whereas, in truth, the cough is due to pleural complication, the expectoration to a breaking through of the abscess into the lung or to secondary inflammation of the lung, and the dyspnœa to paralysis of the diaphragm. Case reports show that mistakes in diagnosis along this line are the most frequent, and fraught with the most fatal consequences. Men like Kocher, Schlesinger, and Gerulanos have treated cases of pneumonia and found a subphrenic abscess on the autopsy table.

The first step in preventing such catastrophes is to remember the possibility of the thing. Once thought of, as Fenwick and Broadbent emphasize, the extremely sick look of the patient which is not like that of pleurisy or pneumonia, the dyspnœa, and this septic appearance will force one to a very careful hunt for subphrenic abscess.

Of course exploratory puncture is necessary. Yet a negative result, or even several such, do not exclude abscess. A positive result cannot decide between subphrenic abscess and empyema. The last decision is reserved for operation. Occasionally both are present, and cases have died because the surgeon opened the empyema and overlooked the other.

Prognosis:—How closely the outlook depends upon early recognition and early operation is shown by a comparison of Maydl's cases before 1894 with those reported since 1894.

Of Maydl's 178 cases, only 74 came to operation; and of these 48 per cent. died. Of the 268 cases (Grüneisen and Perutz) of the last decade, 215 were operated, with a mortality of only 27 per cent., that is an improvement of over 20 per cent. In the non-operated cases, the mortality was from 85 to 94 per cent. in both statistics. The most brilliant gain on the side of operation was in the gastric ulcer cases, in which Maydl's mortality of 70 per cent. was reduced to 30 per cent. in the later cases. In all the fatal cases, death was not due to the operation, but to complications, such as pneumonia, empyema, multiple abscesses, exhaustion, etc.

Treatment:—At the present time, practically the only treatment considered is operation with drainage; this may be either a laparotomy or a transpleural operation with rib-resection, according to the situation of the abscess. In the case of the latter, precautions must be taken to avoid infecting the pleura, either by packing or by suturing the two layers together before incising the diaphragm. But frequently the lower part of the pleural cavity is already cut off by adhesions—this occurred in one-third of Grüneisen's cases,—and infection need not be feared.

Following this general consideration of the subject, Perutz proceeds