upwards to the spine of the left scapula. Heart displaced far to the right.

General condition, critical, orthopnœa, cyanosis, small pulse, scanty urine; temperature 101 1-5.

April 6th—Great dyspnœa. Thoracentesis performed with all possible aseptic precautions. Four litres of thin serous fluid were evacuated in an hour. Marked improvement was soon evident. April 11th—Dyspnœa reappears. Heart is again found strongly displaced to the right. Third puncture performed and three litres sero-purulent fluid withdrawn. Pleural cavity irrigated with sublimate 1-1000 followed by boric acid 20-1000. Temperature fell from 101 1-5 to 98 at once and remained at 101 1-5 until April 27th. The day before the first puncture 10 c.cm. of liquid were removed with a Roux syringe with all antiseptic precautions, two tube cultures made.

Polynuclear pus cells were found with rare non-capsulated non-lanceolate diplococci—at one place a bunch of four together was discovered. Bouillion after 24 hours gave small bunches of staphylococci —no evidence of pneumo or streptococci. Operation was decided on with cocaine anæsthesia. Three litres of sero-purulent fluid were evacuated—drainage tube inserted and antiseptic compress applied.

May 14th—A siphon was introduced and remained until June 20th. Fall in temperature accompanied gradual diminution of pus flow, but on evening of June 20th, the patient is allowed outside. Has a chill and pain—the fistula is found partially closed—dilated with laminaria tent and drained again under better conditions. Lung begins to expand—no retraction—general condition good. Absence of streptococci from serum was noted 15 days after readjustment of the siphon.

Under the treatment of "wait a bit," let the patient alone, pray for rupture into a bronchus, only interfere surgically as a last resort, (and then but partially) we see in all cases a more or less prolonged illness of three to five months in favorable conditions. The evacuation imperfectly performed by tube methods does not completely remove the septic agent, though it be the most favorable staphylococcal pus, free from fibrin and clots. It is doubly unsatisfactory in pneumococcal, streptococcal and tuberculous exudates, where fibrinous septa often become closed off sacs of matter unexplored or a clot of fibrin dams back the exudate from the tube.

But to consider the practice which time has evolved in all its details would require another hour or so. Briefly let me direct your attention to the fact that treatment has long proceeded along two lines—the internal and surgical. Internal remedies designed to cause absorption of a purulent effusion seem to invite the exitus lethalis via toxæmia