AN URETHROTOME FOR INCISING NARROW STRICTURES.

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HITHERTO, among the variety of instruments that have been constructed for internal urethrotomy, none, so far as I know, can be used for strictures through which a No. 6, or, at most, a No. 4 catheter cannot be passed. The treatment of such cases, whatever method of dilation be selected, does not usually present much difficulty; but, with smaller passages, the difficulty of introduction and the amount of suffering to be contended with have induced me to seek for some means by which a narrow stricture, when an instrument has been passed through it, may be at once enlarged to the normal capacity. This may be done by *internal incision* or by *divulsion*; which of the two proceedings should be adopted in any given case, depends upon certain points that are now pretty well agreed upon.

The instruments which I have here are both manufactured and, to a great extent, devised by Mr. Coxeter, who has exerted much skill in constructing instruments to carry out my suggestions—one for cutting, the other for breaking through, the stricture. Before introducing the instrument for enlarging the stricture, the distance of the contraction from the meatus urinarius should be ascertained by passing an olive-headed bougie with a slender graduated stem. This being done, both instruments are passed in the same manner. A guide bougie of fine whalebone, about one-fourth the calibre of a No. 1 catheter, is passed through the stricture to the bladder; should the operator be in doubt if he have reached the bladder, a fine silver catheter, having its end tunneled with an eye, is threaded, and, thus guided, the catheter is slipped along the bougie and through the stricture till the bladder is reached. Urine then runs through the catheter, and makes it certain that the instruments are in the right track, when it may be withdrawn, leaving the bougie *in situ*. However, in most cases, this precautionary exploration may be omitted.

A. The knife. B. The projection to ascertain the posterior limit of the stricture.

The next step is to pass the enlarging instrument along the guide in the same way. The incisor consists of a slender grooved sound of steel, with the ordinary curve, and provided with a tunneled end. In the groove runs this little rod having a blunt end fixed to it by a joint. When run along the groove of the sound, the jointed end and rod are quite concealed until they reach a point $6\frac{1}{2}$ inches down the shaft. Here the groove becomes shallow and ceases; thus, the jointed end is thrown out and projects about one-tenth of an inch beyond the surface of the sound. (See B in the figure annexed.) It thus forms a little catch on the sound, which will travel along the urethra until it reaches the stricture, against which it will be caught. After the grooved sound has been passed along the guide, through the stricture, the little rod may be run down, and its end made to project into the urethra behind the stricture. By drawing forwards the sound thus armed, the posterior limit of the stricture is ascertained; the anterior limit is already known. The little rod is then withdrawn and replaced by another which carries, instead of a blunt point, a knife attached by a joint in the same way; this knife, concealed in the groove of the sound, travels down until it has reached the place

where the groove grows shallow. (See A in the figure annexed.) This termination of the groove being already carried beyond the posterior limit of the stricture, the knife is thus made to project to a distance regulated by a screw at the handle against the floor of

the urethra; and, if the sound be drawn forwards, the knife cuts its way until the whole stricture is divided. When the anterior limit of the stricture is reached, the knife is again brought within its groove, and the sound is withdrawn. The knife projects half an inch as a maximum, but, by adjusting the screw, can be set to any less distance. The sound, with the knife lying in its groove, is of less calibre than a No. 2 catheter, being between that and No. 1 of Weiss's catheter scale. After the incisor is withdrawn, to make assurance more certain that the stricture is thoroughly divided, the split sound of the wedge-dilator may be passed, and the wedge which corresponds to the natural capacity of the urethra No. 14 or 16 may be run through the divided stricture.

This wedge-dilator, which I had the pleasure of showing to the profession at the Plymouth meeting, acts on the same principle as that so well known and so successful in the hands of Mr. Barnard Holt. It differs in being of simpler construction, being a wedge at the end of a rod, which, being pushed between the blades of a split sound, separates them to the required extent, and thus splits the stricture it passes through.

My dilator can be made as small as a No. 1 $\frac{1}{4}$ catheter, is easily passed along the canal, and, when through the stricture, the wedge requires very little force to separate the blades; for the surfaces of friction are together little more than half an inch in extent, instead of being the whole distance traversed by the instrument both within and without the separating tube, as in Mr. Holt's dilator.

At the beginning of the paper, I said that, when forcible enlargement is selected, the rules that influence the adoption of a cutting or a splitting instrument are tolerably well known. I may, perhaps, be allowed to recapitulate the most important.

1. All contractions in front of the bulb—that is, in the penile part—should be cut, not split, because cutting causes less cicatricial tissue to be formed than does splitting; this is important where the layer of erectile tissue is thin and easily replaced by fibrous tissue, by which erection at this point may be wholly lost.

2. Whenever the contraction is very elastic, it stretches rather than breaks before the wedge, and is best divided by a sharp edge.

3. Whenever the induration matter extends more than half an inch along the passage, or is very thick, it is usually best to make an incision through it.

In other cases, as divulsion is simpler and needs less precaution, it is on those accounts generally preferable to incision.

THE TREATMENT OF POST PARTUM HÆMORRHAGE.

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THE question of the treatment of *post partum* hæmorrhage is one so momentous, so many lives literally hang upon the decision arrived at, that I feel I am not at liberty to refrain from offering some observations upon the papers of recent contributors. In doing this, I depart, almost for the first time in my life, from the rule not to enter upon any discussion which might bear the semblance of controversy. Great questions in practice, like this, must eventually be settled by clinical results. To experience, the appeal as to the value of perchloride of iron or some equivalent styptic directly applied to the bleeding uterus, must ultimately be made. A war of words, ingenuity in criticism, will do no more than obscure the facts and retard the full establishment of the truth. And this is the present danger. The not unreasonable prejudice against the resort to a bold and novel practice has been fostered of late by the timid protests of routine teachers on the one hand, or by the subtle argumentations of Zoilistic critics on the other. These combined forces might sway certain minds to stand upon the old ways, however treacherous, and thus to sacrifice lives that might be saved.

It is impossible for me to discuss the many papers, some of sterling value, such as those of Dr. Whittle, Dr. Bassett, and others, upon the anticipation and treatment of *post partum* hæmorrhage. I limit myself on this occasion to the paper of Dr. Boyd Mushet in the last number of the JOURNAL, because it seems to express some current errors as to fact and theory which require correction. He advocates a plan which he "deems novel". This is, "to inject cold water freely into the uterus." That this has its value, is well known, for it is far from novel. But when he goes on to say that "the virtues of the perchloride of iron are mainly to be ascribed to its vehicle, cold water," he emits a perfectly arbitrary theory. Surely Dr. Mushet has never used the perchloride. The choice between cold and styptics depends upon our appreciation of two entirely different physiological conditions. Styptics will act when cold will not. When the diastaltic system