of the peritoneal cavity or of oozing after the kidney is got out.

These last two objections do not appear to me to have much force.

8. The after-complication of ventral hernia is much more probable by this method.

Of all the objections to the abdominal route the danger of interfering with the vitality of the colon, as happened in my case, will be the strongest, but its advantages are manifest where there is much difficulty in getting out the kidney, and in cases of old inflammations where by the lumbar incision it would have to be dug out by touch with very little help from sight.

Mr. Jacobson advises the removal of cases of strumous pyelitis or pyo-nephrosis explored previously and drained by nephrotomy but in which a sinus and discharge persists when the following conditions are favourable, viz., the age and strength of the pateint, the absence of visceral infection tubercular or lardaceous, and, if possible, a date not to long deferred, for the additional reason that the kidney will be increasingly matted down and difficult of removal while its fellow may have become involved in the disease.

Moreover we have found that in advocating in favour of the lumbar incision converted into a T-shaped one or prolonged forward by Konig's method. he says "Thus modified it will suffice for new growths in their early stages." "If these are operated on later one of the abdominal methods will have to be made use of."

Now to return to Dr. E. Hurry Fenwick whom I have already quoted, it would appear that there *are* cases requiring "the much more dangerous incision" as he calls it, and that there is no prospect that the route "will become almost obsolete."

In my case the thickened and adherent capsule would inevitably have to be left behind had the lumbar incision been adopted. To remove the capsule, a second operation would be necessary if the patient did not in the meantime succumb to the drain on her system, and this second operation would have to made through the abdominal cavity.

I confess however if I were doing the operation over again, with my present experience, I see where much valuable time could have been saved. Having by incising the tumour ascertained the nature of its contents I might have removed the elastic ligature, drawn the sac well out of the abdominal wound and emptied the contents as in an ovarian cyst. This would have afforded more room to enucleate the sac later on and to tie the pedicle. It would also have caused less danger of contaminating the peritoneal cavity. Also a smaller wound in the meso-colon would have sufficed, or at least that organ would have been subjected to less handling and violence. But not knowing the strength or extent of the adhesions. below the point to which the finger could gain access before empyting and cutting off the portion anterior to the elastic ligature, I feared any undue dragging on the pedicle. We learn by our mistakes, and if these are fully and candidly recorded others may learn the lesson as well.

As you will be interested to know the pathological conditions presented in this case, I herewith give the report of Dr. Adami of McGill College, to whom the specimen was submitted.

Diagnosis.

Chronic Tubercular Pyonephrosis.

To the naked eye, the portion of kidney presented numerous cysts,—some empty, others containing whitish inspissated material. Many of the cavities in the substance of the tissue appeared to communicate with what I regarded as the pelvic area of the organ. Microscopically: Very little kidney tissue proper remained Here