the urethra taken from animals, plastic operations, have all been attempted, as well as approximation of the remaining portions of the urethra by mobilization which is here specially dealt with.

He relates the case of a young man injured in a railway accident. There was found to be fracture of the pelvis and rupture of the urethra. After various operative procedures and temporary relief the man later appeared with acute retention of urine which was relieved by suprapubic drainage—later the urethra was explored and it was found that the fractured pubic arch lay between the severed ends of the urethra which had retracted upwards.

The following operation was carried out successfully:—

A curved incision was made in the perineum from one tuberosity to the other, passing about one and a half inches in front of the anus. The rectum was freed from the scar tissue and pushed back and the prostate was mobilized by blunt dissection. A vertical incision was then made over the bulbar portion of the urethra and the anterior urethra freed from scar tissue and exposed to a distance of two and a half inches.

The urethra was entirely freed from the surrounding tissues to the penoscrotal angle. The mobilized portion was two inches in length. The divided ends were then approximated without tension and united with catgut sutures over a soft rubber catheter. There was satisfactory union and later a No. 20 F bougie could be passed without difficulty.

Dr. Cabot points out that this case shows the extent to which the perineal and scrotal portions of the urethra can be mobilized without danger to their blood supply and the size of defects which may be thus bridged. At the time of operation the distance between the ends of the urethra was two inches, the mobilization of the prostate diminished the space one-half inch, the gap ultimately filled was one and a half inches. The separation of the urethra from behind forwards did not cause the damage from interference with blood supply which might be theoretically expected. Success depends on approximation without tension; if this cannot be done, retraction will follow, resulting in a long fibrous stricture. Union without stretching of the scar results in an annular stricture which can be treated by dilatation.

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Peritonitis in Children from Unknown Sites of Infection.

The Annals of Surgery of December 1908, contains an article on this subject, by Dr. Charles N. Dowd, of New York.

He says there are certain phases of peritoneal inflammation in children which differ enough from those ordinarily found in adults to justify their special consideration.

Children are more likely to have rapidly spreading insidious forms of peritonitis than are adults, since they are less likely to encapsulate the inflammation. They are less likely to be constipated during its course and hence have less of tympanites. They are much more likely to have associated cerebral symptoms, so that there may be difficulty in determining whether the condition is primarily cerebral or abdominal.

Pulmonary inflammation is often accompanied by abdominal pain and rigidity—beginning pneumonia may be mistaken for appendicitis. Pneumococcus peritonitis is much more common in children than in adults. General gonococcus peritonitis occasionally occurs and tubercular peritonitis is common.