the symptoms persisting. Dr. Bruce, the same month, operated and was able to shove the stone out of the common duct into the duodenum: the patient is now back to normal weight and perfectly well. Mrs. A., aet. 35, was the subject of gall-stone attacks from 1901; she would have spells of colic every week or ten days for two months at a time, during which time she would lose from 24 to 35 pounds in weight, picking it all up again when free from attacks for some months. She has had no attack now for about nine months, having passed three stones which we obtained with the sieve.

Just a word as to the result of physical examination of the abdomen in one who is suffering from cholelithiasis. When the gall-bladder is found to be enlarged, the swelling may be due either to a large collection of calculi in the gall-bladder or to an accumulation of fluid, which fluid may be bile, or it may be pus, owing to infection, or it may be a mixture of all three. A calculus lodged in the common duct does not necessarily dilate the gall-bladder, inasmuch as the spiral valve arrangement in the interior of cystic duct seems to prevent the bile getting into the gall-bladder in some cases. When the cystic duct becomes plugged by a stone, the gall-bladder usually enlarges and dilates from the accumulation of mucus in its interior. The distended gall-bladder is smooth, rounded, larger below than above, moves with the respiration and can be moved laterally with the fingers; it extends downwards towards the umbilicus or along a line drawn from the ninth costal cartilage of the right side to a point one-third of the way from the pubic spine, to the anterior superior iliac spine of the same side. I have, however, seen a gall-bladder holding in the neighborhood of a pint of bile where the enlargement was almost entirely backwards, and could only be doubtfully made out by abdominal palpitation. In palpating such cases, it is well to have the patient sit up and bend the body slightly forward.

Gall stones cannot be demonstrated by Röntgen rays as they are permeable to these rays on account of the cholesterin and large amount of organic matter which they always contain. A patient being seen for the first time in an attack of gall-stone colic, the diagnosis involves a differentiation from renal colic, intestinal colic as seen in lead poisoning, gastric ulcer, hyperchlorhydria with gastralgia, displaced right kidney with twisting of ureter. A renal colic could only be confounded with hepatic colic when the calculus is passing along the right ureter or is in the right pelvis. The pain, however in renal colic radiates down along the loin into the pelvis or thigh, and is associated with bladder symptoms and pathological conditions of the urine (blood etc.) In lead poisoning colic we have the history of