ing no fixed standard, and only to be appreciated by comparing corresponding portions of both sides on the same patient, scarcely ever two patients giving the same resonance on percussion; in case of double effusion, in a child, where the surface to be percussed is small, it is difficult at first to say whether you have effusion at all or not.

On the 8th of April, Louisa and Sarah Meher, twin sisters, had been playing together in the open air during most of the afternoon of the previous day. During the night both took convulsions, followed by pains in the chest, rapid respiration, and pulse in high fever. I saw them on the morning of the 8th, and as measles were epidemic in the neighbourhood, at first I suggested that perhaps they were contracting that disease.

As their temperatures ranged from 103 to 105 constantly and pulse 140 to 160, I soon had to revise the diagnosis. Louisa gave evidence of double pleuro-pneumonia; Sarah, consolidation at left apex without bronchophony.

A consultation was arranged and I was informed that my patients had catarrhal pneumonia; this was April 18th. It was suggested that they should both have large quantities of stimulants, a proposition to which they objected so strongly that it could not be carried out. Sarah was improving but Louisa kept getting worse, and on the 28th I made an exploration of the right side and got pus. I made a free opening. inserted double rubber tube secured by safety pins and irrigated. About a pint of pus escaped and the percussion note became more tympanitic, showing, by comparison, considerable dullness on left side. As there was but little improvement in her general condition, on May 3rd I explored the left side and found that it also contained pus. I aspirated and got about six ounces, followed by mitigation of all the symptoms. On the 13th, as fever was somewhat higher, I aspirated again, getting about two ounces and again on the 31st, the last time, getting only about an ounce of sero-purulent fluid. During all this time the double tube was kept in the right side. She gradually improved after last tapping, and in the first week in June was able to play about again, the tubes were removed. Both children completely recovered and have been strong and healthy since that time. The case of Louisa is, I believe, a rare one; I have not seen the report of a similar case followed by recovery. The left side of this patient is the only case in which I have tried to treat an empyema by aspiration. My intention was to repeat the aspirations as required until the right side was healed, should the patient stand it so long, and then make a free opening, as I would not venture to open both sides at once. However, it has demonstrated, I think satisfactorily, the possibility of a cure being affected by repeated aspirations.

As to treatment I consider it essential to have two openings and so far from endeavoring to exclude air, I consider it useful to let pure fresh air pass freely in and out of the cavity. I have on two occasions seen wounds of the chest in healthy individuals in which air freely entered the pleural cavity, completely displacing the lung, yet the wounds healed rapidly without injury to either lung or pleura. I will not dispute that in a recent case where the lung is not bound down, its expansion may be so great as to occupy the space as fast as the pus is removed and so empty the cavity through a single opening. But, if any one thinks he can do so in an old case where the lung is not only bound down by adhesions, but from lung compression, has in a great measure lost its power to expand, being in fact carnified. Let him try to empty a small keg or barrel by a single opening through a rubber tube. He will find it necessary to make a second opening before the fluid will run and it is necessary that air should take the place of the outflowing fluid.

Dr. Louis A. Sayer, of New York, covers the ground here very nicely in his excellent work on "Orthopædic Surgery," when speaking of the admission of air into deceased joints, he says, "I am not afraid of fresh air but I am afraid of imprisoned air." So long as the surroundings of the patient are aseptic there is nothing to be feared from free ingress and egress of air, more than in any other abscess. The old method of making a second opening lower down than the first was good, its only objection being the difficulty of making it. I have found two rubber tubes fastened together by a large safety pin and one about an inch longer than the other answer admirably, and when necessary to irrigate I inject through the lower tube.

Mrs S., *æt* about 45, the wife of a German farmer. I saw her shortly before her death on February 25, 1884, in company with her medical attendant and another physician. Her pulse was from 180 to 200 intermitting, with cold extremities. It was explained