found that the catheter glides in easily and painlessly with the minimum resistance at the external sphincter.

This technique may seem elaborate and time-consuming, but it must be borne in mind that the urethra is highly susceptible to infection, and minor sepsis may result in a long convalescence from a simple bladder operation or, at worst, an ascending renal infection. The time taken is well spent, as it diminishes the risk of failure, with its inevitable shattering of the morale of the patient.

EDRIC F. WILSON, F.R.C.S.,
Surgeon, South Devon and East Cornwall Hospital.

REFERENCE

Stewart, H. Hamilton (1949). *British Medical Journal*, 2, 1011.

A Modification of Millin's Retropubic Prostatectomy

The object of this communication is to bring forward a slight modification of Millin's retropubic prostatectomy, which simplifies the operation without, I think, detracting from the good results. In most cases it is not very difficult to incise the prostatic capsule transversely, but I have had a few difficult cases, such as adipose patients and those with low-lying prostates, prostates unduly close to the pubes, and bony bosses behind the symphysis.

In one case of adiposity I found I had made the incision through the junction of the bladder and the prostate into the bladder. An easy enucleation followed by a primary closure led to an excellent result. Since then in any case of difficulty I have done the same again, with satisfactory results.

Method

A catheter is passed and the bladder emptied. The table is put up in a 45-degrees Trendelenburg position and raised as high as it will go. A midline incision is made through the skin, fat, and linea alba from the pubes to within 1 in. (2.5 cm.) of the umbilicus—this incision is long, but makes possible a good exposure, and clean healing takes place. Retractors are put in and the retropubic space is opened up with the index finger, displaying the front of the bladder and the prostate. I have found the best source of illumination is a good spot-light adjusted by the anaesthetist.

Any visible veins on the front of the prostate and lower part of the bladder are carefully clamped and diathermy is applied. The bladder is then incised transversely immediately above the prostate, the length of the incision being just greater than the width of the prostate; any bleeding vessels in the incision are clamped and diathermy is applied. The inside of the bladder is inspected and palpated, using the bladder spreader as a retractor.

The table is then lowered and the prostate is enucleated digitally. The upper part of the bladder is retracted upwards and a wedge of the trigone is removed with curved scissors. Any bleeding points are clamped and treated by diathermy. A good light, good retraction, and a sucker are essential here. Oozing is stopped by plugging the prostatic cavity with gauze for five minutes. The catheter is pulled upwards and placed in the bladder,

and the bladder incision is stitched up in two layers with continuous catgut. Penicillin powder is insufflated, a small rubber suprapubic drain is put in, and the wound is closed. The catheter is stitched to the foreskin or to the glans, 20 ml. of sodium citrate is put in the bladder with a syringe, and a spigot is placed in the end of the catheter.

When the patient is in bed the spigot is removed and the catheter connected up to a jar beneath the bed, the end of the tube being under water. Daily injections of "distaquaine" are given for a week, and 20 ml. of sodium citrate is put into the bladder six-hourly for the first 48 hours. The suprapubic rubber drain is removed in 24 hours and the catheter in 48 hours.

The patient is allowed out of bed any time after the first 48 hours. He is usually walking about in three or four days, and goes home, healed, at the end of the second week.

The centimetre difference in the position of these two incisions can make all the difference between an easy operation and a difficult one.

Comment

The advantages of the modification are: (1) it is easier to perform; (2) inspection and palpation of the bladder are simpler and more effective—this may do away with a preliminary cystoscopy and so save time; (3) it is quicker—this is important; (4) bleeding is rather less; and (5) absolutely accurate suturing of the bladder wall in two layers makes leakage unlikely.

The disadvantage of the modification is that it is perhaps a little more difficult to get absolute haemostasis, though it is probably correct to say that the urine is red during the first 24–48 hours whatever method is adopted. If every bleeding point is clamped, diathermy applied, and the prostatic cavity plugged for five minutes, haemostasis is adequate.

The following points are, I think, of importance and perhaps of interest: (1) the general practitioner should be encouraged not to catheterize the patient but to send him into hospital at once; (2) all except the moribund and grossly infected cases can be accepted for operation; (3) acute retention of urine due to prostatic enlargement is an emergency necessitating immediate prostatectomy; (4) with primary closure and clean healing the fear of prostatectomy can largely be dispelled, and we can hope to get more cases early; (5) the operation described is within the scope of the general surgeon, as distinct from the urological specialist.

ERIC COLDREY, M.D., F.R.C.S.