

tension of the gas in the pleura, it was considered highly probable that the perforation in the lung had closed, and therefore that aspiration could be done quite safely. It was evident that no air had at any time been forced into the pleura during cough or other expiratory efforts, as the history showed no condition of extreme dyspnoea. This was an additional reason for believing that the opening had closed. There seemed no doubt that the tension in the pleura after the first two hours was quite as high as that of the air in the lung, the serous effusion being probably secreted rapidly enough to more than replace whatever air was absorbed. In that case the perforation would not have been opened afresh after the first escape of air through it.

Properly speaking, such a case as this should be called pneumothorax, as the serous exudation was only a complication, and caused by the irritation of the pleura subsequent to the escape of the air. As to the cause of the rupture of the lung, there seems no reason to doubt that it was due to the rupture of a tuberculous focus lying beneath the pleura. The focus must have been old and sterile, otherwise the pleura would have been infected and a purulent exudate would have resulted. The man considered himself well at the time, but he gives a history of having had some cough for two years. Some writers believe that it is possible by severe strain to rupture a healthy lung, but such an opinion seems untenable. In the cases so reported there doubtless existed some quiescent tuberculous focus. It is well established that an artery never suffers aneurysmal dilatation without having first been the seat of local disease weakening its wall, and it is probably equally true that a lung will not rupture unless it also is previously weakened by disease. The late Sir William Gull is reported to have aptly said, "Call no man healthy until he is dead, and Dr. — has made the post-mortem."

As to how soon the fluid should be removed will depend somewhat on the individual case. The greater the effusion, and hence the more marked the dyspnoea, the earlier will the fluid have to be removed, but if possible sufficient time should elapse to allow of permanent sealing of the rupture, if such will take place. As soon as air ceases to pass through the opening, if repair of the ruptures occur, it should require only a few days to become firm, so that nothing will be gained in delaying removal of the fluid at most beyond 3 or 4 weeks.

By many the use of the aspirator is not approved, lest the tension in the pleural cavity be too greatly reduced, and subject the healed rupture to too great pressure by the air in the lung. The aspirator is a convenient instrument, however, and judiciously used, as it should be in all cases, is quite as far from risk as the syphon.