try ox-gall pills, malt extract, peptonized food, etc. Still no bile ever appeared in the stools, and the patient kept steadily, though slowly, emaciating.

I proposed cholecystotomy as an expedient that would remove jaundice and itching, and give time to get rid of or overcome, if possible, the obstruction.

Before operating, it was decided to call Dr. J. E. Graham, of Toronto, and, on February 28th, Drs. Graham and Fraser saw him with me.

After careful examination, Dr. Graham confirmed our diagnosis of enlarged gall bladder, inclining to the opinion that the obstruction was malignant, but, possibly, a large, smooth stone blocking the common duct, the chief argument against stone being the entire absence of bile in the stools, as some bile is apt to find its way past a stone.

The proposal to operate was submitted to Dr. Graham, and he advised it.

The whole matter having been explained to the patient, and his consent obtained, I arranged to operate on March 6th, assisted by Drs. D. B. Fraser, Stratford; Minchin, Berlin; McGillivray, Wellesley.

The operation lasted about two hours. An incision about five inches long was made parallel to and about an inch below the lower border of the right ribs, carried through the skin muscles and down to the transversalis fascia. Then, carefully picking up, first, the fascia, and cutting it, I came upon the peritoneum, which I picked up, opened carefully, and ran in a director, upon which I made an incision three inches long, exposing the enlarged gall bladder. This I secured by passing into its wall two strong silk threads, drawing it well into the opening, and thrusting a large trocar and cannula into it between the threads. On withdrawing the trocar about one and a half pints of dark-green tenacious fluid ran out. I washed out the gall bladder, enlarged the opening in it to about two inches long, searched carefully with the finger, then with the probe, for cause of obstruction. I examined also the duodenum gall ducts and pancreas for cause of obstruction, but could not find either a stone or nodular mass such as we would expect to find with a malignant growth. Could not pass probe into the duodenum. As patient was very weak, I was obliged to hasten the close of the operation, which I did by sewing the peritoneal covering of the gall bladder to that of the abdominal wall, and next the orifice in the gall bladder to the skin.

The bile flowed freely during the operation, and I had difficulty in preventing its escape into the peritoneum. Having completed the operation, I inserted a Spencer-Wells ovariotomy tube, and put over it an antiseptic absorbent dressing.

He rallied nicely, and passed a good night. Next morning, on my return, I found him bathed in bile, the whole dressings saturated, and his