thra from one to eleven times, and that very few of them have ever been tested by their attendants, or any effort made to ascertain whether they had posterior urethritis or not.

Such a state of affairs is not professionally creditable, and although neither I nor anyone (in my opinion and belief) can tell you how to cure every case of posterior urethritis, still one may easily learn how to cure many, and diognosticate all cases, and at least may know what he is treating and how to direct his fire against it, rather than to take a random shot into the bushes in the hope of bringing down some game, because, forsooth, some feathers are seen on the boughs.

Gleet is really an insignificant matter (unless still virulent, a point I do not care to touch upon in this paper), and if a like amount of mucous or muco-pus escaped daily from a man's nose, or mouth, or anus, or even his ears or eyes it would generally discomfort him not at all, or certainly much less than it does when he sees it exuding or milks it out of his urethral canal. Gleet must be classed with the little miseries of life, like shirt-buttons, and corns, a mother-in-law, a wrinkled stocking, a cross in hopeless love; yet philosophers have discovered it is the sum of these little miseries that make up the real woes of life, and there are few of us who have not seen a very sensible man driven nearly to the verge of desperation and despair by the very insignificant torture of a protracted urethral discharge; therefore, it is worthy of consideration, and any means tending to modify it is deserving of respectful contemplation.

The morbid conditions capable of producing a gleet are very many, so many that I shall not weary you by enumerating them here, since it is my intention to deal only with that variety dependent upon posterior urethral catarrh. I need only to say that when a gleet is due to anterior urethral catarrh, caused by stricture, granulations, or what not, the source of the pus may be demonstrated without the endoscope by gentle, thorough, hot irrigation of the anterior urethra by means of a soft catherer passed into the sinus of the bulb, and the immediate use of the simple metallic bulbous bougie, provided the meatus be reasonably large; for if the pus comes from granular or strictured portions of the pendulous urethra, the irrigation will only wash away what lies loose in the canal, and the bulb will subsequently bring forth upon its shoulder soft muco-purulent clots generally tinged with blood, which have been scraped off the excoriated areas from around which the inflamed mucous membrane secretes whatever free pus exists. There may be tight areas which the bulb will detect, but if there be not a granulating surface upon the tight area or behind it which the bloody muco-purulent clots on the shoulder of the bulb will demonstrate, or their absence disprove, then the cutting of such tight areas will not, in my opinion, favorably modify a given gleet in most instances. Yet, even allowing that there be some tightish areas, and even granting that they be moderately granular, still, if there be posterior urethritis the cutting of the tight areas, although it may greatly moderate, will not cure the gleet, and the patient should be so informed before any cutting operation is undertaken; or he is quite sure to be disappointed, and often to misjudge the physician who has been zealously working for his relief.

Therefore, again, it is desirable to recognize the existence of posterior urethritis, even when it is associated—as is often the case—with coincident anterior urethral catarrh; and the manner of doing this is so simple that it is surely worthy of being put on trial. Indeed, this diagnostic method is so well and so generally known that I almost hesitate to present it before a body of gentlemen so well equipped in general knowledge as the members of this Academy are; yet its constant neglect in good hands emboldens me and fortifies me in reiterating it with emphasis before you.

When there is posterior urethritis, from whatever cause, the quantity of pus lying in the urethra behind the bulbo-membranous junction is disproportionately great when compared with the amount of gleety discharge that appears at the meatus. This may be easily demonstrated.

When pus forms in front of the triangular ligament, it readily and promptly, for the most part, favored by gravity and the fact that the urethral walls lie in contact with each other, reaches the meatus. When it forms behind the bulbo-membranous junction, it more readily takes the opposite course, flowing backward into the prostatic sinus and into the bladder.

When, therefore, a case of gleet is examined, if the urethra be milked by firm pressure with the finger, from the perineum forward, until all the pus that will come be squeezed out and then the patient be instructed to urinate in two parts, into separate glasses, if he have even moderate posterior urethritis the quantity of pus mixed with the first urinary gush, representing the washing out of the deep urethra, will be disproportionately great when compared with what has flowed out spontaneously from the meatus or been milked out by the physician before the urinary act, as shown by gross inspection of the specimen. And if the grade of posterior urethritis be intense not only will the first urinary gush be purulent, but also the entire second urinary flow will be turbid with pus. In case of doubt the anterior urethra may be irrigated before the urinary test in two flows is applied.

The one obvious source of error here is a focus of suppuration in the substance of the prostate, in a seminal vesicle, in the bladder, or in the kidney.