Dr. W. E. B. Davis uses the small glass tube with a rubber dam and sucker. He only uses iodoform gauze for drainage in cases in which an abscess is not attached to the abdominal wall in order to shut off the general cavity. He packs with gauze around the glass tube, and often removes it in twelve hours if the discharge is not serious. He follows the glass tube with a small rubber one, and closes the end of the rubber one with a pair of forceps. It is evacuated every two or three hours, and the forceps re-applied after it has been emptied. He considers that much depends upon the condition in which the surgeon leaves the field of operation as to whether he should drain or not.

Dr. McMurtry uses a small Keith glass tube and sucker, a hard uterine syringe. He is opposed to the use of capillary drains by iodoform gauze and other substances.

Dr. Kelly drains in cases of general purulent peritonitis; in pus cases in which a portion of a suppurating sac is left adherent to intestine or pelvic walls; in cases in which there is persistent oozing from numerous capillaries; in cases in which extensive lacerations of the intestine requires suture or resection. He usually allows the drain to remain forty-eight hours in simple cases. In intestinal wounds, or where débris or portions of a cyst wall are left behind, the drainage tube is left in from three to five days; and in purulent peritonitis and local collections of pus it is not removed for from four to ten days. In the latter class of cases the sac fills up from the abdomen, and free drainage is kept up by the gauze until the granulation process is complete. In purulent peritonitis gauze is packed in in long strips, and is gradually withdrawn, usually requiring from seven to ten days for its removal. The time for the removal of the gauze depends upon its appearance. If, upon slowly withdrawing it, no odor is detected, and the gauze is comparatively dry, it is at once removed. If saturated with a grumous or purulent discharge it is only partially withdrawn.

Dr. Price considers the drainage tube of great value in abdominal and pelvic surgery. He uses the small glass tube in about all classes, except in cases of appendicitis, where he uses gauze and rubber tubes in all neglected and dirty cases. He considers the value of the drainage tube greater as his experience increases. He drains all the cases of pus in the pelvis. Following the removal of cystoma and fibroids with extensive and healthy adhesions he places drainage. He considers that the results in these cases are bad without drainage. If the toilet of the peritoneum has been carefully attended to, the convalescence is eminently more satisfactory in cases drained than in those not drained. Operators who value drainage and know how to use it rarely have septic cases. The authors of papers and books condemning the drainage tube have most to say about sepsis, bowel obstruction, and atheromatus blood vessels.