stricture felt very hard and dense and was annular. He micturated very frequently and complained of some pain during and after the act. The urine was turbid, alkaline, ammoniacal, and very offensive. The infection was mixed. In this case I divided the stricture and drained the bladder through the perineum. This was followed by an improved condition of urine, the cystitis was much relieved, but the relief came too late to save the kidneys. In this case the autopsy showed the cystitis to be local, limited pretty much to the trigone. The mucous membrane of the ureter was not materially altered, nor the pelvis of the kidney. The abscesses were all through both kidneys and the channel of infection was regarded by Dr. Wyatt Johnston to be probably the lymphatics.

When the infection passes up through the ureter, the pelvis is naturally the first to be infected, just the reverse of what occurs when the infection is brought to the kidneys through the lymphatics or blood channels. To sum up, then, the natural history of stricture is narrowing of the urethra, obstruction to the outflow of urine, dilatation, behind the stricture, of the urethra, bladder, ureters, pelvis of the kidney and hydronephrosis. When infection occurs, then follow cystitis, ureteritis, suppurative nephritis, septicæmia and death.

The symptoms of stricture are well known; they are difficulty in micturition, slowness in starting the stream, lack of projecting force in the stream so that it falls on the boots or trousers, and in extreme cases micturition in the sitting posture.

A definite diagnosis is made by the use of instruments. In the passing of instruments the greatest possible care must be exercised to prevent infection. The instruments and hands of the operator should be thoroughly sterilized and the urethra in front of the anterior triangular ligament washed out by the use of a plentiful supply of an antiseptic solution introduced to the deeper parts by means of a small, soft rubber catheter and allowed to flow outwards.

In regard to the method of treatment to be adopted, I am strongly in favour of dilating all dilatable strictures; and nearly all gonorrhœal strictures behind the peno-scrotal angle are dilatable by the interrupted or continuous method. In a general way, I reserve for cutting gonorrhœal strictures of the pendulous urethra, traumatic stricture and congenital stricture of the urethra. I have not excised any traumatic stricture because I have not met with any cases adapted to this method of treatment. In one case, recently, of traumatic stricture involving fully two inches of the urethra, I found it necessary to lay open the stricture area by dissection, and then to form a new floor, as in the operation for hypospadias. The result was entirely satisfactory.