that has produced collapse. Thirdly, the ribs, if anything, are spaced farther apart than on the normal side, which is again unusual for a lung that has collapsed.

DR. KING: I should have committed myself before I asked that question, but I agree with your conclusions. I cannot be sure that this was not a bronchiogenic carcinoma of the left upper lobe, but my opinion is against that diagnosis. There was also involvement in the left lower lobe. I suppose that this also may have been a tumor. Do you want to commit yourself on that, Dr. Schatzki?

DR. SCHATZKI: I think that I know the answer. It is obvious, as I have said, that there was something outside the lung; otherwise, the stomach would not have been displaced or the ribs separated.

DR. KING: Do you think that it was a tumor or fluid?

DR. SCHATZKI: I believe that it was a tumor.

DR. KING: That is what I believe.

Let us go down to the abdomen. Was the spleen enlarged or was it displaced downward? I should like to omit the spleen if I may.

DR. SCHATZKI: So far as I am concerned, it may be excluded.

DR. KING: Was the stomach involved?

DR. SCHATZKI: There is no evidence of involvement of the stomach. It was displaced, but this was due to the low position of the left leaf of the diaphragm.

DR. KING: Was the liver enlarged? And was the displacement of the stomach to the left due to such enlargement?

DR. SCHATZKI: The liver was not enlarged so far as I can tell.

DR. KING: This is an intravenous pyelogram showing a retroperitoneal mass rotating the left kidney.

DR. SCHATZKI: Both kidneys are low in position, and I am wondering if what we see is not again due to the low position of the diaphragm.

DR. KING: You do not see the retroperitoneal mass?

DR. SCHATZKI: Not that I can be sure of. I do not see the outline of the kidneys so well as I should like to. The upper pole of the right kidney is clearly seen, but the upper pole of the left kidney is not.

DR. KING: I suppose that you have helped all you can. Do you want to say anything more?

DR. SCHATZKI: Yes; there are some rib changes.

DR. KING: You mean the periosteal changes in the rib? I have seen such changes only with pus. Have you seen periosteal changes with large tumor masses?

DR. SCHATZKI: We have seen them in patients who did not have empyema but who had a chronic nonspecific process in the lung.

DR. KING: The films show the periosteal changes clearly, and I am inclined to agree.

Actually, we have no evidence of any source of tumor outside the chest, but the possibility of tumors in the pharynx and the thyroid gland should be mentioned because findings similar to those in this case follow metastases from malignant tumors in those areas. We are not justified, however, in making such a diagnosis with the evidence at hand. Below the diaphragm there is no indication of disease of the stomach, pancreas, liver or kidney. These films at first suggested that the testicle or the prostate was the primary source, or perhaps a so-called "hypernephroma." This is a fairly characteristic picture for metastases from the testicle or prostate, but we have no evidence to make that diagnosis. There does not seem to me to be any justifiable source for the tumor outside the chest, and we are back to the problem of what this tumor was.

Was it bronchiogenic or mediastinal? We have seen exactly this picture with teratomas of the mediastinum that have eventually broken loose. If it was a lung tumor I lean toward a bronchiogenic carcinoma with metastases to the right lung and possibly the retroperitoneal area. The findings were not quite consistent with those of bronchiogenic carcinoma because such tumors are usually not large enough to push the mediastinum to the other side unless a great deal of fluid is present. Also, the rib changes were more like those with a large tumor mass that had been pressing on that area for some time. The process had been going on for perhaps two and a half years. My diagnosis is a mediastinal tumor, probably a teratoma, with metastases to the right lung. I do not believe that the tumor was a lymphoma, although again that must always be considered. I doubt whether it was a bronchiogenic carcinoma with metastases.

DR. F. DENNETTE ADAMS: How do you exclude lymphoma?

DR. KING: I do not exclude it. I have not seen x-ray findings such as these with lymphoma, which usually causes more symptoms than this man had for two and a half years. The other conditions I have named seem likelier.

DR. ALFRED KRANES: Is it not unusual for fluid due to tumor to subside for so long a time?

DR. KING: Yes; that is one of the things against trying to explain the whole picture as tumor. I agree that subsidence of all symptoms for a year after the removal of 1000 cc. of fluid in a case of tumor is not usual. I wanted to make the diagnosis of tuberculosis, but I could not.

DR. CHARLES L. SHORT: I saw this patient on the ward, and I went through much the same line of reasoning as Dr. King has. From the history my impression was tuberculosis, but from the x-ray findings that certainly could not have been the primary diagnosis. I do not believe that most of us went so far as Dr. King in being willing to say that the tumor was primary in the chest. We thought of lymphoma and for that reason small