The limits of this paper will not admit of further entrance into this interesting subject, but I can but cordially commend a study of the minute anatomy of the cerebral cortex, with its physiology, and pathology, as offering most satisfactory results in the elucidation of this "*bête noir*" of medical practice. — A. B. Richardson, M. D., in *Cincinnati Lancet-Clinic.*

SOME PRACTICAL SUGGESTIONS FOR DEEP URETHRAL MEDICATION IN THE TREATMENT OF POSTERIOR URETHRAL CATARRH.

Mr. President and Fellows of the Academy: When I was asked to add my voice to the entertainment, which the Section I help to represent is expected to afford you to-night, I cast about me for a subject which, while as free from technicality as possible, might yet be far-reaching enough to interest the greater number, and at the same time probably provoke from the fellow-members of my Section a discussion profitable for all.

I have been unable to select one which seemed to me more appropriate than the one I have chosen. For posterior urethritis has become of late years a malady very well recognized by those who deal closely and often with genito-urinary cases, and its management is much simpler than what it was a few years ago; yet there exists in the profession at large, seemingly, a lamentable ignorance about it, which leads to much misconception and a considerable amount of mismanagement of cases, the diagnosis of which is very easy and the treatment of which may be successfully carried out by any one in many instances without calling for expert skill in the use of instruments. I have certain ideas on these subjects, ideas which have brought me to the satisfactory conduct of some very stubborn cases, and if a display of these in a general assembly like the present can lead the mind of anyone, until now unaccustomed to make distinctions, to a little more thoughtfulness and the exercise of something like logic in the diagnosis of gleet, and in that way to a more general application of reasonable therapeutics, I shall feel repaid for whatever effort this paper may cost me.

A gleet, as we all know, is not a disease. It is simply a symptom of some morbid condition, the nature of which it should be the function of the physician to determine; and it is as irrational to prescribe for a gleet, in any hope of curing the malady which occasions it, as it is to prescribe for cough with the same end in view without first by physical examination endeavoring to ascertain the source from which the symptom derives; yet my experience leads me to believe that in the profession at large the opposite course obtains, and that a gleet is treated in a routine way by the vast majority of practictioners, either by injections and internal medicine, or by sounds, or internal urethrotomy, or all, according to the imagination of the prescriber which leads him to generalize as to the causes of gleet and the methods of curing it.

This generalization is based upon the very undeniable efficacy of injections in most gleety conditions, and upon the wide-spread and more proper belief that one of the most constant symptoms of urethral stricture is gleet.

Such a generalization would be not unprofitable in a therapeutic sense if anyone were in a position to say exactly what stricture is; but the modern doctrine of stricture of large calibre has rendered this well-nigh an impossibility, for every natural undulation of the canal may be so classed by the physican who is properly impregnated with the large calibred stricture idea, and he is sure to find what he looks for in every case of gleet.

And so it turns out in many and very many an instance. When a patient with a gleet seeks advice, his physician has no thought of, perhaps little knowledge of, the possibilities and the prevalence of posterior urethritis; he neglects to make the very simple tests by which posterior urethritis may be demonstrated, and he first injects his patient and dilates or cuts his urethra, on the stricture theory—often to the considerable detriment of his patient, who finds himself after the treatment with his gleet still persisting, and the added discomfort of a wide-mouthed dribbling urethra, which never clears itself entirely after the urinary act, or possibly a permanent deviation of the penis from the correct line during erection (as a result of over-cutting), or a relapsing epididymitis or permanently irritable bladder from the injudicious use of very large sounds.

I make this general criticism not as directed against any urethral therapeutic measure, or any school of thought in urethral pathology. I personally believe in, advocate, and practice the cutting of anterior (and some posterior) strictures, of large as well as small calibre, when, but only when, they can be demonstrated to be the cause of the gleet which is to be overcome. My criticism is directed against the indiscriminate employment of a method, most useful when appropriate, and against the frequent neglect of such a study of the case as would lead in many instances to a direct localization of the cause of the gleet in the posterior urethra, and thus save the patient unnecessary mutilation, and the general body of the profession many animadversions from the laity.

I speak of what I do know, and can state honestly that the vast majority of cases of chronic gleet which come to me, are referred to me for advice, have already been cut anteriorly in the ure-