where it was doubtless held by pleuro-pericardial adhesions. The compressed lung never re-expanded, but occupied a small portion of the thorax posteriorly towards the apex and the middle line. Numerous aspirations were made and finally in Feb. 1898, a portion of the 8th rib was excised on the left side posteriorly, and large quantities of pus continued to discharge until the patient died, Aug. 29th, 26 months after the occurrence of this complication. All the physical signs together with a fairly characteristic onset of pneumothorax were present in this case, and the patient afforded a striking example of how pneumo-thorax may arrest the progress of pulmonary tuberculosis. This arrested state was inferred from the following facts. The quantity of expectoration was greatly diminished. There was a total absence of febrile movement for several months, except after the application of the tuberculin test. The patient during this period showed little tendency to emaciate. The case terminated with signs of sepsis and chronic diarrhœa, doubtless of tubercular origin. Clinically the opposite lung showed but few traces of disease.

CASE II.—J. L., aged 17, male, was admitted March 20th, 1895, with left-sided pneumothorax of tubercular origin. The onset was sudden, with severe post-axillary pain in left side four months previous to admission, when he felt something giving way in his lung, followed by marked dyspnœa. This was more marked on exertion. His previous health had not been good. For nine months he had had a cough with loss of flesh and weakness. His condition on admission was afebrile, respirations and pulse slightly accelerated. Signs of left pneumothorax were manifest in prominence of left side, character of the percussion note, metallic tinkling, coin sound and succussion splash. The course of the case was favourable, the temperature variable, sometimes febrile, sometimes subnormal. He was discharged, improved, four and a half weeks after admission. Physical signs were not materially changed.

CASE III.—K. F., female, aged 38, with left-sided pyopneumothorax. The onset was indefinite. It was not possible to fix the date. Her health had been failing for a year previous. She had spent considerable time in bed; she coughed and expectorated, but never spat blood. Shortness of breath, variable in degree, had existed several months, but had never been severe until two weeks before admission. Six months after onset of illness, hence about six months before admission, she complained of splashing sounds on the left side of her chest, which were observed over a period of about six weeks, then disappeared. She noticed the heart palpitate on the right side of chest. She presented on admission, well-marked signs of effusion into