Of the remaining 30 cases, 14 were undecided, while the other 16 were divided between thoracentesis, parasitic—peritoneal and intestinal origin—and carious changes in ribs and sternum.

Other observers show about 90 per cent. of cases due to tuberculosis.

In this group of 12 cases the causes are as follows: Tuberculosis, 5 cases; empyema, 2 cases; unknown, 4 cases; B. aërogenes capsulatus, 1 case.

Latent forms were found in (Nos. 3, 11, 8, 12) 4 cases.

Purulent fluid was demonstrated in 9 cases. No signs of fluid were found in 3 cases. Of the twelve cases, six are dead while two are at work, one under observation; one, a child running about; two others showed some improvement under treatment and were finally lost sight of. The left side was involved 8 times, the right side was involved 4 times.

There were 7 men, 3 women, and 2 children, 9 and 14 years of age, and the length of time varied from 2 days to 26 months.

The Diagnosis.

The diagnosis of pneumothorax is not always made clinically. Much stress has been laid upon the two *symptoms* which frequently mark the onset, viz., pain and dyspnœa, while in addition sometimes a sense of tearing or a crackling is realised in the chest. The dyspnœa may amount to orthopnœa,—the pulmonary insufficiency of Wintrich. These, however, may be absent or so slight as to pass unnoticed, as Pierre Angereau has recently pointed out, and the presence of air in the pleural sac may be discovered incidentally when making an examination in the usual way.

This author whose monograph has been published recently deals with the subject of such forms of pneumo-thorax which he terms *latent pneumothorax*. Among other conclusions he states:

1st, that total pneumothorax is attended by much pain and dyspnœa;

2nd, that in partial pneumothorax pain and dyspnœa may be slight or wanting;

3rd, that there exist forms of general pneumothorax absolutely *silent* in their symptoms without pain or dyspnœa.

Lévy is cited by Angereau as saying that partial pneumothorax in its insidious onset is generally in the advanced cases of tuberculosis.

As factors which may mitigate the severity of the symptoms pain and dyspnœa usually noticed on the onset, one may consider the size of the perforation; the directness or indirectness of it; the presence of adhesions, preventing sudden and complete collapse of the lung; the condition of the patient, whether weakened or not; the presence of fluid, already calling for considerable accommodation to this new condition, viz., the use of one lung.