the rectal wound and out of the anus. The forceps is then passed back beside the catheter through the same opening and made to grasp lightly the distal end of the ureter, or rather its rosette of bladder tissue, and this is now carefully conducted through the opening and made to protrude into the rectum. Very great care should be taken not to injure the ureter during this operation.

The same tactics are repeated upon the opposite side, and thus the ureters are drawn through so that their distal ends together with the rosette of bladder tissue, are made to project into the rectum as two prominent papillæ (Fig. 2, B). The catheters, of course, pass out through the anus, and are directed into the mouths of separate bottles containing a solution of carbolic or boracic acid. In this way one can ascertain that both kidneys are working, and if one catheter should become plugged (as happened in one of my cases) with urates or phosphates, it may be immediately withdrawn.

It will be observed that no effort is made to stitch the ureters into position. In fact, I have not found this at all necessary in any case. There is nothing to cause them to move out of their position, and the vitality of the ureters is not impaired by the traumatism which would result from such suturing. In order, however,to support the delicate ureters in their new position, and to prevent the injurious effects of any extravasation that may occur from the rectum to the wound in the pelvic cellular tissue, the wounds are packed on each side fairly firmly with iodoform gauze. This is left in position for two or three days, and when removed it is found that the parts fall together without, as a rule, allowing any extravasation from the rectum; or if there should be any, as happened in my third case, the gauze affords sufficient drainage, and the wound heals quickly by granulation.

The treatment of the exstrophied bladder tissue will depend upon the amount of bladder tissue exposed, and upon the extent of the hiatus in the abdominal wall. In my first and third and fourth cases, I found that all that was necessary was to dissect away the exposed mucous membrane of the bladder, which in these three cases was not of any great extent, and allow the whole to heal by granulation. In my second case, however, the closure of the hiatus in the abdominal wall called for a very considerable plastic operation, which I shall presently describe.

Case 2.—G. R. H., male, aged 13. His family history is good. He has five brothers and two sisters all healthy. He is the youngest of the family. There is nothing in the personal history of any importance except the physical condition for which he entered the hospital, viz.: exstrophy of the bladder, which is, of course, congenital. He was at the time of admission a fairly well-developed boy, but had an extremely listless, depressed and