In the morning a drop and a half of croton oil was given, but it did not act. A consultation was held at four o'clock in the afternoon, when it was decided to operate. The slow pulse and coma pointed to compression. This might be due to meningitis, hemorrhage and clot, or to localized inflammation of the brain substance and consequent abscess. It was also thought possible that a neoplasm might be present with a surrounding cerebritis.

The length of time (two weeks) which existed since the injury would preclude fresh hemorrhage. If a clot had occurred at that time it would have undergone decomposition, resulting also in abscess.

As the spasm or irritation symptoms were found on the left side, and the history pointed to injury on the right side of the head, it was resolved to trephine on the right side, convenient to the leg and arm centre.

In that situation the brain was found healthy, and although the hypodermic needle was inserted into the brain substance in different directions, no pus was found.

An opening was then made on the left side over the arm centre. In this situation there were evidences of inflammation. The dura mater bulged out through the opening, and upon cutting into it inflammatory lymph was seen and small black clots were discovered on the pia mater. Gas was also seen to escape in little bubbles. It was then thought that we must be in the immediate vicinity of the abscess. The hypodermic needle was introduced and no pus found.

An enlargement of the opening was then made posteriorly, on the supposition that the abscess might be in the post cerebral lobe, but without result. The patient did not appear to suffer from shock, but gradually sank and died at 7 a.m. the following morning. No anæsthetic was given during the operation. He moved his left arm and leg when the scalp wound was made. His pulse remained between 70 and 80 during the operation.

Post mortem examination made three hours after death. His head only was examined. Upon removal of the calvarium and membranes an irregular, dirty, dark-colored patch about an inch square was seen on the upper surface of the left frontal lobe, close to the longitudinal sinus. Upon cutting into the brain, this patch was found to be situated over an abscess, which was as large as a horse chestnut, and contained greenish-yellow pus which emitted a very offensive odor. It was situated over the anterior corner of the lateral ventricle, but did not open into it. A small amount of fluid was found in the ventricle. The choroid plexus was much congested upon the left side, and the cerebral convolutions were flattened. The abscess walls were quite thin. Nothing abnormal was found on the right side of the cerebrum.

In all probability in this case the abscess was the direct result of the blow, which must have been severe enough to produce a slight rupture of brain substance in a part of the cerebrum a little distance from the point of infringement. The question naturally arises, might not an abscess have existed previous to the accident? This is, I think, excluded on two grounds: (1) the walls were exceedingly thin, and (2) the patient appeared to have been in excellent health up to the time of injury. According to Fagge, four weeks is the time for a capsule to form in a case of abscess, as shown by the history of a number of recorded cases in which suppuration followed an accident.

Dr. Gull cites a case in which the absence of a limiting membrane was given as proof that the abscess did not arise from an injury received eighteen months previously. In another case the presence of a membrane was taken as proof that the abscess did not arise from pyæmia, the result of small-pox, from which the patient suffered within three or four weeks of his death.

These facts are important in a medico-legal sense, and would appear to prove that in the case related we had to deal with a recent lesion. Moreover, it is stated that in recent abscess the pus is green, viscid, and of acid reaction. In old abscesses pus is bright green and alkaline. No test was applied in our case.

Some years ago Dr. Temple presented before this Society the history of a case of cerebral abscess which I had the privilege of observing with him. In that case the acute symptoms, severe headache followed by coma, were not of more than two or three weeks' duration. There was, however, a previous history of the patient's having had epileptic convulsions, and he had