

In pleurisy, with effusion, so extensive as to dislocate the heart, we have absolute dulness, with total loss of respiring murmur; enlargement of the side, with bulging of the intercostal spaces, and inability to lie on the sound side, and increased size of the liver, as I pointed out some years ago, even when the effusion occurs on the left side. Moreover, when complicated with phthisis, this latter disease is always better marked on the opposite side. Now, in the case of *Monro*, none of these symptoms were present. We had, as you recollect, clearness on percussion posteriorly, with only partial dulness anteriorly; and instead of having complete loss of respiratory murmur we had cavernous râles, with gurgling in the apex of the lung—puerile and feeble respiration throughout the remainder; and careful measurement shewed that there was no enlargement of the side. The patient could lie with equal ease on either side, and the physical signs were better developed in the *left* lung. It was evident, therefore, that the dislocation was not caused by acute pleuritic effusion.

2. But pleurisy may become chronic, and the effusion having been absorbed, the heart is left in the abnormal position in which it may have been bound down by adhesions. What would have been the physical signs of such a pathological state? There should be deformity of the chest, arising from contraction of the side, pointing of the angles of the ribs, depression of the shoulders, tilting backwards of the inferior angle of the scapula. A marked symptom, moreover, of chronic pleurisy is obliteration of the intercostal spaces, with diminished expansion, *resulting from enlargement of the ribs*, in conjunction with contraction of the side—this obliteration is frequently almost complete. In our case, however, there was no deformity—there was equable expansion, and the intercostal spaces were well marked. In addition to these facts, the history of the case (the patient never having had an attack of pleurisy,) went to prove that this disease could not have been the cause of the displacement.

3. We now come to consider another affection which occasionally causes displacement of the heart, viz., emphysema of the lungs—the prominent symptoms of which are, bulging of the chest—morbid clearness on percussion, and feebleness of respiration over an extensive surface; all of which were absent in the present case; besides, dislocation occurring in conjunction with this disease, usually takes place downwards towards the epigastric region, because it gene-

rally happens, that both lungs are engaged in the disease.

4. Another disease which might cause dislocation of the heart is hydrothorax; but when we consider the infrequency of hydrothorax as a consequence of phthisis, and that the cavities of the pleuræ are the last places in which effusion occurs, it being always preceded by œdema of the body and extremities; and when we remember that there was no dulness on percussion, and no loss of respiratory murmur, over the posterior and axillary portions of the lungs, the dislocation could not be attributed to this cause.

5. Acute spontaneous pneumothorax, the occurrence of which is questioned by many, could not in this instance, have produced the dislocation, as the symptoms characteristic of this disease, viz. sudden supervention of dyspnoea, with tympanitic sound on percussion and loss of respiratory murmur, were all absent.

6. Dr. Stokes mentions that chronic empyema of the right side may produce dislocation of the heart to the *right* side by the contraction of the side, which takes place, but as the sides of the chest were symmetrical this could not be the cause.

7. Dr. Swett, of New-York, has published a case of large tumour in the epigastrium, which dislocated the heart, and caused a bruit de soufflet. There was no evidence of the existence of such a tumour in our case.

8. Finally, it could not have been caused by chronic phthisis of left side, as this produces dislocation upwards towards the clavicle.

9. Aneurisms of the aorta and malignant tumours have occasionally dislocated the heart, but, as I shall presently show, neither of these diseases could have been present in this case.

Having now passed in review all the diseases capable of producing dislocation of the heart to the right side, we now come to the question—Was the pulsating tumour *the heart*? There are only two diseases in which a pulsating tumour is present in the thorax and which were at all liable to be confounded with the presence of the heart, viz. aneurism and cancer of the lung; for you are aware that in “pulsating empyema” the tumours are always *external*. The non-existence of the former was evident—from the absence of pain in the front of the chest, extending to the shoulders, of knawing and shooting pains from erosion of the spine—of signs of pressure causing dysphagia and dyspnoea—of feebleness of respiration—of bruit and frémissement and double sound, of aneurismal cough, of that peculiar stridor accompanying expiration, termed the