

The operation in the case of thin-walled sacs is Pratt's operation with a low hernia incision. In the case of thick-walled sacs, the usual "Excision" operation with the same incision.

The incision has been used in all cases since June, 1907, with entire success; and is, I consider, the best incision for hydrocele and varicocele.

A CURIOUS CASE OF FISTULA IN ANO.

The patient was first seen by me on 28th July 1910. The history was that the fistula had been present for several months, and during this period there had been a continuous discharge of pus and fæces from the external opening.

On examining the part, a probe passed in from the external opening entered the anal canal about one inch above the external sphincter. The passage of the probe was difficult on account of a hard gritty mass which lay in the fistulous track and felt like a phosphatic stone.

The case was operated on the following day. The fistula was slit up and it was found that the substance on which the probe had impinged was a piece of chicken bone about an inch long and a quarter of an inch in diameter. The bone was quite hard and showed very little change. Its lower end was sharply pointed. The bone was laying loose in a cavity whose walls were firm and fibrous, and my impression was that the pointed end of the chicken bone had ulcerated through the wall of the bowel and given rise to the fistula. The shape of the cavity and its accurate adaptation to the shape of the bone supports this belief.

NOTES ON THE TREATMENT OF STRICTURE OF THE URETHRA, AND OF FISTULÆ.

BY P. C. GABBETT,

MAJOR., I.M.S.,

Professor of Surgery, Medical College, Madras.

It is very doubtful whether a urethra of which the lumen has become narrowed by inflammatory thickening extending beyond the mucous membrane can ever become free from the tendency to more or less gradual recontraction of its lumen, even excision of a stricture must leave a scar—and it is the nature of scar tissue to contract unless there is some opposing influence.

I have seen a urinary fistula form in the perineum of a patient who had been told that he was "cured" by internal urethrotomy five years previously, and had noticed no symptoms of recurrent stricture during that long period—if he had had a sound passed only once a year

after the urethrotomy he would probably have never had any further trouble.

The average native patient is a firm adherent to the Eastern belief "sufficient for the day is the evil thereof." It must be admitted that his stay in the hospital during the cure of his stricture is probably a painful and disagreeable experience as few urethras ever become quite tolerant of the passage of sounds; it is therefore natural that he should rejoice in his escape and only return when his urethra is of no further use to him as a channel.

In some cases he may endeavour to follow the advice given to him on leaving hospital and making a journey, of perhaps twenty miles, presents the note "requires full dilatation once a month" to a Dispensary Hospital Assistant. The equipment of this dispensary probably consists of an imperfect set of silver catheters kept in what was once a velvet lined case, a set of gum-elastic catheters, which have become more or less glued together by the heat, and a bottle of carbolic oil.

The patient may with luck escape a false passage and septic infection, but he is extremely unlikely to have had his stricture efficiently dilated.

It is no wonder that so many patients are met with whose perineums are converted into watering pots and their urethras have become either "impassable," or if a sound can be passed, the passage is like that of a bullock cart over a bad country road—so bad that it is often difficult to say whether or not there is really a road at all. The most efficient way of dealing with such cases is to make a permanent opening in the perineum.

Any urethral surgery which involves tying in a catheter or even repeated passage of a catheter in such patients is not altogether free from danger.

The urinary apparatus has been overstrained for years and is possibly septic from end to end, so that very slight trauma or infection is sufficient to initiate serious developments.

In the examination of such cases a set of conical steel sounds will give the experienced hand all the information necessary. There is rarely anything to be gained by wasting time with whalebone or filiform bougies—even if a few drops can still find their way out by the meatus.

There is perhaps no branch of surgery in which experience is more necessary and is more dearly bought than in the treatment of strictures. The hand must be educated as well as the judgment.

Compare the effects of the untrained hand in passing a sound through a stricture, or for that matter through many a normal urethra, with the light confident movements of the practised hand.

It is no easy accomplishment to gather information from the end of a sound. I have practically discarded flexible bougies and catheters altogether, retaining only the India-rubber catheter for tying into the bladder or for drawing off urine through normal urethras.

The most valuable part of my equipment consists in a set of solid steel conical sound—the largest being 17—19 English scale.

They can easily be boiled (a drachm of liquid vaseline is boiled in the water with them) and passed without any handling. The most dangerous and useless weapon, especially in unskilled hands is the sound or catheter below size No. 6, with a point like a knitting needle. These weapons have been responsible for many false passages and should not be allowed in the equipment of any out-patient department or dispensary; if they are there, they are sure to be used.

I do not think that any serious attempts should be made to pass or dilate a stricture without a general anæsthetic. It is rarely possible to pass an undilated stricture without causing pain, and I have not found the injection of cocaine and adrenalin a very reliable analgesic for this purpose. If No. 12 sound reveals the existence of an organic stricture, put the patient on your list for the operation theatre.

EXTERNAL URETHROTOMY IN IMPASSABLE STRICTURES.

A long incision should be made, splitting the scrotum, if necessary, until the healthy urethra in front of the stricture is thoroughly exposed.

An attempt should then be made to trace and dissect the urethra for some distance from out the rigid scar tissue through which it runs in the perineum. It is a great help if this can be done before opening the urethra in front of the stricture. The urethra is often dragged quite away from the middle line and in that part of its course is really only a cord imbedded in scar tissue. There are usually numerous fistulæ which serve to still further confuse the operator.

Even if the point of a sound, passed as far as it will go, be cut down upon, it may be found to be in an old smooth false passage on pouch.

When the urethra has been opened in front of the stricture, search is made for the posterior opening in the usual way.

If the prostate be stripped by the finger of an assistant, the appearance of a drop or two of prostatic secretion may be of great assistance in identifying the posterior urethra.

By employing spinal anæsthesia I have twice been able to avail myself of the ability of the patient to pass urine when asked to do so.

If the posterior opening cannot be identified, a transverse incision may be made, so as to separate the urethra from the rectum and so

come upon the dilated urethra behind the stricture.

This method may be tried in preference to retrograde catheterism.

I have never found much use in the hook of the Wheelhouse staff. A pair of urethral forceps passed down to the stricture and opened serves the same purpose better.

Sometimes it is advisable to abandon the operation for the time and resume the search a few days later when the urethra may perhaps be identified by placing the patient in the lithotomy position and asking him to pass urine. The absence of oozing of blood will render the search easier.

I have found a female catheter to be an instrument that finds its way very readily into the bladder from the perineum.

It is usually worth trying to obtain primary union of the urethra by suturing it over a soft rubber catheter. If the attempt fails, no harm is done, provided a way of exit be left along a gauze drain.

The soft catheter may be passed by catching its point as it emerges from the anterior urethra in a pair of forceps and guiding it along a gorget into the bladder.

Whenever a catheter is tied into the bladder, urotropine should always be given so long as it does not cause any hæmaturia.

The only safe way of retaining a catheter is by a suture through the prepuce knotted round the catheter; the patient cannot readily pull it out when secured in this way.

Cock's puncture should never be required—it was only an operation of urgency and is better replaced by a supra-pubic tapping.

I have never found any use for a Syme's staff.

Treatment of Fistulæ.—When the urethral canal has been thoroughly restored, the fistulous tracks may be dealt with by (1) excision; (2) incision and scraping.

If the fistulous track is well defined, running in soft healthy tissue, excision and suture will be the operation of choice. In a rigid perineum riddled with fistulæ, excision of the fistulæ will be impossible. If external urethrotomy has been performed, the fistulæ may be dealt with at the same time, so that advantage may be taken of the drainage of the bladder either through the urethrotomy opening through a tied-in catheter.

If no external urethrotomy has been performed, it is advisable to tie in a rubber catheter for a few days after excision of a fistulous track, so that the chance of primary union may not be interfered with by the leakage of urine, although leakage will not necessarily prevent eventual closure of the track. In conclusion, I would emphasize the point that urethral surgery is an excellent school for patience.