of bed, etc.; optic neuritis began to develop, and the pulse became slow and at times irregular. On the 30th of September (three weeks after the first opening of the cranial cavity) the wound was reopened. Through the trephine opening a livid fluctuating mass protruded, which did not pulsate. I opened it and evacuated a couple of drachms of pus. After using an exploring needle I opened higher up, and evacuated about an ounce of pus. Passing my finger into the cavity I found it to contain a considerable mass of sloughy tissue. It was carefully washed out with saline solution, and a glass drain inserted. The cavity was in the temporo-sphenoidal lobe, which was now a mere abscess wall. Chloroform was given at first in this operation but was abandoned for ether before the operation began, as it was not well taken. From the date of this operation there has not been a bad symptom. The patient speedily recovered, until he is now quite well, and his optic neuritis has almost disappeared.

Dr. G. E. ARMSTRONG congratulated Dr. Bell on the success of his case. This was a new field in surgery that had recently been opened up, and enabled us to treat cases which in the past had too often proved fatal No class of brain surgery was more promising than the treatment of abscess from fracture of the base of the skull, or from middle-ear disease, if the pus could be got at and cleaned away. Where there was headache and other symptoms of meningeal irritation, he suggested that before an osteoplastic flap was made, in the absence of localizing symptoms, when the tympanum and antrum were thoroughly cleaned, a strong light should be thrown into the attic. Probably a few drops of pus or a few granulations might give a lead that could be followed with a fine probe, and thus the abscess could be located in the temporo-sphenoidal lobe or often in the cerebellum. In this way the exact position might be more easily detected. He asked Dr. Bell if there was anything in the sigmoid sinus. These cases brought up another question which had been raised by Mr. Victor Horsley as to how soon cases of middle ear disease should be interfered with by trephining the mastoid, There had been many cases of middle-ear disease in which suddenly acute septic, cerebral, or pulmonary troubles ending fatally had occurred. Many of the insurance companies would not accept a person with chronic discharge from the ear. Mr. Macewen answered the question by suggesting the limit of one year, at the end of which the mastoid antrum should be trephined, the tympanum thoroughly cleaned out, and all allowed to heal. The operation was without danger and could be easily performed. The great objection raised was that there might be loss of hearing. While in some cases here was no change, and others were made worse, there were many in which the hearing was distinctly improved.