easily kept pure is that in which the portion between the eye and the point of the instrument is solid, instead of forming a little cul-de-sac, which is often very difficult to cleanse thoroughly. The spasm is overcome by gentle steady pressure. Even with the greatest gentleness there is often severe pain, and the injection of a drachm of a 4% solution of cocaine gives great relief.

(*c*) Retention of the urine may also occur in consequence of the superaddition of an acute inflammation, with spasm, to an old standing organic stricture. Here, again, the hip-bath, with the other means above recommended, should always be tried in the first instance before attempting to pass instruments; and if the surgeon has no previous knowledge of the case, and is unacquainted with the size of the organic stricture, he should not at once use a small instrument but begin with a No. 6 or No. 7; and if he fails to pass this, he may then try smaller instruments. The smaller the instrument the greater the risk of laceration of the mucous membrane of the urethra. If after a fair trial with instruments, he fails to relieve the retention, he should aspirate above the pubis, continue the use of fomentations and sedatives, and on the following day he will find either that the retention is relieved, or that he is now able to pass an instrument along the urethra into the bladder. This use of aspiration is of value. Repeated aspiration in bad cases of stricture with retention are not, however, to be recommended. In such cases there is a tight stricture, and it is best here to pass a large sized instrument down to the stricture, and the patient being tied up in the lithotomy position, to cut down on the middle line on the point of the instrument, to open the urethra, and, using a fine grooved probe, to search for the stricture; and, pass the probe along it, to divide the stricture with a narrow knife, passed along the groove in the probe. A full-sized gum elastic catheter is then tied into the bladder.

The tolerance of instrumental interference with the urethra varies very greatly in different people, and it should be a rule in practice, in cases in which the surgeon is entirely ignorant of the sensitiveness of the patient, not to pass an instrument, for the first time, in any circumstances in which the patient may be exposed to wet or cold. Before the passage of an instrument, it is well to administer 5 grains of quinine, or some of the more recently introduced antipyretics, *e.g.*, kairin or antipyrin. These remedies have an undoubted value in checking urethral fever. Their power is increased by giving the patient a drink of warm gruel immediately after the instrument has been passed. Shivering and rapid rise in temperature, after the passage of a bougie, must not be confounded with so-called "catheter fever," which has within recent years been brought prominently under notice.

(*d*) Retention of urine in old men is generally due to a congestive attack of the prostate superadded to hypertrophy of the gland. Here, again, the congestion should, if possible, be relieved by hip-baths, fomentations and sedatives, and, if instrumental assistance is required, in the great majority of cases the red rubber instrument relieves the retention. If the instrument fails then a metallic instrument is necessary. In cases in which there is a distinct valvular obstruction from enlargement of the middle lobe of the prostate, the difficulty is overcome by passing a large sized gum elastic catheter with a metallic stylet *in situ* down to the obstruction. If the instrument is then withdrawn to the extent of an inch, by pulling on the stylet, the point of the catheter will rise vertically in the bladder.

(*e*) Retention in young children is very frequently due to the presence of a calculus in the urethra. In rare cases it may be due to malignant disease of the prostate, and sometimes it is due to abscess in the prostate. These conditions are comparatively rare.

THE IMMEDIATE CLOSURE AND RAPID CURE OF FISTULA-IN-ANO.

BY STEPHEN SMITH, M.D.,

The possibility of a prompt cure of fistula-in-ano is a great advance in the treatment of this hitherto troublesome affection. Every surgeon must have met with cases which resisted the old method, and failed altogether to heal. And even when those having a large abscess cavity finally healed after free incision, there was often a deep cicatrix, which was a source of constant irritation from the tendency to the accumulation of filth in the deep sulcus. Occasionaly there was a certain troublesome defect in the action of the sphincter, which remained as a permanent disability. In these latter days of rapid improvement in the methods of operations, it has naturally occurred to many surgeons that fistula-in-ano might be treated successfully by the immediate closure of the wound, provided the track and abscess cavity were properly prepared, and then sutures were employed so as thoroughly to approximate the surface. It has been performed successfully in this country by Drs. Emmet, Weir, Lange and Chamberlain, of this city, by Dr. Jenks, of Chicago, and by several surgeons abroad. In most instances these surgeons have operated without any previous knowledge of the work of other operators. The simplicity and the success of the operation warrant the effort to give it greater prominence than it has yet received.

Attempts have been made, heretofore, to cure fistula-in-ano by incision of the track, followed by the dissection of the lining membrane, but with indifferent success. It is only when the surfaces are quite firmly brought together and maintained in apposition, that union takes place with any greater