

an intervening layer of brain substance between; although a communication may sometimes exist between the collection of matter and the surface. Bergmann says, "so far as we know, there is no such thing as idiopathic abscess of the brain." In other words these collections of matter are secondary, depending upon septic inflammation near or distant. The most usual situations for the abscess are the cerebrum and the cerebellum, seldom in the central ganglia the pons, medulla or middle lobe of the cerebellum.

Mr. Barker says that more than 30 per cent. of cases of cerebral abscesses arise from ear disease. Dr. Gowers gives a percentage of 42.5 in 241 cases. Mr. Thomas Barr of Glasgow says "we are justified in attributing fully one-half of the cases of abscess in the brain to purulent disease in the ear. Dr. Keene of Philadelphia, I observe, gives the percentage as one-half. The intracranial complications of septic inflammation of the ear, whether bony or otherwise, are purulent meningitis, cerebral abscess, phlebitic thrombosis, and pyaemia. The two former are the most common and the least rapidly recognized. The majority of the purulent deposits in the brain from ear disease are found in the temporo-sphenoidal lobe, and the next most frequent site is the cerebellum. Mr. Barker says "cerebral abscess is three times more frequent than cerebellar." Mr. Barr in 76 cases gives 55 in the cerebrum, 13 in the cerebellum, 4 in the cerebrum and cerebellum, 2 in the pons and one in the crus cerebelli. Bergmann quotes Körner who gives a tabulant resume of 67 cases due to otitis. Thirteen of these were associated with thrombosis of the lateral sinus, 31 were

situated in the cerebrum, 19 in the cerebellum, and 4 in both the cerebrum and cerebellum. Another fact brought out by him is the greater frequency of abscess of the brain on the right side as compared with the left, which, he says, is true of all intra-cranial affections arising from diseases of the middle ear and caries of the mastoid.

The temporo-sphenoidal lobe and the cerebellum can better admit surgical interference than almost any other portions of the brain, and are of less value to life. Yet they afford the fewest and most unreliable symptoms for localization: as they are unattended with either motor or sensory paralysis when affected. Not until the abscess has become so large that it presses upon the Rolandic region producing motor paralysis, or until it affects the speech centre, or causes pressure upon the nerves at the base of the brain, are there marked localizing symptoms.

I will now proceed to give the history of a case of abscess in the cerebellum:—
J—F—, admitted to the Victoria General Hospital Nov. 8th, 1890, Labourer. Has never had any previous sickness. Five years ago his ears "began to run." Discharge not constant, sometimes perfectly free from it. Five days ago the left side of his head became tender and painful. His previously defective hearing now almost gone.

Saw the patient on the 8th. Complains of some pain over the whole left side of head. Slept fairly the past night. Quite deaf. Temp. 100. 4. a. m., p. m. 101. Drum membranes gone. Except headache, no other symptom pointing to trouble in head. Slight discharge from ear. Ordered a lotion of morphia and atropine in the ear,