

parietes and there were many relapses. The next step was to separate the fatty capsule from the kidney and pass the sutures through the fibrous capsule, but it was soon discovered that the capsule stripped off very readily. Then advancing a step further the suture was passed into the kidney tissue, including both parenchyma and capsule. Experience soon showed that no apparent injury was done to the kidney and a much more secure approximation was effected which gave better permanent results. Other methods employed have been to abrade the fibrous capsule or to partially remove it in order to approximate a raw surface to the transversalis fascia; to pass the suture around the last rib or through its periosteum, etc. Generally speaking, however, the method employed at the present day is to pass three to four or five sutures through the fibrous capsule and kidney tissue for the space of three-quarters of an inch in length and a quarter of an inch to half an inch in depth and attach them to the cut edges of the transversalis fascia and oblique muscles. There is probably no better arrangement of the sutures possible than that recommended by Mr. Morris—to pass a suture from each edge of the wound near the convex border of the kidney (including muscle, fascia, capsule and kidney tissue) and a third nearer to the hilum, this latter to include both edges of the wound as well as capsule and kidney tissue. For suture material catgut has been pretty generally abandoned. Silk is open to the same objection in this as in other operations—that is, that occasionally a sinus forms and persists until the suture is removed. Animal tendon has been employed, and silk-worm gut has of late been used perhaps more frequently than any other material. It seems to be free from objection and answers every purpose. In the *Revue Médicale*, No. 6, June, 1895, is described a new operation for the fixation of floating kidney by Vulliet and Poulet. It is described as fixation by living tendon and consists in suture through the capsule by a detached tendon of the dorsalis longus muscle. (I can only say of this procedure that it seems to me at first sight to be an unnecessarily complicated one.) It is probably better in most cases to allow the wound in the parietes to heal by granulation, both to avoid the risk of cellulitis and to secure a firmer adhesion in the line of the wound. This does not involve any considerable delay in healing, as the wound contracts and closes with amazing rapidity. The anatomical distinction between floating kidney, which is surrounded by peritoneum, has a distinct mesonephron and is congenital; and movable kidney, which is retroperitoneal, has no mesonephron and is generally acquired, is of no practical importance surgically and probably could rarely, if ever, be made out during the performance of an ordinary operation for fixation of the kidney.