Two deaths occurred in cases complicated by common duct stone and infected bile.

Of hydrops of the gall bladder there were four cases, two of which were complicated by stone in the common duct. In all cases radical operation was carried out without mishap.

Of chronic cholecystitis without stone there were eight cases. These cases had suffered from time to time from severe attacks of pain simulating gall-stone colic. Adhesions were found at operation in all cases. Examination of the extirpated gall sacs showed the presence of chronic inflammation. Pancreatitis was present in three cases. Excision of the gall bladder associated in two instances with drainage of the common duct was practised. One fatality occurred from gangrenous perforation of the gut, due, it was thought, to embolism.

The operative technique of cystectomy remains essentially the same as that formerly described by Körte. The incision begins near the middle line in the epigastrium and extends outward parallel to the margin of the ribs, then descends obliquely downwards and outwards to the level of the umbilicus. The inner portion of the rectus muscle near its attachment to the costal margin is obliquely divided. The outer portion of the rectus together with the lateral nerve remains undisturbed apart from blunt dissection. In the upper part of the abdominal wound division of the ligamentum teres, which should be subsequently sutured, gives better access. In addition to the protection of the abdominal muscles from infection, the field of operation should be isolated from the colon, omentum, stomach and duodenum by means of gauze sponges. In separating the gall bladder two flaps of serosa are provided to cover the denuded liver. After separation of the bladder the cystic duct is divided between clamps. Where the duct is distended with fluid, aspiration before division should be practised. More difficult than the removal of the large inflamed gall bladder is that of the small, sclerosed, usually friable bladder which lies deeply under the liver, especially when that organ is the seat of chronic cholangitis. The author is greatly impressed with the importance of a thorough examination of the gall passages (the cystic, common, and hepatic ducts), without which no one can with certainty exclude the possibility of stone or tumour. Where many small stones are found in the bladder, one must in every case slit up the cystic duct to the point of its entrance into the common duct. In cases where one meets with one or more large stones and the cystic duct is narrow and its mucous membrane normal, one may be reasonably sure that the deeper passages do not contain concretions.

Where stone exists in the common duct, where there is doubt as to the