lobe. Relief followed, but stones soon formed, and in about six months patient was suffering agonies. This was followed by urinary obstruction, distension, rupture of the bladder, extravasation, and escape of urine at the old scar. Such was the condition when I first saw the case, with Dr. Taylor of Goderich. The bladder was opened by the vertical perineal incision, and stones and gland removed. Owing to the fact that the bladder would only hold an ounce or two of urine, the perineal wound never healed. This condition might be accounted for by contractions after extravasation, the possible effects of the cautery extending beyond the gland, the erosion caused by sharp stones, and the double operation. The patient, however, feels well, enjoys the best of health otherwise, and attends to his ordinary duties. He keeps a soft catheter in the small perineal opening, one end of which empties into a urinal, that is worn. In cases where a permanent drain is indicated, the plan is entirely suitable.

This is the only instance in which we have had a faulty result, functionally. There are, at least, a dozen cases in the counties of Huron and Bruce, that many of you know about, in which there is no trouble either in retaining or voiding the urine.

My first operation has a historical interest, and I shall ask your forbearance while I give a brief report of it also.

My First Operation.

This occurred about twenty-four years ago, and was, I believe, one of the first suprapubic prostatectomies in the province. A brief history will show how I stumbled, so to speak, on the operation. It will also show how the operation might have been accidentally discovered in the first place.

Late one night I was called by Dr. McDiarmid of Hensall, to see a man, aged about seventy, who was in agonies of pain from retention of the urine. Not being able to pass a catheter, and no trocar or aspirator being at all convenient, the bladder was opened above the pubes. The prostate gland was found enlarged to an extreme degree. While the patient was still under the anesthetic it was decided to remove a wedge from each lobe, in order to prevent a recurrence of the trouble. The instruments at our disposal were a knife, scissors, and a double tenaculum; but even these were soon to be laid aside for the finger. An antero-posterior incision was made in the right lobe and the capsule pushed aside to make room for the wedge. It was soon realized that it was no easy matter to cut out a symmetrically-shaped wedge. At the same time it was discovered that the capsule separated easily