a few hours. Three days previously he had been seized with severe pain in the epigastrium, which was so severe that he fainted away. Physicians in attendance had been unable to make a diagnosis. At the *post mortem* I found an enormously distended gall bladder containing several hundred small stones, while in the cystic duct there was a small impacted stone. The hepatic and common ducts were free. The case is of interest in several ways. Having operated upon the patient for stone in the bladder not long before, and having inquired carefully into his symptoms, it seems impossible that he could have suffered seriously at least from the gall stones which already must have existed in large numbers. Had he done so I certainly should have elicited the fact. Another factor of interest is the sudden onset of pain and the extreme severity of it in a patient who had not previously suffered from biliary colic, even though there were hundreds of stones in the gall bladder. The gall bladder was also distended and was the most tense of any which I have ever encountered. I might mention many other cases in which gall stones have been found at operation, in none of which cases were there present characteristic symptoms of gall stones such as marked jaundice, clay colored stools, spasmodic pains, or vomiting. At most there was a long continued sense of discomfort in the epigastrium, perhaps the faintest discoloration of the sclera, and urine a little more highly colored than normal, which on examination was found to contain traces of bile.

On the other hand, I have operated repeatedly upon cases having all the characteristic symptoms of gall stone in which none have been found. Exactly the origin of these cases is difficult to determine. A distention of the common duct, acting much as a diverticulum of the oesophagus, suggests itself as a possible cause of the symptoms. At any rate, such cases are relieved by drainage of the gall bladder with traction upon its walls, the gall bladder being fixed by sutures to the incision in the adbominial wall. Following this procedure there is the re-establishment of the flow of bile into the intestines,and I have had the good furtune repeatedly to have such patients entirely recover. Whether stones be present, or whether the symptoms be due to the obstruction to the flow of bile without the presence of stones, is immaterial since the condition is equally serious in the latter and is equally benefitted by operation.

The third consideration is the most important, viz., what complications may arise from delayed operation? The most important of these are inflammatory adhesions. The extent of these may be extreme and may bear no proportion to the number or size of the biliary calculi or to the length of time that symptoms have existed. The most striking case