the posterior edge of the membrane and only slight discharge; the hearing was steadily improving.

Deep seated, or internal secondary acute inflammation of the mastoid.

CASE XI.—W. T., æt. 4, a sickly infant, admitted into the Hospital in July, 1879.

Previous history not obtained. On admission, left ear discharging an abundance of fœtid pus, nearly complete paralysis of the left facial nerve; meatus narrow from swelling, granulations growing from its deeper parts. A probe detected necrosed bone in tympanum, which, however, was not loosened sufficiently to attempt its removal. The treatment consisted in thorough and frequent cleansing of the ear, with attention to the general health.

During the ensuing winter had two attacks of swelling behind and above the ear. The second only yielded after a free incision had evacuated a large quantity of pus.

Shortly afterwards some fragments of bone presented in the meatus, and were removed with fine forceps. One of these, about three lines in length, proved to be half of the margin of the fenestra ovalis. The otorrhœa continues, though not anything like so freely as before. There is a fistulous opening, above and behind the meatus, leading to the carious bone, for the removal of which some operative procedure will probably be necessary. The child is too young to test the hearing power, but there can be little doubt it is utterly destroyed. The other ear, though discharging occasionally, is not much impaired in function.

CASE XII.—A girl about 9 years of age, presenting the usual signs of mastoid periostitis after acute suppuration of the middle-ear, was relieved for a short time by an early incision. This procedure had to be repeated before a permanent cure was effected. There was no caries or necrosis, a circumstance doubtless due to timely and efficient surgical interference.

CASE XIII.—A child four years of age, of French-Canadian parentage. Was brought to the Hospital in a