the prevesical fat with the finger or handle of the scalpel. A large, long-curved sound should now be introduced into the bladder, and its point turned upwards close behind the pubes. The finger in the bottom of the wound should readily feel the point of the sound through the wall of the bladder. An assistant should keep the sides of the wound well separated by suitable retractors, and another, by means of the sound in the bladder, should keep its front wall well up in the bottom of the wound. The bladder should be opened on the point of the sound, a probe-pointed knife being used to extend the incision downward. Once the finger can be introduced, any necessary extension of the incision should be guided by it. Before proceeding to remove the prostate, the lips of the bladder incision should be securely attached to the deeper parts of the abdominal walls by sutures, and, at the completion of the operation, a suture should be inserted at the lower angle to attach the bladder at this point also to the abdominal wall, as a security against urinary extravasation into the retro-pubic space.

The mucous membrane over the projecting part of the prostate should be snipped through with a knife or scissors, but, when possible, it should be enucleated by the finger. The removal should be accomplished by the finger and forceps rather than by sharp-cutting instruments, which cause severe hemorrhage. Whether it be the lateral lobes or the middle lobe, all of the gland that projects into the bladder should be removed. Sometimes there is only a little nodule to be removed. In other cases the mass is very large. From one of Mr. McGill's patients he removed a mass weighing about half a pound.

The prostatic portion of the urethra should be carefully examined. The aim of the operator should be to dilate it very fully, and to lower the level of its floor, so that it will readily drain the whole base of the bladder. It is only by careful attention to these two points that the operation can be successful in restoring the power to pass the urine by natural effort. Belfield advises, in those cases where it is not possible, by operation within the bladder, to obtain a sufficiently low level for the urethral floor, to make a perineal incision also. If necessary, such additional incision may be quickly made, and should not materially increase the gravity of the operation. A large drainage tube should be kept in the bladder for forty-eight hours. The upper part of the incision should be closed by two or three sutures. Very hot water is usually sufficient to check undue hemorrhage.

Results. I cannot deny that published statistics up to the present time give a very high death rate after suprapubic cystotomy. Judging from my own limited experience, I cannot believe that these statistics give a true estimate of the mortality from this operation alone. I have seen it