A CASE OF ABSCESS OF THE LUNG CURED
BY INCISION AND DRAINAGE.

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THE difficulties which may be experienced in locating an abscess deeply placed within the chest, and the comparative rarity of complete success in the treatment of this condition, seem to us sufficient reasons for placing the following case on record.

W. S., aged 36, previously strong and healthy, was taken ill in July, 1907. He was engaged on night duty in a brewery, and besides having very hard work was exposed to sudden changes of temperature. There was no evidence of excessive indulgence in alcohol. His illness commenced gradually with cough and weakness. Afterwards he had several shivering attacks, with pain in the back, shortness of breath, and cough. He was now attended by Dr. Hill of Old Basford, who informs us he detected signs of pleuro-pneumonia, followed by effusion into the left pleura. This disappeared, but, after the patient had been laid up seven weeks, he began to expectorate large quantities of pinkish tenacious sputum, which afterwards assumed the appearance of ordinary pus. Notwithstanding this, he attempted to get about, but suffered from pain, with swelling of the legs and feet, also from cough and shortness of breath.

He was admitted into the Nottingham General Hospital on September 18th, having been ill over two months. He was pale and wasted; mucous membranes of good colour. Weight 8 st., which speedily declined to 7 st. 11 lb., at which it remained with slight variations until December 14th. Pulse 124, regular, low tension. Respirations 28. The temperature was hectic, ranging from 98° to 101° or 102°. The sputum continued copious until the date of the operation (December 14th), consisting of inodorous, thin, frothy pus, the quantity varying from 4 to 18 oz. An examination for tubercle bacilli was negative. The patient always expressed himself as feeling comfortable, but was obliged to lie in a very constrained position—namely, on the right side, with the head near the edge of the bed. Doubtless this facilitated drainage of the cavity, since any attempt to lie on the back or left side caused uncontrollable cough.

Physical Signs.

Heart: The apex beat could not be seen or felt. The sounds were normal, and the organ was not displaced. *Lungs (left side):* Movement impaired; deficient resonance over the whole of the left lung, most marked at the lower part of the axilla, and near the angle of the scapula. Breath sounds everywhere weak, especially below the angle of the scapula, although vocal resonance was present in this position. At the apex; below the nipple; and near the angle of the scapula, the breath sounds were distant and bronchial. There were scattered, small crepitations all over the left side, which were of somewhat amphoric quality, though distant, at the lower anterior region. *Right Lung:* Slight dullness over the apex, and a few crepitations, these signs not being nearly so marked as at the corresponding region on the left side. [It was thought at one time that general pyogenic infection of both lungs had occurred, but the subsequent progress of the case makes it probable that the signs in the right side were caused by pus conveyed from the left side, partly in consequence of the peculiar decubitus adopted, and partly by aspiration.]

An exploring needle was inserted into the dull area near the left base, soon after the man's admission, with negative result. No further attempt to reach the pus was made for three months. In the meantime the patient was treated by tonics, sedatives, and antiseptics, both by ingestion and inhalation. From these he derived no benefit, and was obviously getting worse when, on December 10th, the exploring needle was again used, and a syringeful of pus obtained.

Operation.

On December 14th the patient was placed under the influence of chloroform, and after several fruitless attempts pus was again found by the needle, inserted deeply a little below the angle of the left scapula. After making a free skin incision in this region, a piece of the eighth rib was excised. The pleural cavity was found to be obliterated, and the finger came upon indurated lung covered by thickened pleura. Renewed difficulty now arose in finding the pus, as the needle had been removed during the resection of the rib. After searching in various directions it was suggested that the needle should be passed downwards and forwards, and this resulted in success just when we had almost decided to give up the attempt, pus being found at a depth of 2½ in. from the surface. A pair of dressing forceps was now passed along the track of the needle, and the blades separated with the utmost difficulty, owing to the toughness of the lung tissue. The track thus formed was enlarged by using the rib forceps in the same manner, it being thought unsafe to use a

knife under the circumstances. Pus now welled up from the bottom of the wound. The above manipulations excited a violent fit of coughing, and, if any proof were needed that we were really working in the lung, this was afforded by the expectoration of blood, mixed with pus, and by the free passage of air through the wound. The tip of the forefinger inserted into the wound just entered a small cavity, probably communicating with a larger one, for on turning the patient on to his back about half a pint of blood-stained pus escaped. A rubber tube, of ½ in. bore and long enough to reach the bottom of the wound, was inserted, and a wool-wool dressing applied.

The after-history of the patient was very satisfactory. On the afternoon of the operation day he felt comfortable, and had coughed up traces of blood in the sputum. During the next few days the expectoration rapidly diminished to an ounce or two, and the pulmonary fistula gradually closed, although the to and fro passage of air during respiration was very free at first. The wound healed rapidly. On January 5th, 1908, gauze packing was substituted for the tube, and by the 20th healing was completed by the formation of a sound scar, parallel with the ribs, about 2½ in. long. By this date also cough and expectoration had quite ceased. Resonance was good over both lungs, except at the base of the left lung behind and in the lower part of the axilla. In the same regions the breath sounds were feeble and accompanied by fine dry pleural crepitations. Over the rest of both lungs the breath sounds were normal, and the movement good. The man's aspect and physique had greatly altered for the better. He was discharged quite well on January 25th, 1908, and sent to a convalescent home, his weight being 9 st. 5½ lb., having put on 22½ lb. since December 14th. When seen on February 19th, the patient expressed himself as feeling very well, having gained a further 10 lb.

The opinion is very generally held that uncomplicated crepus pneumonia occasionally ends in abscess of the lung. It is probable, however, that this is a rarer occurrence than is commonly supposed. This is the opinion of Dr. Pye-Smith, and also of the great Laënnec, whom he quotes as follows: "Il n'a pas de lésion organique plus rare qu'une véritable collection de pus dans le tissu pulmonaire." Although this patient presented the signs of abscess of the lung when he came under our notice, it does not follow that the cavity was formed by the actual solution of hepatized lung. While this may be, not improbably, the partial explanation, there may also have been a localized empyema, which by discharging through the lung may have increased the amount of purulent discharge. The pus was not fetid, hence there is no reason to suspect gangrene of the lung or bronchiectasis. The daily amount of pus expectorated (10 ounces or more) left little doubt in our minds that it came from a cavity of considerable size. Yet signs of cavity were for the most part wanting. Instead of loud gurgling and amphoric sounds, as might have been expected, we could only find distant crepitations, and weak tubular breathing. The fibroid thickening of the tissues and the depth of the abscess doubtless accounted for the obscurity of the signs.

We would draw attention to the inability of the abscess to heal, notwithstanding free exit to the pus by expectoration, and to the rapidity of healing after drainage through a dependent opening. The sound cicatrization of the tissues and closing of the bronchial fistula are also worthy of note. A fistula in such circumstances is apt to remain permanent—especially in tuberculous and bronchiectatic cases.²

REFERENCES.

¹ Allbutt's System, vol. v, p. 112. ² West, Diseases of the Organs of Respiration, p. 645.

A CASE OF PHLEGMONOUS GASTRITIS.

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PHLEGMONOUS gastritis is happily one of the rarer diseases affecting the stomach; its exact diagnosis is difficult and its prognosis grave. In recording this case we add one to the list of published cases in which a short history of symptoms is followed by an account of the *post mortem* findings.

There are two features of this case to which we would call attention, first, that the probable source of infection was the mouth, and that it followed the extraction of many teeth; secondly, the presence of an erythematous