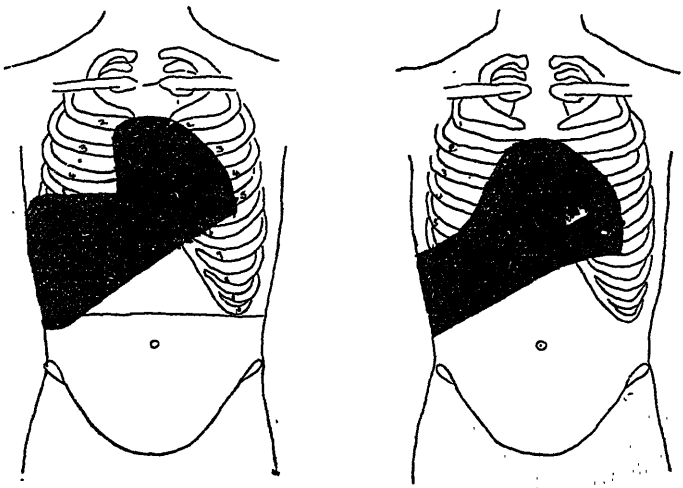
intensity over the left præcordium, and beneath the sternum; in two cases the left shoulder, and in three cases the epigastrium were areas to which the pain was referred. "A paroxysmal character with extension through to the back" describes it in two other instances.

Dysphagia was marked in four of our cases, and in one of these considerable difficulty was experienced even with liquids. Another patient (5882) stated that swallowing induced pain opposite the 2nd and 3rd ribs. Some clinicians with wide experience have never found this sign; others again remark upon its presence among the signs of a large effusion. In these four patients it was an early sign, unattended with tonsillitis,—observed even before definite signs of fluid were detected.



The accompanying illustrations will serve to indicate the shape of the dulness in a few of our cases when effusion was present. Some years ago Shattuck remarked that he did not find "the dulness of the large effusion either pear-shaped, or pyramidal." In these illustrations one sees that the shapes are various. While each of the above-mentioned types is found, yet the semi-circular type or the "hut-type" is quite as frequently mapped out. Upon this point more may be said when speaking of the diagnosis.

In consideration of the fact that much has been made of the physical signs over the lower portion of the left pleura posteriorly, as indicating pericardial effusion, a few reports of autopsy findngs at the left base, although they may not explain the signs in a given case, may yet afford suggestions of pathological conditions possible under similar circumstances. Take the following cases from among our groups:

9400—Compression of the left lower lobe, bilateral pleurisy.

8872—Left hydrothorax with pleural adhesions on the right.