unfavourable situation. Enlarging the opening by galvano-cautery, or removing a part of the middle turbinated seem too severe operations for mere diagnostic purposes. The writer has employed exploratory puncture under the lower turbinated with a relatively strong steel needle twelve times. The puncture failed six times on account of the thickness of the bony wall. He has also tried injection of fluid through a hollow needle introduced in this manner. For about a year he has used for this purpose a straight hollow needle with a bevelled point. This method has been tried in six cases. In only one was it impossible to perforate the bony wall. This method of injecting fluid is preferred to simple exploratory puncture as a diagnostic measure in cases where the pus may be very thick or very small in amount. It is also useful in treatment. Under antiseptic precautions the reaction is insignificant in both methods. If this method is unsuccessful, the writer resorts to puncture and exploratory irrigation through the alveolar process.—*International Medical Magazine.*

SEROUS ABSCESSES.—(*Revue de Chirurgie*). By Dr. E. Nicaise. By the term "serous abscess" Nicaise would designate those curious collections of serous fluid which occur especially under the periosteum (more commonly known as "albuminous periostitis") and similar collections elsewhere, in the cellular planes under the skin, for instance. He believes that they are like ordinary abscesses, true inflammatory processes, due to bacterial irritation, but for some reason, either attenuation of the virus or unusual resistance of the tissues, unaccompanied by the production of leucocytes. The fluid may be pure serum, or may be sticky by admixture of mucin. He regards them as analogous to the blebs often formed in the epithelial layers of the skin, a comparison, by the way, which would be happier if there were not such a great difference between the epithelial and connective tissues in many biological aspects. Their course may be acute or chronic, the latter form being claimed by some as due to an absorption or solution of the cell elements of the pus in a cold abscess, a transformation which Nicaise does not deny, but considers rarer than the serous abscess. These abscesses appear to be most common in connection with tubercular osteomyelitis.—*Inter. Med. Magazine.*

PRIMARY UNCOMPLICATED TUBERCULOUS PERICARDITIS.—Virchow (*Berl. klin. Woch.*) recently related a case of this very rare affection at a meeting of the Berlin Medical Society. The patient, a man aged forty-nine, had taken cold eight weeks previously, having till then been in perfect health. When brought three weeks afterwards to the Salzwedel Hospital, there were signs of fluid in the pericardium, with ascites, effusion into both pleural cavities, and œdema of the legs. No fever was present, and but little dyspnœa. The necropsy showed considerable serous effusion into the peritoneal as well as into both pleural cavities, and the pericardium was filled with a large quantity of dark thin hæmorrhagic exudation. The other organs were normal. The patient was an unusually strong man, without any indication of carcinomatous, tuberculous, or kidney disease: nor had he suffered from acute rheumatism, or any infectious disorder. Virchow showed the heart and pericardium. The former exhibited notable general hypertrophy, while the pericardium was much distended, and its surfaces covered with fibrinous exudation, worked into ridges and tufts by the cardiac movements. On section of the much-thickened pericardial walls, an immense number of tubercles could be seen in the deeper layers. Those examined microscopically were full of unusually large giant cells, but contained comparatively few bacilli. Virchow regards this case, like the others previously observed by him, as one of protracted latent pericarditis, going on to the production of a highly vascularized new connective tissue; and considers the tubercles to be a secondary pathological development in the inflammatory new formation, like those observed in many other situations—for example, the pleura. The first case of the kind which came under his notice—that of an old man of eighty, in whom there was otherwise no trace of tuberculosis—impressed him very strongly as evidence against the then prevailing view of the prior existence of a specific dyscrasia as the essential condition of local tuberculous lesions. In all these cases, also, the pericarditis was the sole affection present, and in most of them the hæmorrhagic exudation was so great as to suggest at first a rupture of the heart. Virchow adds that he is not in a position to explain them.—*British Medical Journal.*