the lips of the meatus together, and the expectation is that it is about to disappear; when, due to some slight cause, some error of diet, some indulgence in alcoholic liquor, it returns again almost to a state of true gonorrhœa This is an universal experience; it tries the patience of the surgeon and his patient to the uttermost.

Why should this be so? Is it because the part from which the discharge comes is so far back in the urethra, that it cannot be thoroughly reached? I think not; for if so, why then do we find strictures, the result of long continued irritation from gleet, situated invariably anterior to the triangular ligament, in the spongy portion of the urethra, probably, most froquently, just at or in front of the bulb; next, not far from the meatus, and, lastly, anywhere in the urethral spongy part. Some surgeons do talk about strictures in the membranous and prostatic portion, but if they are in the membranous they are the result of some injury to the perineum, as by fall or blow, secondarily implicating the urethral canal. The prostatic portion is never truly the seat of organic stricture. Is the explanation of this chronicity to be found in believing that the urethral mucous membrane gets into such a debilitated state, that it is constantly shedding, in an imperfect state, its superficial layer on the slightest provocation? or should we agree with Prof. Otis, and look upon its continuance as an evidence of an abnormal contraction, however slight, of the urethral calibre; in other words, that "chronic urethral discharge means stricture." I cannot go as far as this last statement. I have tested a number of cases, both with olive-pointed and ordinary bougies, and found in many cases that no sign of stricture existed. It is true, I did not use Otis' urethra-meter. Perhaps some member would give his experience with that instrument However, if stricture does exist, it should be combated by appropriate means; more than this, the very passage of large-sized steel bougies in those cases in which I said I could not find evidence of stricture, were benefited by them.

Some cases are managed only by injections, and all cases are in a measure benefited by them; but they should be mild astringent ones, frequently changed.

It is probable that the truth lies as to the pathology in this debilitated state, and that the disease begins in the mucous membrane, extends into the sub-mucous tissue, and continues there very often sufficiently long for the infiltration to become fibrous and make a stricture, while on the surface the epithelial stratum is thickened, the upper or superficial cells of this stratum are constantly dying, exfoliating and mingling with the secretion of mucus from the glands and lacunæ along the utheral tract, and this makes the discharge of chronic gleet, on this basis.

I lately noticed a paper on this, by Lecoper, of Berlin, in which he claims the method he recommends to be tried has the advantages of combining the mechanical and chemical treatments, and I propose to try it at an early date. It is as follows: nickel-plated bougies are used, slightly conical; there are six shallow grooves on them, becoming shallower near the points, before reaching which they cease. Into the grooves of these bougies he pours a paste, which hardens at the ordinary temperature of the air. He tried various forms of paste, containing as the active ingredients, iodoform, zinc, resorcin, and others, but found them all inferior to nitrate of silver; the proportion being, cacao butter, 100 parts; nitrate of silver, 1½ parts; balsam of copaiba, 2 parts. He gives careful directions as to the making of this paste, laying stress on the fact, not to employ too much heat in first melting them, else the nitrate will be reduced to silver and be inefficient. After the salve has become hardened, the bougie is smoothed with any sharp-edged tool. This bougie will readily pass down the urethra. At the temperature of the body the salve melts in one minute.

He maintains no bad effects follow; no chill or fever, or at least no more than an ordinary bougie might produce. The length of time they may be left in varies according to circumstances, but the longer it is left in the more favorable the effect on the infiltration. Improvement begins at once, and in the later stages, when there is little or no discharge from the meatus, by observing the urine in the ordinary way, the character of the discharges found in it will indicate roughly this improvement. Thus, at first, the flakes of matter will contain more pus and fewer epithelial cells; as improvement goes on, the epithelial cells increase in number and the pus cells decrease, until a few only (embedded in the epithelial cells) are seen. It is of course no new idea to employ bougies in these cases, covered with simple salve, or even covered