-ge tube and irrigated with dilute carbolic acid. This was continued until May 26th, when she was quite restored to health and has been strong and healthy since.

In arriving at a diagnosis in all cases of internal abscess, no matter where, I have, during the whole of my professional career, been very much assisted by a remark made by my old preceptor, Prof. W. T. Aikins, in one of his surgical lectures.

It was to this effect: When a patient emaciates with chills, sweats, and local pain, continuing for several weeks, and without evident cause, examine carefully for internal abscess. As to the signs given, they are not, I find, all reliable.

Absence of respiratory murmur given as one, and which we would naturally expect, I have found pretty constantly in hydro-thorax, but not in pyo-thorax.

I can only account for this by supposing that frequently during the intense inflammation preceding the effusion that ought to displace the lung the costal and pulmonary pleuræ become adherent and so portions of lung tissue are held down to the lower part of the pleural cavity, and such cases give trouble both in diagnosis and operation.

Wm. Ross, *æt* 2 years, seen July 1, '79. Ill about 4 weeks. Frequent sweats, dullness on right side. Half inch enlargement, etc., but respiratory murmur over whole of side; explored and got pus. Assistance was called; patient anæsthetized, and using hypodermic needle before operating as we both felt timid. On account of respiratory murmur we found it impossible to obtain any pus and gave up.

On 9th, finding my patient getting worse I used the needle again and got pus. I unscrewed the barrel from the needle of the syringe and cutting down beside the needle obtained eight ounces of pus; inserted drainage tube and irrigated, this was continued for four days when the tube came out with the dressings and could not be reintroduced. It was not required and patient made uninterrupted recovery.

Sometimes it would appear that pleurisy is not the primary disease but that inflammation of a neighbouring organ or viscus extends to the pleura. An empyema of this class is likely to be somewhat circumscribed.

Miss H., *æt* 24, of German parentage, was taken suddenly ill about midnight, Jan. 2, 1887. Severe pain in right hypochondria, shooting to left side and right shoulder. I saw her about 8 a.m., Jan. 3, pulse 48, temperature 97; cold perspiration, vomiting. Two years before had had an attack of bilary colic with jaundice. The only cause which she could assign was drinking a glass of cold lager beer about noon the previous day which caused her to feel chilly. Gave morphia hypodermically and treated the case as one of bilary colic. Jan. 4—Pulse 120, temperature 103; no friction sounds but pain over liver and base of right lung, increased on deep respiration. Patient rapidly emaciated with slight jaundice, chills, fever, and sweats. Jan. 10—Dullness above natural superior border of liver. Explored but got no pus, as I strongly suspected, either above the liver or empyema. I frequently explored until Jan. 18; on my ninth attempt I obtained fœtid pus between ninth and tenth ribs, a little to the front of the axillary line.

I made free opening, inserted double drainage tube secured by strong safety pin, irrigated with tr. iodine, one teaspoonful to the pint until it ceased to have an offensive smell. There was only about a pint and an half of fluid in this case but so offensive that the attendants were compelled to leave the room. After thoroughly irrigating I dusted the side with iodoform covered with antiseptic gauze and over this a thick pad of antiseptic marine lint.

On removing dressings on the 19th, I found the discharge again offensive and temperature of patient, which shortly after operation, had fallen to normal, rising. I again irrigated the cavity, removed the drainage tubes, and replaced them by freshly disinfected ones, and renewed antiseptic dressing as before.

This patient recovered somewhat slowly; frequently, no matter how cleanly kept, the discharge would become offensive, requiring repeated irrigation which gave her no inconvenience. Temperature and pulse always affected when discharge became offensive. By February 1st was able to sit up for a couple of hours. Tubes removed February 8th, and on the 20th all healed.

Since then has enjoyed excellent health. My opinion is that in this case the inflammation began in the liver.

Empyema may be double, adding materially to the difficulty of diagnosis. As the terms dullness and flatness on percussion are relative terms, hav-