THE PREVENTION OF STRICTURE; AND OF PROSTATIC OBSTRUCTION

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The prevention of stricture; and of prostatic obstruction by Reginald Harrison

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BY

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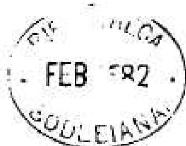

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PREFACE.

The first article, *On the Prevention of Stricture*, originally appeared in the *Lancet*, of May 15th, 1880: it is now reproduced with some additions, and I have coupled with it a paper *On the Prevention of Prostatic Obstruction*. These conditions are so frequently followed by results of an analogous kind that I have thought it convenient to consider them together, and at the same time to endeavour to show what may be done towards their prevention.

38, Rodney Street, Liverpool,
October, 1881.

THE PREVENTION OF STRICTURE.

The Prevention of Stricture of the Urethra is a direction of inquiry hardly less important than that of the treatment of stricture itself.

It may be stated generally that, with the exception of strictures caused by injuries to the urethra, such as contusions, and by cicatrices, the preliminary stage is one of more or less chronic inflammation proceeding from a specific disorder. This condition of inflammation is distinctly a curable one, whilst its effect may be amenable only to relief.

It will, I think, be at once admitted that there are very few practitioners who have not at times experienced the greatest difficulty in effecting the cure of gleet—in arresting the small quantity of urethral discharge which persistently, and in spite of all treatment, local and general, remains after the acuteness of a gonorrhœa has abated. Many patients have in despair given up the attempt to obtain a cure, and so have incurred the risk of a stricture as a consequence.

And yet what is all this trouble about? Simply a slight purulent discharge from a chronically inflamed patch in the urethra, which, by reason of its position, presents difficulties in its treatment. It is a lesion which, if it occurred in one of the more accessible

spaces in the body, such as the mouth, nose, or larynx, where remedies can be directly and unerringly applied, there would not be the least difficulty in curing.

For the treatment of gleet a great variety of means and appliances have been suggested, including internal remedies in the shape of what are called anti-blennorrhagics, which are chiefly remarkable for their very nauseous taste; astringents of all kinds and degrees, applied locally as injections, or in the form of urethral pessaries; potent injections of caustics, which are only to be used by the practitioner himself with a suitable instrument; urethral brushes for the sweeping of the canal with a variety of solutions; insufflators for throwing in powders; contrivances for the application of ointments to the deeper portion of the urethra, portes caustiques, and the urethral speculum, or, as it is called, the endoscope—have all in their turn been brought into play. And for what purpose? For drying up somewhere about two minims *per diem* of muco-purulent discharge, which, were it not offensive to the sight, would probably be overlooked. We are often told in text-books that a persistent gleet is a sure forerunner of organic stricture; in fact, that a gleet may be regarded as indicating that a stricture is forming. By a train of reasoning, the force and soundness of which I am unable to recognise, the relative positions of gleet and stricture, as parts of a continued inflammatory process, have been transposed. We are

now told that pathologically we have been putting the cart before the horse, and that, as a matter of fact, from henceforward we are to understand that a gleet is an intimation to us, not that a stricture *will* form, but that it already exists.

If we admit the truth of this, and set aside our old-fashioned dogma about gleet being indicative of the inflammatory process that precedes the formation of a stricture, and so agree to alter the relative positions of the two, we shall then be prepared to adopt the view that a gleet can be effectually cured only by removing the stricture of which it is merely a symptom. And this latter we are asked to do by the employment of a dilating urethrotome and dilators, the use of which, judging from their size, would at once be misunderstood if they were described as being adapted for the treatment of stricture. Hence they are spoken of as instruments to be used in cases of gleet for the purpose of bringing urethras up to their "individuality," as if there were grounds for believing that in respect of form there is any more "individuality" about a man's urethra than about his rectum.

I must say that I viewed with positive horror the idea of performing an internal urethrotomy on a patient for a gleet on some presumptive evidence that his urethra lacked "individuality." I do not admit the soundness of the reasoning by which the different relationship of gleet to stricture is supposed to be proved, or the propriety of the practice which it is proposed to base upon it. In several instances which

have come under my notice, the performance of internal urethrotomy, as recommended by Dr. Otis, has entirely failed to remove the disease—namely, the gleet for which it was undertaken.* True, the "individuality" of the urethra was restored, but "la goutte militaire" remained—a compromise which the patient, at all events, failed to appreciate.

Nor is Dr. Otis's operation free from dangerous as well as disappointing consequences, as I have shown by a published record of Mr. Berkeley Hill's cases referred to elsewhere.† If we consider certain conclusions which the examination of gleet and stricture cases, in considerable numbers, enable us to arrive at, I do not think we shall have difficulty in explaining our want of success, or in improving our treatment without resorting to an operation which I have already referred to as being, in my belief, both hazardous and disappointing.

The conclusions I would lay stress upon are these:—1. That a large majority of strictures, excepting those caused by injuries to the urethra, are preceded by more or less chronic gonorrhœa or gleet. 2. That the most frequent seat of stricture corresponds with that of gleet—namely, the subpubic or deeper portion of the urethra.

Assuming these conclusions to be true, which I do, not only from my own personal observation, but from that of others who have had sufficient opportunities of

* "On Stricture of the Urethra," by F. N. Otis, M.D., New York.

† *The Lancet*, April 8th, 1876.