came under my care, and with cocaine I passed No. 2.5 conical steel sound, and finding that he seemed to suffer very little I passed the rest up to No. 12.

After the first attempt his temperature at night rose to 105°, and he had great general discomfort. After the dilatation with cocaine anaesthesia, his temperature rose only to 101-3°, and the general discomfort was slight.

Strictures complicated with fistula in perineo I have also successfully dilated and temporarily cured. Cases which are due to loss of tissue, and constant infiammatory action over a considerable area of perineum, are not usually the most promising for simple dilatation, but frequently require some operative interference, urethrotomy, or generally external perineal section.

I said temporarily cured, because I think most surgeons find that, no matter in what manner the strictures may have been dealt with in order to effect a cure, such a state of full dilatation does not remain. Slowly, but certainly, the strictured part contracts and requires to be kept patent probably for the rest of the patient's life.

I have advocated in this paper but one method of treating strictures, and I have done so purposely. I believe that to the great bulk of practitioners in Canada this mode of treatment is most available, most simple, most safe; and in many cases of urethral stricture, especially those in the neighborhood of the bulb, I feel confidence in advising a trial of interrupted gradual dilatation. Again, the limits of such a paper as this forbids entering into the merits and demerits of all the ways and modes of treatment. I am aware that many may prefer to combine dilatation and internal urethrotomy, especially in tough undilatable strictures in anterior portion, or in those cases in which, owing to grave constitutional symptoms, which may occur as a result of dilatation compel it to be thus modified, or in cases where contractibility or resilience is strongly marked, and all our efforts at dilatation are neutralized by this peculiarity.

I am inclined to believe that internal urethrotomy is not yet undertaken by many, because they fear the possibility in unpractised hands of very serious consequences; for it cannot be denied that incision of the urethra is not infrequently followed by special dangers, chief among which are hemorrhage, urinary fever, extravasation, and abscess, as well as blood poisoning in all forms of pyemia, septicemia, phlebitis, embolism, and thrombosis. Others, again, neglect to give a trial to the simpler and safer method, preferring to incise each and every case of organic structure of the urethra, quite independent of site, character, or anything else. I do think that though I am privileged to open the discussion, and in doing so strongly advocate dilatation, our good president will not object to any member favoring us with his view on urethrotomy, internal or external; dilatation, gradual, or interrupted, or continuous; by splitting rapidly, by electrolysis or any other recognized method.

The second cause of obstructed urinary outflow that I propose shortly to review is hypertrophy or enlargement of the prostate—that disease incidental to advanced age, the morbid anatomy of which is sufficiently precise, but the etiology of which is unknown, affecting as it does all sorts and conditions of men, from the judge on the bench to the coachman on the box.

It is important to make the diagnosis as early in this case as possible, and to relieve by mechanical means at an early period also. I do not think this is sufficiently appreciated. It is not usually done as early as it might be. Let me give a typical case of delay in the use of the catheter:

C. S. G., aged 68, a particularly well made, healthy-looking man, consulted me for a pain in the eleventh interspace on left side, not far from the angle of ribs, and dribbling of water into his bed at night, generally between the hours of 5 and 6 a.m.; now and then in the day time into his trousers as well. Questioning revealed that during the day the calls to micturate were infrequent, but that he made water first thing on rising, after partially dressing again, and just after he was dressed, or three times in an hour, and a fair amount passed each time. The stream was normal in calibre, but not well projected, and towards the end dribbled a good deal. Chemical and miscroscopic examination of urine revealed nothing except that urine was rather light colored and of low specific gravity. He had quite distinct fulness and dulness in the hypogastric region; advised to have a catheter passed to relieve the bladder, but the idea was very distasteful to him, and he declined to allow its use, preferring to go to England and seek advice there. He first of all consulted a