on the one hand, and a purely negative, temporising course on the other." Let such be our practice.

I am, Sir, yours obediently,

ARTHUR W. EDIS, M.D., F.R.C.P.

Wimpole-street, October 28th, 1879.

ASPIRATOR FOR LIVER ABSCESS.

To the Editor of THE LANCET.

SIR,—I beg to submit for consideration a modification of the aspirator, adapting it for the evacuation of liver or other abscesses.

It is simpler than that now in use. The tubes are larger, to give free exit to thick pus and flakes of tissue, and the points of the cannula are guarded so as to prevent

injury to the sac of the abscess itself. I enclose a sketch of the instrument, which was constructed for me by Messrs. Wright and Company, of New Bond-street, some time ago. I am inclined to think it will be an improvement, for liver abscess at all events, on the instrument now in use. I should have called attention to it ere this, but delayed until I had had an opportunity of satisfying myself of its efficacy.

But, as my attention has just been called to a very

practical paper on the subject by Dr. Hamilton, A.M.D., I think it expedient to say now that the difficulties so well described by Dr. Hamilton induced me, some time ago, to suggest the construction of an instrument that should obviate them, and I am very glad to find that an officer of such large experience should, quite independently, have arrived at the same conclusions as myself.

Yours truly,

24th Oct., 1879.

J. FAYRER.

PLEURAL AND DIAPHRAGMATIC TENSION.

To the Editor of THE LANCET.

SIR,—I think Mr. McLaurin (page 631) has missed the whole point of my argument. Even children are taught that atmospheric pressure alone enables a heavy weight to be raised by a piece of wet leather tightly pressed thereon; so, I argued, the opposing surfaces of the pleuræ could not separate so long as the pleural cavity was left intact; let this, however, be opened, as in the case alluded to, then the lungs must contract, and the vacant space be filled. That the contracting lungs should attract the intestines is a novel idea!

Sir W. Jenner, as the champion of the expiratory theory of pulmonary emphysema, can be safely left to defend this theory against all objectors. Certainly, at present, none have *proved* him wrong.

Mr. McLaurin must surely have forgotten that pneumothorax could not follow rupture of any pulmonary vesicles, unless their pleural covering was destroyed; as well, also, as the fact that communications exist in the mediastinal spaces, by means of which air from ruptured vesicles may pass into the cellular tissue of the neck, and thence into other parts.

Obediently yours,

RICHARD NEALE, M.D. Lond.

Boundary-road, St. John's-wood, N.W., Oct. 28th, 1879.

SEQUEL TO "CASE OF DISEASE OF THE AORTIC VALVES PRESENTING SOMEWHAT UNUSUAL SIGNS."

To the Editor of THE LANCET.

SIR,—The patient, R. D—, whose case was recorded in the columns of THE LANCET of October 25th, was re-admitted into the Newcastle Infirmary on October 23rd, complaining of great difficulty in breathing, pain in the chest, cough, hæmoptysis, and œdema of the legs. He rapidly got worse and died, evidently from *failure of compensation*, on the 26th of October.

The autopsy revealed, on raising the sternum, an enormous heart occupying anteriorly the greater part of the left chest, the anterior border of the lungs being widely separated by the colossal ventricles. As the organ lay *in situ* it measured transversely at the widest part nearly 17 centimetres ($6\frac{1}{2}$ in.), and from the base to the apex 19 centimetres ($7\frac{1}{2}$ in.) It weighed 31 oz. The aortic valves were markedly incompetent, the leakage occurring principally through a hole (through which a crowquill could be passed) in the extreme posterior part of the right posterior semicircular flap, just in the angle between the free border and the attachment to the wall of the artery. Running up from the united attachments of the right posterior with the left posterior and the anterior segments, closely adhering to the wall of the artery, were two small masses (vegetations) about a centimetre in length, and standing rather prominent into the vessel. The aorta was otherwise healthy. The remaining valves of the heart were normal. The left ventricle was considerably hypertrophied (so-called *excentric*), the walls being $2\frac{1}{2}$ centimetres thick. The middle lobe of the right lung was in a state of extreme engorgement amounting almost to pulmonary apoplexy, the tissue breaking down like currant jelly. The liver was nutmeggy; the brain and kidneys were markedly congested. The cæcum was found to be closely and strongly adherent to the iliac fascia and neighbouring muscles, the usual loose areolar tissue being augmented by firm bands which pressed somewhat on the external iliac artery.

From the above account of the post-mortem appearances, it will be seen that every feature in this somewhat unusual