

adherent is an uncertain test, because it is almost impossible to stop the point of the needle just when it pierces the visceral pleura, and if it goes much further the lung tissues move it up and down. I have usually found that if the parietal pleura was thickened adhesions were present. If in doubt, and the patient's condition permits, one may remove one or more bits of rib and suture the two layers together as recommended by Yean, Tuffier and Roux. In suturing the pleural layers, round needles are preferable, and Garrè recommends inserting them during expiration and covering the pleura with the finger during inspiration. I have never known any infection to occur from this operation. If the condition is urgent, incision may be immediately made and the lung entered, but it is safer to wait for a couple of days for adhesion to take place. In other cases when in doubt I have applied the cautery, and in others simply packed the cavity tightly with iodoform gauze with equally satisfactory results. The first, however, is the procedure of choice. In one instance, when in doubt, I made a small puncture with the end of a knife—the entrance of a puff of air discovered that no adhesions were present. I packed the cavity with iodoform gauze, and three days later found adhesions sufficient to allow me to go in without any trouble.

If the pleura is accidentally opened and the lung recedes, W. Müller has found it possible to catch the receding lung with a pair of forceps and bring it back into the wound and suture the two pleural layers together. Incision through the lung tissue into the abscess cavity may be made in several ways. In some cases where the tissue is hard and dense, particularly if the fluoroscopic examination has shown the abscess wall to be near the periphery of the lung, one may enter simply by blunt dissection. In these cases I have found it very satisfactory to first insert a director, and when entrance into the abscess cavity was demonstrated by the flow of pus, to pass a pair of narrow-bladed forceps along the groove, and by separating the blades to secure an opening sufficiently large to permit the introduction of a finger for purposes of exploration. I have found this a valuable detail, as it enables one to determine the size and direction of the cavity and the location of any communication with a bronchial tube. In one of my cases I found the communication with the bronchial tube at the very upper end of a long cavity. This patient did not do particularly well for some weeks after operation. Then finally I made a second opening through the chest wall into the lower end of the cavity, thus securing a dependent drainage, when the cavity closed rapidly,