fell from the top of a hayrick, and, although the fall was from a considerable height, she soon recovered from the shock, and there was no further injury apparent at the time. In the course of a few weeks, however, she had what appears to have been an epileptic seizure. She suddenly fell down and became unconscious, and the mother immediately noticed she could not move her right arm and leg. The face was not affected.

In July, 1892, she had two slight epileptic seizures, and again in July, 1893 (six months prior to her admission), she had several seizures, but these were not followed by any appreciable difference in the hemiplegia.

In the fits the convulsive movements always commenced in the right thumb and fingers, and she became quite unconscious. There was nothing further to note with regard to the previous history, and the family history was good. On examining the head it was found that the left supraparietal region was distinctly flattened, and sloping straight away from the vertex, the parietal eminence appearing to be pushed down and becoming more abruptly prominent than on the opposite side. A vertical section through the parietal eminences, viewed from behind, would be represented as in the engraving. There was no evidence of facial paralysis;

the eyes were normal, there were no fundus changes and no ocular paralysis; the left pupil was very slightly larger than the right, and both acted well to light and accommodation.

The right arm was a quarter of an inch shorter than the left, was cold and bluish-red in colour, the movements being confined to flexion at the elbow-joint, necessarily limited by the general rigidity of the limb. The thumb was held across the palm of the hand, and, like the fingers and wrist, remained strongly flexed. The leg was rigid, the foot inverted, and the child could only walk, and that with great difficulty, by holding on to something.

The flattening of the skull over the motor region of the cortex corresponding to the right arm and leg centres, the condition of the right hand, and the fact that the epileptic seizures always commenced in the thumb and fingers, led me to the conclusion that the symptoms were probably due to some irritating lesion affecting the cortex, probably the result of an injury caused by the fall from the hayrick. I therefore asked my colleague, Mr. Cotterell, to see the case, with the view of removing by operation any focus of irritation, and thus arrest the tendency to epilepsy and restore power to the limbs. Certainly the result has been so far exceedingly satisfactory, the hand and arm are freely used, and now, eleven months after the operation, the patient can run about as well as most children, without limping; nor has there been any return of the epileptic seizures.

DESCRIPTION OF THE OPERATION BY MR. COTTERELL.

In January, 1894, I saw this case, in consultation with Dr. Outterson Wood, and found the condition as he has described it. The flattening of the left upper parietal region was very marked, especially when viewed from behind. We determined that it would be the best thing to explore the flattened region, and to be guided then by what was found as to any further operative measures.

Accordingly, on February 2nd, the scalp having been rendered thoroughly aseptic, the child was anaesthetised and a semicircular flap 4 inches long was reflected up, from the left parietal region. The periosteum was raised over an area of about 2 inches, the centre of which corresponded to the middle of the flattened region. A trephine having a diameter of $\frac{3}{4}$ -inch was applied to a point on the skull corresponding to the middle of the fissure of Rolando and the disc of bone removed. This opening was enlarged with cutting forceps. The dura mater was opened, and directly underneath there appeared a small cyst filled with serous fluid, situated apparently under, or between the layers of, the arachnoid. The dura mater was somewhat

thickened over the cyst and adherent in places. The adhesions were separated and two pieces of the external wall of the cyst were removed. The dura mater was stitched up except at the lower angle, a catgut drain inserted, and the wound closed.

The child was collapsed after the operation, but quickly rallied. The after history of the wound presents nothing worthy of note, as it all healed up by first intention, except the track of the drain. A large amount of cerebro-spinal fluid escaped, rendering dressing of the wound necessary twice a day for the first three or four days. The wound was completely healed by February 11th.

After the operation the child rapidly improved, in spite of attacks of whooping cough and chicken-pox. Dr. Guthrie Blandford, our late house-surgeon, to whom I am indebted for the great care and attention which he bestowed upon this case, notes that on March 17th, 1894, that is, about six weeks after the operation, "the child can now walk without support. The hand can be opened spontaneously; no fits since operation." The improvement has steadily continued, and at the present time very little remains of the hemiplegic condition from which she suffered.

The situation of the cyst corresponded to the arm and leg centres, and it was doubtless the cause of the hemiplegia and of the epileptic convulsions. The exact nature of the cyst I am unable accurately to determine, but I am inclined to think that it was the result of hæmorrhage, probably, into the subdural space. We know that in these cases the coagulated blood in the course of time becomes completely decolorised and forms a thin membrane-like layer of tissue, which encloses a cavity containing serous fluid. As far as I can learn, I believe that this condition has been found very rarely during operation.

FLAP OPERATING IN LAMINECTOMY AND SUBCUTANEOUS CYSTS.

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THE eulogium pronounced by Professor Chiene in the *BRITISH MEDICAL JOURNAL*, October 4th, 1894, on the flap method of operation, will draw the attention of all surgeons to its wide application and advantages. I add now to his list two other operations in which the flap will be found preferable to the linear incision:

1. In operating upon the spinal column, whether for disease or traumatism. The linear vertical incision, though it unites at first, may under the pressure of the spinous processes, as the patient lies in bed, break down, especially where, in a traumatic case, there has been much bruising. Such an accident has occurred in my own practice. Lately operating for fractured spine on two adults, both in the dorsal region, I made a horseshoe flap with the convexity upwards, and crossing the middle line between two vertebral spines, well above the area of injury. The sides of the flap were prolonged downwards, parallel to the spine, as far as requisite. In both cases primary and sound union followed; there was no pressure on the scar, since it only crossed the middle line of the spine once; and then between the prominences of two vertebra.

2. In operating on subcutaneous cysts generally, and on enlarged bursa patellæ especially.

In the latter, a horseshoe flap is made, crossing the middle line just above the patella, and prolonged downwards by two parallel lines on either side of it, as far as necessary. The flap is reflected downwards. The scar is thus completely out of the way of all pressure. A further advantage in these cases, as in subcutaneous cysts generally, is that the cyst is first attacked below its summit, at a spot where there is always a good thickness of subcutaneous tissue; there is therefore less liability of injuring the cyst than when a vertical incision is made over its summit, where the skin is often closely applied to it. More room is also obtained, and the manipulations being freer, the operation is more rapidly performed.