in the substance of the temporo sphenoidal lobe for about one inch. On withdrawing the trocar greenish pus exuded, and on enlarging the aperture with a director about half an ounce of very fetid pus escaped, mingled with broken down cerebral debris. A tube was gently inserted into the abscess cavity, which was washed out with warm antiseptic lotions. The flap was replaced and carefully sutured, the tube being brought out through an aperture in its base, and the parts dressed antiseptically. The stertor was somewhat lessened by the operation, and slight movements of the limbs were afterwards noticed; but it may be generally said that no marked improvement resulted. The woman died at 2 A.M. on the following day. A post-mortem examination was refused.

Notwithstanding the unsatisfactory termination of this case, I have thought right to record it. In such an important surgical proceeding as trephining for cerebral abscess, it is meet and right that all cases should be related. In the absence of a post-mortem examination, we can only conjecture the cause of the failure of the operation. Meningitis, encephalitis, or the bursting of the abscess into the ventricular cavities, are possible and probable explanations. The operation was, in fact, undertaken too late, the general paralysis indicating a condition that is too rarely relieved by the trephine in cases of pressure by pus or blood.

Mr. Barker, in a paper on the subject of Ear Disease and its Cerebral Complications, alludes to the comparative frequency of temporo-sphenoidal abscess, and the tolerance of that region of the brain to surgical interference. Treating of the regions affected, he speaks thus: "Nine-tenths of them (abscesses) will be found to lie within a circle with a radius of three quarters of an inch, whose centre lay one and a quarter inch above, and the same behind the auditory meatus." In the same paper it is pointed out, with truth, that subdural suppuration is often most difficult to certainly differentiate from abscess. But this, too, may be reached and relieved by operating in the same region, which is probably the best situation to choose. It cannot be too strongly impressed upon us all that the symptoms of cerebral abscess may be readily overlooked and misunderstood. It is only by the general symptoms of vomiting, delirium, optic neuritis, and the like that we may suspect abscess in the temporo-sphenoidal lobe; localisation symptoms are quite exceptional. Percussion of the scull might be of some use, and fixed pain, or œdema of the soft parts, are valuable guides when present.

HYOSCIN IN INSANITY.

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It is now some two years since Dr. Mitchell Bruce, in an article in the *Practitioner*, drew attention to the value of hyoscin as a cerebral sedative. That so powerful a remedy has as yet come but little into general use in this country is probably due to the fact that it has constantly been confounded with hyoscyamine—as evidenced by a correspondence in the *Journal* last year—a drug which, though isomeric with both hyoscin and atropine, has quite distinct therapeutic effects from either. Many have abandoned the use of hyoscyamine on account of the dangerous symptoms which have been observed to result from its action, and, being under the erroneous impression that the two drugs were identical, have refrained from the use of hyoscin.

In what follows I shall confine myself to the delineation of the one distinctive action of the drug, which places it in quite a unique position as regards others of a similar class, namely, that of a safe, certain, and rapid cerebral sedative, unattended in the vast majority of instances by any unpleasant results. It is incomparably superior to the older sedatives, such as morphine and chloral, and none of the newer ones, in my opinion, approach it in value as a remedy for controlling paroxysms of furious excitement and turbulent maniacal outbreaks. The following cases will illustrate its action:

Case I.—Male J. R., aged 26; acute mania; excitement day and night for