possible. The child was returned to the ward in excellent condition and left the hospital at the end of the third day.

On account of the inability to resect a portion of the cyst wall, some anxiety was felt in regard to the possibility of a recurrence. A letter from the mother on March 7, 1916, in reply to my inquiry as to the child's condition, is as follows: "There is not a sign of trouble in his throat. He is feeling fine and has been all winter. He has not had a cold, whereas before he had a cold continuously. He plays out of doors all day long. If we ever notice anything wrong we will bring him in to see you at once."

Osborn Building.

A CASE OF EPIDURAL ABSCESS WITH PARALYTIC SYMPTOMS SIMULATING BRAIN ABSCESS AND MENINGITIS. OPERATION AND RECOVERY.

MAJOR J. C. CALHOUN, London, England.

P. W., 20 years of age, admitted into the hospital April 27, 1916.

Complaint. Discharging ear (right) of many years' duration but with no particular symptoms till recently, since when he has complained of severe headache and vertigo.

Examination. *Left ear:* Normal. *Right ear:* Canal almost completely occluded by a large polyp with profuse discharge escaping with difficulty and under pressure; slight tenderness over mastoid.

The polyp was removed by snare to facilitate drainage and patient put on routine treatment. The discharge continued profuse each day.

May 17. Complained of feeling very ill with severe headache; tongue heavily coated; mastoid moderately tender.

May 18, A. M. Headache less severe but vertigo marked; mastoid less tender; discharge less; physiological nystagmus on extreme abduction to left; no stiffness of neck nor retraction of head; no Kernig sign. Examination of chest and abdomen, negative; examination of eye grounds, negative.

May 18, 7:30 P. M. Eyes turned to right, could only abduct to left with difficulty; pupils dilated; neck stiff; suggestion of Kernig;

pulse slow; patient much more comatose. Cerebro-spinal fluid withdrawn under pressure; turbid, no actual organism found.

May 19. Very comatose, head and eyes turned to right, unable to move eyes to left beyond mid-line; imperfect closure of left eyelids; left pupil dilated more than right with sluggish reaction to right; pulse slow, respiration slow and regular. Knee jerks absent, ankle jerks absent; dorsi-flexion of left great toe; no clonus; neck muscles stiff, slight if any retraction. Kernig positive on both sides; abdominal reflexes absent; no rash. *Fundus examination:* Right, normal; left, slight swelling of optic disc and distension of ophthalmic veins.

May 21. Complete paralysis of left arm, slight facial paralysis (corner of mouth drawn to right side and no wrinkling of skin on forehead). No aphasia. A diagnosis was made of temporo-sphenoidal abscess.

May 21. Operation. Radical mastoid done with complete exposure of dura of mid-brain and sinus. Free escape of foul, green pus, pulsating under pressure which came more or less indefinitely from the epidural region over tegmen of antrum and middle ear. The bone comprising the roof of the antrum and middle ear was very much necrosed. Sinus was covered with granulation but appeared healthy. Dura edematous and generally discolored. An exploratory incision into the substance of the brain in the temporo-sphenoidal region did not locate any abscess and as free pus had already been encountered further explorations into brain tissue were not made. Wound packed with iodoform gauze and left open.

May 22. General improvement. Temperature normal; partial recovery of movement of left arm, although no grip or finger movements. Normal plantar reflexes and knee jerks on both sides. Divergence of pupils not so marked.

May 23. Patient rational but cloudy; neck still slightly stiff; facial paralysis markedly improved; able to abduct eyes to left; slight movement of fingers with weak grip.

May 24 and 25. General improvement.

May 27. Grip markedly stronger. General improvement in every way except a continued slow pulse ranging between 48 and 56.

From this date until the present no untoward symptom has arisen.

This case appears interesting because although the pus was epidural and covered a considerable area, the symptoms were so definitely focal of an abscess. It also emphasizes the importance of any acute lighting up of a chronic aural suppuration.

Canadian Expeditionary Force.