neuralgia. These irregularities in the symptom complex of the carcinoma of the lung account for the high percentage of incorrect diagnoses.

a) Subjective Symptoms. Coughing is one of the first and most common symptoms of lung carcinoma. In the beginning it is usually dry, hacking, and may become later productive, especially when gangrenous cavitation of the lung develops. A paroxysmal cough having at times an agonizing or even emetic character is observed in cases where the carcinoma is proliferating in the bronchial lumen.

Dyspnea is, also, an early symptom and present in 90 per cent of the cases (Fishberg). It is caused by the peribronchial and perivascular, carcinomatous infiltration of the lung, producing a rigidity of its tissue and a compression of the alveoli. Dyspnea is aggravated by obstruction of a large bronchus by tumor invasion or by bronchial compression from the outside. Pleural effusion has the same effect. Dyspnea is sometimes an intermittent condition when the mechanical condition of the air passages changes. It may become more severe in the course of the disease and harder to bear. It cannot be relieved by rest in bed. Stridor is rare and occurs only in a late stage.

Pains in the chest are an early and main symptom. They are present in 90 per cent (Fishberg) to 50 per cent (Brandt). They may be continuous or paroxysmal in character. The intercostal neuralgic type is the most common one. They radiate into the shoulder and the arm of the affected side. Pains in the left side may be due to pressure of metastases upon the brachial plexus. Pains in the right costal and lumbar region are caused sometimes by metastases in the liver. The pains become more severe when the patient is lying on the involved side.

Fever is present in only 25 per cent (Brandt) of the cases and due to a secondary infection of the lung by micro-organisms. It is usually of a subfebrile type. High temperatures are present if complications, such as abscess or gangrene of the lung, exist.

Night sweats are observed frequently.

b) Objective Symptoms. Cyanosis and edema of the face and neck are present in 50 per cent at an early stage. Compression of the superior vena cava is responsible for this condition if it is bilateral; compression of the innominate vein produces a unilateral effect. Absence of pulsation in the congested large veins of the neck is produced by thromboses. Sudden attacks of cyanosis accompanied with small, irregular, rapid pulse occur and are caused by cardiac metastases. Superficial ectatic veins appear on the chest, arms, and lateral to the spine in the back. Acrocyanosis and clubbed fingers are observed in 25 per cent (Fishberg). Clubbed fingers appearing in middle-aged persons point to the presence of a carcinoma of the lung. Pressure of the tumor on nerves may result in an inequality of the pupils and paresis of the recurrent nerve (in 6 per cent). Other nervous symptoms may be caused by metastases in the central nervous system.

Cutaneous hyperaesthesia is found in the lumbar region. Palpatory tender-