The patient being placed upon the operating table the pubes were shaved and the field of operation thoroughly cleansed, Dr. McColl administered the anæsthetic, and Dr. Clinton assisted me in the operation. The usual pear-shaped rubber bag was inserted into the rectum and slowly distended with eleven ounces of warm water. I adopted this procedure for the reason that, having distended the rectum and thus raised the fundus of the bladder, I would be enabled more readily to decide how much water would be required to safely distend the bladder as much as required.

By percussing over the bladder as it was being slowly filled with warm boric solution, I found that when eight ounces were injected the bladder had become quite prominent against the anterior abdominal wall to a distance of over three inches above the pubes. A rubber tube was tied around the penis to retain the water. An incision three inches in length was made in the mesial line through the abdominal wall down to the prevesical fat, which was carefully divided without tearing or undue disturbance, and the wall of the bladder reached. Having provided two full curved needles armed with sterilized silk, a suture was passed through the wall of the bladder on either side of the incision and given to my assistant. At this stage the patient was seized with vomiting and the peritoneum was observed to bulge down slightly into the wound. Dr. Clinton kept it out of harm's way with his finger and I at once opened the bladder with a quick thrust of the knife: the incision was extended so as to readily admit two fingers.

At this stage the hæmorrhage was free. The fingers were quickly passed into the bladder and the stone located. Some difficulty was experienced in dislodging it from its imbedded position, but with the aid of the index finger and seizing the stone with the lithotomy forceps this was soon accomplished and the stone extracted.

Hæmorrhage became still more free but soon subsided as the rectal bag was emptied. The bladder was thoroughly irrigated with hot boric solution. It was not considered advisable to attempt to close the wound in the bladder. Two rubber tubes eighteen inches in length and carefully prepared were selected, stitched together at intervals with silk, and several inches dropped into the bladder. The abdominal wound was partially closed by deep sutures, leaving the tubes in the lower angle of the wound. Iodoform gauze was then packed firmly in the wound around the tubes and the patient conveyed to bed. An additional piece of tubing was attached to each of these so as to facilitate drainage over the side of the bed into a vessel. This arrangement of tubing acted so admirably, that the dressing was not even soiled, and it was found possible to irrigate the bladder