to be diseased. With a sharp chisel I removed the upper wall of the osseous auditory meatus, and then, cutting upwards, I chiselled through the root of the zygoma and opened up the cerebral cavity. The dura mater was incised and a Macewen's pus-searcher passed upwards and inwards for about an inch into the temporo-sphenoidal lobe. Here (the usual place) a large abscess cavity was opened and a quantity of offensive pus escaped. The attic and neighbouring mastoid cells were then opened and scraped. The cutaneous auditory meatus was slit open so as easily to admit a finger, and its upper and posterior parts were excised so that a large drainage tube might at some future time be introduced. An india-rubber tube was then passed through the upper wound above the ear into the abscess cavity and the wound plugged with gauze and iodoform. The three following days a fair quantity of pus escaped. Then for three days there was no discharge of pus, and the cerebral symptoms began to return. The tube was removed, and the pus-searcher re-introduced. A large quantity of pus came away. After this the patient made an uninterrupted recovery. He left the hospital on March 22nd, and has since returned to business, and feels perfectly well. The wound was kept plugged from above, and allowed to heal from below by granulation. At first the drainage tube was introduced through the upper wound, but after ten days the ear was drawn up and the tube was passed through the enlarged cutaneous auditory meatus. The abscess cavity was never syringed, but insufflations of boric acid and iodoform were used daily for two months.

The advantages of this method of operating are obvious. In the first place, we get good and efficient drainage from below. The drainage tube can, if necessary, be kept in position for months without any discomfort. It can easily be removed and replaced, and there is no danger of not again finding the abscess cavity. We can also at the same time efficiently treat and cure the attic and mastoid cells, which in these cases are nearly always affected, and thus prevent any recurrence of the disease. Only one incision and only one operation are necessary. The operation and after-treatment are more difficult and tedious than in the ordinary method of trephining, but the results are certainly more satisfactory.

NOTES OF TWO CASES OF DYSTOCIA ARISING FROM RELATIVE SHORTENING OF THE UMBILICAL CORD.

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DYSTOCIA arising from this cause is not a common occurrence, but probably it exists more frequently than is reported. These few facts noted below may be of interest as bearing on the diagnosis and treatment of this and allied conditions.

CASE I.—Mrs. H., aged 24, 2-para, was admitted to the Glasgow Maternity Hospital in February, 1897, with strong labour pains and with the history of being in labour for the previous two days, and of having had an easy first confinement. Abdominal palpation elicited the following facts: The quantity of liquor amnii was excessive, bordering on the condition of hydramnios. The foetal parts were masked and the position could not have been made out but for the violent action of the limbs, which made the diagnosis easy. The head was situated above the brim and balloted freely from side to side. On auscultation the foetal heart sounds were readily heard, but were irregular in rhythm, and especially in intensity. The sounds of the foetal movements were very distinct.

From these observations the conclusion arrived at was that the delay in the fixation of the head was caused by the degree of hydramnios present. The item in the history regarding the length of labour was discounted. Preparations were made to rupture the membranes, coincident with the vaginal examination, should this be thought desirable. The vagina on examination was found blocked by the protruding membranes, and the os was fully dilated. After rupturing the

membranes and pushing the head into the superior strait, the descent of the head was very rapid. The head was soon born, and the cord was found so tightly grasping the child's neck that it was impossible to slip it over the head. By exerting pressure on the fundus the cord was with difficulty slipped over the shoulders, and labour terminated successfully. The length of the cord was $19\frac{1}{2}$ inches.

CASE II.—In this case—which occurred before No. 1—the relative shortness of the cord was more marked and the hydramnios less so. Mrs. R., aged 36, 10-para, was admitted to the Glasgow Maternity Hospital in January, 1897, with strong and very rapid labour pains and with a history of being in labour for some hours. Her previous confinements had been natural. The position of the child was readily made out abdominally. The head was found freely balloting above the pelvic brim. The foetal heart sounds were distinct during only a period of from ten to twenty seconds, with absolute pauses during intervals corresponding to the duration of the pains. The stoppage of the sounds was very abrupt, and showed the interference with the circulation to be very complete. A diagnosis was made of dystocia due to short cord or of one relatively so from being coiled round the child's neck. Vaginal examination revealed the same state of affairs as existed in the other case. The membranes were ruptured and the case left to Nature. After an interval, notwithstanding powerful contractions, the head still remained above the brim. Suprapubic pressure was applied so as to depress the occiput into the superior strait, after which engagement and descent were very rapid till the head was born. The cord was found very tightly coiled twice round the child's neck, and was pulseless. On applying pressure to the fundus enough of the neck was available to allow of the cord being cut. Just as this was being done, and as the result of an extra strong pain, the shoulders, trunk, and breech were successively swept past the head, which remained anchored at the vulva, thus performing, outside of the pelvis, movements similar to those which go by the name of "spontaneous evolution" when performed in the pelvis. In this case the actual length of the cord was 30 inches, and the available less by two turns round the child's neck.

REMARKS.

The points which occur to me as being worthy of notice are:

1. Neither patient was a primipara.
2. In both the presenting part failed to engage, and in No. 2 the head remained free, even after rupture of the membranes.
3. The condition was in each accentuated by the excess of liquor amnii.
4. The utility of abdominal examination, and especially of auscultation, as illustrating the feasibility of diagnosing interference with the circulation through the cord, be it due to tension or compression.
5. The success of suprapubic pressure in causing or hastening engagement.
6. The indication for treatment being to express the child rather than deliver with forceps, so as to push down the placenta *pari passu* with the child.

HERPES ZOSTER OF THE FACE WITH PARALYSIS.

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EICHHORST has written an article on this subject epitomised in the BRITISH MEDICAL JOURNAL of June 12th, 1897, in which he refers to the recorded cases of those combined affections—only 18 in number. Usually the herpes has appeared before the paralysis, there being only 3 exceptions to this. Herpes occipito-collaris has been most frequently seen, but when the facial paralysis has appeared first the herpes has been in the distribution of a single branch of the fifth nerve. Only 1 case is recorded in which the herpes was present on a mucous surface; taste may be affected.

On looking up the literature of the subject I find no reference to it in the early edition of the *Medical Digest*. Hebra