the rectus muscle. The temperature did not drop, however, as was expected after this procedure.

On November 20th he first complained of pain in the right side, in the region of the liver, and this gradually became more severe. A pleuritic friction rub was made out, and air did not seem to be entering the lower portion of the right lung. There was, too, at this time, some tenderness over the gall-bladder and increased dulness. This gradually became more marked, and the line of liver dulness descended. On the 25th Dr. W. P. Caven was called and examined the patient and thought that the gall-bladder was infected with the typhoid bacillus, and on the 6th of December Dr. Bruce came up again.

I will here give my notes of his condition on December 6th. His temperature the previous evening had been 102⅕, pulse 130, and respiration 22, and now his temperature was 101⅗, pulse 112, and respirations 22. On examination I found the liver about two inches below the ribs, the extent of liver dulness being greatly increased. The right side was bulged out, making it appear as if the liver was greatly enlarged. At the lower edge there was a great deal of tenderness, and the skin was red and brawny.

Dr. Rogers gave me a history of the gall-bladder having been markedly enlarged, and that only during the past couple of days had the swelling at the lower edge become diffused, and the outline of the gall-bladder disappeared. Chloroform was given by Dr. Walker, and Drs. Rogers and Tait assisted me. Owing to the above history I made an incision in the right semilunaris, and exposed the liver and gall-bladder. The gall-bladder was not enlarged, and appeared to be normal. On palpating the liver to the outer side of the gall-bladder, fluctuation could readily be made out. I made an incision into the liver at this situation, and evacuated about a quart of pus. On passing the finger through the opening in the liver, its margins were felt to be somewhat ragged, and my finger entered a large space behind the liver filled with pus. On passing my finger still further I could feel the ribs posteriorly. It was evident then we were dealing with a large subphrenic abscess, which had secondarily invaded a portion of the liver, destroying a small area about the size of an egg. An opening was then made in the tenth intercostal space, and another quart or two of pus was drained out through this. In making this incision the pleura was not opened into. I then explored the cavity through the posterior opening, and could make out pretty well the extent of it. After this pus was evacuated an enormous cavity was left between the liver and the diaphragm. Two drainage tubes were put in, and a large quantity of gauze. There was sufficient room between the