definite ulceration. The tissue removed from the tumor for microscopic diagnosis was lymphosarcoma. There were no glands palpable in the neck. The eye and ear examinations were negative. The hemoglobin was 78 per cent, the erythrocytes 4,054,000, and the leukocytes 12,500; two hundred cells were counted, the polynuclear neutrophils were 75.0, the small lymphocytes 16.5, the large lymphoyctes 6.5, the esosinophiles 1.5, and the basophiles 0.5. Wassermann reaction and the urinalysis were negative. A diagnosis was made of primary lymphosarcoma of the right nasopharynx.

COMMENT.

Primary lymphosarcoma in the nasopharynx without symptoms is a very unusual condition. I have seen similar cases in which the glands of the neck were involved and in which the primary growth in the nasopharynx was without symptoms. This, however, is the first case I have seen in which there were no symptoms or signs of disease and the routine nasopharyngeal examination was the only way in which the tumor could be found. Radium treatment in a case of this type is very satisfactory and may permanently clear up the trouble.

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REPORT OF AN UPHOLSTERER'S TACK IN THE RIGHT MAIN BRONCHUS FOR SEVEN YEARS. REMOVAL BY PERORAL BRONCHOSCOPY. DRAINAGE OF LUNG ABSCESS. RECOVERY.

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Hilda H., 21, U. S. The following case is remarkable for the length of time the foreign body was in the lung, and for the fact that although her sickness dated from the aspiration of an upholsterer's tack, of which she gave a clear history, this fact was never ascertained until she had passed through many hospitals and clinics and through the hands of many physicians. Her sputum had been repeatedly examined for tubercle bacilli, always with negative results; her chest had been X-rayed on two occasions without finding a foreign body, and twice the right pleura had been aspirated

and no fluid discovered. She was admitted to the Presbyterian Hospital, Medical Ward, November 6, 1920, complaining of haemoptysis for the past 18 months. Her family history was negative. She was found to live and work under good conditions. And with the exception of measles and whooping cough in childhood, she had been well up to the age of 14. At that age she had an attack of pneumonia, which kept her in bed for 4 months. During this entire period she had fever, night sweats, sharp pain in the right axilla and a hacking cough. The cough has persisted ever since. At varying intervals she has been forced to go to bed with fever, night sweats and exacerbation of her cough. As a rule these attacks lasted 2 weeks. The last was in February, 1919. In May, 1919, the patient coughed up blood for the first time. In May, she felt first a severe epigastric pain followed by a tickling sensation in the chest. Then blood was coughed up. At intervals of several weeks since then the haemoptysis has recurred. The last haemoptysis occurred on the day of admission to this hospital. There has been no loss of weight.

The patient was admitted to a large hospital in September, 1919, and again in September, 1920. On both the X-rays of the lungs were reported negative, and no tubercle bacilli were found on repeated examination. On these occasions attempts were made to aspirate fluid from the right base, which were not successful.

Physical Examination on Admission: The positive findings were confined to the lungs. The right lung showed slightly diminished expansion and a triangular area at the right base behind, where there was diminished voice, breath sound and fremitus. Transient groaning and crepitant rales were heard all over the right lung.

While in the hospital the patient had several attacks of paroxysmal cough, during which a variable amount of fresh blood was brought up.

Examination of sputum for tubercle bacilli—negative on 2 occasions. Red blood cells 4,500,000. Haemoglobin, 85 per cent. White blood cells 11,700. Polys 76 per cent. Lymphocytes 18 per cent. Trans 4 per cent. Lm. 2 per cent.

At this stage of the proceedings it looked as though we, at the Presbyterian Hospital, were to meet the same fate of failure in diagnosis until one of the interns thought to ask her whether she had ever aspirated a foreign body. She answered: "Of course." Three weeks before her first attack of pneumonia, she was standing up one day with a tack in her mouth, and suddenly turned round to speak to some one. As she did so, the tack went down her throat.

This was followed by coughing, wheezing and pain in the zyphoid region. Catharsis was given and one stool was searched, but the tack was never found.

The lesson of this story is that patients should always be questioned directly as to the possibility of a foreign body, and no trust put in their spontaneously giving the information. Having secured the correct history, the rest was easy. The X-ray plates were carefully searched, and the shadow of what was thought to be a tack, sharp end up, located near the base of the right lung, close to the spine, behind the heart shadow.

Operation: Morphin gr. 1/8 A. 1/100. Cocain. 9 mm. tube. Bronchus was closed just about the origin of first dorsal branch by a mass of granulation tissue. Continuation of lumen posterior to this. An alligator forceps was pushed through this opening and a considerable amount of thick pus released. Lumen dilated with the forceps. Tube then replaced by 7 mm. This pushed into an abscess cavity at the bottom of which the edge of the head of the tack could be seen in the wall of the cavity. This was grasped and removed. Further search of this area revealed a mass of black tissue, which was taken to be the disentegrated tack and removed. Cavity cleaned by pumping and sponging. Opening of other bronchi could then be seen below. Time 40 minutes.

The patient made an uneventful recovery. Haemoptysis ceased and signs in lungs disappeared. A safety pin swallowed was passed by rectum. X-ray of chest negative. Discharged November 21, 1920.

Points in History: 1. Story of foreign body missed for years by good men in good institutions. 2. Negative X-rays. 3. Excellent condition of patient—no clubbing of fingers, etc.

Readmission 11/23/20: Remained home 2 days after first discharge from hospital, then returned in hysterical condition, complaining of severe cough and pain in chest. These symptoms cleared up on reassuring the patient, but slight cough continued. No fever. X-ray of chest negative. Lungs scattered signs of bronchitis. Patient hysterical when told she must leave hospital, but quieted down. Slight dullness and diminished breath sounds and voice sounds at right base.

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