internal auditory canal, and the total removal was done without difficulty.

In the other two cases, neurological findings were those of the typical acoustic neurinoma with the involvement of the 5th, 7th, and 8th cranial nerves & the cereberum. Tumors were acertaind by the myodil study of the posterior fossa.

These two cerebellopontine angle tumors were removed by the translabyrinthine approach, one total and the other subcapsular-removal.

When the tumor is intra-canalicular or when there remain some possibility of other diseases, surgical exploration through the middlefossa extradural approach is preferable.

When the tumor has grown on the cerebellopontine angle, it is still a problem. In such cases the translabyrinthine or posteriorfossa transmeatal approach is more convenient.

Discussion to 22.

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Combined surgery by way of translabyrinthine and suboccipital approaches was done on three patients with acoustic neurinoma. All of them noticed deafness in involved ear. Papilledema was evident in two cases. All of tumors were too large, arriving in the vicinity of the vagus nerve. Two tumors were partly cystic.

In two early cases, suboccipital craniectomy succeeded in subtotal removal of the tumor, and then the residue of tumor in the internal auditory canal was removed by the translabyrinthine approach. Simultaneous surgery by way of suboccipito-petrosal approach was performed on one patient with large acoustic neurinoma, and obtained extracapsular removal of the tumor. All of them have come back to their previous occupation.

Combined suboccipital-petrosal approach seems to offer an ideal method to remove large acoustic tumor completely. However, the sigmoid sinus crosses the surface of tumor in this approach. Division of the sigmoid sinus in the second stage of surgery, as indicated by House and Hitselberger, widens the surgical field to perform total removal of tumor easily.