No. 6.—Brockville Asylum District, to embrace the counties of Leeds, Grenville, Dundas, Stormont, Glengarry, Prescott, Russell, Carleton and Lanark, having an aggregate population of 288,440, for which there is accommodation in the District Asylum for 1 patient to every 487 of the inhabitants.

The territorial district allotted as No. 4, or Toronto, may appear at first sight to be comparatively small, but it must be borne in mind that, in the higher pay wards, there is accommodation for 230 patients, which leaves only 478 beds available for warrent cases. The higher pay wards are available for patients from all sections of the province, and are not limited to any territorial division, from which they may be admitted.

Abscess of Lung Treated by Drainage and Iodoform; Recovery.—J. Eustace Webb, M.B., Aberd., *Lancet*, June 29, 1895, gives the following important contribution to our literature on the surgery of the lung.

A woman aged twenty-seven years came under the care of my partner, Mr. Wm. Hammond, and myself on Aug. 1st, 1894. She had given up all hope of recovery, as she had been told by two medical men that she could not live many weeks. Her mother died of lung disease at the age of thirty-two, and on the maternal side there was a decided history of phthisis. Her father was aged fifty-eight; he suffered from rheumatic gout. She had no brothers or sisters. She had inflammation of the lungs in early childhood, since which time she had been perfectly well. In the latter part of June, 1894, she was suddenly attacked, at the time of her menstrual period, with pain in the right side of the chest, which was followed by cough and expectoration. When examined on Aug. 1st, the right chest gave the following physical signs: Great dulness, extending all over the base of the lung posteriorly to a line well above the angle of the scapula, and at the side and anterior part of the chest below a line continued horizontally round from the ensiform cartilage; vocal resonance and fremitus were present, but not markedly increased; the breath sounds were distant, but heard to the extreme base. The tape at the level of the ensiform cartilage showed an increase of one inch on the right side. The breath was fetid, had the characteristic odour of pus, and the air of the whole cottage was pervaded with the same sickly odour. The expectoration was purulent and nummular. The body was fairly well nourished, but she stated that she was losing flesh rapidly. Her pulse was 120, her temperature 102° F., and her respiration 30. Her appetite was very bad, and the tongue was red and glazed. As she lived six miles from my house a record of her temperature, etc., could only be taken once daily. On Aug. 9th the chest was aspirated in the axillary line in the sixth intercostal space; the needle penetrated to a depth of two and a half inches, and twelve ounces of pus, slightly mixed with froth, were drawn off. For some days after the operation she appeared greatly relieved, the fetor of the breath was very much diminished, and she was able to relish her food. No marked improvement, however, was noted in her pulse, temperature, or respiration; the breath sounds could be heard more distinctly at the base, but there was no appreciable diminution in the dulness. On Aug. 25th she vomited about half a pint of pus, and again the fetor of the breath became less. The physical signs suggesting an increased collection of pus then became more marked, the dulness extending to above the middle of the scapula behind and to a corresponding level in the side and anterior part of the chest. She was losing flesh rapidly. Her respiration was 40, the pulse was 120 and very soft, and she was passing loose evacuations many times in the day. On Sept. 2nd a large trocar and canula, the size of a No. 14 English catheter, was passed through the chest-wall into the lung just above the angle of the scapula, and between it and the vertebral column it was directed forwards and outwards. This spot was chosen because it seemed to be that of the maximum density. When the trocar was withdrawn, a flow of pus through the canula continued until fourteen ounces were collected. A drainage-tube six inches long was then passed through the canula into the abscess cavity, the canula was withdrawn, the drainage-tube was secured to the skin with thread and sticking plaster, and covered with a thick absorbent dressing. Each day the dressings were changed, and at first they were always found saturated with discharge. During the dressings the patient was brought to the edge of the bed in the dorsal