semi-comatose condition, could be aroused when spoken to loudly, and gave us his name and address. The extremities were not paralyzed, but there was present a certain amount of rigidity, the right side being more affected than the left. No ankle or rectus clonus was present. Plantar flexion was present. Knee joints were normal. Pupils were equal, and reacted to light and accommodation. Pulse at entrance 60, an hour afterwards 45, and at the time of examination 65, full and regular. Blood pressure 175, bladder empty. Patient lay on his back. On admittance he had a hæmorrhage from the nose and vomited blood. No discharge from the ears. Dr. Armstrong diagnosed the case as a probable fracture of the anterior fossa of the cranium. On applying a cloth saturated with ammonia to the patient's nose, sense of smell was seen to be present. On pricking any part of his body with a pin, he resisted and moved about saying, "Leave me alone." Dr. Armstrong said that from his experience in cases where coma became deeper after the patient's entrance to the hospital, a grave prognosis was probable. He wished to have our opinion whether it was wise to carry out a trephine operation and ligature of the middle meningeal artery. With Drs. Blackader and Lafleur, I was of the opinion that, as there were no definite clinical signs pointing to the need of this, it would be advisable to delay for a short time. I suggested that there was a point which might aid us in arriving at a diagnosis, namely, that a lumbar puncture be made to ascertain if blood was present in the cerebral spinal fluid. This was done, and the serum was drawn off into three different test tubes. Blood of a bright red colour was present in equal proportions in each of the tubes. This at once proved that some cortical laceration was present. If the middle meningeal, which is sub-dural, was alone involved, the blood would not likely be present in the cerebral spinal fluid.

Half an hour afterwards, while Dr. Armstrong was showing me a case on the opposite side of the ward, we were hurridly called across by the nurse to see our patient in convulsions. It was a condition of bilateral epilepsy. Tonic and clonic spasms, well marked with retraction of the head and eyes to the left side and pupils markedly dilated. Ten minutes after this fit, a well marked external squint was seen in the right eye, this probably being due to the irritation of the cortcial sixth nerve.

The above symptoms pointed to the need of immediate operative procedure. The patient was taken upstairs and put under chloroform. He had four attacks between the first fit and the time of reaching the operating table. After he had been prepared for operation, a large wound was found penetrating down to the pericranium, starting about one and a half inch above the inner canthus of the eye, and three-