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SURGICAL TREATMENT OF EMPYEMA.

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Although in some situations abscesses may exist for long periods without leading to any bad result, pus, even when it is "well-formed and healthy," is an injurious and destructive agent, for it leads to erosion and absorption of the neighboring tissues; it burrows widely, and leads to the formation of long sinuous passages lined with degenerating pyogenic membrane; it sometimes makes its way into a large blood-vessel or into a joint; or, in the case of empyema, its presence is associated with the compression and binding down of the lung, and sometimes with ulceration of the pleura and necrosis of the ribs. On the two-fold grounds, therefore, (*a*) that there are grave dangers in leaving large collections of pus to burst spontaneously, and (*b*) that there are means by which pus can be safely removed, the practice with a large number of surgeons at the present day is to open abscesses as soon as they are detected. My belief is that, with further experience of the vastly improved results of interference, early evacuation will become the rule to which there will be but very few exceptions. There is a further argument in favor of letting matter out at once. It is that the mere presence of a collection of pus promotes suppuration. In common, no doubt, with many other surgeons, I have often met with cases in which, although before the abscess was opened it was enlarging at a rate which indicated that half an ounce of pus was being formed every day, after evacuation the quantity of pus discharged amounted to only a few drops, and soon entirely ceased. But the contention that, as an abscess, an empyema should be evacuated as soon as its presence is established is strengthened by the danger that the lung may become bound down. From this point of view every day is a matter of importance. Nor, in this connection, must other results be forgotten. The patient may be placed at a great disadvantage by the bursting of the abscess into the air passages; and a few weeks since a case was met with in which suppuration had extended through the diaphragm and produced fatal peritonitis. That there should be no delay when once pus has formed in the pleura, I should, speaking merely as a surgeon, think it advisable, if empyema were so much as suspected by the physician, to introduce a fine needle connected with an exhausting syringe, to ascertain whether matter could be reached.

Whether in the treatment of empyema the aspirator should be used is, I think, a doubtful point. I believe that, generally, it is better to make an incision, and establish free drainage. The aspirator may, no doubt, be successfully used, and after two or three, sometimes after a single aspiration, the formation of pus may cease. Yet, as a rule, it is necessary sooner or later to make a free opening; and it seems advisable, in order to give the lung an opportunity of expanding as soon as possible, to open and drain the pleural cavity at once. The cases in which the aspirator is most likely to be successful are those of recent empyema, but these are also the cases which do best under free incision and drainage. In cases of long standing, where pus is thick and flaky, and where the pleura is lined with a thick deposit of lymph, drainage through a free opening seems to be decidedly called for. As pus is often too thick to flow through the needle, it is necessary in any case in which aspiration is to be tried, to arrange beforehand that, if the tube becomes blocked, the means are ready for making a free incision.

If, as I think is best, an incision is de-