ON TAPPING THE BLADDER FROM THE PERINEUM THROUGH THE HYPERTROPHIED PROSTATE.

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TAPPING the bladder is an operation which is not often necessary; I believe it may occasionally be resorted to even when a catheter can be passed. Assuming it to be required, how is it to be done?

Tapping with the aspirator-needle above the pubes is a safe proceeding, and, for affording temporary relief, is to be recommended. A surgeon who finds himself in difficulties with a distended bladder, a large prostate, and false passages, is likely to do less harm with the needle than with the catheter, and is sure to give relief. Taking off the tension by withdrawing the urine generally permits the instrument to pass on the next trial. This method, however, can only be used for temporary purposes.

Tapping the bladder above the pubes with a trocar, for the purpose of establishing a more or less permanent drain, is very much like opening an abscess at its least dependent spot. Urine ascends the cannula against gravity, and the products of inflammation of the bladder, usually present in some degree, remain behind in the pouch, undischarged. Tapping through the rectum requires the retention of the cannula in the intestine, and is thus an obstacle to defecation. Forcing the end of the catheter through the enlarged prostate is an unsurgical proceeding, not to be entertained. Tapping the membranous urethra leaves us in the position of having the obstructing prostate behind the opening. There is a point in the wall of the bladder, unconnected with peritoneum, through which a trocar and cannula may safely be passed: I refer to the prostate gland, which in old men, where paracentesis is more frequently required, often affords a considerable area for the operation. I will illustrate this method by the following case, only premising that over twelve months ago I recognised its propriety, and tested it on the dead subject. I then had the instrument made for the purpose; but, though having considerable opportunity for dealing with retention of urine under all circumstances, it was not till quite recently that a case in point presented itself. I mention this as explaining how I came to be prepared, instrumentally, for doing that which I will briefly describe.

N. D., aged 84, was admitted into the Liverpool Royal Infirmary at 2 A.M. on November 4th, 1881. My house-surgeon, Mr. Laimbeer, found him bleeding from attempted catheterism, with a large prostate, and a distended bladder. Recognising the urgency of the case, and finding catheterism impracticable, he emptied the bladder with the aspirator above the pubes. I saw the patient a few hours afterwards, and found that he had not passed urine since, and that no catheter could be introduced. His tongue was brown, and he was much exhausted. Later on, I again visited him, when the bladder had become fully distended.

I then had him placed under ether, and succeeded in passing a gum-elastic prostatic catheter. Beyond demonstrating that the difficulty had been overcome, I declined letting any more urine be drawn off, for a reason arising out of recognising that either the catheter must be retained, or re-introduced when required; neither of which proceedings I was disposed to recommend.

Retaining a catheter in the bladder of an old man, somewhat childish and disposed to remove any appliance if not closely watched, is not easy; and, when it is done, it often ends with death, from cystitis, pyelitis, and exhaustion. This was a case where, in my judgment, it was wisest to establish a permanent drain; and to do this in the manner on which I had determined, required a tense, and not a flaccid, bladder. Taking a trocar which had been made for the purpose, with a silver cannula, I introduced it in the median line of the perineum, three-quarters of an inch in front of the anus, and pushed it steadily through the prostate into the bladder, at the same time retaining my left index finger in the rectum for a guide. On withdrawing the trocar, a large quantity of ammoniacal urine escaped. The cannula, being provided with a shield, was secured in its place by tapes much in the same way as a tracheotomy-tube. A piece of India-rubber tubing was attached to the portion of cannula which projected beyond the shield, and conveyed the urine into a vessel placed at the side of the bed. Through this tubing urine continued to dribble. The patient was at once made comfortable by this arrangement, and in forty-eight hours he was up, sitting in an easy-chair—an important matter with old persons. To permit of this, the rubber tubing is shortened during the

day-time, the end of it being tucked through a light abdominal belt, where it is compressed by a small pair of bulldog-forceps, which are removed when the patient desires to pass urine. He is quite as well as most men of eighty-four years of age are. He gets up daily, takes his food, and sleeps comfortably, either on his back or his side, without any narcotic, and is quite free from any urinary inconvenience other than wearing his tube. During the night, his sleep is not broken by calls to micturate or pass catheters, as his urine runs off by the tubing as it is excreted; whilst, in the day-time, when he is up and about, his act of micturition practically resolves itself into something equivalent to the turning of a tap. His urine, which had been fetid and ammoniacal, is now nearly normal, the bladder being readily washed out by applying a syringe to the cannula twice a day. On two or three occasions, the cannula has accidentally slipped out, whilst the tapes were being changed, but has been readily replaced by the nurse. The somewhat enthusiastic manner in which the patient compares his present, with his past condition, cannot be passed by entirely unnoticed.

The operation was devised much on the same lines I endeavour to take in commencing my lithotomy incision—namely, the selecting of a point in the perineum which endangers no vessel of importance. My object in planning the operation, was to obtain what I can best describe as a short low-level urethra, adapted to the altered relations of the bladder to the prostate when the latter becomes enlarged, for the purpose of securing the most complete drainage. I should add, that since the tapping, as far as we are aware, the patient has only passed a few drops of urine by the urethra.

What the future of the case will be, I cannot say. Apparently, the old man has a prospect of living comfortably for an indefinite period; but, if it were not so, and he should sink before this communication comes under the notice of my professional brethren, I should never hesitate again to resort to this proceeding, under similar circumstances, for the complete comfort it has so far afforded my patient.

ON THE RELATION OF ANTEFLEXION OF THE UTERUS TO DYSMENORRHOEA.

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IN the number of the JOURNAL for Saturday, October 29th, there is published an abstract of a paper on the above subject, from the pen of Dr. Herman, with much of which I agree. I concur in the main with his propositions 1, 6, 7, and 8, but disagree entirely from 5, viz., that painless menstruation is as common when the uterus is anteflexed as when it is not; and still more decidedly from 9, that dysmenorrhœa and anteflexion "are not cause and effect, but merely a coincidence". This last is an error of so grave a character, so calculated to lead to malpractice, that I must point out how a careful observer as Dr. Herman evidently is has been led into a mistake by building up a theory on the anatomical examination of the uterus in women who were probably in general free from painful menstruation, and omitting to study during life the cases in which it occurs, with equal care. A *post mortem* examination, made without a knowledge of the previous history of the subject, is nearly always useless; and it is seldom that we are in a position to prove the exact condition of the uterus in cases of dysmenorrhœa, as the disease rarely proves fatal.

But while I agree with Dr. Herman that there is no clear anatomical evidence that anteflexion causes any hindrance to the escape of the menstrual flow, I hold—and, from careful and protracted observation, am convinced—that well-marked anteflexion of the uterus is a common and important factor in cases of, and frequently a primary cause of, dysmenorrhœa in sterile women; and this, I believe, no experienced gynaecologist can for a moment doubt. My opinion on this point is thus expressed in my *Lectures on the Diseases peculiar to Women*, sixth edition, p. 55: "Painful menstruation is frequently observed in women in whom the uterus is flexed; but though flexions of the uterus may, and certainly do, interfere with the exit of the menstrual flow, they seldom do so unless the flexion be complicated by the existence of chronic inflammation." It is because gynaecologists often overlook the existence of this latter condition, that great confusion occurs and contradictory statements are made on the subject.

I hold with Dr. Barnes that anteflexion, in the vast majority of cases, is a congenital condition. I may be asked: How is it, then, that often menstruation is performed in a perfectly normal manner for years, and that then, for the first time, pain is experienced? The answer is obvious; the flexion was of no importance till an additional element was introduced, that being the occurrence of chronic endometritis; but