of relief in severe dyspnœa, but should be followed at once by an operation for the establishment of efficient drainage. Aspiration is usually performed in the mid-axillary line in the sixth or seventh interspace. The operation need not be detailed here. Care should be taken that the needle is sufficiently long to reach the interior of the cavity, and one must avoid injuring the lung with the needle-point. One is inclined to believe that in the vast majority of cases aspiration will fail in children as it does in adults. There can be no doubt that the best results are obtained in those cases which have been operated upon early. The advisability for early and efficient operative interference cannot be too strongly urged, and this applies to children as well as adults. The moment pus is detected in the pleural cavity means should be adopted to secure drainage. The precise form of operation will depend on what may be found necessary to accomplish this. In children it will entail resection of a rib, and in the adult incision, and possibly also the removal of a piece of bone, depending on the size of the intercostal space.

The two cases of which I now give you a short account illustrate the good results which usually follow early operative interference in children:

CASE 1. G. McC., æt. 4. History of illness extending over two weeks before admission into Hospital for Sick Children. Over left chest there was an an extensive area of dullness; breath sounds absent in the lower part of chest and tubular in character above. The left side of chest was almost motionless during aspiration. I aspirated and drew off 16 oz. of creamy pus; there was some odor, but not very fœtid. The aspiration was done in sixth interspace in the mid-axillary line. The temperature, which had been elevated, fell to normal, and child seemed much improved. On examination of the chest there was no dullness, and the breath sounds were normal. Subsequently, however, pus reaccumulated, and Dr. Thistle (in my absence from the city) opened the chest and drained for a short time, after which the child was discharged cured.

CASE 2. G., æt. 3. Had been ill about a fortnight before admission in November, 1894, to the Toronto Hospital for Sick Children. Dr. Thistle aspirated the chest on November 10, and drew off 10 ounces of thick greenish pus. The aspiration was done in the sixth interspace, just in front of the posterior axillary fold. The temperature, which had been elevated, came down, but in forty hours began rise to again, and dullness reappeared, and the condition of the child was as bad as on admission.

On November 13, I resected one and a half inches of the sixth rib in front of the posterior axillary fold; a large amount of stinking pus came away. A dressing of moist gauze under a piece of protective was applied.