at least desirable—we may state the peremptory necessity to connect both the branches of the lower jaw with a prothesis, permitting to fix the tongue to, and avoiding by the same its falling backwards and causing suffocation. In fact, it has been proved by the case related above that such a simple prothesis which, I think, at least one surgeon in every greater town or medical centre must be able to work himself out of a piece of malleable metal, *e. g.* aluminium, is able (1) to keep the external contour of the chin, especially in male patients, who can let their beards grow, and to learn (2) in a short time swallowing, and (3) speaking distinctly enough for ordinary conversation. Then it is evident that the surgeon, who knows as an anatomist the anatomical conditions much better than any manufacturer of instruments, spends less time in making such kinds of simple protheses within an hour or something more himself, than in giving to a technical mechanic such directions as will do to produce exactly what he wants, ready for use.

PRIMARY INTRA-NASAL SYPHILIS.

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Syphilitic manifestations in the nose are commonly of the tertiary type, with an occasional secondary display, and while the primary sore is mentioned by various authors as occurring in the nose, the lesion described is usually vestibular. The under-mentioned case emphasises the fact that the Hunterian sore may be so hidden in the nasal interior, and may be so unlike the ordinary chancre, as to escape detection, and render diagnosis a thing of the very greatest difficulty.

The patient, a male, aged twenty-five, was first seen by me on April 19, last year, when he complained of soreness in the inside of his left nostril and nasal obstruction on the same side. There was no history of any previous nose trouble, and the present discomfort apparently commenced like a cold in the head on or about the 10th of the month, and after a day or two of coryza and stuffiness, something painful and tender made itself evident.

Examination revealed a slight swelling of the left ala nasi extending to the junction of the cartilage and the nasal bone, and involving also the adjacent part of the cheek. There were three or four very hard and enlarged lymph-glands in the left submaxillary triangle, and pain was complained of in this region during the act of deglutition. No morbid change could be seen in the buccal, faucial or pharyngeal mucous membrane, and the right side of the nose internally appeared normal. The left side of the nose was almost completely occluded, and only after

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cocaine and adrenalin application and somewhat forcible use of the speculum, an area of intense inflammation, about the size of a threepenny piece, could be seen on the anterior end of the inferior turbinal, and this patch, which appeared circular in outline, was covered by a yellowish-white membranous new formation. Any interference with the fibrinous deposit caused free oozing of blood.

A swab was taken from the infected nostril, and in due course the bacteriologist reported the presence of strepto- and pneumococci in great numbers.

An alkaline lotion and a colloidal silver preparation were used, and five weeks after the onset of symptoms, though the false membrane had vanished and the inflammatory reaction seemed less inside, there was much greater glandular swelling, and the infiltration of the ala became more marked.

The actual sore could not, on account of its situation, be palpated; its centre or base was red and had a soft pulpy appearance, and the circular margin was slightly raised.

Meanwhile constitutional disturbance was marked; lassitude, limpness and pains in the legs, with an entire absence of headache. There was a little pyrexia all the time, and the pulse was accelerated out of proportion to this.

The tentative diagnosis of primary syphilitic infection was confirmed about the end of the sixth week of the illness by the appearance of a typical secondary rash. The Wassermann test was not done.

The patient is a clean, careful man, of good social position, who, in the course of his employment, has been brought into close relationship with a man now known to be suffering from early secondary syphilis, and though the presumption is that the infection was conveyed by the fingers, he would not admit the habit of nose-picking.

BRAIN ABSCESS OF AURAL ORIGIN.

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On April 24, 1913, I was asked by Dr. Alex. Lewers, senior physician to St. Vincent's Hospital, to see a patient in his ward who showed signs of intracranial complications of ear disease. The patient, R. B——, aged sixteen, was in bed and complained of headache—frontal and occipital. The headache had started four weeks prior to admission and had been continuous since. Eight days previously he vomited several times and had vomited off and on since.

The patient noticed some dimness of vision, especially in the left eye. Dr. Edward Ryan, oculist, examined the eyes and stated that there was definite left optic neuritis. A week before I saw the patient he stated that he had noticed some weakness of the right hand, and on several occasions after sitting for some time and then getting up he became giddy.

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