felt over the same area. Pupils natural, great congestion of left eyelid. No subconjunctival hæmorrhage. Pulse slow, 56.

March 7. 6.30 p.m. Still unconscious, quiet. Given ether. Incision enlarged and deepened, etc.

March 8. Somewhat recovered consciousness. Asks for food, but gives many names. Dressed, outside dressing only.

March 9. Conscious at times; irritable, and answers foolishly. Sometimes passes urine and fæces into bed, and at other times calls for receptacle.

March 12. Dressed. Catgut drain slipped out owing to sudden movement on part of patient. Is irritable and requires holding during dressing, otherwise is fairly conscious, but cannot give his name.

March 14. In same stupid condition. Continually poking finger in under his left eye.

March 17. Temperature rose suddenly last night to 101⅓°, this a.m. 101. Patient wholly unconscious. Both eyelids red, glistening, and œdematous. Dressed. Œdema of scalp and forehead to the right of wound, none on the left. Irrigated and catgut drain reinserted.

March 18. Temperature remains up and œdema still present. Dressed. Fluctuating surface over area to right of wound; opened, evacuating a large amount of pus, leaving bare bone and showing another fissure running longitudinally. No communication between the two wounds except by probe. Drainage tubes inserted in all.

March 20. Temperature lower. Patient again somewhat conscious.

March 21. Oozing; dressed; clearing up; wholly conscious.

March 25. Temperature normal since 22nd. Dressed.

March 27. Up and walking about.

March 31. Dressed.

Dr. Armstrong described his operation as follows: He elevated the bone, and after washing out the wound found no evidence of injury beneath the membranes. The bone was then replaced in small pieces. This was done on the 7th; for nine days afterwards the temperature remained normal, but the patient was unconscious for most of the time. When the unconsciousness passed off, delirium set in; he disturbed the dressings, fingered the wound and, he thought, inoculated it. The temperature then began to rise and went up to 102.4°. Although carefully redressed, the mischief seemed to have been done, as an abscess developed over the external angular process. In the subsequent manipulations entailed by these complications another fissure fracture was discovered.

Dr. Armstrong thought the interest of the case was chiefly in connection with the man's future, and what after trouble of a cerebral nature was in store for him. He asked for an expression of opinion about opening the membranes in these cases. He had here a man decidedly unconscious; there might have been laceration of the brain, but the membranes were intact and normal and pulsation beneath was distinct, and he did not think it wise to open them in the presence of a possibly septic wound.

Dr. JAMES BELL regretted not having heard the report of the first case. In the second case he was not quite clear as to Dr. Armstrong's description; he would like to know if portions of the bone were removed and afterwards replaced in small fragments, and which, in spite of the septic condition present, retained their vitality, and developed. With regard to the point Dr. Armstrong wished discussed, he thought it was very hard to lay down any rule in such cases; it was a question to be decided upon at the moment, and under the circumstances he felt that he should have acted as Dr. Armstrong had done. There being no localizing symptoms within the membranes pointing to any particular area, and considering the danger of introducing sepsis, he could not see that any other course lay open to the careful surgeon.

Dr. ARMSTRONG, in answer to Dr. Bell's question regarding the replacing of the pieces of bone, after mentioning the dimensions of the whole area of removed bone, said that several small pieces not more than half an inch square were replaced, and as he had seen nothing of them since, he presumed they were still in the wound. The wound, however, he did not believe was infected until later, which might remove that obstacle to union taking place. At any rate, the fragments were there as far as one could feel, and appeared to be good firm bone.

Seborrhœa.—Dr. J. M. JACK read a paper on this subject.

Dr. SHEPHERD said that he must acknowledge himself disappointed with the paper; he expected something more modern. This was seborrhœa and its treatment of twenty years ago which Dr. Jack had given. The latter had said nothing of the micro-organisms which caused the disease, nor of seborrhœa congestiva, nor of Unna's theories with regard to the sudoriparous glands, all of which he had been in hopes of hearing and getting fresh light upon. The most important thing for the general practitioner to remember was that seborrhœa was apt to run into eczema, and it was sometimes hard to draw the line between the two conditions. With regard to the general treatment, it was not hard to treat, the diagnosis being once made. In the first place, seborrhœa ought never to be diagnosed from the scalp eruption alone, the body ought also to be stripped and examined, and often what first appeared a seborrhœa would turn out to be a psoriasis. As to