towards the mastoid antrum. Above the posterior wall of the canal is cut through by carrying the gouge or chisel directly inward on a plane slightly above the superior wall of the bony canal. As the wound is deepened above along the plane of the upper meatal wall, that portion of the external wall of the attic formed by the junction of the posterior and superior walls of the meatus, will come into view. This bony segment should next be removed by the gouge, the instrument being directed upward and inward so as to remove this portion of the outer wall of the tympanic vault. In this way the aditus ad-antrum is exposed and forming its floor, will be seen the prominence of the horizontal semi-circular canal, and closely amalgamated with this, the adeductus Fallopii lodging the Facial nerve. The position of this bony ridge varies considerably in different subjects, sometimes lying very high up, and sometimes much lower down, so it is well to proceed very carefully in the removal of the posterior wall of the meatus, until the aditus has been entered and these important land-marks seen. The remainder of the enternal wall of the tympanic vault should then be removed, that is the entire inner extremity of the upper wall of the bony canal should be chiseled away, leaving only the thin internal table forming the tympanic roof and separating the middle ear from the middle cranial fossa. In this way the tympanic cavity, antrum and external canal have been merged into one cavity. The remnants of the two larger ossicula can now be easily seen and extracted. If we now dry the field of operation we can make out the head of the stapes if this has not been destroyed by caries, and can also see the niche of the round window. To see these land-marks perfectly, a thin scale of bone must be removed from the posterior wall of the canal lying just below the prominence of the Fallopian aqueduct. This procedure must be done with every care, as a little too much and the facial nerve is injured. It is necessary in these cases to remove all diseased bone. But it is not necessary, however, to completely obliterate the entire pneumatic structure of the mastoid.

After the bony cavity has been thoroughly curetted, and the operator has assured himself that no diseased bone remains either in the middle ear or in the mastoid cells which have been