act of micturition. When this condition is unduly persistent, and all ordinary remedies fail to give relief, the patient continuing to suffer for weeks, or even months, we may suspect that the trouble is located in the vesiculæ seminales and not in the prostate. We must not come to this conclusion on these grounds alone, but an examination per rectum may aid us, and we may be able to detect the position of an inflamed vesicula seminalis, which we will find indurated and very tender, occupying a position extending beyond the base of the prostate. The inflammatory process in the vesiculæ seminales follows a similar course to that occurring in the epididymis, an organ of a like anatomical structure, namely, a convoluted tube. We are familiar with the character of the inflammatory process in the epididymis. At first, very acute with intense pain, and probably high fever; after the acute stage has passed off, a subacute stage supervenes, in which there is still a considerable amount of tenderness and the organ remains indurated; the induration and pain may persist for some months; suppuration may occur, and is by no means infrequent. We find the statement made that inflammation of the prostate may lead to suppuration and the formation of an abscess. It is quite possible, however, that many of the abscesses which are supposed to originate in the prostate are really in the vesiculæ seminales.

Mr. Jordan Lloyd recently read a paper on what he termed "Spermato-cystitis,"* dealing with the subject of inflammation of the vesiculæ seminales. In that paper Mr. Lloyd makes the following statement: "So little attention has been paid to inflammatory diseases of the seminale vesicles, that the subject is dismissed in a few words, even in special monographs upon venereal or genito-urinary disorders; but since my attention was first directed to the subject I have met many cases, and have satisfied myself that these maladies are by no means rare. They are, indeed, amongst the most common complications of gonorrhœa. They are usually overlooked, not because they do not give rise to definite signs and symptoms, but because these symptoms are misinterpreted and are wrongly attributed to diseases of different organs altogether." The history of the following case, recently under observation, suggested the implication of the seminale vesicles in a gonorrhœal inflammation. H.D., æt. 24, contracted a gonorrhœa; the pain and urgency from which he had suffered in the early stages of the attack had subsided, and the discharge had almost ceased, when at the beginning of the third week he was seized with severe pains, deeply seated in the perineum. Hot fomentations were applied and antipyrin administered. Despite this treatment the pain increased so greatly in a few hours that it was necessary to administer morphia hypodermically for his relief. A mixture containing chloral and bromide was prescribed, and during the next few days the pain diminished somewhat, but then recurred with increased severity, so that morphia was again necessary. During this time he had increased frequency of micturition and urgency. In order to check the irritability of the bladder, bicarbonate of potash and tincture of hyoscyamus were administered, and the bowels were kept regular by giving sulphate of magnesia. Three weeks after the onset of these symptoms, the pain at that time being much less acute, an examination was made per rectum. This revealed the presence of a swelling on the posterior aspect of the bladder. It was more marked to the right of the middle line than on the left, and its posterior margin was not determined. The examination caused him much pain, and there was excessive tenderness on pressure over the swelling. It was thought probable that the inflammation was situated in the seminale vesicles, more marked on the right side than on the left. During this time the urine was examined frequently. It was noticeable that the urine first voided was clear and of normal appearance. At the end of the act of micturition, discharge of mucopurulent material took place, accompanied by blood; the amount of blood lost from time to time varied but was usually small. The urine was of spec. grav. 1006 and alkaline reaction, albumen 1/8th contained pus cells; there were no casts and no epithelial cells. During the second and third weeks of the attack (fourth and fifth weeks of the gonorrhœa) the most distressing symptom was the urgency of micturition. The pain was no longer constant, but he suffered acutely after voiding urine, the pain lasting a variable

Lancet, October 31, 1891, p. 974.