that he had suddenly once more become deaf in the left ear. There had then been complete nerve deafness. There was no history of any vestibular disturbance, but there had been some passing tinnitus. The left ear had probably permanently lost its function. He (the speaker) thought the most likely explanation of these cases was that given by Neumann, seventeen years ago, namely, that they were due to a toxic condition, the incidence of the toxin falling on the spiral ganglion, the most vulnerable point in the cochlear apparatus.

Mr. Sydney Scott said that this case reminded him of the nerve deafness associated with mumps. He (the speaker) had never seen a post-mortem examination on one of these cases, but the pathological condition had been described in a neurological journal edited by the late Dr. Alexander Bruce, "petechial hemorrhages" being discovered "in the medulla" in the region of the auditory nerve, in a French soldier who died shortly after an attack of mumps, which had caused sudden absolute deafness.

Sir James Dundas-Grant said that galvanic tests were more satisfactory when not applied to both ears at the same time. Nystagmus might be induced by the tests on the good ear, and this would conflict with the evidence sought from the affected one.

Mr. G. J. Jenkins (President) said the condition in this case might be due to a toxin, but why it should select the auditory rather than the vestibular path he did not know.

A Case of Chronic Middle-ear Suppuration, Labyrinthitis and Meningitis; Operation; Recovery.

By Arthur Cheatle, C.B.E., F.R.C.S.

A girl, aged 14, came to the hospital suffering from a chronic offensive discharge from the right ear with deep-seated pain behind and below it. Fourteen days previously she had had an attack of giddiness and vomiting with frontal headache and greatly increased deafness. Temperature, 103'6° F., pulse 120. The labyrinth was found to be dead. With the tuning-fork on any part of the head the sound was referred to the healthy ear. Rotation to the left gave no nystagmus, to the right ten seconds. There was no Rombergism or spontaneous nystagmus. Slight past-pointing to the left. The fundus was occupied by granulations. There was no mastoid œdema nor swelling. Reflexes normal. Mentally clear. Slight stiffness of the posterior neck muscles. Lumbar puncture: fluid turbid and under pressure. Cells, 100'0 per c.mm.; polymorphs, 26 per cent.; lymphocytes, 22 per cent.; ependyma cells, 3 per cent.; protein, 0'14 per cent.; sugar, 0'0 per cent. Radical operation: cholesteatoma and granulations were found in the antrum and middle ear, and an opening in the external semicircular canal. Superior and inferior vestibulotomy were performed and an opening was made into the internal auditory meatus through the inner vestibular wall. As no flow could be established from the internal auditory meatus, the front of the cerebellum was exposed, the dura incised, and the cisterna pontis opened; turbid cerebro-spinal fluid escaped; a gauze drain was inserted, the drainage being maintained for four days. Slight facial paralysis was noticed the day after operation but it soon disappeared. The temperature gradually came down in about fourteen days. It is interesting to note how quickly the original vestibular disturbance subsided.

A Case of Acute Middle-ear Suppuration, Mastoiditis and Cerebellar Abscess; Operations; Recovery.

By Arthur Cheatle, C.B.E., F.R.C.S.

A boy, aged 18, came to the hospital with left mastoid infection following an acute inflammation of the middle ear. After the mastoid operation the temperature did not settle down and fine nystagmus to the left was noticed. Lumbar puncture: twelve leucocytes per c.mm. A week after the mastoid operation the posterior