In August of the same year the operation of litholapaxy had to be repeated, as in this short interval another stone had formed, which was also successfully removed in the same way. On this occasion the stone was formed of phosphates, which is the usual kind in the case of recurrences. Again, he made a speedy recovery so far as the removal of the stone was concerned. The patient, however, still remained dependent on the use of the catheter. By September, 1900, he had formed other stones, which were removed in a like manner. He still remained dependent on the use of the catheter. For the fourth time, in February, 1901, he again applied to me with symptoms of stone. Feeling sure that this rapid recurrence of stone was not due to any fault in the operation or to any want of care on the part of the patient or his medical attendant, before proceeding to remove the stones I examined the patient with the cystoscope. The view thus obtained of the interior of the bladder was extremely interesting. There was no enlargement of the lateral lobes of the prostate, but the third or middle lobe was prolonged, and took the form of a pendulous mass which projected upwards into the bladder, and evidently played the part of a ball valve. Thus the urine was mechanically prevented escaping from the bladder, except when the catheter was used, and being allowed to decompose, the formation of phosphatic stones necessarily followed. I should add that under cover of the projecting lobe of prostate a portion of two calculi were seen by the cystoscope. This condition at once explained how these stones were formed, and I decided upon removing that portion of the prostate which was hypertrophied, as well as the stones it partially concealed. It seemed to me quite unnecessary to remove the entire prostate, and I therefore advised the minor operation.

This was done by opening the membranous portion of the urethra on a grooved staff as if for median lithotomy; this enabled me to pass a pair of forceps into the bladder, with which I seized and twisted off the polypoid excrescence of prostate as you see in the specimen. Subsequently I withdrew two calculi and introduced a temporary perineal drainage tube into the bladder. In a few days the latter was withdrawn, when the wound rapidly closed.

It is now over two years since this operation was done, the patient has had no further recurrence of stone, and what is also of great importance, he has never had occasion to use the catheter since, though he had been dependent upon this instrument for so many years previously.

It was quite clear in this case that the partial enlargement of the prostate which I have described was the direct cause of the recurrence of stone from which this patient suffered for so many years. Further, this case illustrates the great assistance the cystoscope affords in all cases of this kind. It clearly showed how limited the prostatic enlargement was, and how this could be removed by a very simple and safe operation. The days are now passed when the cystoscope was regarded as a toy. Every one who desires to obtain a practical knowledge of the disorders affecting the urinary tract must make himself acquainted with it if he desires to diagnose and treat correctly the disorders of this part.

Partial operations on the prostate must be limited to such conditions as I have just illustrated. They are not to be recommended when the entire organ is more or less involved in a hypertrophy. Two instances have recently come under my attention where no permanent good followed suprapubic cystotomy and the removal of some portions of the enlargement. In one the suprapubic opening never closed, as the urine failed to escape by the natural channel, whilst in the other, though the suprapubic wound healed by the aid of a retained catheter, the patient could never dispense with the latter instrument. In the latter case I advised that an attempt should be made later on to rectify this by a more complete enucleation of the balance of prostate than remained. This I heard was followed by a most satisfactory result, the patient within a month after the revised operation obtaining full voluntary power over the act of micturition, besides other advantages.

There is another point to which I should like to refer in connexion with the subject of entire enucleation of the prostate as now practised.

There can be no doubt that in the large majority of these cases the prostatic urethra is more or less damaged if not entirely removed. This is evident from the examination of specimens after removal. The question has been raised, Is there not some liability to what amounts to a urethral stricture after a wound of this kind? I have met with an instance where there is some evidence of this being the case. The prostate was removed from a gentleman 67 years of age in February, 1902. The urethra was somewhat freely separated on the anterior aspect of the prostate in front of the junction with the membranous portion. The whole canal was no doubt much toughened by the very long dependence on the catheter, and by no less than eight crushing operations for stone which had preceded the prostatectomy. Since the latter operation this patient has had some trouble in passing urine. Sometimes a good stream passed, at others no urine could be voided until after the introduction of a bougie. A good

stream then immediately followed. Apparently there was an obstruction of a valvular nature which thus caused the difficulty in urinating. It could not be called a stricture as after the hitch was overcome just at the entrance to the bladder a No. 14 metal bougie, English gauge, passed easily. Three months after the prostatectomy I passed a urethrotome and divided what seemed to be a fibrous band or bend at the point where the hitch occurred. This completely freed the urethra for all purposes and the patient has since had no further trouble in urinating naturally with a large stream.

A Clinical Lecture

ON A SIXTH SERIES OF CASES OF

TOTAL EXTIRPATION OF THE PROSTATE FOR RADICAL CURE OF ENLARGEMENT OF THAT ORGAN.

Delivered at the Medical Graduates' College and Polyclinic.

By P. J. FREYER, M.A., M.D., M.Ch.,
Surgeon to St. Peter's Hospital, London.

It will be within the recollection of many of you that I first called attention to my new operation in a lecture delivered in this College on June 26th, 1901, and published in the *BRITISH MEDICAL JOURNAL* of July 20th, 1901. In that and subsequent lectures delivered in this College, and published in that *JOURNAL*,¹ I have placed before the profession at large full details of my first 31 cases of this operation, which carried my work on this subject down to the end of 1902. I propose to-day placing before you details of a further series of 14 cases of the operation performed in the present year, the first of which unfortunately died from pneumonia, the remaining 13 being one and all completely successful. Let me in the first instance, however, once more describe the anatomical and pathological features on which my operation is based, as well as the method of carrying it out. (These details have already been published in the *BRITISH MEDICAL JOURNAL*, and need not be repeated here.)

CASE XXXII.

A gentleman, aged 65, seen September 3rd, 1902, with Dr. Kildare Dobbs, of Tutbury, for prostatic symptoms of ten years' standing, and latterly those of stone in the bladder superadded. Catheter employed for four years; complete catheter life for two years. Had had frequent attacks of cystitis, with high fever and great difficulty in passing the catheter at times. Large stone detected on sounding. Prostate greatly enlarged per rectum, bilobed, tense, soft, elastic, and movable. The case was regarded as a suitable one for removal of the prostate, but the patient was in such an extremely feeble condition, with his kidneys probably much affected, that I determined in the first instance to remove the stone, and, if possible, to get him into better health before undertaking this operation.

On September 15th I removed the stone by litholapaxy, a hard urate stone weighing 622 gr. Convalescence was slow and attended by several rises of temperature; but the patient was able to travel home on October 9th. He continued to improve gradually in health, but the difficulty in passing the catheter remained, and he had a severe attack of cystitis early in December.

On January 12th, 1903,² Dr. Dobbs considering him sufficiently strong to undergo the operation, he returned to London, and on January 14th I removed the prostate entire in its capsule, the lobes opening out along their superior commissure and the urethra being left intact. There was some venous bleeding from the suprapubic wound in the bladder necessitating the application of a ligature.

The patient did well for the first three days, but on January 17th lobar pneumonia, involving the lower two-thirds of the right lung, declared itself, and though the wound was quite healthy, he succumbed to this on January 21st. Whether the pneumonia was contracted during the journey to London or was incident to the operation; it is impossible to say.

It was with great diffidence that I undertook the operation in this case, owing to the enfeebled condition of the patient and the diseased state of his kidneys; but his sufferings were so great, particularly owing to the difficulty in introducing the catheter, that I felt bound to give him the only prospect of recovery. The prostate, which weighs 5½ oz., is a fine specimen of symmetrical enlargement of that organ.

CASE XXXIII.

Colonel P., aged 66, consulted me January 8th, 1903, on the advice of Surgeon-General Spencer, C.B. Prostatic symptoms for ten years, gradually getting worse. Catheter employed for 33 years on the advice of London urinary specialist. I passed a *coudée* (No. 8), and drew off 6 oz of residual urine, of fishy odour, containing some pus and albumen. Sounded; no stone present. Prostate moderately enlarged per rectum,

tense, elastic, and movable. Cystoscopy on January 13th revealed moderate enlargement of both lobes, particularly the left, in the bladder. I advised delay in operating till the enlargement of the prostate should become more pronounced, thus rendering the enucleation of the organ more easy, unless the symptoms should become more unbearable, so he returned to the country.

Severe cystitis set in in the end of January, for which the patient was treated by Dr. Maberley, Eversley. The symptoms were so distressing that the patient returned to London for operation, and on February 9th, Surgeon-General Spencer being present, I removed the prostate, weighing $1\frac{1}{2}$ oz. Uneventful recovery, some urine passing naturally February 18th, but the wound not finally closing till March 11th. Patient went home March 18th. On March 27th he wrote me that he was perfectly well, and could retain and pass his urine "better than ever before," and he has since remained perfectly well.

CASE XXXIV.

Colonel M., aged 61, consulted me on January 9th, 1903, on the advice of Dr. Guthrie Caley, Ealing. Prostatic symptoms for eleven years. Retention of urine in 1892; relieved by catheter by Dr. Simpson of Weymouth. Catheter employed continuously since then; urine passed entirely by catheter for last eight years. Frequent attacks of cystitis; passing blood since September, 1902. Vasectomy performed in 1897 by a provincial surgeon; no improvement whatever therefrom. Prostate much enlarged per rectum, bilobed, soft, elastic, movable. Cystoscopy on January 14th revealed an enormous outgrowth of the right lobe, resembling a large tomato, in the bladder, and slight outgrowth of the left lobe. Patient went home and contracted influenza some days after, which left him very feeble.

He returned to London and entered a surgical home on January 28th, but was so feeble that I deferred operation. On February 11th, Mr. C. Braine, anaesthetist, Sir William Collins and Dr. A. Crombie being present, I removed the prostate easily and rapidly, entire in its capsule, leaving the urethra behind uninjured. Some urine passed naturally February 25th; wound closed March 3rd. Temperature normal throughout. Patient left for home in good health March 14th, retaining and passing his urine as well as he ever did.

The prostate (Fig. 1), which weighs $3\frac{3}{4}$ oz., is a remarkable

Fig. 1.—Prostate weighing $3\frac{3}{4}$ oz. removed from patient, aged 61. B, enormous outgrowth of right lobe in bladder; A, smaller growth of left; C, C', circular groove, caused by constriction of recto-vesical fascia at neck of bladder.

specimen of unsymmetrical growth. Three-fourths of its bulk lay in the bladder, the right lobe being enormously enlarged in this direction, and the left only slightly so.

CASE XXXV.

A gentleman, aged 65, seen December 19th, 1901, on the advice of Dr. McManus, of Clapham Junction, for prostatic symptoms of six years' standing. Residual urine, 7 oz. Employment of the catheter twice daily advised. The symptoms growing worse gradually, and attacks of cystitis occurring, he was sent to me again February 16th, 1903. I found that the residual urine had increased to 18 oz. and that the patient was in great

distress from frequency of micturition and pain. Prostate not much enlarged per rectum, but tense, rather hard, bilobed, smooth and movable.

On February 19th I made a cystoscopic examination and saw that there was a teat-like growth projecting from the left lobe of the prostate into the bladder. Suprapubic cystotomy was at once performed, and conditions found as seen by cystoscope. I enucleated the prostate entire in its capsule, leaving the urethra untouched. Uninterrupted recovery. Some urine passed naturally March 2nd and the wound closed March 11th. Went home perfectly well March 19th, retaining and passing urine naturally.

The prostate, which weighs only $\frac{3}{4}$ oz., is the smallest removed by me entire in its capsule. I had not imagined hitherto that a prostate of this limited enlargement could be enucleated whole in its capsule. The case is a good illustration of what one finds in practice—that, as a rule, the symptoms attending enlargement of the prostate do not depend on its size, but on other conditions, such as its density and the manner in which it is bound down by the surrounding tissues. A prostate of several ounces in weight, if soft and loosely bound down by the recto-vesical fascia, may cause little or no trouble; whereas, one of less than an ounce in weight, if hard and bound down, may cause unbearable symptoms.

CASE XXXVI.

Sir J. D., a distinguished member of the medical profession, aged 71, seen at Putney in consultation with Mr. E. White on February 28th, 1903. Three years previously had painless haematuria for fourteen days without apparent cause. Remained quite well since then till January 21st, 1903, when bleeding again set in, at first intermittent, but latterly continuous, which necessitated his remaining in bed for the last three weeks. At times the bleeding was very profuse, almost pure blood passing. The only other symptoms were great frequency of micturition since taking to bed, not before; some pain at the neck of bladder; and uneasiness in the loins, particularly the left. The catheter had latterly been passed twice daily and the bladder washed out by Mr. White. Rapid loss of flesh with anaemia during last few weeks. The patient had been seen several times by Dr. Allchin and Mr. Makins, by whose advice I was called in consultation.

I drew off 15 oz. residual urine containing much blood. Sounded, but no stone detected. Prostate somewhat enlarged per rectum, but not at all prominent. Bimanually some fullness felt in the bladder, of an indefinite nature. The cause of the haemorrhage was thus very obscure, and grave apprehensions were entertained by the medical gentlemen mentioned and myself that its source was a growth either of the bladder or kidney.

The patient was conveyed to London by ambulance, March 2nd, and kept in bed in a surgical home, under the observation of Mr. Makins and myself. Rest and astringents for a week had little or no effect in reducing the bleeding, and the latter rendered diagnosis by the cystoscope impossible. Examination of the kidneys by the x rays negative. Eventually we came to the conclusion that the haemorrhage was due either to a growth in the bladder or an outgrowth of the prostate, so we determined to open the bladder suprapubically for diagnosis and such measures as might be found advisable.

On March 9th, Mr. White giving the anaesthetic, and Mr. Makins kindly assisting in consultation, cystoscopic examination revealed an irregular mass in the bladder, but the view became so rapidly obscured from the bleeding that no definite opinion as to its nature could be formed. Suprapubic cystotomy was forthwith performed, and on introducing my finger I found, happily, that the growth consisted of a very decided outgrowth from both lobes of the prostate, united below, and forming a U-shaped, or cart-horse-collar, projection in the bladder. The lower lip of this projected $1\frac{1}{2}$ inch beyond the neck of the bladder. The prostate was easily and rapidly enucleated entire in its capsule, the urethra being left behind. There was very little bleeding or shock. The patient made a most satisfactory recovery, passing some urine naturally March 29th, and the wound being quite dry April 1st. On April 8th he left for home in good health, retaining and passing urine quite naturally. Since the operation there has been no trace of haemorrhage.

The prostate, which weighs $2\frac{1}{2}$ oz., is an excellent specimen of symmetrical adenomatous enlargement of the organ. The case is a remarkable one from many points of view, but particularly in regard to the masked character of the prostatic symptoms. There were really no external signs or symptoms to indicate prostatic mischief, as, though there was a large quantity of residual urine, this did not give rise to the usual symptoms of frequency of micturition till the patient took to bed. It has to be noted that there was profuse haemorrhage from the prostate long before a catheter was employed, due, no doubt, to a varicose condition of its veins.

CASE XXXVII.

Gentleman, aged 79, consulted me March 16th, 1903, on the advice of Dr. J. F. Tuohy, of Hove. Five years ago had haematuria for two days after a game of tennis. Consulted two London surgeons, one of whom sounded him and washed out his bladder in a home for several days. Scalding and increased frequency of micturition ever since. Three weeks previously haemorrhage set in again, when he saw Dr. Tuohy, who found he had a large quantity of residual urine, the result of a very much enlarged prostate, and advised him to have the prostate removed. Catheter

employed twice daily. I drew off 8 oz. residual urine, which was turbid from muco-pus. Prostate greatly enlarged per rectum, markedly bilobed, soft, tense, smooth, movable; felt bimanually like a large orange.

On March 18th, Mr. C. Braine, anaesthetist, and Dr. Tuohy assisting, I removed the prostate entire in its capsule, the urethra being left behind. Both lobes were very prominent in the bladder—almost pedunculated outgrowths. The enucleation was easy and rapid, only ten minutes elapsing from commencing the suprapubic incision till the prostate was delivered from the bladder. Scarcely any bleeding or shock. The patient made an uninterrupted recovery, the temperature remaining practically normal throughout. Urine began to pass naturally April 14th and the wound was quite closed April 19th. Went home to Brighton April 23rd in good health, able to retain and pass his urine as well as he ever did.

The prostate (Fig. 2) is a fine specimen of the symmetrically enlarged type, weighing $5\frac{1}{2}$ oz.

Fig. 2.—Prostate weighing $5\frac{1}{2}$ oz. removed from patient, aged 71. The constriction at A is the boundary between the intravesical and extravascular portions of the gland.

CASE XXXVIII.

H. D., aged 57, admitted to St. Peter's Hospital, March 10th, 1903. Had retention of urine six years previously, and the usual prostatic symptoms since then, gradually increasing. Habitual use of catheter for two years; urine entirely passed in this way for twelve months; difficulty in passing catheter. Prostate much enlarged per rectum, bilobed, soft, tense, movable; felt greatly enlarged bimanually.

On March 18th I removed the prostate (Fig. 3) entire. The capsule was adherent to the sheath, and in the enucleation a thin band of the latter (c) was removed with the prostate, as well as a portion of the prostatic urethra. The patient made an excellent recovery; began to pass urine naturally March 30th; and the wound was dry April 6th. Discharged April 18th. I have now the pleasure of showing you the patient in perfect health, able to retain and pass his urine quite naturally.

The prostate (Fig. 3), which weighs $6\frac{1}{2}$ oz., is a fine specimen of the non-symmetrically enlarged organ, the right lobe (A, A') being enormously enlarged in the bladder, and forming a pistol-shaped valve (A) to the urethral orifice. This is the youngest patient on whom I have performed this operation. The great size of the prostate is remarkable in a man of his age.

CASE XXXIX.

G. B., aged 72, admitted to St. Peter's Hospital, March 20th, 1903, with prostatic symptoms for six years. Totally dependent on catheter for eighteen months. Urine contained much pus. Prostate considerably enlarged per rectum, bilobed, soft, elastic, and movable. Patient very feeble and anaemic.

Prostate removed entire March 25th, urethra being left uninjured. The wound was rather slow in healing, and reopened twice, but finally closed April 29th. Discharged cured May 13th, able to pass and retain urine as well as he ever did.

The prostate, which weighs $3\frac{3}{4}$ oz., is symmetrically enlarged.

CASE XL.

Gentleman, aged 61, seen with Dr. Horace Duncan, London, March 28th, 1903. Prostatic symptoms for ten years. Retention in August, 1901, relieved by catheter by Dr. F. E. Nichol, of Margate. Catheter life since

then, a pint of urine being drawn off morning and evening. Has had frequent attacks of cystitis, double orchitis, and latterly severe haemorrhage. Symptoms very distressing; patient greatly reduced in strength; asthmatic. I drew off 19 oz. urine containing much pus and blood. Prostate felt much enlarged per rectum; bilobed, tense, soft, and movable easily felt bimanually.

On March 20th, Mr. Thomson Walker and Dr. Duncan assisting, I removed the prostate easily and rapidly, eight minutes only elapsing from commencing the operation till the prostate was delivered from the bladder. Uninterrupted recovery, the temperature remaining normal throughout. Urine passed naturally April 11th; wound dry April 16th. Is now in excellent health, able to retain and pass urine as well as he ever did.

The prostate weighs $2\frac{3}{4}$ oz., and is encircled by a thin band of the sheath or recto-vesical fascia, so that a portion of the prostatic urethra was removed with the gland.

Fig. 3.—Prostate weighing $6\frac{1}{2}$ oz., removed from a patient, aged 57. A A', enormously enlarged right lobe terminating in pistol-shaped projection (A) in the bladder. B B' left lobe. C, thin band of sheath or recto-vesical fascia removed with prostate.

CASE XLI.

Gentleman, aged 62, seen with Dr. Inglis Mason, of Sudbury, March 20th, 1903. Prostatic symptoms for one year only; much pain in micturition; dribbling of urine, wets the bed. I had much difficulty in introducing a *coudle* catheter; drew off 26 oz. residual urine. Prostate enlarged per rectum and rather hard, but movable. Cystoscopy on March 26th revealed a test-like outgrowth of both lobes in the bladder. Patient very stout.

Prostate enucleated March 30th, Mr. Wylie and Dr. Mason assisting, both lobes coming away separately. Recovery somewhat slow. Began to pass urine naturally April 22nd, wound dry April 28th. Is now in perfect health, untroubled by any urinary symptom.

The prostate, which weighs $1\frac{1}{4}$ oz., is much harder than usual, but fibro-adenomatous microscopically.

CASE XLII.

Gentleman, aged 62, sent to me from Florence for operation by Drs. Coldstream and Gordon of that place, on the advice of Dr. W. Playfair. Prostatic symptoms for ten years, during which time he had consulted many urinary specialists in London and elsewhere. Catheter employed since 1898; cystitis with fever from time to time. The pain and constant irritation of the bladder caused sleeplessness, for which narcotics were taken. Straining to micturate caused involuntary action of the bowels, great frequency of micturition, hourly by day and half-hourly by night. Nervous system utterly broken down; very excitable and irritable; intermittency and irregularity of pulse. I drew off 10 oz. of residual urine containing much pus and mucus. Prostate much enlarged per rectum, round, soft, smooth, movable; felt bimanually.

On March 31st, 1903, Mr. C. Braine anaesthetist, I enucleated the prostate entire in its capsule easily, the urethra being left intact. Nine minutes only elapsed from commencing the suprapubic incision till the prostate was removed from the bladder. Though there was scarcely any bleeding during the operation, owing to the restlessness of the patient there was for several days some oozing, giving rise to clots which caused irritation of the bladder and necessitated removal of the sutures, so that the suprapubic wound gaped and was slow in healing. Small quantities of urine passed naturally almost daily, but not in quantity till May 10th. A sharp attack of rheumatism retarded his recovery, but the patient went home on May 23rd in fairly good health, passing and retaining his urine naturally.

The prostate, which is symmetrically enlarged, with small nodulated outgrowths from each lateral lobe in the bladder, weighs $2\frac{1}{2}$ oz.

CASE XLIII.

A gentleman, aged 71, consulted me March 28th, 1903, for prostatic troubles. Catheter employed for twenty years, not a drop of urine passed naturally for last eighteen years. Calculi removed by crushing on three occasions by London specialist; double castration by another London surgeon for cure of prostatic troubles in 1897, but without any amelioration of his symptoms. Slight paralytic stroke in January, 1903, from which he completely recovered, but has had a nurse ever since. Extremely feeble and hysterical; breaks down and weeps without apparent cause. Patient's condition most pitiable. Haematuria from time to time. Urine contains much pus and blood, and is most offensive; bladder can contain only small quantity; hence catheter used half-hourly day and night. Enormous enlargement of prostate per rectum, soft, smooth, bilobed, movable. Cystoscopy on March 30th revealed an enormous outgrowth of prostate in the bladder.

On April 1st, Mr. Wylie assisting, I enucleated the prostate entire in its capsule, leaving the urethra behind. The prostate projected into the bladder in the form of a cone, the urethral orifice being shaped like the crater of a volcano. Considerable force had to be employed to separate the capsule from the sheath. After delivery of the prostate as a whole into the bladder, owing to its large size, the lobes had to be separated to facilitate its removal, though it was very soft and spongy. Only eleven minutes elapsed from commencing the operation till the prostate was delivered from the bladder. There was scarcely any bleeding or shock. The patient made an uneventful recovery. Urine passed naturally April 26th, and the wound was dry May 5th. He was quite overcome with joy at passing urine naturally again after eighteen years of complete catheter life. Went home May 11th, and is now in excellent health, able to retain and pass his urine as well as he ever did.

The prostate (Fig. 4), which weighs $8\frac{1}{2}$ oz., is a very large one, the second largest I have removed. The right lobe (A) is enormously enlarged, the left lobe (B) less so. The case is, indeed, a remarkable one, showing what wonderful results

Fig. 4.—Enormous prostate weighing $8\frac{1}{2}$ oz. removed from patient, aged 71. A, right lobe; B, left lobe. The transverse groove indicates the boundary between the intravesical and extravasal portions.

may be accomplished by this operation even when the patient is almost moribund.

CASE XLIV.

General X., aged 63, had consulted me on and off for seven years for urinary trouble, due first to stricture, and latterly to enlarged prostate. Internal urethrotomy ten years ago; since then steel sounds passed periodically. Decided prostatic symptoms for last three years; frequent attacks of cystitis; catheter employed and bladder washed out; for last four months symptoms very distressing. Cystoscopy on March 24th, 1903, revealed considerable outgrowth of both prostatic lobes in the bladder, which latter was sacculated from the backward pressure due to the stricture and prostatic enlargement.

On April 1st (Dr. Dudley Buxton, anaesthetist) I opened the bladder suprapubically, and removed the prostate, both lobes coming away separately, the urethra being left intact; scarcely any bleeding or shock. Uninterrupted recovery, some urine passing naturally April 5th, and wholly in this way April 21st. The patient went home May 1st, retaining and passing urine naturally, and in better health than for many years.

The prostate weighed $1\frac{1}{2}$ oz., and was rather hard.

CASE XLV.

A member of the medical profession, aged 61, with prostatic symptoms for four years. Retention two and a-half years ago, relieved by catheter by Dr. Beaver, Sturminster Newton. Had double vasectomy performed by a well-known provincial surgeon; no relief therefrom. Practically the whole of the urine by catheter for eighteen months; several attacks of cystitis. Prostate decidedly enlarged per rectum, rounded, soft, tense, smooth, and movable. Cystoscopy on March 4th revealed well-marked outgrowths of both prostatic lobes in the bladder, particularly of the left.

On April 6th, 1903, I removed the prostate entire in its capsule, the lobes opening out along their superior commissure, leaving the urethra uninjured. The patient was only twenty-three minutes on the operating table, and only seven minutes elapsed from commencing the suprapubic wound till the prostate was delivered from the bladder. Scarcely any bleeding or shock. Several ounces of urine were passed naturally during the first few days; then all the urine by the suprapubic wound for several days. The latter finally closed May 3rd. During the first ten days the wound was covered by much phosphatic grit, which required removal twice daily, and some grit was also passed per urethram with the urine. The patient left for the country May 5th, and is now in excellent health, able to retain and pass his urine naturally. I under-

stand that he has recently read a paper on his own case at a Branch meeting of the British Medical Association.

The prostate is an excellent specimen of non-symmetrical enlargement, the left lobe being much more bulky than the right. It weighed $1\frac{1}{2}$ oz.

REFERENCES.

- 1 BRITISH MEDICAL JOURNAL, February 1st, July 26th, and November 8th, 1902; April 18th, 1903.

SOME POINTS IN THE PATHOLOGY AND TREATMENT OF PROSTATIC OBSTRUCTION,

WITH AN ACCOUNT OF THIRTY-THREE OPERATIONS FOR ITS REMOVAL.

By W. BRUCE CLARKE, M.B., F.R.C.S.,

Surgeon to St. Bartholomew's Hospital; late Surgeon to St. Peter's Hospital for Stone; Examiner in Surgery, University of Oxford, etc.

THOSE who have read the critical remarks of Sir William Thomson on the removal of prostatic adenomata in the BRITISH MEDICAL JOURNAL of May 31st, 1902, will, I am sure, agree with me that his views are in the main correct and much to the point, but it appears to me that he has only touched one side of the disease to which we apply the term prostatic obstruction. To my mind, it is of some importance that in clinical descriptions of this condition we should

employ the term prostatic obstruction, and avoid the term which is in more general use—namely, “prostatic enlargement;” and for this reason: that in many of the cases in which the patient finds it quite impossible to empty his bladder, there is no prostatic enlargement.

One of the main points to which attention is called in this paper, to which I just referred, is the question of how much of the prostate is removed by those who have performed prostatectomy; in other words, Is prostatectomy really a removal of the whole gland, or is it not? Amongst others, I am referred to as having stated that I have removed the “whole prostate;” and it may perhaps tend to clear up our ideas on this subject if I state briefly how it was that I arrived at the notion that I had removed the whole of the organ. It was because after I had shelled out an enlarged mass from the prostate by the suprapubic route I found that I could get my finger down as far as the triangular ligament, and no trace of prostate could be detected, and further when the patient was restored to health, a digital examination of