pository after the operation, and prevent movement of the bowels for three or four days.

Division of the base of the fissure is very frequently done by introducing the finger into the anus, and then, with the finger as a guide to the upper extremity of the fissure, a sharp pointed curved bistoury is introduced at the side of the anus and carried through the base of the fissure up to the point of the finger. This method of performing the operation is dangerous, and surgeons have been attacked with syphilis in consequence of pricking the finger with the point of the bistoury. The safer plan is to lay a straight blunt pointed bistoury flat upon the finger, to introduce the finger with the bistoury in position, to feel for the upper extremity of the fissure, and then to turn the sharp edge of the bistoury towards the ulcer, the back of the bistoury lying on the finger. The knife is then carried through the base of the fissure by the pressure of the finger. The bistoury to be used, though probe pointed, must have a cutting edge to its extremity.

Prolapsus Recti in the child is very often a symptom of stone in the bladder. The child may be brought to you with the prolapse down for some time. It may be reduced by manual pressure, but the simplest way to reduce it is by elastic pressure with a T shaped bandage, placing a pad of cotton wool between the bandage and the prolapse. In elderly people, prolapse of the rectum is generally due to chronic relaxation of the sphincter ani, and levator ani muscles. The removal of the redundant skin around the dilated anus may assist in keeping up the prolapse. Special instruments are made for preventing its descent, but the most efficacious method is a double T bandage, with two vertical limbs, each one attached, both in front and behind, to a firm pelvic band, and crossing in the perineum over the anus. At the point where they cross, a pad of lint is interposed between the bandage and the anus.

Fistula in Ano The most satisfactory way to divide a complete fistula is to pass a probe from the external opening along the sinus, through the internal opening, and then by bending the probe to bring its point out at the anus. The probe is then cut out, and the septum is in this way completely divided. There is a grove in the probe which acts as a guide to the knife. Care must be taken in the after treatment by stuffing the wound, to cause it to heal from the deepest parts towards the surface.

Bladder. Chronic cystitis is one of the most troublesome affections that the surgeon is called upon to treat. The primary cause is often due to the introduction of organisms with an unclean instrument, and therefore in all cases in which, by the presence of increased quantities of mucus or of pus in the urine, along with frequency of micturition, a diagnosis of cystitis is made, the urine should be carefully examined for the presence of organisms. If they are present, corrosive sublimate should be administered internally in small doses, and the bladder should be washed out with antiseptic solutions. No rule can be laid down as to the special antiseptic to be used. The great point to attend to is that the bladder be repeatedly filled and emptied until the fluid escapes free from all sediment. The best way to wash out the bladder is to introduce a red rubber catheter with a "velvet eye," and to attach to this a T tube of glass. To the vertical branch of the T an india-rubber tube four feet long is fixed, and is passed into a vessel containing the fluid to be injected. This fluid should be tepid and contain an antiseptic. To the horizontal limb of the T another piece of tubing is attached, in order to carry the fluid from the bladder. The outlet tube being pressed with the finger and thumb, the vessel connected with the inlet tube is raised, and the fluid is allowed to flow into the bladder until the patient feels slight discomfort. The inlet tube is now grasped with the finger and thumb and the fluid is allowed to escape by the outlet tube. This is repeated again and again until the bladder is thoroughly cleansed. In many intractable cases this method of treatment is not sufficient, because the bladder is an organ which is never at rest. When it is inflamed from any cause, its diastole and systole, instead of being repeated three or four times within the 24 hours, takes place much more frequently. In such cases it will be necessary to give the bladder rest, either by bladder drainage, according to the method recommended in the MED. ABS., p. 4, 1881; or should this plan fail, as it may do if there is much mucus which plugs the tube, the membranous urethra must then be opened on a grooved staff, and a tube introduced into the bladder through the wound, which allows the urine constantly to drain away as it escapes from the ureters. The tube introduced should be as large as possible to prevent any risk of blocking, and the bladder should be washed out through this tube, so as to clear away any mucus which may collect at the floor of the bladder. Such a tube may be kept in for a fortnight without risk of a persistent fistula remaining.

Hypertrophy of the Prostate. If a patient says he has to rise at night to make water, and that he makes water during the day with increased frequency, always be suspicious that he is not emptying his bladder completely. He makes only the overflow from a distended viscus. When there is a tendency to obstruction of the flow of the urine in consequence of hypertrophy of the prostate, there is little doubt that the occassional passage of a large-sized bougie is of value in keeping the channel patent.

Stricture of the Urethra. Organic stricture of the urethra is caused either by an injury to the urethra or by gonorrhœa. After a gonorrhœa