

butable to the want of proper discrimination in the selection of cases. Formerly, when the profession was in great measure ignorant of the physical signs indicative of effusion into the pleural cavities, it is not surprising that numerous instances of erroneous diagnosis and consequent faulty practice should have occurred; such as puncturing an enlarged liver or spleen, or medulary tumour, under the impression that fluid existed in the thoracic cavity; or even opening the sound, instead of the diseased side, when such effusion absolutely existed, and thus giving rise to collapse of the healthy lung, and consequently to speedy dissolution. But now that the physical signs are known to afford great certainty in determining the extent and character of thoracic disease, such errors cannot occur, except as the result of culpable ignorance or carelessness; and it is owing to the great improvement in this department of our science that the operation of paracentesis is beginning to be viewed with more favor by the profession.

It would be a work of supererogation, at the present time, to enter fully into details in regard to the physical signs indicative of intrathoracic effusions, and my remarks under this head shall, therefore, be as brief as possible. Dulness on percussion is one of the most important indications of such a condition, and it exists to even a greater degree than in pneumonia, whilst at the same time the elasticity of the chest is entirely destroyed. In those cases where the pleural sac is not filled with fluid, the line of dulness can generally be varied by changing the position of the patient; occasionally, however, the fluid is limited by adhesions, and, therefore, uninfluenced by position. The distension of the chest should next claim our attention. In some instances, the circumference of the diseased side will exceed the healthy by one or two inches; whilst, at the same time, the intercostal spaces may be distended or bulging. In extreme cases, the heart will be displaced to the right or left, and the liver depressed by the superincumbent fluid. The absence of all vocal vibration, also, constitutes an important indication. In like manner, auscultation is all important in forming our diagnosis; thus, when the fluid is not considerable, a distinct ægophonic resonance of the voice, and a peculiar modified bronchial respiration, can be generally heard over the back, and even in the axillary region; whereas, when the accumulation is very great, these phenomena entirely disappear, or, at most, can only be heard over the root of the lung. Where most of the above signs coexist, as is generally the case when there is an extensive effusion, it would be quite impossible to fall into any serious error as to the true nature of the disease. At the same time, however, it is important to