member of these occupations to deviate from his normal routine, but the belief is almost universal that the doctor should be available at all times day and night, and that he may be consulted or called upon to visit at any time which suits the convenience of his patient, and that he may be summoned at the time which causes the least inconvenience to send for him.

Society novels are admitted to be often good records of the manners of the time. In a recent one an aged baronet is represented as dining in town in his usual way, and then sending his butler to ask his doctor to step in because he, the baronet, was feeling uneasy about his health. Even if the accuracy of this as a picture of what is likely to have occurred is open to question, it yet shows that in the mind of the writer there was nothing which made him think such an occurrence unreasonable. In hardly any other occupation is it found possible to allow such uncertainty as to hours of work. In medicine the occurrence of real emergencies interposes an obstacle to any rigid limitation to definite working hours. However, these emergencies are rare, and my observation leads me to the conclusion that when a medical man is systematic and habitually keeps his temper under control, he can be successful in securing a life of reasonable comfort. By method and order he does better for his patients than the men who submit to irregularity and desultoriness. There is much more system in medical life than there was fifteen or twenty years ago, still there is plenty of room for more. The labour of daily work might be diminished and comfort might be increased. With hardly any exceptions every one could have regular consulting hours differing according to the nature of his practice but at rational times. Those hours alone may be adhered to for all ordinary home work. Every one can also fix hours for starting visiting. Some disability may be imposed on requests for visits at times which suit the patient, but are obviously inconvenient to the doctor, and such as are received after the usual hour of commencing the day's work. A method which succeeds very well is to require a special fee for such visits; another is to arrange that this work is undertaken by an assistant; yet a third one, which I cannot say I recommend, is plain speaking; it is not given to every one to bear the truth, and however thoughtless people may be, they are apt to resent the imputation of being so. But in whichever way it is done the comfort of medical life is much increased by requiring from patients due consideration and the avoidance of waste of time.

In no relation of life is legitimate independence more necessary than between doctor and patient. Unfortunate is the patient who feels bound to hold to his doctor for any other reason (be it social, family, or personal) than that he has faith in his professional capacity. He is in a condition of bondage apt to be tempered by subterfuge and deceit. No less unfortunate is the doctor who is afraid of his patients, afraid of his neighbouring practitioners, and whose actions are conditioned by the dread of losing practice. He had set for himself a low ideal and a still lower real is sure to result. I would have every man not only guard his own independence, but be too self-respecting to interfere with that of any one else.

In all that we do and in all that we aim at we must ever remember that we are members of an organized society with multiform relations to those about us. We are governed by the inexorable laws of supply and demand; we have our rights within those laws and so have others. We do well to obtain what is due to us, but only so long as we do not seek to encroach on the rights and freedom of others.

THE *Medical Record* says that at the Lisbon International Medical Congress last spring there was to be found a table of equivalent obstetrical terms in different languages constructed by a German medical man for the benefit of his colleagues. In the English division the German term for triplets was represented by "three-twins," the umbilical cord by "caul," and the umbilical murmur by "hiss of the navel string." Other equally happy translations into English were "mooncalf" for hydatid cyst, "gastrostomy with removal of the pregnant uterus" for Porro's operation, "combined inquiry" for bimanual examination, "impervious mouth" for undilated cervix, and "cephalic carve" for craniotomy. The interchange of ideas with a German medical man who had studied this vocabulary must have been somewhat exhausting.

THE PRESENT POSITION OF PROSTATIC SURGERY.

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THE development of prostatic surgery presents in its history three periods—the pre-castration period, the period during which the claims and practice of castration largely diverted attention from prostatectomy, and the present period of renewed interest in prostatectomy.

Successful prostatectomy comprises three prime factors:

1. Procedure by *enucleation* (digital or otherwise). This removes the prostate, leaving the capsule *in situ*. On its successful accomplishment mainly depend the patient's chances of life.

2. *Efficient removal* of the obstructing prostatic mass. This commonly, but not necessarily, means total, or nearly total, removal of the organ.

3. The existence, after recovery, of a *mucous urethra* in the prostatic region—a urethra preserved intact during the operation or renewed by natural processes during the course of healing.

The essential importance of all three factors is now universally acknowledged. All three were familiar to not a few operators in the pre-castration period. All three were lost sight of by the majority of surgeons in the castration period, and to this fact must be attributed their somewhat remarkable rediscovery as new within the past five years.

Prostatectomy may be performed by one or other of three methods: The vesical (suprapubic), the perineal, and the submucous combined (vesical and perineal). The perineal (pure and simple) I have rarely practised, and propose here to deal with the submucous and vesical methods alone.

OPERATIVE PROCEDURE.

Extended experience has confirmed me in the opinion formed in my earlier cases¹ that the first step in prostatectomy should be the opening of the bladder by the suprapubic route. This permits the completion of the

Fig. 1A.

Fig. 1B.

Retraction forceps for suprapubic cystotomy wound in prostatectomy. The terminal parts of the blades are of plated copper, to permit of their form being readily altered by the fingers to suit varying degrees of corpulence.

diagnosis—the exclusion of carcinoma of the prostate and of encysted abscess or calculus—and the complete bimanual examination of the prostate (one finger in bladder and the other, gloved, in rectum). On the results of that examination a decision is come to as to whether the urethra and mucous floor of the bladder are to be preserved intact or not. Such preservation is unattainable by the vesical method, is occasionally effected by a happy chance by the perineal method (pure and simple), and can be uniformly secured by the combined or submucous method alone. The further course of the operation, therefore, takes the form of the submucous combined or of the vesical method of enucleation. As a

preliminary to either it is well, in cases in which a difficult operation is anticipated—a tough, fibrous prostate or a fat patient—to secure the margins of the bladder wound to the skin incision by a couple of stout silk sutures, or by use, in corpulent patients, of the retractors shown in Figs. 1A and 1B.

SUBMUCOUS ENUCLEATION.

Pass a metal urethral sound. Place the patient in the lithotomy position. Expose the prostatic capsule by a perineal incision, and open it on its postero-inferior aspect. Enucleate the prostate from its capsule, leaving intact the mucous floor of the bladder and the mucous urethra, the former being defined (and protected) by the fingers of one hand in the bladder, and the latter by its contained metal sound. The perineal wound (including the empty prostatic capsule) is lightly packed with gauze. The vesical (suprapubic) wound is sutured round a drainage tube. The abdominal parietal wound is partly closed. The practice of tying in a catheter, formerly followed, has been discontinued.

Comment on submucous enucleation as above described concerns the following points:

The Perineal Incision.—The most suitable is the lithotomy-inverted Y. It has been in use for prostatectomy in the practice of more than one surgeon for at least fifteen years, and its recent appearance as a new feature, at the instance of a distinguished American surgeon,² constitutes one of many instances of late of the effect of the "castration period" in obliterating the records of pre-castration work. The inverted Y incision, and, in a few of my earliest cases, a single "median lithotomy" incision are the only incisions I have ever made use of, despite the illustrated descriptions of various ideas in this matter attributed to me by recent authors.

The Opening of the Capsule.—This is effected either by a median vertical incision or by a crucial incision. These are the only methods I have ever made use of or published, and I have no claim to the "H incision" or the "two lateral incisions, near and outside of the median line," which have been repeatedly described as mine.

The Completeness of the Removal.—In my first published description of the operation, twelve years ago (*Lancet*, 1894), occur the following: "Briefly, the operation is a submucous removal of the entire prostate or as much of it as may be deemed necessary," and again, "the surgeon . . . removes by the fingers of his right hand . . . the entire prostate," piecemeal, in two lobes, or *en masse*. The accompanying illustrations indicate the scope of the operation in one direction, removal *en masse*. They are photographs, and show the difference in surface appearance of specimens removed by digital enucleation alone and by that aided by instruments. Specimens 2 to 5 inclusive were shelled out of the prostatic capsule entirely by the finger alone. Specimen 6 shows in its upper part the easily detached, and therefore smooth, surface of a prostate enucleated by the finger, and in its lower part evidences of the action of the scissors in detaching the layer left around the intact urethra. Specimen 7 shows the rough aspect of the internal faces of the lateral lobes as detached by scissors from the urethra. The back (external aspect) of the specimen has the smooth, rounded cortex of the organ which has been "shelled out" by the finger.

Complete removal of the prostate was not new in 1894, when the paper quoted above was published. At that date complete or total removal of the prostate had of course been performed by other surgeons, making use of different methods. From that date onwards total removal of the prostate became quite common. When, therefore, in 1901 total removal was announced as something new, it is difficult to say whether amusement or indignation predominated in the minds of surgeons who were abreast of prostatic operative developments.

THE METHOD OF ENUCLEATION.

By whichever method operating, vesical or submucous, the surgeon, once the prostatic capsule has been opened, requires no other instrument than his finger, *provided he is prepared to bring away, in whole or in part, the mucous urethra*. This was emphasized long ago by McGill, and digital enucleation has been constantly made use of since his day. It is, therefore, not a little suggestive of the lack of knowledge of the work of the pre-castration

period exhibited by certain recent writers that the past five years should have seen digital enucleation put forward as something new on the one hand, and, on the other, its feasibility denied on theoretical grounds.

Operating by the submucous method, it is possible in 70 per cent. of the cases to enucleate the prostate by the finger alone without damage to the urethral or vesical wall. In dealing with tough "fibrous" prostates, however, it is necessary, if the urethra and bladder are to be preserved intact, to make use within the capsule of some form of cutting instrument in addition to the finger. For such cases of hardish prostates two Continental surgeons have recently each independently published an operation, the feature of which is the preservation of the integrity of the urethra by leaving a layer of prostatic tissue adherent to it. That is, of course, the essence of success in cases of *hardish* prostates, and its necessity has been evident to these surgeons. Their papers appeared in the *Centralblatt für Chirurgie*, October 11th, 1902, and *Deutsche med. Woch.*, October 29th, 1903, respectively. Like many other recent converts to prostatectomy they have been placed at a disadvantage by the hiatus in the records caused by the castration period. The procedure is one of pre-castration origin. Reference to my papers in the *Lancet*, April, 1894, and *BRITISH MEDICAL JOURNAL*, October, 1898, will show a description of the procedure, while in the *Lancet*, July, 1894, is figured the gouge cutting forceps I formerly used in carrying it out.

The idea of removing the prostate in two lobes after bisecting it longitudinally along its inferior aspect has been recently advocated by another Continental surgeon. He has embodied it in a monograph on prostatectomy. His first description of it, however, appeared in the *Compte Rendu de l'Assoc. Franc. d'Urologie*, 1902. It is a useful manoeuvre in certain cases, and constitutes what I have for years been in the habit of calling "slitting the book up the back" (and then removing the lobes separately from their beds as they lie enfolding the urethra (Fig. 8), as against "opening the book from the front" (Fig. 9).

DAMAGE TO THE MUCOUS WALL OF URETHRA AND BLADDER.

The submucous method was devised to obviate this, at a time when it seemed essential to keep the (often putrid) urine of the patient from entering and lodging in the vacant prostatic capsule, with possible pyogenic toxæmic effects, and when the preservation of the urethra appeared to be the *sine qua non* in the securing of early restoration of normal micturition. Of late two facts of importance have been demonstrated by increasing experience. The first is that many chronic catheter prostatitis are immune with reference to putrid urine. The other is that the mucous urethra is very readily reproduced after removal in the course of a prostatectomy. (It has been suggested that the mucous wall is reproduced by proliferation of portions of the glandular tissue of the prostate left adherent to the capsule after enucleation of the prostate. From appearances observed in a case in which death occurred from cerebral embolism three weeks after prostatectomy, I am inclined to the view that, in cases in which complete enucleation has been performed, the restoration takes place by extension from the mucous membrane of the bladder behind and the urethra in front of the gap.) The immunity of a number of the patients dealt with and the ready restoration of the mucous urethra have combined to render the submucous method in my practice now a matter of choice as between it and the vesical, and I find the tendency increasingly towards vesical enucleation. For a considerable proportion of cases, however, the combined submucous method is retained. Its comparatively small hæmorrhage, the preservation of the evacuated prostatic capsule from urinary contamination and phosphatic deposit, the early restoration of urethral micturition, and the shortness of the bedridden stage of convalescence, all tend to make it the method of choice in old or much-enfeebled patients. As against these advantages my statistics show the disadvantage of the second wound to be inconsiderable.

FREYER'S FIRST CONTRIBUTION TO PROSTATIC SURGERY.

When, towards the end of the Nineties, the castration period finally gave place to the inevitable revival of general interest in prostatectomy, the periodicals were so burdened with records of castration that enthusiastic

Fig. 2.—Entire prostate removed by perineal enucleation in 1899. Patient aged 68. Weight of prostate, 5 oz. Urethra and bladder left intact.

Fig. 4. Entire prostate removed by enucleation in 1895. Patient aged 62. Weight of prostate, $3\frac{1}{2}$ oz. Urethra and bladder left intact.

Fig. 5.—Entire prostate removed by perineal enucleation in 1899. Patient aged 75. Weight of prostate 2 $\frac{1}{2}$ oz. Urethra left intact, but a portion of the mucous floor of the bladder, of size of sixpenny piece, came away, adherent to the projecting median lobe.

Fig. 3.—Entire prostate removed by perineal enucleation in 1900. Patient aged 59. Weight of prostate, 4 oz. Urethra and bladder left intact. The lobes have been folded into their natural position embracing the urethra.

Fig. 6.—Prostate, weighing 5 $\frac{1}{2}$ oz., removed by perineal enucleation in 1900 from a patient aged 66. Upper portion (smooth) enucleated by finger; lower portion (rough) detached from urethra by scissors cuts.

Fig. 7.—Prostate, weighing 4½ oz., removed by perineal enucleation in 1902 from a patient aged 71. A considerable layer of prostatic tissue, cut bit by bit with scissors, was left surrounding the urethra (vide text).

Fig. 8.—Lateral lobes of prostate removed by perineal enucleation in 1897. The prostate was bisected, and the lobes detached from the urethra, which was left intact. The gaps represent wedges removed for histological examination.

Fig. 9.—Entire prostate removed by perineal enucleation in 1901. Patient aged 77. Weight of prostate 5 oz. The specimen is viewed from the anterior aspect. It is pinned out, opened like a book. The two lobes were folded round the urethra, which was left intact.

Fig. 10.—Entire prostate removed in two lobes by vesical enucleation in 1903. Weight of prostate, 1½ oz. The lobes have been placed in their natural relations, and above them a button-shaped calculus, which lay behind the prostate and was diagnosed only after the bladder had been opened. No mucous membrane could be identified adherent to the specimen.

Fig. 11.—Entire prostate removed in two lobes by vesical enucleation in 1900. Weight, 3½ oz. A portion of the urethral mucous membrane is adherent to the left lobe.

Fig. 13.—Prostate enucleated *en masse* by vesical route in 1899. Weight, 4½ oz. The specimen possesses an unusually perfect "capsule." The urethra traverses the specimen longitudinally.

recent converts to prostatic surgery may well be pardoned the somewhat wholesale overlooking of previous work in prostatectomy which many exhibited. None the less, throughout the castration period prostatectomy was being practised and improved by surgeons who had early become convinced of the inefficiency of castration. Amongst these, Mayo Robson, Albarran, Fuller, Alexander, Goodfellow, and the present writer

Fig. 12.—Entire prostate removed *en masse* by vesical enucleation in 1899. Weight, 3 oz. No mucous membrane could be detected in the specimen, but the urethra torn transversely across was identified in the cavity left by passing a bougie and examining around it with the finger.

had all put on record published results which were available. To the overlooking of these and others must be attributed much of the confusion which followed. Amongst those whom the general revival of prostatectomy brought into the field was Mr. P. J. Freyer, who within eighteen months published two "new" methods of removing the prostate, one by the perineal and the other by the vesical route. The ideas underlying both were the preservation of the urethra and the removal of the entire prostate. Neither operation was new. Mr. Freyer's first

Fig. 14.—Prostate enucleated by vesical route in 1902. Weight, 4½ oz. The urethra traverses the specimen.

publication concerned a perineal operation which he regarded as an improvement on the combined submucous method as above detailed. It was described to the Medical Society of London in 1900 under the title of A New Method of Performing Perineal Prostatectomy. By this method, he states in his pamphlet, *Stricture of the Urethra and Hypertrophy of the Prostate* (page 105)

"Nicol's objects are attained by a much less serious proceeding.' The operation described consists in the removal of the prostate from its capsule by one hand while the organ is hooked down into the perineum by a finger passed into the bladder through an incision made

Fig. 15A.—Prostate enucleated by vesical route in 1897. Weight, 3½ oz. The urethra traverses the specimen. A year previously, castration had been performed without benefit.

in the urethra. Mr. Freyer has ignored both my private note to him regarding the misrepresentation of my operation contained in the above statement and the two letters which I sent to the BRITISH MEDICAL JOURNAL regarding his position and claims in the course of the general correspondence in the autumn of 1901. In the matter of this perineal operation Mr. Freyer is doubly in error. In

Fig. 15B.—Lower aspect of Specimen 15A, showing aperture of urethra.

the first place, the operation he describes does not, as he asserts, attain the object of the operation known as mine. That object is, primarily, the preserving intact of the bladder floor and urethra, in order to prevent urine entering the evacuated prostatic capsule and perineal wound. An operation such as he describes, and which involves the initial opening of the deep urethra and neck of

the bladder, can attain no such object. In the second place, the operation described is not new. It was a well-recognized procedure in the pre-castration period, and has been continued since. References to such enucleation, as carried out by different operators, exist in surgical literature at least from 1890 onwards. From documentary evidence in my possession, I am inclined to the belief that, amongst the earliest, if not indeed the first operator to enucleate the prostate in this way, was Sir William Macewen. So far as I am aware, Macewen's work in this direction has not as yet been published, though known to others, vide both editions of Mansell-Moullin's *Enlargement of the Prostate*. Perineal enucleation, as is well known, has passed through several phases. That which commended itself to Mr. Freyer was, when he published it as new, one of the best known of these, as having at that time been the basis of several modifications or improvements, amongst which may be mentioned the following: The substitution for the finger of the left hand of various forms of tractors, as occupying less room; the substitution for perineal traction of depression from above, by pressure on the suprapubic parietes, by a finger passed into the prevesical fat, and by a finger passed into the bladder, and the submucous method of enucleation.³

VESICAL ("SUPRAPUBIC") ENUCLEATION.

The method followed in my practice is that of McGill as modified and extended in scope by subsequent operators, notably Mayo Robson, Fuller, and Watson. The bladder having been opened over the pubes, a scissors snip is made in the mucous wall of its neck. Through this the finger of one hand is introduced into the interior of the prostatic capsule, and the entire prostatic mass, so far as identifiable by sense of touch, enucleated in one or more portions, counter pressure being meantime made by the fingers of the other hand (gloved) in the rectum. The glove having been removed, the suprapubic vesical wound is partially sutured (usually round a large drainage tube), and the skin incision similarly partly closed. The accompanying photographs illustrate the appearances of prostates so removed (Figs. 10 to 15). Comment on the vesical method as above described concerns the following points:

Control of Haemorrhage.—I have never seen fatal haemorrhage following prostatectomy by any method. It is, however, occasionally considerable for some hours after operation. This occurs only in the vesical operation. In the submucous it does not occur, being prevented by the packing introduced into the evacuated capsule. In cases of old and feeble patients, where the loss of blood may seriously delay convalescence, I am in the habit of following the submucous procedure, or, if adopting the vesical method, of employing the special catheter figured below as a means of applying pressure by means of a pad soaked with adrenalin for a few minutes to a few hours as may be deemed necessary. The catheter (Fig. 16) is passed, the end detached and brought out by the suprapubic wound. In its place the gauze bag filled with gauze (or a gauze pad) is attached to the silk string and lodged in the vacant capsule and vesical neck. The syringe and tube are used for the application of adrenalin (Fig. 17), and pressure is secured by firmly pulling on both string and catheter, and fixing them in position for a

time if necessary. It is but [rarely, however, that such measures prove necessary.

The Method of Enucleation.—This is performed by the finger, as originally advocated by McGill, and practised since his time by various operators, including Mayo Robson, Fuller, the present writer, and others. Of the many astonishing instances of "rediscovery" of old facts as "new" within the past five years, none has been more striking than that of "digital enucleation" of the prostate.

FREYER'S SECOND CONTRIBUTION TO PROSTATE SURGERY.

In 1901 Mr. Freyer⁴ described a second "new" method of removing the prostate (this time by the vesical route), which he claimed "opens up a new and promising era in this field of surgery with far-reaching results." The operation described consists in the digital enucleation of the entire prostate in one or several masses. Such an operation was, of course, a well-known measure in use by various operators when Mr. Freyer published it as new, and in the correspondence in the JOURNAL which followed his publication, many of these operators drew attention to the remarkable oversight on the part of Mr. Freyer of descriptions of it and references to it existing not only in periodical literature but in standard works. The operation constitutes the final form of McGill's method, in the ultimate development of which two names, amongst others, stand prominently out, those of Mayo Robson in Great Britain, and Fuller in America. At the date of Freyer's publication it had become quite common, and, as stated at the time,³ I had then seen it carried out by several surgeons, and, though largely then practising the submucous method, had myself employed it on several occasions, removing prostates which constitute specimens quite as "complete" as anything Mr. Freyer has shown us. Complete enucleation of the prostate was well-established practice in 1900.

So far the issue is of the simplest, and the confusion which arose, and is only now being cleared up, was due to the fact that the claim which, in this vesical operation, Mr. Freyer put forward, was a triple one. That of priority in "total" enucleation could only have been made by one unfamiliar with the records of prostatectomy, and at the time at which it was made—a date at which, owing to the intervention of the castration period, these records had been largely interrupted. Had that been Mr. Freyer's whole claim the refutation it met, wide and emphatic though it was, would have been more so; for not a few of those familiar with total enucleation of the prostate were puzzled by the further claims which Mr. Freyer included. These were somewhat striking, and time has been necessary to test their value. So far as opportunity has enabled me to ascertain the opinions of other operators, I find them ranged with my own against their validity. These claims were two:

(a) **Removal of the Prostate and its Capsule.**—Mr. Freyer's claim to have removed the prostate surrounded by its capsule was more than a little puzzling. In the correspondence which followed I published in the BRITISH MEDICAL JOURNAL an untouched photograph of an entire prostate removed in the Alpin Home, Glasgow, in 1889, and in referring to it⁶ said, "if the photograph . . . be

Fig. 16.—Apparatus for control of haemorrhage in vesical enucleation (vide text).

examined it is possible to discern the strands and contour of a fibrous investment. That is possibly what Mr. Freyer refers to as the 'capsule' in his description of his specimens. And in the same correspondence I stated that I had in my possession several complete prostates removed by operation (by both vesical and submucous methods), all of which possessed the same fibrous-looking investment or capsule. Since that date I have seen Mr. Freyer's specimens. Their investment or capsule is exactly that possessed by mine and by many others which existed in the collections of various operators when he believed he had accomplished something new.

With reference to Mr. Freyer's further conclusion that he had discovered something new in the anatomy as well as in the operative surgery of the prostate, facts are again against the claim. Mr. Freyer announced the discovery of a second or true capsule of the prostate, and⁷ in support of this claim stated that

Appeal to the anatomy of the prostate as taught in the schools and textbooks was of no avail. He had in his first lecture shown that this was defective. . . . He supposed that the chief object of anatomy was to teach surgery, but they might have gone on to the "crack of doom" without discovering this operation if guided by the anatomy of the textbooks.

Probably one of the most popular text books of the schools is Gray's *Anatomy*. Had Mr. Freyer consulted it he would have found this—

The prostate is immediately enveloped by a thin but firm fibrous capsule, distinct from that derived from the rectovesical fascia, and separated from it by a plexus of veins,

and had he been desirous of information on the matter he might have got from anatomists and surgeons alike further information regarding it. In a recent paper on prostatectomy in the *Annals of Surgery*, April, 1905, Fuller puts the matter clearly:

I remove the same amount of capsule and the same amount of hypertrophy that he (Mr. Freyer) removes, as can be seen in the pictures in my article (*Journal of Cutaneous and Genito-Urinary Diseases*, June, 1895). I do not, however, assume in my article that the capsule I remove is the capsule proper of the prostate. I purposely left that question open as one for the anatomists and histologists to decide.

Fuller's specimens, when Freyer wrote, were numerous, and at that date, as my own publications show, such specimens existed in possession of many other operators, and, in my own case, had been discussed by prominent anatomists, with special reference to this "capsule," which Freyer puts forward as "new." Space does not permit further discussion of the matter here, but in a future publication it is my intention to return to certain observations made regarding the investment of the hypertrophied prostate in which I have recently had the valuable assistance of Drs. J. H. Teacher and Leslie Buchanan of Glasgow.

(b) *The Removal of the Prostate "as a whole" while the Urethra is left "Intact."*—Shortly after Freyer published this claim one of my students, who had been practising prostatectomy on the cadaver, told me he had failed to do this, and asked if it was any more easy on the living patient. The statements I made to him were: (1) That I had good reason to believe that in supposing he had accomplished removal of the prostate in one mass by the vesical route, while he left the urethra intact, Mr. Freyer would, with further experience, discover that he had been in error; (2) that my experience of prostatectomy had taught me that it was not always easy to say at first

glance whether the enucleated specimen contained a portion of the mucous wall of the urethra or not, and that until the specimen had been placed under still water and inspected by a lens at the time of the operation, and, further, hardened and examined histologically, I had learned to distrust my own impression, and any man's statement as to the presence or absence of mucous membrane; (3) that Mayo Robson and others had demonstrated years ago that the entire prostate could be removed by vesical enucleation, leaving the urethra intact, provided the prostate was brought away in two or more lobes; (4) that by combined (vesical and perineal) enucleation alone could the urethra be preserved intact while the prostate was removed in one mass. That was in 1902, and I have seen no reason since to modify these statements.

MORTALITY RATE OF PROSTATECTOMY.

Prostatectomy by enucleation constitutes the cure for senile hypertrophy of the organ and its effects. When efficiently carried out the cure is complete and permanent in the large majority of cases. In the few in which it is not so the degree of relief obtained is considerable. The mortality rate shows a steady tendency to decrease, and

may now, over all (operators and methods) be fairly stated at from 5 to 7 per cent.

My own results demonstrate the effect on an operator's statistics of a factor familiar in other operative work, namely, the judicious choice of cases. Excluding cases in which castration, or partial operation, have been performed, the cases in which I have performed enucleation fall into three series or periods. The first series comprised 48 cases, with 4 deaths, or rather over 8 per cent. The second comprised 25 cases, with 5 deaths, or 20 per cent. The high mortality rate of this period was the direct result of unconscious overconfidence, the effect of previous favourable experience. Two of the five deaths occurred in cases in which I had previously, on account of the patients' feeble and unsound condition, discouraged the idea of operation. The third or most recent series shows a much lower death-rate. Ending December 31st, 1905, it shows 38 cases, with two deaths, or, approximately, 5½ per cent. There would appear to be no reason why, by a rigid selection of cases, the mortality rate should not be brought down to something approaching that of the radical cure of hernia. Fuller's latest statistics, which are the lowest of which I have knowledge, now touch 4 per cent.

Fig. 17.

REFERENCES.

- ¹ *Lancet*, April 14th, 1894, and *BRITISH MEDICAL JOURNAL*, October 29th, 1898.
- ² *Journal of American Medical Association*, August 15th, 1903.
- ³ *BRITISH MEDICAL JOURNAL*, August 24th and September 14th, 1901.
- ⁴ *Ibid.*, July 28th, 1901.
- ⁵ *Ibid.*, August 21st, 1901.
- ⁶ *Ibid.*, September 14th, 1901.
- ⁷ *Ibid.*, October 17th, 1903.

MR. WALTER EMDEN'S scholarship of £100 for the best original work performed in the laboratories of the Middlesex Hospital has been awarded this year to Dr. Victor Bonney.

UNDER the will of the late Colonel Oliver Minster, of Coventry and the 2nd Volunteer Battalion Warwickshire Regiment, the Coventry and Warwickshire Hospital will benefit to the extent of some £15,000. The greater part of this amount it will receive at once, and the rest on the decease of certain persons mentioned in the will. The income of the estate immediately inherited is to be used for sending poor patients to convalescent homes.