to shock, sepsis, and prolonged healing. The beginner is prone to the mistake of opening the bladder too near to the pubis for fear of wounding the peritoneum.

The enucleation of the gland must next be considered. For this almost the sole instrument that I use is a knife of my own design. The knife has a slender straight handle about eight inches in length, with a stout short sickle-shaped blade, having a cutting edge of from one-quarter to one-third of an inch. Guided by the fingers, the blade is plunged into the right lobe towards its upper or back part. Into the opening thus made the finger is inserted and enucleation continued in the lines of least resistance, above, below, backwards and forwards. The object aimed at all the while is to save every portion of the capsule and interlobular septa and to remove the gland substance only. When resistance is met, brute force is not used, but the little knife comes to the rescue. It is passed into the opening in the gland and a short cut made at the seat of obstruction, the direction of the cut being, as a rule, inwards and upwards or towards the abdominal wound. The whole gland may be removed from this opening. I frequently open on the left lobe as well, from which I work with the left hand. The vessels in the gland substance are not large and there is not much bleeding if the operator hugs the gland, as it were, and keeps the capsule to the outside of the finger. When enucleation was carried out in this way, we never had bleeding that called for packing or other measures, besides the parts fall naturally into position after the gland is removed.

As the operator gains experience, he will often dispense with his own fingers or the fingers of an assistant in the rectum and also the use of a catheter in the bladder as a guide.

A clumsy or rough assistant may cause distress and even much damage to the rectal wall. This will be manifest in the after-treatment of the patient.

The Sutures. Two only are required. The upper passes through the recti and takes a deep bite of the peritoneal fat, care being taken to avoid the peritoneum itself. The lower one goes through the recti just above the pubes and takes a bite of the tissues below the bladder wall. These are tied loosely and must be removed early if observed to cut. Sloughs are allowed to separate naturally. The patient chooses any position that is most comfortable and is encouraged to sit up for a time (not long enough to tire), on the second or third day. Water is given freely. Urotropin and other medications are at times given with benefit.