The Facial Nerve.—There are two principal points where the nerve is exposed to injury in operative procedures around the mastoid—first, in the aqueduct of Fallopius, and, secondly, for the first quarter of an inch after it next enters the mastoid.

In its first situation, danger of wounding it is practically limited to over-vigorous use of curette. In the other, on the contrary, it lies open to more dangers, of being cut in the bone itself, or of being injured by pressure from a mastoid guide, and, I fear, the instrument designed by myself is open to this reproach.

The method to be employed in holding the guide in order to obviate this risk is, to hug the external wall of the iter with the instrument and not to allow it to press on the deep wall.

The other risk, that of severing the nerve, is only liable to occur when the bone is very dense, *i.e.*, in sclerotic mastoids, in which there is either no antrum, or practically none. Here the burr should present an advantage over the less accurate cutting instruments.

One most useful hint to bear in mind is, not to cut away the posterior wall of the meatus at a lower level than the bottom of the iter (this, of course, only applies to the inner third of the meatus); the upright limb of the guide shows exactly where this is. The proposal to freshen and rejoin the divided ends of the severed nerve certainly deserves trial, the nerve being exposed down to the digastric or stylo-mastoid foramen.

The Vestibule.—The only part of the labyrinth which is exposed to any real liability to suffer is the external semicircular canal, the depth of which is only that of the Fallopian canal from the surface.

This structure is not unfrequently exposed by erosion of its bony wall or case, and the only probable danger lies in the indiscreet use of fine pointed instruments. Its exposure or the involvement of the bony canal by extension of the osteitis from the mastoid or elsewhere gives rise to lateral nystagmus, which can at times only be elicited after syringing with hot water, but however obtained the oscillations are small, an important point in differential diagnosis, as in cerebellar cases they are large.

From these considerations one is able to define a certain deep area in which we can work in safety. It is bounded on its deep surface by the inner wall of the adnexæ; below by a level of the lower iter wall; above we can work further up as we go deeper; and posteriorly a small half-inch from the supra-meatal fossa.

As a final piece of advice I would urge the invariable removal of the external attic wall, as any deficiency in the tegmen is then easily and promptly discovered.

ERRATUM.

BRITISH LARYNGOLOGICAL SOCIETY.

THE case shown by Dr. THORNE for Dr. GRANT was under the care of Mr. LENNOX BROWNE (*vide* p. 185).

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