At this date there was no suspicion of anything being wrong with the bladder. The little patient seemed better for a short time after the removal of the fluid, but soon began to complain as before, especially when he attempted to urinate. The effort at micturition was attended with a good deal of straining and bearing down pain, and the child was constantly pulling at the prepuce. The parents again took the patient to the consulting surgeon and gave him an account of the symptoms. He immediately suspected stone of the bladder. He did not sound him at the time, however, as he had no suitable instrument, but told them to call back in a week or ten days. It was about two weeks before they returned, the symptoms evidently not being very urgent at that time. The surgeon administered chloroform, introduced the sound and examined carefully. He could detect no stone, but felt some thickening of the anterior wall of the bladder. Considerable hemorrhage followed the introduction of the sound. The child continued to strain very much in urinating, and now and again seemed threatened with retention of urine. A few days after the introduction of the sound, there was again some hemorrhage from the bladder; these were the only occurrences of hemorrhage. The amount of blood was not great—probably about half a teacupfull. The surgeon in charge then advised the parents to take the child to the Toronto General Hospital for treatment, and he was admitted under my care. At the time of his admission his mother stated that he had not passed any urine for nearly 24 hours. The abdomen was enlarged and felt quite hard as if the bladder was ready to burst. I introduced a catheter, but was astonished to find that only a small quantity of urine mixed with muco-pus escaped. On placing my hand over the abdomen it still felt quite hard, and there appeared to be a solid mass between the point of the catheter in the bladder and my hand, for which I could not account. On examination per rectum, I made certain that the instrument was in the bladder, and the posterior wall of that viscus felt quite normal. On the supposition that it might be an abscess in the abdominal wall, I ordered the child to be put to bed, to have a warm poultice applied, and a few drops of laudanum administered. This gave great relief. As might have been expected there was considerable febrile disturbance; skin hot and dry. The bowels were kept freely open. On the following day the catheter had again to be introduced as the child was still unable to pass any urine. After drawing off the urine, which was small in quantity and mixed with pus, I introduced a very soft catheter with the view of leaving it in, but it was not long until the child, in one of its fits of straining which came on at intervals of a few minutes, forced it out with great violence. I then introduced a small silver catheter with a short beak and tied it in. Through this the urine escaped for the next two or three days. In the meantime there was no amelioration of the symptoms—the child was evidently growing rapidly worse. I had held out no hopes of the child's recovery to the mother from the first. Fearing that the catheter might increase the irritation I removed it, and drew off the urine as required by means of a gum-elastic catheter. Although somewhat puzzled at first in regard to the diagnosis, I had now come to the conclusion from a close scrutiny of the history, that it was a case of polypoid fibroma of the bladder. I stated my conclusions to several of my confrères, but they seemed incredulous. Some thought it was a perineal abscess, and advised me to make an incision. This opinion was, in some measure, justified by the fact that the urethra was enlarged, and pus from the bladder escaped through it during the last day or two of the child's illness, but as I had watched the case closely and examined the parts carefully, I felt certain there was no abscess. The passage of a small polypus about this time verified my diagnosis. The child died on the 11th day from the date of admission, and a *post mortem* examination revealed the true nature of the case. The bladder was completely filled to distension with polypoid growths which sprang from a pedicle about an inch in width and a quarter of an inch in thickness, and was attached to the left anterior wall of the bladder. The coats of the bladder were thickened except at the summit, which had ultimately given way by ulceration. Urine and pus escaped into the abdominal cavity and brought on fatal collapse. The ureters and pelves of the kidneys were very much dilated, and the kidneys more or less congested. The urethra and neck of the bladder were also dilated. The polypoid growths which were globular in shape, smooth and even, have shrunken very much since placing the specimen in alcohol. Under the microscope the tissue appears lax and