

As I said to you last week, it is proper when you have a patient in this condition to put the question to him, whether or not he wants anything further done. In a case on which I operated two or three years ago, where a portion of the urethral tract had been wholly obliterated, and where I established a new passage through cicatricial tissue, the patient found so much difficulty in keeping the passage open that he finally concluded to let it close again, and to be satisfied with urinating through a fistula in the perineum.

CHRONIC ENLARGEMENT OF THE TONSILS.

The next patient is one on whom I expect to perform an operation which I am not in the habit of doing, and one which I do not recommend; but we must judge each case by itself. This young man has enlarged tonsils. He wishes to enter the navy, but has been rejected on that account. I have no doubt that in the course of a few months, we could reduce the size of the tonsils without an operation, but I think that the particular exigencies of the case justify the use of the knife in this instance. Some surgeons do this operation with great freedom, but I do not like to perform any operation when I think the case can be cured without it. The old plan of performing this operation, and a good plan it was, was described by the older surgeons in the words, "*vollesello excipere et scapello excidere*," that is to say, catch the tonsil with the fulsellum forceps, and cut it off with a blunt-pointed knife. The only precaution to be adopted is to cut towards the median line, and not towards the side. If you cut towards the side, you run some risk of wounding the carotid artery or the internal jugular vein. The modern plan is to use a guillotine; the best is the one devised by Fahnestock, and since modified by various French instrument makers. It consists of a ring which surrounds the portion of the tonsil to be removed, a fork which is pushed forward and holds the tonsil, and a concealed knife which cuts off the slice intended to be removed.

These tonsils are so large that I can remove but small portions of them, but this will be sufficient to start the process of involution. Occasionally there is troublesome hemorrhage after this operation. For this bleeding, one of the best applications is a gargle of turpentine. This has been recommended by Prof. Erichsen, and is, I believe, as good a mode of stopping the hemorrhage as can be adopted. The plan which I recommend, and which I believe to be always successful if properly carried out, is the application of iodine. If you simply paint the tonsils with the tincture of iodine, you give a great deal of pain, and the application is not effective, because the patient has to wash away the iodine on account of the pain. The application which I use is composed of equal parts of tincture of iodine and glycerine. The glycerine renders the iodine less painful, and at the same

time it is retained longer in contact with the tonsil. You may, in addition, use iodine internally in the form of the iodide of iron. I have never failed by this method (the application of iodine and glycerine and the internal administration of iodine) to reduce the enlargement. The tonsils may be painted about twice a week. This requires several months to effect a cure, and if the patient is in a hurry you will have to adopt some other plan.

HYDROCELE.

This patient presents an affection with which you are all familiar. You say at once that this is a hydrocele. You see the pyriform shape, which is characteristic. It has also an elastic feel, and, perhaps more distinctive than anything else, its weight is not great in proportion to its bulk. The differences between hydrocele and hernia are marked. If you invaginate the scrotum with the finger, you will find in hydrocele that the external ring is clear; but in hernia you will feel a tumor extending into the inguinal canal, and find that the ring is not clear. Sometimes you have a source of confusion in the existence of hydrocele of the cord in connection with hydrocele of the tunica vaginalis. In these cases you have to resort to other tests. Another test for hydrocele is that by transmitted light. It is not always practicable, however, to make use of this test, which may fail on account of several sources of error. Thus, the pigment of the skin may prevent the passage of light. If the patient be a colored man, or deeply pigmented, this test may fail. Again, the tunica vaginalis may undergo such changes as will prevent the transmission of light. Many years ago, when I was a house surgeon, I remember a patient who came to the hospital with a scrotal tumor. It was examined by transmitted light, but no light could be seen through it. The surgeon, therefore, decided that it was a tumor of the testicle and proceeded to remove it; but at the first incision there was a gush of fluid which showed that it was a hydrocele after all. The tunica vaginalis had undergone calcareous change, and the plates of calcareous matters had prevented the transmission of the light. This patient does not wish to have the operation for radical cure performed. It is not convenient for him to remain in the hospital at present, but at some future time he will return. The only precautions to be observed in tapping a hydrocele are, in the first place, to have the trocar in working order. I have seen a surgeon tap a hydrocele, and then find that the trocar was so firmly rusted to the canula that it could not be removed. The second precaution is to avoid the superficial veins. The third is to introduce the trocar perpendicularly to the surface of the hydrocele, and as soon as the trocar has entered the tunica vaginalis, to depress the handle of the instrument. If you push