cholecystectomy may be attended with grave risks, immediate and remote. Twice have I been called upon to make the attempt to re-establish the continuity of a common duct completely occluded, in both of which cases the gall-bladder had been previously removed by another and supposedly competent surgeon, and there was reason to believe that the obstruction to the duct had resulted directly from faulty methods pursued at the time of its removal. The advocates of cholecystectomy will at once say the methods were faulty, that there was no need of obstruction following. True, but here is a situation which did develop and which might result from other causes, and which when it does occur is an extremely difficult one to handle. Let us consider, then, some of the questions which have just been raised. Failure to remove stones when they exist! Is it possible in every case to remove every stone? Is it possible always to find them when present? My own experience compels me to answer both of these questions in the negative. I have had it happen twice, that upon opening the abdomen and palpating the biliary tract that as much care as I could exercise (and the greatest care should always be exercised) I have surely felt a stone in the common duct. Upon subsequently opening the duct and after the most diligent search, I have not been able to find it again and have been compelled to experience the chagrin of having to close the abdomen and leave the stone. During our manipulation, did it escape into the duodenum, or did it recede into the hepatic duct or liver? A question I cannot answer, but there is good reason for believing that sometimes it follows one and sometimes the other course.

I have a patient in the hospital now who had been operated upon twice before for gallstones. The first operation, performed about three years previously by another surgeon, left a persistent biliary fistula. The second, performed by myself, a cholecystectomy, was followed by complete relief for over a year. Recurring attacks of colic accompanied by pain, chills, fever and jaundice, caused him to return to me again for relief. He had a typical and severe attack in the hospital, the night before the third operation, a month ago. This case well illustrated the difficulty often met with, owing to the absence of the gall-bladder in finding and freeing the common duct, in case a subsequent operation is necessary after a cholecystectomy. After some considerable difficulty in freeing dense adhesions, the duct was exposed and opened. We had confidently expected to find a stone in the ampulla, as the history had been so characteristically that of the type described long ago by Charcot. Greatly to our surprise, a most thorough search of the hepatic and common ducts showed them to be empty. A full-sized uterine sound passed readily into the duodenum showed no