on the right side, and not only the bladder, but also the large vessels of the pelvis were exposed to view, my intention being to find the ureter, and to cut it off close to the fistula, and to transplant it into the bladder higher up, without opening the peritoneal cavity at all. Although I nearly succeeded in doing so, and would have no difficulty in doing so should I ever have a similar case, yet on this occasion several circumstances threw me off the track, and I was eventually obliged to follow the same plan as I had seen Sanger follow in a similar case in Leipsic, when I was there three years ago, namely, to open the peritoneum, running over the large vessels at the brim of the pelvis and to feel for the artery, see the vein and pick up the third tube, which was the ureter. One of the circumstances above referred to was the vomiting, which started violently the moment the anesthetizer ceased to pour on the anesthetic, and this he often stopped doing, because she was so weak; and another was the distension of the stomach and colon with gas, although the bowels had been well moved and the small intestines were collapsed. The third circumstance was the retroversion of the uterus, owing to which I found two round tubes dipping down into the pelvis—one being the ovarian vein, and the other the round ligament. I mention these little difficulties so as to help any of my hearers who may have to perform this operation. Had it not been for the vomiting and distension of the large bowel, the intestines would have been easily pushed into the upper abdomen, as the patient was in the highest Trendelenburg posture, without which, indeed, the operation for me would have been well nigh impossible. Another cause of the difficulty in finding the ureter was in not first passing the probe into it from the vagina before the operation; for when I asked one of my assistants to do this during the operation he was unable to find it. When at last I was reluctantly compelled to open the peritoneal cavity, I had only to make a little slit in the peritoneum lining the wall of the pelvis in the line where I knew the ureter should be, when I quickly came upon it, and picked it up. About one inch of the lower end of it was imbedded in cicatrized tissue, and, of course, this much of it had to be scarified; a silk ligature was passed around it, while my assistant pulled it taut and tightly tied and cut it off. The ureter was then severed a little above the ligature, and covered with a gauze sponge, as urine came from it. As most of the deaths or failures to unite have been due to the septic condition of the urine, I had taken the precaution to administer urotropine for a week before, so that I was not afraid of a drop or two of urine escaping; and as stricture of the ureter is another cause of failure, I did not wish to bruise it with a Pean forceps. We all thought it much thicker than we had ever seen it before; perhaps the obstruction at the site of the injury had caused it to hypertrophy, as it is a muscular tube capable of peristalsis. The