It may likewise be suggested that the particular operative procedure attempted, namely, intra-peritoneal cystotomy, may have contributed to the occurrence of the accident; the support which the rectal walls receive from intra-abdominal pressure being lessened by the incision in the walls of the abdomen.

There are only two recorded instances of rupture of the rectum, prior to my own, occurring during an attempt to perform supra-pubic opening of the bladder. There are several references made to other cases, but these cannot be authenticated. Prof. Keyes, of New York, quotes the case of Nicaise, and then remarks that four or five other instances of this accident have occurred in France. It has been impossible to find any other reference to these cases except in the course of some remarks by M. Th. Anger, in the discussion upon M. Nicaise's paper, above referred to, and which is reported in connection with the latter. Mr. Anger says: "The case of M. Nicaise is the fourth or fifth of the same kind; I have therefore rejected the use of Petersen's balloon." A most thorough and extended search in the library of the Surgeon-General's office, including the proof-sheets of the forthcoming number of the Index Catalogue (Vol. XI.), having proved fruitless, I am forced to conclude that either M. Anger has not been properly reported, or else the cases which he referred to had come to his knowledge through channels other than the ordinary ones of information through publication.

The same kind of hearsay evidence seems to have been accepted by no less an authority than Sir Henry Thompson. In the article, "On the Supra-pubic Operation for Opening the Bladder," he makes use of the following language:

"First, in regard to the rectal distending bag. It has hitherto been made of a spheroidal or pyriform outline, and some operators, *it is said*, have, in emptying it, burst or seriously injured the rectum."

A further detail of facts in these cases, such, for instance, as those relating to the amount of fluid employed in distending the rectal bag, together with the condition of the rectal wall, would have been of incalculable importance in clearing up the question as to the dangers to be apprehended in the employment of this device. Two facts are undeniable: First, the advantages which the supra-pubic route to the bladder affords in certain cases, and second, the almost indispensable assistance afforded by the rectal bag in overcoming the principal difficulties and dangers of the operation.

THREE LAPAROTOMIES ON ONE PATIENT. RECOVERY.

BY H. C. DALTON, M.D.,

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Peter M., laborer, æt. 30 years, a strong stout man, was admitted to the hospital June 28, 1888. An examination revealed acute appendicitis, for which I operated the next day. The case was reported in the *Annals of Surgery*, February, 1889.

He returned to the hospital August 12, 1889, with a ventral hernia at the site of the operation. The hernia was pendulous, and formed a tumor as large as the double fist. In the operation to remove the diseased appendix, an incision, four inches long, was made, commencing an inch above the centre of Poupart's ligament, extending upward and outward. The cicatricial tissue covering the hernia was extremely thin.

I concluded the best procedure would be to make an incision in the centre of the cicatrix, cut away all of the same, and bring the sound tissue together. In attempting to execute this idea, I made an incision in the centre and in the long axis of the cicatrix, holding it well up, as I supposed, from the intestines. When the knife entered what we took to be the peritoneal cavity, I was mortified to find that I had cut directly into the intestine. Fluid fæces flowed from the wound. The finger introduced showed that the gut was adherent to the entire under surface of the cicatrix—that they were virtually one wall. I next made an opening into the cavity through sound tissue to the inner side of the cicatrix, introduced the finger and attempted to break up the adhesion between it and the intestine. I succeeded in this, but in doing so tore the opening in the gut still larger. I now had the gut denuded of four inches of its peritoneal coat, with a transverse hole in it occupying half its circumference. Resection being plainly the only feasible procedure, I then removed four inches of the intestine, together with sufficient mesentery to make the proper V-shape. The mesenteric wound was closed by a continuous silk suture.