

by the presence of several of these important symptoms. If compression exists the unconsciousness is more complete, the patient lies in any position placed and does not move unless a restless change of position of a leg or arm. He will not respond to questioning, does not talk. While in fracture without compression the patient, after shock has passed off, frequently talks incessantly, a senseless meaningless talk, and frequently moves and claws about the bed, and against any object within reach. In compression the pupils are usually dilated and do not respond to light, the pulse is slow, full and irregular with breathing slow and stertorous, but the symptoms which readily diagnosticate the condition are those of paralysis. The bladder and bowels are usually paralyzed and hemiplegia is common. The significance of localized paralysis is of great value in the diagnosis of the location of the lesion.

The treatment of fracture at the base may be simplified by remembering that a compound fracture exists, exposing a structure as sensitive as the peritoneum to the invasion of bacteria and that a toilet requiring even more attention than a laparotomy must be made if we expect to save our patient. The ear must be mechanically cleansed of blood and dirt and then disinfected by a stream of 1-1000 bichloride, then packed with sterile gauze and bandaged. At the same time as thorough disinfection as possible of the nose and throat will be obtained by thoroughly cleansing with sterile water followed by douching with a solution of Seiler's tablets in sterile water, and repeating the process daily. When compression exists, trephining under strict antiseptic precautions and elevation of the depressed bone will demand immediate attention. The field of cerebral localization is too exhaustive to admit of discussion in this article.

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