Both Jansen and Richards lay special stress on this point. Proceed to the cochlea by way of the promontory.

*Vestibulotomy.*—The vestibule may be opened by way of the external semicircular canal, and above and behind the facial nerve. This method is called superior vestibulotomy. Or it may be opened by way of the foramen ovale, which is below and in front of the facial nerve. This method is called inferior vestibulotomy. Although inferior vestibulotomy has the best position for drainage, yet superior vestibulotomy is the preferable operation, for the following reasons:

1. The region is more accessible.
2. There is less hemorrhage.
3. You obtain a better view into the vestibule.
4. You can explore the external semicircular canal at the same time.

Between these two openings into the vestibule is a ridge of bone, and in it is the facial nerve. Milligan has called this the bridge operation. The two operations should practically always be done together. The operation then is called double vestibulotomy. It is better not to expose the facial nerve, for in the after-treatment it is likely to become injured by the discharge from the granulations. Facial paralysis usually occurs if it is exposed. This may clear up in time, provided the nerve does not become disintegrated.

*Sequestrotomy.*—This was the first described operation on the labyrinth. Facial paralysis was the usual result. This was due either to disease or to the destruction done by removing the sequestrum. Suspect a sequestrum where granulations persistently re-form. Never remove a sequestrum forcibly. If necessary, chisel away healthy bone, so that the sequestrum may be picked out of its bed.

*Extirpation of Labyrinth.*—When this operation is done, it is usually for tuberculous conditions.

*Indications for Operation:*—

1. Labyrinthitis, as evidenced by one or more fistulous openings or other signs of disease in the external wall of the labyrinth.

2. Luxation of stapes. Jansen recommends operation after 24 hours if there is nystagmus, disturbances of equilibrium increasing, tongue coated and temperature going up.

3. Ménière's disease—labyrinthine apoplexy. Patients suffer with marked vertigo, intense nausea, severe tinnitis and absolute deafness. Richard Lake has reported five cases where he has