hand, if the patient be uneasy, or if the entry of blood to the right heart be hindered, I do not hesitate to tap at once. The favourable aspect of operation in such cases is that suppurative conversion rarely occurs in these highly organized effusions, even if air enter the pleura. Once, in a case of impending death from double rheumatic pleurisy and pericarditis, all with effusion, we, being in haste, did not hesitate to plunge a bistoury into the fuller pleural cavity, and to allow the effusion to escape as it might, relying on the highly fibrinous quality of it which did not tend to suppuration. The wound soon closed, and the patient did well. Such effusions, being full of clots, are often difficult to remove by small cannulæ, or even to exhaust by aspiration; if opportunity permit, however, the proper plan is to use the aspirator with fine cannulæ, and to puncture the pleura repeatedly, drawing off what is to be had at each point. It is better to do this than to fumble in the first puncture, and the patient and his friends must be prepared beforehand for the probability of repeated punctures; I repeat, however, that operation is rarely needed in acute fibrinous pleurisy, and that its exudations, even if profuse, tend for the most to steady reabsorption. If, when all fever is past, such an effusion linger at its height or linger after a partial ebb, the use of a blister or repeated blisters certainly favours its removal. It is better to repeat the blisters than to allow the first or any one of them to procced to full vesication. Sometimes, indeed, these measures may fail, and abiding dulness, silence, and immobility in the affected side will continue. Such a condition is often treated with indifference, and no doubt some time may elapse before such a side is completely restored to its normal state; nay, more, it is rare that the marks of such a pleurisy vanish as they came. More often they remain for years, or even for a lifetime. But, on the other hand, if the dulness and other signs be considerable, I am very unwilling to treat them with neglect, for such conditions may end in serious impairment of the lung, and even to chronic interstitial fibrosis of the lung. It is my practice, therefore, and I speak from some experience, as pleurisy is very common in Yorkshire, to put the patient under a course of mercury rather than allow this morbid state to remain. A combination of the bichloride of mercury with iodide of potassium and bark or iron may be given fearlessly for weeks, and will rarely fail to promote the removal of the remaining products of the inflammation and to restore health and activity to the affected organs. Such a course must needs be given most carefully, and the patient, on the conclusion of it, advised to take sea-air and tonic medicines. Routine drugging, pursued in ignorance of the natural course of disease, very rightly was displaced by expectant treatment; yet I fear that expectant treatment, having now helped us to learn more clearly the ways of disease, has in its turn sins of omission to answer for as great as or greater than the sins of commission laid at the door of the apothecary.

I will now pass on to Class III, quiet effusive pleurisy in the serous stage. Although the acuter pleurisies may run to large effusions and to effusions poor in fibrin, yet we more commonly see the larger and poorer effusions in cases where the pain has been trifling and the pyrexia moderate if more continuous. A daily evening rise of two degrees is easily overlooked by the physician and easily regarded by the patient as mere malaise. Such patients, with one moiety of the chest full or nearly full of water, are treated with tonics to relieve debility and anæmia, or are sent to watering-places to recruit their strength, until, perhaps, their actual state is revealed by accident. If such effusions come on slowly, as no doubt they often do, the sufferer may complain of but little more dyspnœa than is common to most weakly persons, and one patient who consulted me was able to lie on either side and to sleep on either side, although his left pleura was crammed with effusion. On the other hand, such effusions may come on with great rapidity and destroy life by the sudden dislocation of parts. Such cases, however, are not likely to be misapprehended; as, although fever and pain may be slight or absent, the dyspnœa compels a minute examination of the chest. But, let me earnestly impress upon my brethren a warning which, sounded again and again, has not yet aroused the profession to a full sense of the