felt much more comfortable, could sleep on his right side, and had no pain or nausea. He was transferred to the surgical wards, and on April 23rd Dr. Shepherd, under ether, made a vertical incision some four inches long in a line with the nipple, and commencing immediately below the costal margin on the right side; the parts were carefully incised, and it was found that the wall of the abscess cavity was adherent to the abdominal parietes, and consisted of a thick mass of inflammatory tissue. When the abscess cavity was opened there was a gush of fluid, and afterwards each inspiration caused the pus to flow more freely; to facilitate the exit of pus a large rubber tube was introduced, which acted as a siphon; in this way some 80 ounces of pus were drawn off. The patient now showed signs of collapse, breathing shallow, pulse extremely feeble, so the evacuation of pus was discontinued. On exploring the abscess cavity with the finger the diapragm could be felt above, reaching as high as the third rib, but owing to the size of the cavity its lateral and posterior limits could not be made out; its lower limit consisted of a dense mass of inflammatory tissue, through which the liver could not be felt; a probe introduced could be felt posteriorly between the fourth and fifth ribs. The cavity apparently now contained as much pus as had been already evacuated, but owing to the condition of the patient it was decided it would be more prudent to allow it to drain away gradually through a rubber tube; so the wound was sutured, a large drainage-tube left in, and a dressing of sublimated jute and washed gauze applied. Patient, on getting to bed, under the influence of heat and stimulants soon rallied. During the next three days there was a large discharge of pus, and the dressings had to be changed daily. Temperature never rose above 99°, and from the day of his operation patient improved, the abscess cavity rapidly diminishing in size. By the 1st of June the discharge of pus had almost ceased, the abdominal organs had resumed their normal position, and liver dulness was normal, but breath sounds over right lung still feeble. Patient rapidly gained flesh, and when discharged from hospital in August there was a small sinus at the site of the wound which discharged a little serum. For the last three months patient had been at work, and looks, and says he feels, well. The sinus has not yet quite closed. The breath sounds could be heard over the whole right lung, but at the lower part, both in front and behind, still rather feeble.

Dr. Shepherd said that there was no doubt in his mind about this being a case of abscess which originated between the diaphragm and the liver. The remarkable point about the case was the absence of history of fever or rigors, the slow and comparatively painless growth, and absence of jaundice. These conditions are those which generally indicate echinococcus disease: so at first, until a microscopical examination gave a negative result, the case was diagnosed. The symptoms were not acute enough for liver abscess, but when no hocklets or other evidences of echinococcus were found it was thought probable that it was such a case. He had intended making a counter opening posteriorly to facilitate drainage, but the collapsed condition of the patient, after the evacuation of so large an amount of pus, warned him to complete the operation as soon as possible and to apply restoratives. The result was quite as satisfactory as it would have been had an opening been made posteriorly as intended, a dependent opening when abscesses above the diaphragm being much more important than when they are below it, on account of pressure of the abdominal walls on the contents of the abdomen always tending to obliterate any cavity that may exist. In this case it was remarkable how soon such an enormous cavity disappeared.

Dr. RODDICK thought that it was not improbable that the case originally had been one of empyema; that the pus had ulcerated through the diaphragm, and got between that structure and the liver.

Dr. GEO. ROSS said that the explanation offered by the last speaker was an ingenious one, but not practicable. The anatomical structure of the parts did not give any likelihood to the supposition. The case had probably been originally one of subdiaphragmatic peritonitis which had become localized. We may have a pleurisy following a subdiaphragmatic inflammation without perforation of the diaphragm, but that such a small opening as would naturally result from an ulcerating empyema could completely drain the pleural cavity, and collect below the diaphragm, was not probable. Any empyema would surely come forward more readily than downward.

Dr. MACDONNELL related a case of peri-cæcal abscess, in which pus found its way up behind the peritoneum, between the liver and diaphragm, and