the exact point at which the implantation is to be made. The requisite qualifications are: (1) It must be above the internal sphincter; (2) it must be in the lateral and not in the anterior wall, so as to avoid kinking (this actually occurred in the first instance in the author's case, necessitating a subsequent adjustment of the implantation); (3) it must be high enough up to permit the ureter to project slightly—say 1-4 to 1-2 inch—into the lumen of the bowel without stretching. If the ureter thus projects it forms a papilla, which, when pressed upon from within the bowel, becomes converted into a valve, similar to that at the entrance to the bile duct and the salivary ducts. This point having been decided upon, the operator or his assistant passes a slender forceps through the anus, presses them against it from the rectal aspect, and lifts it carefully into the anterior wound. The wall of the bowel is now excised upon the projecting forceps, which are then forced gently through. By stretching and cutting the wound is enlarged with great exactness, so that the ureter, with its contained catheter, will actually fill it, and yet not be injuriously pressed upon. The forceps are now opened, made to grasp the distal end of the catheter, and withdrawn into the bowel and out of the anus, the operator at the same time carefully directing the ureter through the slit, and satisfying himself that its termination forms a papilla at least 1-4 inch long upon the rectal mucous surface. In guiding the mouth of the ureter through the slit in the rectal wall forceps may be passed back again beside the catheter, and made to grasp the edge of the rosette of bladder tissue around the ureteral papilla. This process is repeated upon the other side. The sponge plug is now withdrawn, care being taken not to disturb the catheters while doing so.

There seems to be no necessity whatever for stitching the ureters in position, and in my case the attempt was not made. The catheters are left in position at least two or three days, or until they come away of themselves, which occurred in my case in about sixty hours.

The Dressing.—I do not think it judicious to attempt any plastic operation for immediate closure of the abdominal wound. The whole area to be healed will be found surprisingly small, and a moderately firm packing with iodoform gauze will afford efficient drainage, and at the same time furnish a support and splint to the delicate ureters in their new position. When the implantation has healed securely, and granulation has been established, a plastic closure may be done if it be deemed advisable. I allowed my case to heal entirely by granulation, and the scar is quite small and firm."

Harry M. Sherman[10], of San Francisco, reported a successful case by the Peters method.