With Sauerbruch's pneumatic chamber the chest may be opened without shock due to collapse of the lung, and I believe the time is not far distant when every well regulated hospital will be provided with a special room for operating on lung cases. Even at the present time many cases of gangrene and abscess of the lung are cured by an early operation. It is difficult to distinguish between abscess and gangrene of the lung, yet for all practical purposes the diagnosis is unimportant as the treatment is the same in both conditions. The main point is to open early, before extensive changes have taken place. If one waits until the abscess wall becomes very thick, with infiltration and induration of the surrounding parts, or where, through aspiration, other parts of the lung become involved, the prognosis is not nearly so good. An X-ray examination will aid very much in the localization of the disease. The aspirating needle is a dangerous instrument in such cases, as its employment subjects the patient to increased risks of infection.

In the early operation, simple thorough drainage will usually be followed by recovery, otherwise, free resection of the ribs becomes necessary. Where a fistula is left after an abscess has been drained, the lung may be resected. Even the whole lobe has been successfully removed, with cure of the patient. When Sauerbruch's chamber is not available, the careful application of sutures which attach the pulmonary to the parietal pleura should be made. Where further security be desired, and the condition of the patient permits, a weak iodoform gauze tampon may be applied to the pleura, and allowed to remain for one or two days before opening the diseased focus.

An interesting point in connection with the anesthetic, is, that it is only needed at the beginning and end of the operation, as the lung and pulmonary pleura are not sensitive to pain.

Diseases of the stomach and duodenum have been discussed so much during the last few years, that it seems superfluous to say anything about them, yet many of the cases of cancer come too late for a radical operation. Hoffman in an analysis of 665 cases received in the Mikulicz clinic, found that the patients were referred to the surgeon on an average of 10.3 months after the beginning of the disease, and usually they were treated by the physician three months before surgical aid was sought. This should not be. Unless an early diagnosis be made, the result must be unsatisfactory. Take a middle-aged patient with good previous history, or history of old digestive derangements, who begins to complain of stomach trouble, which is not relieved by