chondriac and epigastric regions, I repeated the enema with the head and shoulders lowered. During the administration of the last of the enema, about six ounces of greenish fluid burst from the mouth, and I then allowed the water to escape per anum. No fæcal matter, mucus, nor blood came away with either enema.

10 p.m.—Has rested well since enemata. No vomiting, and no movement of the bowels since visit. No tumor felt. Pulse, 145.

Oct. 20, 9 a.m.—Doing well; pulse, 136. Countenance improved. 9 p.m.—No vomiting since the disappearance of the tumor. Has had two or three greenish motions to-day. No blood.

Oct. 21.—Appears almost well. Takes the breast and vomits nothing.

REMARKS.—That a distended abdomen is not necessarily present in all cases of internal obstruction is quite evident from the first case reported above. The belly was really *retracted* in that instance, which was of course due to the seat of trouble being so close to the stomach, thereby leaving only a few feet of intestine above to be dilated, the portion below becoming empty and contracted as is usual. It would undoubtedly have afforded this patient a much better chance for life if laparotomy had been done earlier; but one is apt to hesitate and delay about resorting to so serious an operation, that the latter is often not undertaken until symptoms of collapse, or general peritonitis, or gangrene supervene, and then the patient succumbs. I intended to have performed the operation on the morning of January 15th. had there not occurred a passage of flatus downwards for the first time, which led me to hope that the obstruction was about to yield. Besides, it will be observed that the abdominal section was made before the end of the 4th day, and as I had previously operated on two cases* of internal strangulation at the end of the 5th and 6th day respectively—the former of which recovered, and the latter lived till the 7th day after the operation—I thought I could afford to wait a little. But it is quite clear that the *length of time* that has elapsed cannot be relied upon entirely as a guide to the condition of the bowel, and consequent urgency for surgical interference, any more in cases of internal obstruction than in those of strangulated hernia, and one must evidently be largely governed as to the advisability of immediate operation by the degree of the acuteness as well as the severity of the symptoms attending the attack.

As to the character of the second case reported, I think there can be little room for doubt. The acuteness of the symptoms, the vomiting, the passage of the thin, bloody serous discharges, the presence of the sausage-like tumor, and the speedy and complete relief obtained by the use of the large enemata, all combine to prove the existence of an intussusception. The patulous condition of the anus, I think, is also mentioned by some as likely to be found in such cases. I did not give an anæsthetic before administering the enemata, because I did not suppose there would be much muscular resistance offered to prevent the reduction of the bowel in a subject so young, and in one who was so much prostrated by the disease. The readiness with which that object was attained is sufficient evidence that the assistance of such was not required.

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## THORACO-PLASTIC OPERATION OF ESTLANDER.*

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GENTLEMEN,—It is not possible for me, within the time assigned, to discuss satisfactorily the pathology, or even the clinical history of empyema, although the disease is one of the most interesting which the surgeon is called upon to treat. I shall, therefore, confine myself entirely to the treatment of the chronic form of the disease by what is known as Estlander's operation. I also desire to draw the attention of the profession to this operation which, so far as I know, has rarely been performed in America the first reported case being given by Dr. Fenger, of Chicago, in the *Medical News* for Sept. 1882.

The resection of a portion of a rib for the more thorough evacuation of pus, and for the application of remedies to the cavity of the pleura, has long been practiced; but the object which Estlander had in view in his operation, was the obliteration of of the suppurating cavity and occlusion of the per-

*Read before the Canada Med. Association, August, 1884.