can provide, although not always, important information as to the histogenesis of a given neoplasm and particularly its primary or secondary (metastatic) character, aspects of considerable medicolegal significance. Whereas the histological evidence, when furnished by an experienced pathologist, must be considered as the most reliable one, there exist here sources of error or opportunities for differences in interpretation and opinion, which should be taken into account and carefully weighed in each case. Whenever such difficulties or uncertainties arise, it should be insisted upon and made obligatory that in the case of subsequent death, a