In stricture, however, the onset is very different—it is sudden. There has been for a long time a gradual contraction of the urethra, until finally the patient passes but a very small stream. At last comes a day when, from spasm or from some inflammatory condition, the urethra entirely closes. There will then be great pain, constant efforts at micturition, and the development of a large suprapubic tumor. In this patient we had dullness reaching olmost to the umbilicus.

Before admission, efforts had been made to relieve the retention by the use of instruments, but they were not successful. Not only were they not successful, but a false passage was made. As I have said, when admitted to the hospital this patient was suffering greatly, and the question arose as to what should be done. Our resident surgeon, Dr. Dunn, made one attempt to pass the catheter, but not being successful he immediately desisted, put the patient into a warm bath, and gave him full doses of opium. This is the best palliative treatment that you can adopt in retention from stricture. Under this treatment, the patient in a few hours relieved himself. The congestion which had caused the attack had subsided. When I saw him he was passing water in a small stream, and frequently. Two days later, another attempt was made to pass an instrument into the bladder, but without success. Whether from the irritation thus produced, or from other causes, I cannot say but on the fourth day retention again occurred. When I saw the patient he was suffering greatly, and there was again a large tumor reaching almost to the umbilicus. The patient could hardly keep still on account of the pain.

I have learned from experience that when a patient is in this condition, it is not safe to leave him before securing the evacuation of his bladder. Some years ago a patient with retention from stricture was under my care in another hospital. I endeavored, without success, to pass the instrument. I divided one stricture in the anterior part of the urethra, but there was one farther back which prevented the introduction of the catheter, and which it was evident would require external section. As it was late in the day, I concluded to postpone the operation till the next morning, leaving instructions that if the symptoms became more urgent the bladder should be aspirated. My instructions were not carried out, but a few hours after midnight the information was sent to me that the urethra had burst, and that urinary infiltration was taking place. When I reached the patient, I found that the urethra had given way behind the stricture, that the urine had escaped into the cellular tissue of the scrotum and thighs, and that the scrotum was becoming gangrenous. There was nothing to be done but to make free incisions into the scrotum and soft parts of the thighs, and then to puncture the urethra behind the stricture. If the bladder had been full I should have aspirated, but as the urine had escaped into the cellular tissue it was necessary to make openings to drain it away. The patient, unfortunately, did not recover; he lived for some two or three weeks. After the operation, he had no further trouble with his urine, but succumbed to the sloughing of the scrotum and other tissues.

Hence I tell you that it is not safe to leave a patient in this condition without relief. It is not safe to rely upon other people to do what is proper. It is better to anticipate by a few hours than to run any risks.

When I found that I could not pass the instrument in this present case, that its introduction produced urethral hemorrhage, I decided to relieve the retention by a more radical method. I should have aspirated, but that our aspirator was out of order. I, therefore, adopted the next best plan—it is really perhaps as good as aspiration—that is, tapping the urethra behind the stricture. This, which is known as Cock's method, is a very simple operation if you are familiar with the anatomy of the parts. The patient is placed in the lithotomy position. You first pass the index finger of the left hand into the rectum, and fix the apex of the prostate, the point where the membranous joins the prostatic portion of the urethra. An incision half an inch long is now made in the raphé, in front of the anus; next a slender knife with a sharp point is introduced into the wound in front of the anus, and with its back towards the rectum, and is passed backwards towards the bladder, being guided by the sensation of the finger of the left hand to the point where it is designed to open the urethra. We know, as has been pointed out by Sir Henry Thompson, that stricture does not affect the prostatic portion of the urethra, or that, if it ever does, it is an exceedingly rare occurrence. In this operation, therefore, you are pretty certain to get behind the stricture. This procedure, of course, would not be applicable to cases of retention from enlarged prostate. Having introduced the knife, as I have described, push it cautiously onwards, and then cut forward for about half an inch, thus making an opening into the urethra just at the apex of the prostate. A grooved director is to be passed into the bladder, and the urine will then probably begin to flow. It is better while the director is in the bladder to pass in through the wound a flexible catheter.

This is what I did in this case, and here I show you the wound half an inch in front of the anus and in the median line. The guides in this operation are the apex of the prostate as ascertained by the finger in the rectum, and the median line as marked by the raphé. There was a little oozing of blood, which we checked by packing lint around the catheter, just as we would in hemorrhage after lithotomy. The lint and catheter were removed in a few days. The patient has had no further trouble with his water. He now passes it as a woman does, through the perineum. He has complete control, because the sphincter is behind this opening. The only inconvenience is that he has to sit down to urinate.