the right infra-scapular region and right infra-axillary region, and the percussion note perceptibly higher in pitch in the right infra-clavicular region. Auscultation reveals an absence of respiration and of vocal fremitus in the region of flatness, with respiration of somewhat increased intensity on the left side. There is fluid in the right pleural cavity; the history and the symptoms help us to decide its nature. The duration has been short and without rigors or sweats, and with no increase in the temperature. By the introduction of a hypodermic needle we may obtain some of the fluid, should doubt still exist. Consolidation of the lung, which would give a decided increase of fremitus with bronchial breathing, we exclude. The diagnosis is acute pleurisy with effusion. All cases are not so clear. We will note the variations from time to time as they appear. The indications for treatment are to favor the absorption of the fluid, and to nourish the patient. An occasional saline laxative, as magnesium sulphate, a combination of potassium acetate with infusion of digitalis (grs. x — ℥ss.), three times a day. A dry diet as far as possible, and later, when the absorption takes place less readily, counter irritation will meet the former indication. Good food, iron and quinine and stimulants when necessary, will fulfil the later indications. Thoracentesis will not be required in this case. When the effusion is very great the operation becomes necessary. The needle of the aspirator is usually introduced in the intercostal space just below the inferior angle of the scapula. It is safer to withdraw only a small amount of the fluid at a time, yet I have drawn very large amounts from the chest without mishap; it saves the patient the annoyance of repeated operations. There is one precaution that should always be taken, and that is to strap or bind in some manner the chest wall, and administer an anodyne before the introduction of the needle, for in two instances, one in my own experience, I have known the needle to have been broken off by a violent fit of coughing, and lost in the pleural cavity. It did no injury in my case, which was one of empyema. The needle was subsequently found at the bottom of the pleural cavity, imbedded in a mass of fibrin and pus, having excited no additional inflammation.

Our third patient is this young lad who says that he has "taken cold," and that he has been coughing for several days. He has no pain anywhere, but there is dyspnœa on exertion, and particularly severe at the present time. Examination of his chest gives no dulness on percussion, but on auscultation there is a moderate amount of sonorous breathing on both sides. The bronchitis is not extensive enough to account for the dyspnœa, and besides, it is of a longer duration than the cough. We find upon inspection that the apex beat of the heart is most distinct in the left mammillary line, beyond and below its normal position. Upon auscultation I hear a blowing murmur most distinct at the apex and in systole, an indication of mitral insufficiency. That this murmur must be always heard at the back is not true; it, however, is frequently heard there. This cardiac lesion accounts for the dyspnœa which the bronchitis has temporarily augmented. As the hypertrophy of the heart is compensatory to the mitral insufficiency we will simply caution him against over exertion and undue excitement, and direct our treatment to the bronchitis. Confinement to the house for a few days, counter-irritation of the chest with turpentine or mustard, and the administration of the following mixture will be sufficient:—

℞	Tr. opii. camph.....	5.60 gram.	℥iss
	Ammon. carb.....	2. "	℥ss
	Syr. ipecac.....	2.50 "	℥ss
	Syr. tolu.....20.	"	℥ss
	Mucil. acaciæ ad.....60.	"	℥ij

Sig. A teaspoonful (diluted) every four hours.

We recognize two forms of these bronchial affections, a catarrhal and a croupous. The specimen I hold in my hand is a cast from a case of croupous bronchitis, the second and rarer variety. It is made up of coagulated fibrin and lymphoid cells. It is not uncommon for a croupous laryngitis to extend into the trachea and bronchi, but a croupous bronchitis occurring primarily in the bronchi is less common. Little seems to be known in regard to its predisposing or exciting cause I will give you the history of this particular case.

J. B., a school-girl, twelve years of age, of American parentage, lived in good circumstances, the surroundings sanitary, and the family history was good; no laryngeal or bronchial affections being traceable. The height of the patient was four feet eight inches, the weight one hundred pounds; complexion good, tongue clean, pulse and temperature normal. The date of my examination was nearly two years from the beginning