

tatic urethra, the shape is influenced by the enlargement of the two lateral lobes; by them it is compressed from one side to the other, which frequently compress it so tightly as to present great difficulty in passing a catheter. Any increase in the upper part of the lobes has but very little effect on the urethra, as the bulging is invariably upward.

The frequency with which the different portions of the prostate are affected would be very difficult indeed to determine, as specimens kept for museum purposes are invariably retained because there is something unusual about them. It will be found, however, that in the majority of cases all parts of the gland are affected more or less.

The changes in the bladder due to enlargement of the prostate are vitally important. In all cases where the symptoms are at all severe, a post-prostatic pouch is formed. This is the result of a combination, the elevation of the urethral orifice and the depression of the vesical floor. There is no doubt but this pouch is a much more frequent cause of residual urine than the blocking of the urethra by a pedunculated middle lobe. In voiding urine the floor of the bladder is the last part to be emptied, and as the urethral orifice is elevated beyond its normal position, considerable strain is exercised to effect its complete evacuation. As the floor is the weakest part of the viscus, it naturally becomes more depressed with each effort to empty itself, until finally this pouch is formed and sometimes attains a very considerable size.

The effect on the bladder walls is more or less constant. First, on account of the increased work thrown on them in their efforts to empty the viscus, the muscular layer becomes hypertrophied; this, in turn, is followed by dilatation and atony. If by this time the obstruction to the urinary flow is not relieved, chronic retention is liable to occur, and, as the visceral walls continue to dilate, the amount of residual urine becomes in some instances enormous. This is the one extreme. The other is when the walls do not dilate at all, but instead become thickened and corrugated, sometimes contracting so much as to allow of only an ounce or two of urine in the bladder at a time.

Cystitis is an almost invariable accompaniment in all cases of long-standing prostatic hypertrophy. Catarrh of the bladder is a frequent diagnosis, and this is emphasized by the presence of a thick, stringy mucous, which is evacuated with the urine. The mucous membrane is congested and not infrequently ulcerated. Cystoscopic examination shows the veins standing out prominently on the surface, and as a result of their turgidity, hæmaturia frequently develops directly the urinary presence is relieved.

If prostatic hypertrophy with residual urine has remained for any considerable length of time, the kidneys and ureters cannot escape involvement. In the normal condition the ureters pass obliquely through