

A CASE OF ACUTE SUPPURATIVE PLEURISY.

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W. C., aged 24, white, a farmer's son, of strong muscular build and first-class family history, spent the 27th of last Nov. doing the ordinary chores about the farm buildings. He said he felt tired and dull. He went to bed early, and was awakened from sleep by a dull pain in his left side. I saw him early the next day, Saturday, the 28th Nov. His temperature was 102° , pulse 116, and respiration 40. He had pain in the left side, which was increased by cough and deep respiration. He was constipated, and had the usual accompaniments of fever. Physical examination revealed friction and slight dullness at lower part of left thorax.

In three days the temperature was $102\frac{1}{2}^{\circ}$, pulse 120, and respiration about forty. There was an increase of two inches in the measurement of the left side, the ribs were widely separated, there was flatness on percussion, and absence of vocal sounds over the lower lobe, with friction and subcrepitant sounds at upper chest. The impulse of the heart's apex showed itself to the right of the xiphoid notch. The 4th day the temperature was down 1° , and he felt somewhat better.

On the 10th day of the disease, the temperature was $99\frac{1}{4}^{\circ}$, pulse 80, and respiration 30. In a couple of days, his temperature began to go up again. His pulse and respiration became more frequent, and he began to sweat profusely. Day and night he was covered with perspiration. When he fell asleep, which was seldom, he would sweat even more. A constant diarrhoea, which would not yield to any of the usual drugs, took the place of the former constipation; a grain of opium every three hours, day and night, had only a slight appreciable effect upon it. As I have intimated he spent sleepless nights. His respiration was rapid, and the cough was troublesome, but he never spat up anything but white frothy mucus—no blood—no pus from first to last. The side was quite œdematous and bulging, with not much motion. The œdema was very marked from about 3rd rib to crest of ilium, attaining its great

est degree over the 7th and 8th ribs, in the axillary line.

I allowed this to run along for seven days, when with the temperature at $102\frac{1}{2}^{\circ}$, and pulse at 120, respiration 40, and no amelioration of the symptoms, I determined to aspirate. On the 19th day of the disease, I passed the aspirator needle in at three different places, and got only about 3i, of what the microscope proved to be pus.

I could not understand why I could not obtain more, so I asked for a consultation. Next day, Dr. Lange, of Granton, met me at the patient's home. We passed a large aspirator needle, and got over a pint of pus, when the flow stopped. We could get no more. This did not mend matters much, so we made a free opening next day, in the following way. At the upper border of the 8th rib in the posterior axillary line I made an incision through the skin $2\frac{1}{2}$ in. long. By using a director and incising the underlying tissues separately, I was able to avoid a vessel that exposed itself between the intercostals, and which otherwise I must have severed. When I reached the pleura, I passed the aspirator needle to make sure I was not opening too low. Having found the incision was in good position, I nipped the pleura, as in hernia operation, and with a blunt-pointed bistoury, completed the incision. The pus flew in all directions. The Dr. assisting me clapped his hand on the opening to steady the flow. It squirted through his fingers into the basin, out on the floor, and fairly deluged the bed, so that the patient sat in a pool of pus. It was now evident from the many large-sized flocculi which escaped with the pus, *what stopped* our aspirator needles.

When two or three quarts had been allowed to come away, we put on an antiseptic pad and bandage, and left it till next day, when I found the pleural surfaces united. However, they were easily separated, and the remaining pus was allowed to escape. Two rubber tubes, one large and one small, were inserted. The small one for inlet, in case the cavity would require washing out, and the large one to act as an outlet tube. The former was left long and fastened at its end, while the latter was left open at the surface of the skin. From the first, antiseptic precautions were taken. The dressings were always made under carbolic spray. A large perchloride gauze pad was put over the tubes, over this cotton and a bandage.

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