

life be sufficiently prolonged, and thoracentesis be not resorted to, it will, sooner or later, make its way either into the air passages or through the thoracic walls. We also find by referring to European journals, that it is not uncommon to have unfavorable results in those cases. In fact one English publication asks whether we may not be compelled to go back to old ideas again (in view of the number of deaths), and consider thoracentesis a very dangerous operation, and only to be performed as a last resource. We find different methods advocated by the profession. In Guy's Hospital Reports for 1877, Dr. Goodhart strongly recommends a free opening at the ninth intercostal space, and the insertion of a drainage tube, in the majority of cases. Also repeated tapplings by means of an aspirator, and the attempt to exclude air from the cavity. Others recommend two openings, one high up and the other at the lower margin of the cavity.

The drainage tube, and local antiseptic treatment seem to be gaining ground, and I think we are indebted to a Canadian, Dr. Richardson, of Toronto, for its first introduction into practice in Canada. His case treated in 1869 is, at all events, the first recorded here, and I am glad to say that it proved successful. According to a number of writers on the subject, the great danger to be apprehended, is the admission of air into the cavity; but if you will consider for a moment the form of the chest, with a non-yielding external wall, and also the probability of adhesions, surrounding the contracted lung, more especially in cases of long standing, it would not only be unscientific, but positively injurious, to attempt the withdrawal of fluid, and at the same time prevent the entrance of air into the cavity. It is well known that after air is admitted, that it changes the nature of the pus, and it sometimes very rapidly becomes offensive. This change would be a serious objection, providing it would increase the liability to absorption, but we have every proof to the contrary. The exclusion of air is also recommended on the supposition that it will interfere with the expansion of the lung; but we know that atmospheric pressure is the same, whether internal or external to the walls of the chest, and it could not possibly offer any resistance to the expanding lung, unless the opening could be hermetically sealed, which, under the circumstances, would be a very difficult undertaking.

Again, if we attempt the exclusion of air for the purpose of facilitating the lung expansion, its place must either be supplied by fluid, or the expanding lung itself; but the attempt to rapidly expand the lung by means of a vacuum, might endanger the patient's life by forcible laceration of the adhesions or pleura. In cases of this kind the aspirator should never be used, under any circumstances, for the following reasons:—1st, It will not remove all the fluid in cases of long standing; 2nd, it will not prevent re-secretion of fluid; 3rd, its employment is attended with danger in recent cases, from the point of the needle coming in contact with the expanding lung; 4th, where the fluid is purulent the operation must be repeated, causing more inconvenience to the patient, besides the danger of piercing the lung, and in that way complicating the disease; 5th, the main object to be attained by its use, viz., the exclusion of air from the cavity, is not now considered necessary, for it is admitted on all hands, that the admixture of air with serous fluid, will not lead to its becoming purulent.

*Case.*—Mrs. H., aged 24; good family history; never had any illness until five months ago, when she suffered from pains in the right side, following confinement, with cough and shortness of breath on exertion. On February 9th, 1877, found patient suffering from constant hacking cough, frothy expectoration, with pain in the right side. Has had chills and night sweats; pulse, 120; temperature in axilla, 102° 5F. Pain increased by coughing, and patient can only rest on right side. On examination I found the whole of the right side of the chest dull on percussion, and below the third rib the dulness was absolute. Above the third rib, there was tubular breathing with increased vocal resonance. The left side, in front, was resonant, breath sounds tubular and respiration exaggerated. At the back, on the right side, there was absolute dulness, with the exception of a small space above the spine of the scapula, where the breathing was tubular. Below this point, there was no transmission of voice or breath sounds. On the left side, behind, there was increased respiratory sounds, with resonance on percussion. The right side measured three-quarters of an inch more than the left, and there was flattening of the intercostal spaces.

On the 13th, after getting the patient well under the influence of brandy, I inserted a large sized