ance of a man in an advanced stage of pulmonary phthisis. Obviously the man suffered from an empyema of long standing, and a large communication existed with the lung or bronchus. The pus cavity was discharging in two directions; chiefly by the sinus on the surface of the chest when he stood upright, and chiefly into the lung and air passages when he lay down. Through a vertical incision some two inches of the sixth and seventh ribs were incised in the anterior axillary line. A free flow of pus resulted, and on exploring with the finger a very large cavity was found. The thickened parietal pleura (fully three-quarters of an inch thick), and the periosteum in the region of the resection were carefully cut away. The operation was by no means devoid of danger, as the recumbent position, plus the insensibility produced by the chloroform, permitted the pus to accumulate in the air passages, and the patient became almost asphyxiated. The cavity was washed out with 1 in 20,000 bichloride of mercury, and a vulcanite tracheotomy tube secured in position for drainage. The patient made a remarkable recovery after the operation. He gained rapidly in weight so that as a matter of actual observation he gained twenty-one pounds in twenty-one days. In March, 1894, five months after operation, he entered the Street Railway employ as a motorman, and continued at that occupation in apparently excellent health for some months. I saw him at his work towards the end of June, 1894, and he was then strong and well, but shortly after this he was unfortunate enough to contract pneumonia on the right side of the chest, and to this he rapidly succumbed. Dr. Fotheringham, who was present at the *post-mortem,* informed me that the left pleural cavity where the empyema had existed had become completely obliterated.

The point is also illustrated by the following case where a chronic course threatened, but was prevented by the establishment of efficient drainage:

G. S., aged 3½. Operation was performed, June 29th, 1894. The child had been ill two months before admission. One month previously a surgeon had incised below and to the left of the left nipple, and inserted a drainage tube. The tube came out after a few days, and the drainage was not efficiently maintained. On admission a fistulous opening was discharging a scanty amount of foul-smelling pus. I resected 1½ inches of the fifth rib, and a large quantity of stinking pus escaped. The cavity was flushed with sterilized water, and a vulcanite tracheotomy tube placed in position for drainage. The child made a rapid recovery.

Robert McGuire in a "Discussion on the Treatment of Pleuritic Effusion in Childhood," at the British Medical Association, in 1899, expressed the view that pneumothorax with or without effusion may well be left alone if its tension be not very high. "Pus," he adds, "in the body is bad, but in the condition to which