off. It may be unnecessary to reintubate. At any rate, it is usual to see a great deal of membrane coughed up immediately after the removal of the tube, and if dyspnœa returns, and it must be replaced, there is less coughing and danger of plugging of the tube.

J. C. CONNELL.

ESTLANDER'S OPERATION FOR CHRONIC EMPYEMA.

J. H.S., a farmer aet. 28, came under my care in February last, being kindly referred to me by Dr. Mather, of Tweed.

The patient had a fistula in the eighth left interspace in the axilliary line which gave vent to a constant discharge, since the opening in the chest wall was made about two years previously. He gave a history of repeated attacks of pleurisy beginning six years ago. His case was evidently diagnosed as tubercular in character, since Koch's tuberculin was given him by injection, and he was ordered from his home in Ontario to Manitoba for a change of climate.

This change proved beneficial, the patient considered that he had quite recovered, and in a little over a year returned to Ontario. In a few months, however, the left side again "gave him trouble," and he decided to locate in the North-west, where after a residence of some months, he consulted a physician who made a diagnosis of empyema, and after aspirating several times finally made a free opening and evacuated a large amount of pus.

The empyemic cavity thus emptied, instead of closing in the average time, has continued to discharge ever since, the daily quantity of pus varying, according to the patient's statement, from a few ounces to half a pint.

Last December the patient had an attack of pepticomnia characterized by the usual chills and high temperature, and up to the date of his admission to the hospital he had more or less evening rise of temperature. Careful examination of the sputum and also of the discharge from the fistulous opening in the thorax