dentia was, of course, the most urgent, and operation for this was performed on November 7th, 1896. It was not, however, until two years and eight months later (July 15th, 1899) that the ureters were transplanted into the rectum.

Operation for Procidentia Recti.—On December 7th, 1896, an incision was made in the median line above the umbilical opening (Fig. 3 *d*). It must be remembered that there was really no proper umbilicus, as the open wall of the extroverted bladder occupied all the space between what should have been its lower margin and the public area. To one assistant was given the sole duty of preventing the urine from entering the wound or coming in contact with the bowel during the operation. A wound about 2 inches long having been made, the fingers were inserted, and the sigmoid felt for and identified. The procidentia was then reduced with great ease by traction from within the abdomen. The next step was to produce a narrowing of the lumen of the gut by folding in its anterior wall (Fig. 1, *a* and *e*), and stitching together the edges of the gutter so as to retain the fold. Six stitches of silk were inserted and made to include a goodly portion of the serous and muscular coats so as not to be readily pulled out. The lowest stitch was placed as low down towards the anus as it was possible to reach. In this way the wide part of the prolapsed bowel (the intussuscipiens) was narrowed so as greatly to prevent the tendency of the part above to effect a descent through it, and a strong fleshy column was created on its anterior unsupported aspect.

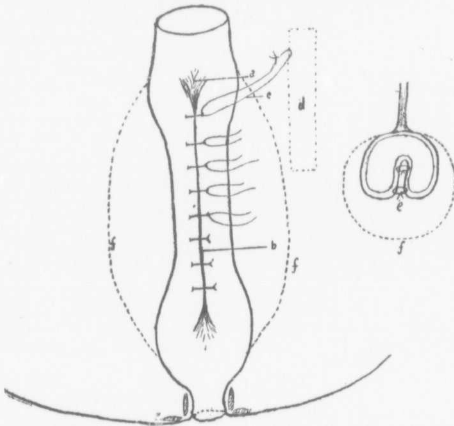

Fig. 1.—Narrowing lumen and forming fleshy column by infolding anterior wall of rectum. *a*. Top of fold; *b*, the fold stitched by one or two rows of Lembert sutures; *c*, suture in position to anchor rectum to abdominal wall *d*; *e*, transverse section showing fleshy column formed by fold; *f*, approximate relative size of rectum before infolding.

In order still further to secure the bowel one end of each of the sutures was passed by a needle deeply through the peritoneum and fascia of the abdominal wall (Fig. 1 *d*) as high up and as far outwards towards the crest of the ilium as possible. In this way the rectum was drawn up and anchored by tying the sutures a second time. The abdominal wound was then closed by silkworm gut sutures, and the buttocks and legs were strapped together by rubber adhesive plaster. Immediately after the operation violent straining came on and continued at intervals for about twelve hours. There was no protrusion, however, and the anus seemed well drawn up into the perineum. The bowels moved naturally on the