An assistant then passed into the rectum the other half of the button, so held by a long pair of forceps that it was adjusted in proper position to the anterior portion of the rectum immediately below the stricture. This part of the button being felt within the pelvis, an attempt was made to incise the rectum immediately over it in order to complete the anastomosis. Before making this incision it was observed, as should have been anticipated, that the cul-de-sac of Douglas had been obliterated, by the previous removal of the uterus and that the bladder lay in intimate apposition with the anterior wall of the rectum; in fact was so adherent that the separation of the two was impossible. For this reason it was feared that the incision of the rectum might transfix the overlying and adherent bladder, and this is just what happened; the incision over the projecting button permitted the escape of about half an ounce of urine into the pelvic cavity. The bladder wound was immediately sutured, and, as the location of the stricture did not permit of the higher apposition of the button within the rectum, the futility of attempting to complete the anastomosis was apparent.

I was now forced to consider the formation of an artificial anus, but as the patient's consent to this disagreeable operation, with its disgusting discomforts, had not been obtained, I temporized by closing the opening I had made for the Murphy button in the sigmoid flexure, and then fastening that portion of the bowel to the incised parietal peritoneum in such a manner that it lay immediately beneath the centre of the abdominal wound, the latter in turn being closed, with the exception of its central portion, which was plugged with iodoform gauze down to the sutured portion of the underlying sigmoid flexure.

On the following day, the situation having been fairly laid before the patient, and her consent to the formation of an artificial anus having been obtained, the iodoform plug was removed, the surface of the exposed bowel was painted with cocaine and opened by removing the sutures of the day before. Through this wound the contents of the bowels found an avenue of escape, and the patient was immediately relieved of a distressing flatus.

On the following day an attempt was made to pass bougies through the stricture by passing them into the bowel at the abdominal opening, and then downward into the rectum; this attempt, however, failed. A stout silk thread was then passed into the bowel, one end, however, being fastened by adhesive strips to the skin of the abdomen, and a cathartic administered, in the hope that the string would be carried through the stricture; this also failed; then a string, weighted with a small revolver bullet whittled to the diameter of a slate pencil, was tried; a cathartic was again administered and we were rewarded by finding, on the following day, the bullet with the attached string, lying immediately above the internal sphincter.

The two ends of the string, one of which projected from the abdominal opening and the other from the anus, were tied together to prevent the escape of the string from the bowel.

It was now a comparatively easy matter to tie urethral bougies, beginning with the small sizes, to the silken circuit that had been established, and draw them up by way of the rectum through the stricture and