

there might be in the peculiar termination of the ureter upon the inner surface of the bladder should be retained when the transplantation was completed. As soon as the entire thickness of the bladder wall (which is here uncovered by peritoneum) has been snipped through with scissors or scalpel, blunt dissection may be employed, and it will be found not to be difficult to free the lower end of the ureter along the wall of the pelvis without injury to the peritoneum.

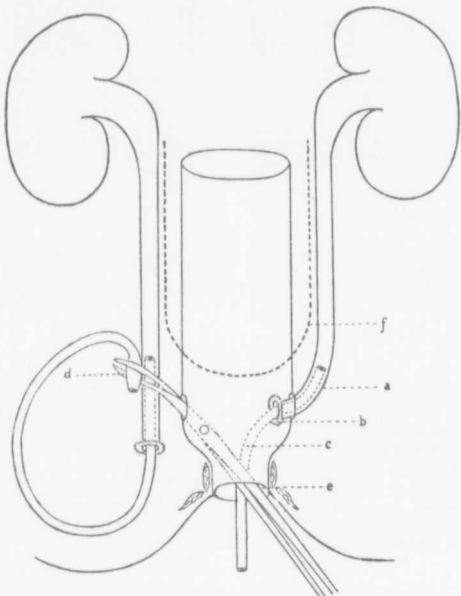


Fig. 2.—Scheme of transplantation of ureters into rectum by extra-peritoneal method. *a*, Ureter in transplanted position with (*b*) rosette of bladder mucous membrane and muscle; *c*, catheter stitched into ureter by suture at *b*, and protruding through *e*, the anus; *d*, forceps passed by the anus through the opening in the bowel and grasping the catheter; *f*, reflection of peritoneum.

Both ureters having been isolated, the whole of the bladder tissue was remorselessly ablated, from the perimeter, where it merged into the skin, to the prostate where the vesiculae seminales debouched. (During this dissection great care must be taken not to expose or injure the peritoneum; and if its hazardous proximity be suspected, a portion of the bladder muscle may be left, though every vestige of its mucous membrane must be removed. In my case the peritoneum gave no trouble whatever, and was never in the least jeopardised.)

The next step was to expose the lateral aspects of the rectum at a point below the reflection of the peritoneum (Fig. 2, *f*). The deep dissection was found to be surprisingly easy, and by pressing back the retro-vesical cellular tissue I was able to expose the anterior and lateral walls