Kidneys small, capsule adherent, cortical portion very narrow. Liver about normal in size; surface covered with the cicatrices of an old perihepatitis. Stomach considerably dilated; the pyloric end lying adjacent to the gall bladder. The mucous membrane was rather pale and covered with a yellowish, tenacious, offensive smelling mucus, but not markedly diseased in any part. On attempting to pass the finger through the pyloric opening it was found that the outlet was nearly closed by some constricting bands about its external or peritoneal surface. Using considerable force, thereby tearing their constricting fibres, the index finger could be forced through into the duodenum. A hard lump in the midst of a mass of adherent viscera at the site of the gall bladder proved to be viscus contracted to about the size of a large pigeon egg, and inclosing tightly a calculus of the size just mentioned. This calculus, when dried, had a dark-brown exterior, rather brittle, and when cut traversely showed a nucleus the size of a hazel nut, dark colored and structureless; around this core are shown arranged in concentric circles layers of bright yellow inspissated bile, each separated from the succeeding layers by a whitish or a dark narrow zone. The gall bladder walls were thickened, and it had lost all resemblance to its normal appearance by being enclosed in a mass of tough fibrous connective tissue, which bound together all the parts in relation to that viscus. The lower surface of the right lobe of the liver, on either side of the cystic fissure, the hepatic flexure of the colon, the anterior wall of the abdomen, and the pyloric end of the stomach were attached to, enclosed, and tightly drawn by these connective tissue bands. The presence of the gall stone had evidently set up a chronic inflammatory process about the gall bladder, plastic lymph was thrown out, which in course of time contracted, and the pyloric end of the stomach happening to be involved in this cicatrical contraction, stricture of its lumen resulted necessarily. No carcinomatous processes nor syphilitic gummata were discovered anywhere.—*J. C. Falk, M.D., Ph.G., in the Medical Fortnightly.*

REMARKS ON THE EVACUATION OF DÉBRIS AFTER LITHOTRITY. — Surgeon-Major Forbes Keith having described in *The Lancet* of June 11th, 1892, a method of removing stone fragments after lithotrity other than by the process of evacuation with the aspirators at present in vogue, I will describe a procedure I have seen during the last twelve months at M. Guyon's clinic at the Necker Hospital and elsewhere in his practice, which seems to possess certain advantages. I have adopted it myself to some extent and I know that other surgeons think favorably of it. There can be no doubt that the shortcomings of lithotrity are chiefly connected with the difficulty existing of guaranteeing that every fragment, however small, is removed and that nothing is left behind on the completion of a crushing operation which is capable of furnishing a starting point for another concretion. Of all the conditions favorable to the reproduction of stone this is probably the most fertile one, and all proposals tending to diminish the liability in this direction are deserving of careful consideration. M. Guyon's practice, as I have now observed it on several occasions in public and private work, is as follows: The patient being fully anæsthetized, the fenestrated lithotrite is introduced, and the stone is not merely broken up but absolutely pulverized. In the last case I saw, a urate-phosphate stone with a diameter which only just brought it within the grasp of the largest lithotrite, was subjected to a process of trituration which lasted for twenty-five minutes by my watch, without, I believe—as far as I can remember—a single withdrawal of the instrument. When no fragments could be felt with the lithotrite the evacuating catheter was introduced. The latter consisted of a full-sized instrument with a large eye on either side of the beak. No aspirator was attached to it such as we are in the habit of using for withdrawing fragments by suction-pressure, but after the bladder had been allowed to empty itself spontaneously of its contents by the catheter an ordinary syringe was attached to the latter and about six ounces of warm boracic lotion were gently injected. Then the syringe was disconnected and the bladder allowed to empty itself, this process being continued until the contents of the syringe were returned absolutely pure. The bladder was finally washed out with a solution of nitrate of silver (1 per 1000) and a rubber drainage catheter was passed and retained for twenty-four hours. The opera-