

serous or sero-fibrinous, quite large quantities of it may be more or less rapidly absorbed. When the dyspnea is not urgent, and the cardiac impulse in normal position, it is prudent to wait, although the quantity of fluid may be quite extensive. The restriction of fluids and the use of saline cathartics, diuretics, diaphoretics, lung gymnastics, massage, dry cupping and a series of "flying" blister may be tried to help in the absorption of the fluid.

Fowler lays down the following indications for paracentesis: (1) When there are signs of positive intrathoracic pressure; (2) when the following symptoms which usually accompany the above condition are present—a small irregular pulse, and urgent dyspnea palpitation on slight exertion, lividly, or evidence of engorgement, and edema of the opposite lung. These symptoms may, however, be absent in cases accompanied by positive intrathoracic pressure so long as the patient is lying perfectly still. (3) When the fluid has been ascertained to be purulent its removal is necessary in all acute cases.

It may be necessary to remove the fluid more than once, but only a few repetitions can be borne by the patient without impairing his strength.

In aspirating strict antiseptic precautions must be observed. The needle, or the canula—if a trocar be used—should be about one-tenth of an inch in diameter and about three inches long.

The positions usually selected are the interspaces between the sixth and seventh ribs in the mid-axillary line, or between the ninth and tenth just outside the line of the angle of the scapula. The fluid should be withdrawn slowly, and a careful watch kept on the action of the heart and respiratory movements. On the occurrence of urgent dyspnea or faintness the flow should be stopped and stimulants given. When evacuation is complete or sufficient relief given some antiseptic dressing should be securely fastened over the puncture. The evacuation of a purulent exudate belongs to the domain of general surgery.