I, then, in presence of a purulent effusion? But there was hardly any elevation of temperature; the general state, in spite of the dyspnœa, was indeed satisfactory. There was no œdema of the thoracic walls. I tapped the chest with the aspirator and withdrew 54 ounces of *serosity!* pure serosity, without a single leucocyte on microscopical examination.

Therefore, M. Bacelli, there are cases of pleuritic effusion where pectoriloque aphone is not heard, and still the fluid is serous, not purulent! Consequently, the absence of your sign, a pleuritic effusion being given, is not sufficient to make us conclude that there is pus in the chest!

However, I paid again more careful attention afterwards, and I must say that pretty often I observed large *serous* effusions, without nevertheless perceiving the phenomenon of pectoriloque aphone. But what I particularly looked for was a *purulent effusion*, with co-existence of Bacelli's sign. Fortunately for our patients, empyema is not of a very frequent occurrence. Still, I met successively with two cases, and with regard to these two patients the Roman professor was right; it was utterly impossible to hear the whispered voice through the chest.

About the beginning of May, 1888, I was called to attend B——, aged 11 years. She had been sick for five weeks, and was complaining of a pretty severe stitch on the left side. The cough, at first dry and unfrequent, soon became very troublesome. Lateral decubitus was impossible; when lying on the right side she at once would be threatened with suffocation, and the left lateral decubitus used to provoke severe fits of coughing. The facies was pale, but dyspnœa could hardly be detected unless the little patient would attempt to walk. I remarked at the precardial region a considerable bulging, with absolute dullness on percussion, and total absence of vocal fremitus. At the apex, percussion showed a tympanitic resonance and also the finest cracked pot sound I ever heard in my life. This phenomenon, gentlemen, is very rare in pleurisy; it is generally met with on a level with pulmonary cavities in consumption. Behind there was also dullness on percussion in the inferior two-thirds of the chest, and auscultation revealed the existence of bronchophony and also of *pectoriloque aphone!* The heart was displaced to the right of the sternum and at the anterior part of the chest, we could hear equally well the bronchophony and pectoriloque aphone. A few days later œdema of the chest-walls appeared in front, the temperature evidently rose, there was pus in the pleura, and still the whispered voice. Bacelli's pectoriloque aphone could very plainly be heard, especially at the posterior part of the chest. I then at the time pointed out all these physical symptoms to Mr. Lambert, a young student who was accompanying me, and told him that, in spite of the presence of Bacelli's sign and contrarily to this author's assertion, we would certainly find pus in the pleural cavity. The operation, which I performed forthwith, proved my assertion to be correct.

Therefore, I think I was right to conclude that if, on one hand, pectoriloque aphone was sometimes wanting in serous effusions, contrary to Bacelli's teachings, it could also occur that this phenomenon would be perceived in purulent effusions. Consequently, Bacelli's sign cannot give but illusive indications as a means of testing the nature and character of pleuritic effusions. Besides, the careful study of the physical conditions which govern the existence of pectoriloque aphone, suffices to indicate the circumstances under which we are justified in expecting the presence of this phenomenon. In fact, I always remarked that the whispered voice was transmitted to the ear that auscultated only in the cases where at the same time there existed bronchial respiration and bronchophony. When these two latter symptoms were wanting, whatever might have been the nature of the effusion, pectoriloque aphone was also absent.

In pleurisy, compression of the pulmonary vesicles by pleural exudation, transmission of vocal sounds by the large bronchial tubes only, here again we find bronchial respiration and bronchophony. But, in the first case, the indurated pulmonary tissue, possessing a better sound-conducting power will transmit the vibrations with greater intensity than in pleurisy with effusion, in which the conditions of propagation of the sound are less favorable. The bronchial respiration and bronchophony in pneumonia have a brazen, harsh character, the sounds seem as if they were