about a month's time the symptoms recommenced; he commenced to lose flesh, suffered from night perspirations, with raised temperature. The sputum was stained for tubercle bacilli, but none were found. As the patient did not improve, and an abscess in the lung was suspected, the following operative procedures were carried out on the 122nd day of his illness: Chloroform having been administered an aspirating needle was inserted about one inch below the angle of the right scapula, and nothing being withdrawn from the pleura, it was thrust through the lung tissue until a large cavity was struck, from which some very offensive pus was withdrawn; the needle was left as a guide: an incision was made down onto the rib, and one inch and a half of the latter resected; the lung tissue was cut through until the abscess was freely opened; into this a drainage tube was introduced; dressings of wood-wool were applied. The patient bore the operation well. The dressings were changed as often as the discharge soaked through them. From the date of operation the patient progressed most favorably, the temperature never reaching above normal, and the expectoration ceasing in a few days. Forty-nine days after the operation the patient was discharged as well, and sent to a convalescent home at the seaside, where in the course of a month he gained a stone in weight.—*Lancet*, March 31, 1888.

H. PERCY DUNN., (London).

III. Cases of Gall-Stones Exciting Suppuration: Operation: Recovery. By A. PEARCE GOULD, F.R.C.S. (London), and C. B. KEETLEY, F. R. C. S. (London.)—Gould's case was that of a gentleman, æt. 38, who had had symptoms of gall stones for two years. The abscess was in the abdominal wall at the junction of the epigastrium and right hypochondrium. 140 small biliary calculi were removed, together with pus. No bile was discharged through at any time, but the sinus was long in healing. Mr. Gould had found reference to thirty-five other cases of gall stones making their way through the abdominal wall, but this was the only one in which the diagnosis appeared to have been made prior to the abscess bursting.

In a case of my own in which over a hundred gall-stones were re-

moved from an abscess in the right hypochondriac and lumbar regions, the incision was made as nearly as possible in a convenient place for following the track of suppuration up to the gall bladder, and not over the centre of the abscess. A probable diagnosis was easy to make and proved to be right. Before me is the house-surgeon's notice paper, sent out the day before operation, in which he describes what is to be done as "for suppuration of the gall bladder." My patient was a middle aged woman, operated on at the West London Hospital, Jan 18, 1887, and exhibited at the West London Medico-Chirurgical Society soon afterward. As a matter of fact some surgeons in reporting such cases do not think it necessary to write what they thought before the operation, as there is no room for difference of opinion afterward. In my case the gall bladder itself was explored, and bile escaped for some weeks afterward. The patient was seen recently in good health. Mr Gould's case was read before the Clinical Society of London on March 23, 1888.

C. B. KEETLEY (London)

IV. Notes on two Cases of Laparotomy for Penetrating Gunshot Wound of the Abdomen; Recovery of One. With remarks on Recent Statistics. By ARTHUR J. BARKER, F.R.C.S. (London.)—Mr. Barker gives a table of 26 cases of abdominal section performed on account of gunshot wound, and reported since MacCormac published his 32 cases. Of the 26, no less than 6 are quoted by Mr. Barker from the *ANNALS OF SURGERY*. [November, 1887, and July, 1887, papers by C. T. Parkes and J. I. Skelly, respectively. Cases also by McGraw and Murphy.]

The following are abstracts of Mr. Barker's own two cases :

Case I. A. T., æt. 23, a French jeweller, admitted into hospital 3:20 A. M., having shot himself in the abdomen half an hour previously. Moderate shock, conscious, but dazed and groaning. Pulse 56, markedly dicrotous (probably normally so) of good volume. Temperature in rectum 98.2°; no vomiting; lay on right side with knees drawn up. Breathing slow and shallow, with an occasional catch. Small bullet wound with blackened edges over border of right costal cartilages, one inch from middle line at level of tip of ensiform cartilage.