The nephrectomy may, however, be carried out after the stone has been removed from the other kidney.

I have already said that nephrectomy should not be performed for hydronephrosis except in certain cases. As a primary operation for injuries of the ureter it is unjustifiable. If the patient cannot be relieved by plastic operations then a nephrectomy may be the final resource. Of late I have said that conservative surgery advises the fixation of a movable kidney and not its removal, the thorough irrigation of a pyonephrosis with curettage, or even partial excision, rather than a nephrectomy.

In placing the ligature on the pedicle the novice should be careful to thoroughly isolate the vessels. I lost one patient owing to neglect of this precaution. The tumor was a large sarcoma of the kidney. I had never removed a kidney. It was difficult to reach the upper portion of the tumor owing to the fact that the ribs and the liver were in the way. I sometimes have thought that we get better control of our tumor through the lumbar region than by the transperitoneal incision. A small wedge-shaped portion of the tumor was included in the ligature. I saw this and endeavored to remedy the defect, but the ligature slipped and the woman was almost bloodless within a few seconds. I grasped the vessel with my fingers, mopped away the blood, placed forceps when I could see the stump, placed the ligature and returned the patient to bed. She was almost pulseless. Owing to the hasty and imperfect technique, septic infection of blood clot collected in the space formerly occupied by the kidney set in, the patient developed septic diphtheria of mouth, throat, rectum and vagina, and died.

Several patients from whom I have removed tubercular kidneys are still in the enjoyment of good health. I doubt whether the conclusion that has been drawn, that the mortality of primary nephrectomy is greater than that of secondary nephrectomy, is based upon sound statistics. If primary nephrectomy is performed upon patients, debilitated as a consequence of pus absorption, the mortality will be very high. But, again, the risk of operation is very much increased as a consequence of the fixation of a kidney bound down among septic sinuses. I scarcely think, however, that the one risk counterbalances the other. For my own part I have found it better to do primary nephrotomy and secondary nephrectomy with its accompanying difficulties. A large portion of the weight of responsibility hangs upon the shoulders of the surgeon. If prepared to cope with these difficulties rapidly, carefully, and with the skill acquired by long experience, he can save most of his patients.

Careful estimation of the quantity of urea eliminated should be made before nephrectomy is undertaken. If this is well up