

it as *exo pericardial* in origin, arising from the left parietal pleura. The patient having entered the hospital on November 6th, was discharged December 17th, looking well and healthy, the respiratory and vocal sounds being fairly audible over the back and axilla, while the left side measured an inch less than the right. He returned to his work as a stableman, and two weeks afterwards, while engaged in lifting with a fork, he felt a little "crackle" at the top of his left chest. The following morning, December 31st, while getting out of bed he experienced the same pain as before with dyspnoea and weakness to the degree of fainting. When examined five days afterwards, the same physical signs were found as in November. He remained in the hospital for four weeks, and was discharged again while the process of air absorption was yet incomplete. On March 4th the heart was in its normal position. Vocal fremitus and resonance were feeble on the affected side, and respiration was not audible under the clavicle where the percussion note was somewhat tympanitic. Dr. Finny thought that, while the lower part of the chest was well filled by the expanding lung, the upper part still contained some air in the pleura.

In the review of this Dr. Finny calls special attention to the following physical signs :

1. The existence of *amorphic* respiration in the earlier periods when the aperture was closed.
2. The metallic tinkling audible for ten days without other satisfactory signs of the presence of a fluid.
3. The friction sound audible over the lower left sternal region, synchronous with the movements of the heart.

After referring to writings of West, Allbutt F. de H. Hall and Brünnicke, Dr. Finny states that from the foregoing facts and references he is able to deduce the following conclusions :

1. That simple or *idopathic* pneumothorax is a very rare disease of the lungs and pleura.
2. That a repetition of the disease in the same lung is of still greater rarity,
3. That in a very small number of cases the entrance of air into the pleura—to stretch it to its utmost limit—does occur *without any effusion* of fluid, and this even may happen the second time in the same lung.
4. That the absence of fluid renders the disease less fatal than when air and fluid has effused.