The differentiation of these sources of purulent flow opens up a field rather too wide to be critically considered in a paper of the limited length my time affords. Suffice it to say that prostatic and seminal vesicular suppuration may usually be demonstrated by a milking of the prostate and seminal vesicles by a finger in the rectum, between the first and second urinary flows, a portion of urine being retained in the bladder to be ejected in a third urinary flow and the specimens examined microscopically after settling.

Bladder and kidney suppurations, although they may occur in company with both anterior and posterior urethritis, and will of course render all the urinary specimens turbid with pus, are beyond the scope of this paper and need not be considered.

The commonest kind of posterior urethral catarrh, ordinarily following a protracted gonorrhœa, is the one upon which I prefer to concentrate my and your attention.

Its clinical picture is this: A patient has gonorrhœa, following a more or less protracted course, perhaps complicated toward the end with swelled testicle or a more or less pronounced attack of gonorrhœal cystitis or vesical irritability, and then subsiding into a condition of mild gleet. Such a patient procures some, as he conceives, suitable injection. and as long as he continues to use it once or twice a day his urethra remains apparently dry, and he considers himself well. Within a day or two, however, after leaving off his favorite injection the discharge reappears and goes on to reach a certain grade of intensity, possibly without other symptoms, or perhaps accompanied by itching or discomforting sensations in the anterior urethra near the meatus, or referred to the perineum, and sometimes accompanied by a little urinary urgency and precipitancy. Such a man, even while keeping down his show of gleet by means of injection, will notice that if he drinks wine or spirits, or if he indulges in sexual intercourse, especially to excess, even or if he has a nocturnal emission, that his show of gleet will certainly become promptly aggravated. These are the cases that get a new gonorrhœa every few months, and those who claim to have acquired a new discharge from perfectly healthy women—and their number in the community is considerable.

They are cases of posterior urethritis often pure and simple. They fly from one nostrum to another, and from one physician to another. Sooner or later all of them have the anterior urethra widely cut for alleged stricture of large calibre, and some of them by this means receive temporary, permanent, benefit—when the membranous others urethra is the seat of soft stricture which keeps up the posterior urethritis in their particular cases, and when the deep urethra will tolerate the passage of sounds without resenting the traumatic violence thereby inflicted.

But this factor of deep urethra tolerance to sounds does not by any means always exist, and the sequel to the cutting and the passage through the deep urethra of large dilating instruments is quite often an aggravation of the discharge and a lighting up either of mild cystitis, prostatitis or epididymitis,

This picture is surely a familiar one to many of you.

Take such a patient at his best, between his acuter attacks, when he thinks that he is keeping himself well, as he calls it, by the use of an injection, and when he has no visible show of gleet—and ask him to urinate in a glass. Floating about in the urine will be noticed cottony chunks and irregular masses of fleecy muco-pus (not simple compact linear shreds), and more or less free pus. This patient is playing the ostrich role, and ignorantly imagining that because he sees nothing there is nothing to see, when all the while the drops of pus are oozing backward in his urethera and being washed out by each urinary act—drops which, if they did come forward and show at his meatus, would convince him that his injection was a snare, and only a mask to conceal the presence of the enemy.

If one of these little fluffy cottony chunks that float about in the urine be caught up in a pipette and examined microscopically, it will be found to be made up of more or less closely arranged rows of layers of pus-cells, strung out in straited films of colloidal prostatic mucus, entrapping the larger oval and rounded succlent cells from the neck of the bladder, some granular bodies, occasionally a crystal of oxalate of lime or uric acid, occasionally a stray spermatic element or a sympexion, sometimes a perfect hyaline prostatic cast—a cast to deceive even the elect, especially when, as is often the case in patients showing prostatics casts, particularly if there be also spermatozoa, the urine contains a faint trace of albumin.

A case like the typical one I have just described is often posterior urethritis pure and simple; there may be a small meatus and points of physiological anterior narrowing, but often the posterior urethra is alone at fault, and is responsible for the relapsing attacks of urethritis, and for the mild persistent gleet.

The sceptical among you may well ask at this point, if this be a case of pure posterior urethritis, why does any of the discharge at all show at the meatus, and why does an injection, which does not reach the alleged diseased area behind the triangular ligament, so positively moderate or even control the anterior discharge, at least in so far as causing it to cease to appear at the meatus is concerned. The explanation is easy.

Although the focus of disease is posterior