best situation, for the bulb is thereby avoided. If the surgeon prefer, however, to cut the floor of the canal, all he has to do, when he has passed the staff of the urethrotome, is to reverse the instrument, so that its point is turned behind the prostate, as in lithotrity. The urethrotome can be made with a lateral or inferior blade, if desired. As soon as I have ascertained that the canal is perfectly free from one end to the other, I withdraw the instrument and introduce a No. 25 silver catheter, for the purpose of demonstrating that the urethra has been restored to its normal calibre and to completely empty the patient's bladder. By ensuring that the bladder is empty, the patient can go for some four or six hours without wanting to make water, by which time the wound will be covered with a firm clot, and the pain in micturition be considerably diminished.

I do not leave any catheter in the bladder after the operation, and I allow the patient to pass his urine naturally. I believe I was the the first surgeon in this country to dispense with the use of the catheter after the operation. If there be one practice more persistently insisted on than another in English surgical works, it is that of the necessity of the use of the catheter after urethrotomy, the instrument to be either left in the bladder or else employed to draw off the patient's urine; and the writers point out the disastrous consequences which will take place, in the shape of abscess, fistula, or infiltration of urine, if the practice be not observed. To Dr. Gouley of New York belongs the credit of having shown the utter groundlessness of the surgeon's fears.

After the operation, I am in no hurry to commence the passing of instruments, usually waiting till the fourth day, and not introducing them oftener than twice a week. At the end of ten days, I begin to teach the patient how to pass a catheter for himself, and order him to do so every Saturday night till further orders. By passing a large No. 25 bougie or catheter several times after the operation, the insertion of a good "cicatricial splice" is guaranteed.

Now as to results. I have operated in all on thirty-three cases, all of them of the worst description, and for that reason relegated to the operation, without a single death. In one instance, the urethra was so indurated in its entire length that I left in a catheter after the operation, to set up urethritis, and so lessen the thickening. The inflammation was, however, more than I desired; and abscess, followed by fistula, ensued. The case ultimately got quite well. In one case only had I troublesome bleeding. It proceeded from the meatus, which I had divided, and was a hint to me for the future not to cut the meatus at the same time as the stricture, but several days before. As a rule, not more than a dessertspoonful of blood escapes either at or after the operation. Secondary hæmorrhage I have never seen. Rigors occurred in about two-thirds of my cases. I look upon them as entirely nervous and of no importance. It is stated in books that rigors are due to the passage of the urine over the wound. This, however, cannot be the correct explanation; for, unless pyæmic, they are never seen after lithotomy or external urethrotomy. I look upon rigors after internal urethrotomy as caused by the sudden *stretching* of the nerves in the wound through the distension of the canal by the urine. In three of my earlier cases, I had to repeat the operation, as my incisions had not been sufficiently free. I am sure that every one who performs the operation will be pleased with the soft supple cicatrix which follows it, so different from the rough, tough, irregular cicatrix which forms the so called "immediate treatment," which is neither more nor less than absolute laceration, not always of the tough stricture, but sometimes of the unoffending healthy urethra, where, as elsewhere, "the weaker goes to the wall."

Now for statistics. I think they will be found to be eminently satisfactory, and will carry conviction. They are the largest, I believe, which have ever been placed before the profession, and show what internal urethrotomy can accomplish. No other operation for stricture with which I am acquainted can produce such favourable results. I consider that no operation can be performed on the urethra without a certain amount of risk; but how slight that risk is you will immediately see. I find by examination that the operation has been performed by six surgeons in London, Paris,