(curetting, the removal of ossicles, &c.) the ear should be carefully syringed. It may be said at once that the ear (and especially a suppurating ear) does not lend itself to *asepsis* and, therefore, *antisepsis* has to be the order of the day. Fortunately, the ear will, as a rule, tolerate very strong antiseptics and this fact is made use of in aural surgery. The antiseptic to be used for preparing the ear for operation will vary with the surgeon. One (and to some surgeons, carbolic acid is almost a kind of fetish) will prefer carbolic lotion. If this is used it should be of a strength of 1 in 20. Another will use Perchloride of Mercury, 1 in 1,000. But whatever is ordered, it must be used efficiently. If no mention is made of any special antiseptic the nurse will do well to use 1 in 1,000 perchloride solution.

Should the discharge from the ear be very foul, or contain flakes of dead skin and debris, the ear should be carefully dried after the syringing, the patient made to lie upon the opposite side, and the ear filled with peroxide of hydrogen for from 15 to 20 minutes, and then syringed again. Whether this be necessary or not the passage of the ear should, after syringing, be swabbed with Lister's strong mixture (an aqueous solution of carbolic acid, of a strength of 1 in 25, with the addition of 1-500th part of perchloride of mercury). Finally, the whole outer ear should be washed with antiseptic, every nook and cranny receiving careful attention, any blackheads squeezed out, the meatus plugged with sterilised or antiseptic gauze, and the whole ear covered by a pad of gauze, retained by a turn of bandage.

When the operation is to be one in which it is necessary to turn the ear forward by a post-auricular incision (removal of impacted foreign body, opening of the mastoid, radical mastoid operation), the hair must be shaved from the region round the ear for an area of at least 2 to 2½ inches radius, and the skin over the mastoid and round the ear thoroughly cleansed and included in the antiseptic pad already mentioned.

One or two surgeons endeavour to obviate the necessity for removing the hair by enveloping the head in a sheet of thin rubber, in which a hole is cut for the ear to pass. The writer prefers the more efficient and cleaner method of shaving. It is true that women sometimes object to the removal of a part of their crowning glory, but a little tact on the part of the nurse will generally overcome this, and the hair very quickly grows again.

In operations in which the ear has to be turned forwards and there is likely to be much bleeding, it is well, when the patient comes on to the operating table, to pack a large pad of wool down by the side of the neck. This small precaution will save much of the blood accumulating by the neck and back of the head and giving the nurse much extra trouble in washing the patient. At least three sterilised towels will be required in these operations, one for the envelopment of the head, one for the shoulder and chest, and one under the head.

For the after dressings of all the above-mentioned operations the chief requirements of the surgeon will be: syringe and warm antiseptic lotion to use therewith, a pair of angled aural forceps, ribbon gauze for packing, and small sterilised wool swabs for drying the meatus. It should be remembered particularly that *all after dressings of ear operations require to be done under as scrupulous asepsis and antisepsis as the operation itself.* Neglect of this may lead to much vexation. All syringes, forceps, or other instruments should, therefore, be sterilised and proper precautions taken with dressings.

Occasionally it may fall to the lot of the nurse to perform some of the after-dressings of a mastoid operation. It is, therefore, proposed to briefly describe these.

For all practical purposes the nurse may take it that the varieties of mastoid operation are two: Simple opening of the mastoid (performed in acute conditions only), and the radical mastoid operation, performed for the cure of chronic discharge or as a preliminary to exploring the cranial cavity for cerebral abscess or other intercranial complication of ear disease. In the radical operation the mastoid antrum, middle ear and meatus are thrown into one large cavity.

In simple opening of the mastoid the wound behind the ear is left wholly or partly open, and made to close from the bottom by packing. A small packing is also put in the meatus. In the radical operation this wound is sutured in its entirety, and all packing is carried out through the natural opening of the meatus.

The after-dressings of these operations, therefore, differ somewhat. In simple opening of the mastoid it consists in removal of packing from the wound and the meatus, syringing both wound and meatus gently with warm antiseptic, drying with sterilised wool swabs, and repacking. It is *most essential* to the welfare of these cases that the wound should be packed *to the bottom.*

In the radical operation, dressing consists in removing the packing, cleansing, drying, and repacking. Should the old packing stick, it

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