have heard metallic tinkling spontaneously produced in these cases, as seems implied in Dr. A.'s remarks.

In any case, a few drachms of any carminative mixture, by expelling, or displacing the flatus, will remove the source of error.

20. It cannot be determined by physical examination whether pneumonia have or have not supervened upon tubercles, although the prognosis in the two cases would be very different.

With due deference, we do not see how the prognosis can be much affected in the manner alluded to by Dr. A. For if we are satisfied that phthisis is *unquestionably* established, the supervention of pneumonia can only affect the prognosis, as far as the probable *duration* of life is concerned, it does not render the disease more fatal, though it no doubt shortens the duration of the sufferer's existence.

21. I doubt whether physical examination can in any instance determine with certainty, the existence of simple tubercles in the lungs.

We do not purpose trying to convince Dr. A.; we would, however, advise him to apply himself to this branch of auscultation; and as he appears to be far behind the age, we recommend to him the manual published by Dr. Hughes, his colleague.

22. When serous effusion is very considerable, giving rise to unequivocal bronchophony, tubular respiration, and want of resonance and vocal vibration, physical examination has repeatedly led to a mistaken belief that these signs resulted from pneumonic or other consolidation of the lung.

Setting aside altogether the fact that when serous effusion advances to the extent alluded to by Dr. A., it generally produces a displacement of the heart, to the right side, when the effusion is situated on the left side of the chest, and a displacement downwards of the liver, when the effusion occurs on the right side: it must not be forgotten, that enlargement of the side and bulging out of the intercostal spaces, signs so characteristic of extensive serous effusion, are never noticed in pneumonia; but as they occur in some cases of cancer of the lung, the diagnosis might be rendered obscure. As I have already drawn the attention of the profession to the points which will enable them to form a correct diagnosis in such cases, I shall content myself by merely alluding to those observations. A consolidation of the lung from pneumonia never yields *absolute dullness* on percussion, and as this sign attends all cases of pleuritic effusion of any extent, it alone would serve to distinguish the one from the other.

Besides, in extensive pleuritic effusion, there is complete absence of tussive and vocal vibration over the affected part, signs which are never absent in pneumonia.

23. When a patient presents himself with febrile affection of any kind, we may, on examination, detect dullness or percussion, tubular respiration, bronchophony, and a râle not distinguishable from the submucous crepitation commonly observed in pneumonic hepatization; and yet physical examination should not enable us to determine whether the chest affection be recent or of ancient date. When a portion of lung has been compressed by pleuritic effusion, and has been prevented from expanding again by adhesions, the physical signs may remain permanently, and be found to resemble precisely those which result from recent pleuro-pneumonia.

We are sorry to appear so captious, but we really cannot allow another gross blunder to pass unnoticed. Firstly, we maintain that submucous crepitation is *not* heard *in* hepatization of the lung, but *after* the hepatization has commenced to pass into the stage of resolution. Secondly, "when a portion of the lung has been compressed by pleuritic effusion, and *has been prevented from expanding again by adhesions*—a process of contraction commences in the parietes of the affected side, which quickly and very perceptibly produces a flattening of the chest, corresponding to the seat of the disease, accompanied, moreover, by depression of the shoulders, and tilting outwards of the angle of the scapula.—Has Dr. A. ever seen such consequences follow recent pneumonia? or is *he* in the habit of making a diagnosis without inquiring into the history of the case? if so, we wonder not at his alluding to sources of fallacy, which we venture to say, no auscultator but himself ever encountered. We are not surprised, that if Dr. A. attach but as little importance to the pathology of thoracic disease, and to the order of succession, combinations and modifications of physical science as it appears he does, that he should have derived but little assistance from the stethoscope.

24. Experience leads me to the conclusion, that pleuritic friction-sound cannot in all cases be distinguished from the rubbing produced between the inflamed peritoneal surfaces of the liver and diaphragm; neither can the croaking sounds produced in the bronchi be always distinguished from the pleuritic rub.

Admitting the probability of the error alluded to, in the first part of the above sentence, (although it has never occurred to us to meet with friction sound, arising from the rubbing of the inflamed peritoneal surfaces of the liver on the diaphragm, except when the liver presented tumours on its surface), yet it can only occur on the right side. Sometimes there is, no doubt, difficulty in discriminating between the rubbing sounds and those generated in the bronchial tubes, yet the accompanying symptoms and the history of the case will always enable us to distinguish the one from the other.

25. A simple pericarditis is rarely attended with pain, and as the other symptoms of that disease are equivocal, the physical signs are chiefly to be relied upon in forming a diagnosis. Nevertheless, when effusion has taken place to a certain amount, the friction-sound commonly disappears, and auscultation fails to recognise the disease.

If friction sound has been heard in a case of pericarditis, and has suddenly disappeared, the change indicates, either a return to a perfectly healthy condition, adhesion