narily latent. Ewing quotes a duration from 10 days to four years, and Fishberg one of six months to four years. But these statements are of a dubious value because lung carcinomas cause late clinical manifestations, and sometimes none at all. On the other hand, there may occur occasionally an acute activation of a lung carcinoma after pneumonia.

Cancers of the lung may originate from the following three structures: a) the columnar epithelium of the bronchia and bronchioli, which may undergo (under pathalogical conditions) a metaplastic change into a squamous-cell type; b) the cuboidal epithelium of the peribronchial mucous glands; and, c) the flat polygonal cells lining the alveoli, which under pathologic conditions (atelectasis) may become cuboidal or low columnar in shape. The bronchiogenic carcinomas are the most frequent; cancers derived from the peribronchial glands occupy second place; and those originating from the alveolar cells are exceptional. Many investigators do not recognize the actual existence of the last variety, as it is still controversial as to whether the cells lining the alveolar spaces are histogenetically of epithelial or mesodermal derivation. Such theoretical considerations have little significance for several reasons. Pulmonary cancers have been reported closely imitating the alveolar structure of the lung in the presence of intact bronchiolar structures (Kretschmar; Gordon; Briese; Ribbert; Hueper; and Oberndorfer). Inasmuch as the mesodermal transitional epithelium, lining the dome of the urinary bladder, gives rise to malignant tumors morphologically identical with those originating from the entodermal epithelium, covering the trigonal and paratrigonal region, the histogenetically different, cellular elements composing the lining of passages whether they carry urine or air, seem to possess the same neoplastic potentialities.

The histological structure of pulmonary carcinomas depends upon the tissue of origin and the presence of metaplastic changes. There occur squamous-cell carcinomas with and without cornifications, round-cell carcinomas, adenocarcinomas of various degrees of differentiation and function (simple adenocarcinoma, papillary adenocarcinoma, and gelatinous adenocarcinoma), and highly anaplastic carcinomas of sarcomatoid appearance (the so-called oat-cell carcinomas). There has been in recent years a change in the numerical relation of the different histologic types, according to Probst, who claimed that a shift in favor of the cancroid variety of pulmonary cancer has taken place (squamous-cell type of cancer represents, according to various data, from 11.7 to 30.1 per cent of the total number). This investigator found in his series that from 1905 to 1912 there were 25 per cent cancroids, from 1919-1922 there were 38.5 per cent, and from 1923-1925 there were 42.9 per cent belonging to this type of carcinoma. Brandt reported that in his series there were 22.5 per cent squamous-cell carcinomas, 48 per cent basal-cell carcinomas, 9.5 per cent differentiated adenocarcinomas, and 20 per cent undifferentiated carcinomas. There were 17.2 per cent squamous-cell carcinomas in the series reported by