toms following the operation. The patient has little or no pain or rise of temperature, while the pulse remains practically normal. In about ten days the suture can be removed, leaving the kidney entirely free from any foreign substance. I usually have the patient remain quiet from two to three weeks after the operation.

Up to date there has not been a single instance of a return of the disease, so far as I have any knowledge, the patients are all enjoying good health, and are entirely free from the reflex symptoms which were so annoying prior to operation. In two of these cases it was my fortune to have an opportunity to examine the result; in one case several months afterwards, and the other nearly two years. In each case the patient had to be operated for ovarian trouble, and in each I made a careful examination of the kidney which had been anchored and found it firmly fixed, and, so far as I was able to judge, in a perfectly healthy condition.

I do not claim that the few cases which I have reported are sufficient to establish the fact that this method is without fault, but I do claim that up to date the results secured are better than those usually obtained by other methods.

SUBPHRENIC ABSCESS.—The difficulty of diagnosing this condition is well shown by the fact that in only two of the five cases observed by Dr. Carl Beck, was the true nature of the case recognized before operation. He states that it is sometimes impossible to distinguish an encysted pyothorax from a subphrenic abscess. As regards exploratory measures, he advises that after every aseptic precaution had been observed, the exploratory needle should be introduced over the seat of abscess. If the first trial is negative, the needle should be reintroduced several times in different places—as the pus cavity may be either of small extent or it may contain a cheesy accumulation, or, finally, it may be divided into several minor uavities by adhesions. After each negative result a wire should be pushed through the needle, so that any pus which may have remained adherent to the inner surface of the needle may become detached. Occasionally, it will be found useful to fill the syringe with sterile water after the operation and force the solution through the needle into a Petri dish. If the microscope does not give sufficient information, after examining this fluid, cultures may be made in properly prepared tubes.

The treatment of subphrenic abscess is practically the same as that of pyothorax, that is, resection of a piece of rib, the subphrenic abscess generally being within the extent of the ribs. Only resection secures a sufficiently wide opening for thorough evacuation.

As a rule, the eighth, ninth or tenth rib, preferably in the median axillary line, is selected. If the abscess be large, in subphrenic abscess as well as in pyothorax, two or three ribs should be resected in order to be able to pack the whole cavity with gauze, which procedure seems to be the ideal treatment of any abscess. If the abscess be small, it will not generally be found within the axillary line; then the exploratory needle will always indicate the ultimate route of the incision line. Exceptionally, such abscesses may be reached below the costal arches or the xiphoid process.