The next step consists in dissecting out the distal ends of the ureters with a fair-sized rosette of the adjacent mucous membrane and muscle wall of the bladder. In making this dissection, my experience teaches me that the safest and easiest method is to commence the dissection at the portion of the papilla nearest the pubes, as it is quite certain that here, at all events, the ureter will be uncovered by the peritoneum. One soon enters a cellular space through which the ureter with its contained catheter can be easily felt, and with the finger in this space the dissection is proceeded with, being exceedingly careful not to injure the peritoneum, which lies very close to the ureter at the upper part. However, with care there is, I think, practically no danger to the peritoneum, and in none of my cases have I any reason to suspect that the membrane was injured or molested. It will be found when the circular rosette of bladder tissue has been completely separated, that the remainder of the ureter can be easily dissected free, and care should be taken without any traction to follow it back in its curve, so that it will, when transplanted into the rectum, run practically in a straight line from the brim of the pelvis to its new situation in the wall of the rectum.

This part of the operation having been completed on both sides, the surgeon's attention is next directed towards laying bare the lateral wall of the rectum. This must be done largely, of course, by blunt dissection, and the process is very greatly facilitated by the presence of one finger of the operator or his assistant in the bowel. The absence of the pubic arch renders it comparatively easy to lift the rectum towards the wound of operation, and thus bring it almost to the surface. If care is taken to keep well to the lateral aspect of the pelvis during this dissection, and to approach the rectum from this direction, the peritoneum is not endangered, but this portion of the operation should be conducted with extreme care, as it is difficult to tell how low down the peritoneum may reach in these abnormal cases, and the essence of my operation is its completely extra-peritoneal character.

The point selected for planting the ureter is that on the lateral aspect of the bowel (Fig. 2, B), just above the internal sphincter, and it has been found in every case that the ureter could be brought to this position without the least trouble.

Having thus determined upon and exposed the seat of implantation, a pair of forceps is passed into the rectum, and pressed against the selected spot. A slight cut is now made from the external wound upon the end of the forceps; this is forced through, and the little wound dilated very accurately, so that it will receive snugly and yet without compression the ureter with its contained catheter. The forceps is then passed through and made to seize the end of the catheter, and this is drawn through