viously cleared by a purge and enema, was washed out with an antiseptic solution of non-poisonous strength. A fair-sized sponge, to which a tape was attached, was then passed into the rectum as high up as possible. This not only prevented any passage of faecal matter, but assisted materially in raising the anterior wall of the rectum towards the bladder. Turning now to the bladder, a Jacques soft rubber catheter, about No. 5 (English), was passed for about 2 inches into each ureter. The part containing the eye was cut off, so that the urine entered the opening upon the end of the catheter freely. A silk suture was then "caught" through the extreme end of the ureteral papilla once or twice, and was also passed by a needle through the substance of the catheter, so as to effectually prevent its slipping out, as it was the intention to retain these catheters in position at least 48 hours. Care was observed not to obstruct the lumen by passing the thread across it or by tying too tightly. The distal end of the ureter, with a goodly rosette of bladder muscle and mucous membrane, was then dissected free, the catheter affording an excellent guide to its position. The idea was that whatever virtue 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.

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 jeopardized.)

The next step was to expose the lateral aspects of the rectum at a point below the reflection of the peritoneum. 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 of the rectum with readiness. This part of the operation was greatly facilitated by an assistant, who inserted his finger into the rectum and lifted it into the wound.

The final step of the operation was the implantation of the ureters into the lateral walls of the rectum, and this was accomplished in the following manner:

With his finger in the rectum the operator carefully determines