In the posterior part of the left thorax below the scapula, there would not exceeding three-quarters of an inch. Some bloody

The post mortem examination, by order of the coroner, revealed a profuse effusion of blood into the pleura from the

The wound was not necessarily fatal, bad surgery, and gross carelessness of management, had produced the death of the patient.

Mrs. M. Zimmerman was, in 1849, stabbed by her husband with a shoemaker’s knife, into the left thorax under the scapula, between the seventh and eighth rib. The wound, of two inches immediately closed by a practitioner in attendance, Internal bleeding followed with oliguria, delirium, fever, and pleurisy, terminating in death on the fifth day. I did not see the patient while living, but made the post mortem examination, when the broken point of the knife, one inch and a-half in length and half an inch in breadth, was found lying in the wound, and, between the ribs, its point irradiating the surface of the lung. The pleural sac contained a large amount of effused blood from the wounded intercostal artery. Can it be denied that the neglect of probing the wound, and the hasty closing of it, was the immediate cause of this lady’s death?

August Lansler, aged 30 years, was, in 1858, stabbed with a broad-bladed knife between the fourth and fifth rib of the right side, posterior to the nipple. The wound was six and a-half inches in length, profuse bleeding ensued, the patient becoming anemic, and pulse flagging. A physician called in closed the wound by nature; the respiration now became oppressed. I found entire absence of inspiratory murmur over right chest, and, removing the stitches, opened up the wound, inclining the patient to the injured side; thus allowing the effused blood to flow out, with decided relief. Ice, with position on the right side, arrested the bleeding: active antiphlogistic treatment, with repeated leeching, moderated the inflammatory action and removed the effused blood. Eventually, his recovery was complete. The immediate relief which the reopening of the wound, the evacuation of some of the effused blood, with position of the body on the wounded side, produced, can the old practice of early closing the wound, with the idea of preventing the entrance of atmospheric air, be any longer sanctioned?

I need not adduce further proof of the success of a practice in opposition to one, which, though old and venerable, must nevertheless yield to the test of scrutiny and observation. I submit these remarks on the insensuousness of atmospheric air entering the pleura as well as the other serous membranes, to the professional reader, fully convinced that pure air—our most important of the medullary—I is not only not the enemy of the surgeon, but rather his friend and helper. Air does not compress the lung nor inflame the pleura when admitted to its cavity; it does no injury to pleura or lung than it does if admitted to the interior of large abscesses when open. It is true, that large collections of matter, the consequence of deep-seated organic disease, when freely opened, will hasten the dissolution of the patient, as in abscesses and some others. These instances are not the admittance or admixture of air in these cavities which, by changing the quality of the pus, or increasing its quantity, destroys the patient, but the exposing a large secreting surface of pseudoplasma, from which wax, pus, and exudate are secreted, the resulting evacuation of the cavity, contained matter, being freed of the pressure and support of the superincumbent pus, are excited to action, and pour out the secrections increased in quantity and altered quality, on the immediate surface of the neck of the abscess, on the skin, and as with exuberant granulations, will secrete unhealthy matter profuse until supporting dressings close the mouth of the secretion, and arrest the growth of the granulations, and thus convert it into a healthy sore, ready and able to exude slowly. Air does not vitiate the matter in large abscesses;