certainly diagnosed by needle exploration, or where the pain and other symptoms lead one to believe there is a stone present. If left, the stone is certain to disorganize the kidney, cause much suffering, and probably death. The operation of incising the kidney (*nephrotomy*) has not proved a dangerous one, and it has been frequently demonstrated that the kidney can be easily explored through a lumbar incision, and even cut into with great safety. In cases of strumous or calculous pyelitis, the sacculated kidney can be drained through a wound in the loin and the patient freed from the danger and pain of retained matter. Nephrotomy, as an operation, is merely palliative, and, nephrectomy, or removal of the kidney, is a much more formidable operation than the foregoing. The dangers are greater, and many cases have been followed by suppression of urine. It has also proved fatal from hæmorrhage, and wounds of neighbouring organs, as lung and pleuræ. As yet it has not been positively determined in what cases, or at what period, it should be performed. It has been done for tumour, cancerous diseases, and strumous and calculous pyelitis. It is a question whether before nephrectomy is performed, a preliminary nephrotomy should not be tried. Now the loin is the most favourable position for nephrotomy and, perhaps, the most difficult incision for nephrectomy, so this would be an objection. Some hold that if a preliminary nephrotomy is performed, it much increases the difficulty of a subsequent nephrectomy. Again, it is important, in considering the advisability of performing nephrectomy, to find out whether the pyelitis is confined to one kidney, or, rather, whether the other kidney is healthy. Strumous pyelitis is rarely confined to one kidney, and, therefore, excision of the kidney must be a defective operation, as the pyelitis is only a small part of a general disease.

Th. Gluck has lately suggested a method of pointing out which kidney is diseased. He advises cutting down on the ureter of the supposed morbid kidney, and obliterating its lumen with ligature or clamp. A solution of some salt, rapidly excreted by the kidneys is then injected subcutaneously, and its presence after a short time ascertained in the urine by means of tests; if none is found, then the other kidney is diseased, and the ligature should be removed and the wound sewed up; but if found readily, the operation of excision is proceeded with.

These are some of the difficulties in the way which make one hesitate to perform nephrectomy. Having, however, decided on the operation, which is the best incision, through the loin or abdomen? Certainly the abdominal incision gives the operator more room, and the surgeon sees what he is doing. Removal through an incision in the loin is very difficult, especially the ligaturing of the vessels entering the pelvis of the kidney, besides, in some people, the distance between the last rib and crest of the ilium is very short; in these cases, of course, the 12th rib has to be excised, or a T incision made, both of which procedures increase the risk of the operation. The only objection to the abdominal incision is that two layers of peritoneum are wounded; but now-a-days we are not so fearful of wounding that structure as formerly. I leave the further discussion to you as to when and how we should perform nephrectomy.

*Treatment of Club-foot.*—As long as these deformities occur, so long will the remedying of them engage the attention of the surgeon. Ordinary simple cases may be successfully treated by bandaging and manipulating, or the use of elastic springs. More severe cases by tenotomy, and afterwards with the proper apparatus, plaster-of-Paris, splints, &c. I should like to hear from the members of this Association their opinion as to the performance of tenotomy, whether, for instance, in a case of talipes equino-varus (the most common form of club-foot), the tibial muscles and tendo-Achillis should be cut at the same time, or whether two operations should be made of the tenotomy. I feel inclined to favour the latter method, following in the lines of the older authorities,—first, to remove talipes varus by tenotomy, and after application of a splint, and later on, say in two or three weeks, to cut the tendo-Achillis, and place the foot in good position in a plaster boot or Scarpa's shoe. It seems to me that if the operation be thus performed in stages, the