patient was placed under ether, the bladder emptied of urine and injected with a warm solution of boracic acid. The largest size Barnes' dilator was inserted in the rectum and distended with warm water.

An incision was made over the hypogastric region about three inches long, reaching to the pubes, when the distended bladder came into view. To make sure of the incision into the bladder, I passed a No. 16 sound without allowing any of the boracic solution to escape, and cut down on the point of the instrument.

A silk ligature was then passed through the upper edge of this bladder wound, to prevent the bladder receding during the subsequent steps of the operation.

The sound was then withdrawn, the bladder wound enlarged, and the stone, which turned out to be an oval mulberry calculus about one inch long, was removed from the bladder by the finger. The bladder wound was then stitched closely with continuous catgut suture. The abdominal was also closed with continuous catgut suture, except at the lower part, where a small rubber drainage tube was inserted, but this was afterwards found to be useless, and was removed on the third day.

A soft rubber hose catheter was inserted in the bladder through the urethra, tied in and not removed until the eighth day. Strict antiseptic precautions were carried out during the operation, and the wound dressed antiseptically as after a laparotomy.

The urine was bloody for several days, but the patient never had any elevation of temperature, while the pulse kept normal, and the wound healed completely without a sign of pus. A few weeks afterwards he returned to his occupation, and expressed himself as feeling better than he had for fifteen years past, and to-day he is in excellent health.

While most of the authorities advise the bladder wound to be left open, and even a drainage tube to be inserted in the bladder to allow the urine to drain away, I thought that as Sir Wm. McCormack, in his cases of laparotomy for ruptured bladder, had stitched the bladder wound and closed the abdominal wound, the same treatment ought to hold good in suprapubic lithotomy.

SEVERE BICYCLE ACCIDENT—PERITONITIS HÆMATURIA—RECOVERY.

BY J. J. CASSIDY, M.D.

Having recently read, in the daily papers, of a fatal acccident to a young man, caused by falling from his bicycle, I have thought that the report of the following case would be interesting to the readers of the PRACTITIONER.

June 8, 1888, 8 a.m. Saw A. M., aged 25. The patient was in bed at his lodgings and was suffering from shock; pulse irregular, surface of body cool. He informed me that while alighting from his bicycle, about an hour previous, his left foot had caught in one of the pedals of the wheel, and he had been thrown forward on the road. The parts of his body, which struck against the macadamized road were the umbilical and right lumbar regions. So severe was the shock that he could not speak and was unable to rise. Some bystanders helped him over to the sidewalk, where he remained for about a quarter of an hour. He subsequently endeavored to reach his lodgings, taking his bicycle with him, but looked so ill that an acquaintance took charge of the bicycle, while A. M. struggled on on foot, and finally reached his lodgings, which were about a mile from the spot where he had fallen.

I ordered complete rest in the recumbent posture, and prescribed morphine gr. ¼ every four hours.

June 8th, 8 p.m. The patient, who had recovered from the shock, passed a considerable quantity of bloody urine. No pain in the region of the bladder, tenderness in the right lumbar region.

June 9th, 10 a.m. Temperature, 100°; pulse, 100. Abdomen tympanitic and tender. The patient's mother arrived and began to nurse him. Milk diet. 6 p.m. Urine quite bloody—patient urinates twice a day. Treatment continued.

June 10th, 10 a.m. Temperature, 103°; pulse, 129. Urine very bloody. Added to diet 4 oz. whisky per diem. 9 p.m. Temperature, 101¾°; pulse, 129. Complains of great distension of abdomen.

June 11th, 12 noon. Temperature, 100½°;