All metallic quality of voice and respiratory sounds have disappeared. The patient suffers no inconvenience except that due to overexertion and is now attending to light house work.

Signs of fluid were never found.

CASE VII.—J. P., aged 59, male, seen in consultation with Dr. H. S. Shaw, was one of pneumothorax of doubtful origin. Previously he enjoyed good health. On Nov. 27th, 1897, he fell and broke his leg. He remained under treatment in bed till Dec. 22nd, when some pain developed in right side of the chest. This pain passed away by 26th. On Jan. 1st, while still in bed severe right-sided pain developed and a few râles were heard over the area. On the 2nd a dyspnœic attack occurred and the signs of pneumothorax were manifest. The coin sound was obtainable widely over his right chest, weak distant amphoric breathing was present. The patient improved, signs of cardiac displacement disappeared, the coin sound also disappeared and was completely absent on 11th Feb., and March 1st patient was at work, and has been in good health ever since. The cause of this case is doubtful, and must remain so since there is no evidence either from the history or the physical signs pointing to tuberculosis, while the occurrence of such an event in one confined to one's bed by no exhausting illness inducing thrombosis or embolism, with subsequent localized pulmonary gangrene, renders a decision very difficult.

CASE VIII.—H., male, aged 19. The date of onset is doubtful. His previous health had been good. While walking upon the street four or five months previous to admission he experienced dyspnœa. It was not severe, he continued his journey to his place of work performing his duties that day. Some thoracic pain developed after a few days, but no distressed breathing to interfere with his work. About three weeks ago, about Oct. 1st, while pulling on a hoist, he experienced dyspnœa and subsequently pain in the left side. On admission he presented signs of pneumothorax on the left side shown in cardiac displacement to the right side, fulness of the left chest with obliteration of intercostal spaces, hyper-resonant note throughout, metallic echo of vocal resonance, and faintly heard coin sound. There was no succussion. He was afebrile, not dyspnœic. The course of the case has been uneventful except that it is thought the left chest shows less fulness, while the area of cardiac pulsation is less prominent toward the right, succussion splash has not developed, the coin-sound is very variable. It is best heard when tested in the left supra-clavicular area and the lower portion of axillary space. It transgresses the median line, passing to the right above the junction of the 1st and 2nd pieces of the sternum. It may be heard also from axilla posteriorly