The points to be considered in a case of this kind are:

1. An early diagnosis.
2. Urgent surgical interference.
3. A proper after-treatment.

The diagnosis is not inferred, alone, from absence of urine in the bladder, because shock may be so severe as to cause suppression; neither from a rise of temperature or blood in the urine, because these conditions are often present when no rupture has taken place; but that dulness was present above the pubis, even after the catheter had been used, and that measured quantities of boric solution flowing into the bladder failed to return when called upon, and not only failed, but increased the dulness previously marked out, was all evidence of the strongest character that rupture of the bladder had occurred.

Some advise the injection of air as an aid to diagnosis, but it seems a risky thing to force urine through a possible rent in the wall into the peritoneal cavity, when a mild aseptic solution, such as boric acid, answers equally well.

My reading of several cases of rupture of the bladder satisfies me that some of the fatal cases were those in which the surgeon endeavored to do too much rather than too little. A case is recalled to me, where a patient was operated upon for right inquinal hernia for the fifth time. Evidently adhesions had formed extensively, for the bladder was caught in the grasp of one of the sutures. Five days later, the peritoneal cavity gradually filled up with urine (two gallons, if a tablespoonful). The wound was reopened by the attending physician, a tube inserted and the patient recovered, to be operated upon again for the sixth time, doubtless, by some aspiring and adventurous doctor.

If this case of rupture of the bladder had been intra-peritoneal, the same immediate operation would have been necessary, double suture of the bladder wall, dry mopping of the peritoneal cavity with sponges, and retention of a catheter in the bladder.