of the muscles of the back of the neck, and slight delirium. Five days later inequality of the movements of the lower portion of the face was noted. There was slight paresis of the lower left face. On the 8th of September I decided to operate next day. There was then, in addition to the symptoms already given, a low pulse (45 to 55), but no localizing symptom and no optic neuritis. I therefore decided to expose the brain by the removal of an osteoplastic flap, which would give access to both middle and posterior fossæ of the skull. Next morning, however, there was distinct paralysis of certain groups of muscles of the left arm, especially the extensors of the wrist. As it was then quite clear that the lesion was an ascending one involving the motor area, and from the history and symptoms almost certainly a subdural abscess, I simply exposed the skull by extending the original incision in the soft parts, and made a half inch trephine opening at a point one inch above the posterior root of the zygoma, and in a line with the posterior osseous wall of the meatus. In marking the point for the trephine pin with a drill, although prepared for a thin skull, and exercising the utmost caution, the drill went through the skull and wounded the posterior branch of the middle meningeal artery, which bled very freely. When the button of bone was removed with the trephine I cut away further forwards with rongeur forceps, attempting to expose the artery in order to ligate it. I was unsuccessful and was finally obliged to clamp it with the bone in a pair of Pean forceps, which were left *in situ* for several days. The dura mater bulged but did not pulsate, and on incising it a couple of drachms of fœtid pus escaped from above, and on pressing up the base of the brain about half an ounce more escaped from below with shreds of sloughy tissue. The brain surface was covered with lymph, and neither sulci nor convolutions could be identified. The wound in the mastoid antrum was made to communicate with the base of the skull, and the lower border of the trephine opening was cut away with rongeur forceps down to the level of the base of the middle fossa. A drainage tube was inserted along the base of the skull and brought out through the wound. Chloroform was the anæsthetic used and the operation was well borne. After the operation the temperature fell to the normal, the pulse rose to 80–90, and by next day the paralysis was noticeably less; in forty-eight hours it was almost gone and in another forty-eight hours it was completely gone. All his symptoms improved, and he seemed to be on the way to recovery. On the fifth day after operation he became alternately drowsy and irritable. Later, he became sullen and morose and difficult to manage, complained of severe frontal headache, tore off his dressings, insisted on getting out