

in the peritoneum with ascites. The left pleural cavity showed a discharge. There was compensatory emphysema in the left lung. The anesthetic female died of cardiac insufficiency following the lung dissection.

The second observation was made by Alkous. The autopsy was performed by Fischer-Knecht. As a consultant, I became involved with this case. The eleven-year-old male (6/13/31 to 9/19/41) had been working in an asbestos rubber plant for 42 years, until 6 months prior to his death. He became ill in January of 1941 with increasing shortness of breath and loss of weight, with symptoms of left pleural secretion. The respiratory sounds were totally suppressed and sustained, and there was right cardiac repression. His sputum contained considerable amounts of asbestos particles. In the jelly-like red secretion, mostly obtained through puncture, numerous tumorous cells could be found. Above and under the right lung, individual fine bubble-like rattling sounds could be heard. The sedimentation rate quickly increased. There were no tubercle bacilli to be found in the sputum. Based on the x-rays, a moderate asbestosis was diagnosed, with the primary tumor thought to be in the right hilus. The autopsy revealed a mild case of asbestosis, with a diffuse primary mucus-forming glandular cell carcinoma in the left pleura of mostly adenomatous character, and metastases on the abdominal side of the left diaphragm cupola, the serosa and the small pelvis, and the left side of the chest musculature. The autopsy report on the thoracic organs is quoted here, since no report has yet been made on the subject.

Autopsy of the chest. Moderately developed panniculous adiposes. The thorax is moderately expanded and flexible. The rib cartilage can easily be cut. The diaphragm is on the right, at the level of the fifth intercostal space; on the left side it is folded under, and penetrates far into the abdominal cavity. Its bottom pole here is lower than the neck of the pelvis. In the pneumothoracic test, almost 3,000 ccm of yellowish-brown fibrous fluid is released by the left pleural cavity. The entire mediastinum is displaced to the right. The heart hangs in the shape of a drop in the mediastinum; its left edge lies along the median line. The right lung floats freely in the pleural cavity up to small string-type growths. In the pleura costalis, there are gray and white tendon-like scales about the size of the palm of the hand, with isolated tubular nodes which are also gray and white. In the pleura of the right lung upper lobe, there is a large radiating scar. On the pleura of the right lung, there is a fine moderately firm adhering gray felt-like layer. The right lung itself is normal in size and filled with a moderate amount of air and fluid. The pleura and the surface of the cut show moderately severe black mesh-type markings. Generally, the lung tissues are red in color. There are no clusters to be observed. In the lower lobe branching of the right pulmonary artery, a small brownish-red blood thrombus adheres to the intima. The pulmonary arteries are empty. The left pleura is entirely covered with rind-like skin. On the inner surface, there are massive, tightly-packed tuberosities reaching the size of a walnut, with a mulberry-type surface consisting of blister-like (white on the surface of the cut) tumorous tissues. When cut, the latter secretes a