Common errors in the treatment of the urethra and bladder / by James Pedersen.

27

COMMON ERRORS IN THE TREATMENT OF THE URETHRA AND BLADDER.

BY

JAMES PEDERSEN, M. D.,

NEW YORK.

Reprinted from the

New York Medical Journal

INCORPORATING THE

Philadelphia Medical Journal and The Medical News

May 1, 1909.

Reprinted from the New York Medical Journal for May 1, 1909.

COMMON ERRORS IN THE TREATMENT OF THE URETHRA AND BLADDER.*

By James Pedersen, M. D.,
New York.

Excluding cases marred by errors of judgment, mistakes in diagnosis, and the accidents of instrumentation, to all of which a liability must necessarily exist, there remains a fair percentage of urethral and bladder cases which have been overtreated or erroneously treated by a conscientious physician or surgeon while striving to do his patient full justice. This may happen by reason of a failure to appreciate certain *general* conditions that influence the *local;* by reason of overzealous treatment in the anxiety to get the patient well quickly; through lack of special knowledge or training; and, finally, through want of skill in instrumentation.

The urethra and bladder seem especially exposed to errors in treatment, apparently because many of the symptoms they give rise to—perhaps because some of the diseases they are exposed to—are not taken seriously by the majority. The few illustrations here brought together are random examples of cases seen in consultation or referred for treatment. They are offered as evidence in favor of careful discriminations in the search for a solution of the problems presented by many of the urethral and bladder conditions that come under observation.

The use of the sound indiscriminately,—some-

*Read before the American Association of Genitourinary Surgeons at its annual meeting, May, 1908.

times with violence,—for diagnostic or exploratory purposes, is a common error. Often it amounts to overtreatment in the sense of meddlesome treatment. Every now and then it would seem that the sound had been used because no indication for any other treatment had been recognized. Possibly sometimes there had been a failure to recognize the *contra*indications to that form of treatment.

CASE I.—A young man, accustomed to moderate coitus with his mistress, noticed, on a certain day, a slight discharge from his urethra. He consulted his physician, who promptly pronounced it "no infection," and at once passed a full sized sound. This gave the patient considerable pain and produced some bleeding. The following day he had a chill and rise of temperature, and there developed an increasing frequency of urination with a progressive sense of obstruction. A few days thereafter he had to take to his bed. Twenty days after the unwarrantable instrumentation, complete retention occurred, and for one week he was catheterized once daily. The urine was described as having contained blood and pus. He now came under my observation. A soft rubber catheter passed without difficulty, and drew twenty-four ounces of chocolate colored urine from the overdistended atonic bladder. Forty-eight hours later, the prostatic abscess was evacuated through a perineal incision. After one more catheterization, nine hours after the operation, he began to urinate spontaneously. His recovery from then on was rapid and uneventful.

In this case there was, apparently, a failure to recognize the cardinal rule that instrumentation of the urethra should not be performed in the presence of a urethral discharge, unless the discharge have a history of chronicity, and only then if the patient declare no recent illicit coitus. To this rule there are, I believe, only two exceptions—retention of urine, and extremely severe acute posterior urethritis, not yielding to palliative measures. A criticism may furthermore be entered against the use of so large a sound, and with such evident violence. As

it is not known whether the sound was passed to explore for strictures or to dilate any that might exist, the question whether a further error was made in not choosing a *bougie à boule* instead of a sound, cannot be discussed.

CASE II.—A similar case. A middle aged man on whom a sound had been passed and bladder irrigations given by catheter because he complained of painless frequency of urination. After the second irrigation the patient complained of still greater frequency and of slight pain. To relieve this pain, he had been directed to drink large quantities of water. During the evening before he consulted me, he had drunk a quart; during that night he had risen ten times, once every hour, to void about six ounces each time.

An analysis of his history readily disclosed the fact that the patient was neurotic and came of a neurotic family, that his original frequency of urination dated back thirty years, to the days of his youth, and was due to a polyuria of neurotic origin, and that his present frequency was partly that of volume and partly that of irritation. Subsequent developments under the sedative treatment instituted proved these deductions to be correct. The errors in this case were the omission to get a detailed history of the patient and, secondly, to note that there existed no indication for bladder irrigations.

Overfrequent instrumentation,—usually with the sound,—in the treatment of urethritis, is perhaps the next most common error.

CASE III.—A case in point is that of a young man with a history of three attacks of urethritis. The first ran a mild course of seven weeks. The second (six years later) ran a course of nine months under irrigations of potassium permanganate and silver nitrate, supplemented by sound 32 F for "slight stricture." The third (again six years later) was treated for eleven months with a variety of internal medication. Thereafter, for six weeks before he came under my observation, sounds from 30 to 36 French were passed "every few days."

In addition to two strictured zones and the characteristic endoscopic picture of a chronically inflamed urethra, he presented a chronic prostatitis and right seminal vesiculitis. A moderated treatment of the urethra plus massage of the prostate and affected seminal vesicle, cleared up the con-

dition in seven weeks. Not only had there been overtreatment of the urethra, but also neglect of the prostatitis and vesiculitis.

CASE IV.—Somewhat in line with the foregoing case, at the same time furnishing an introduction to a class that is to follow, is that of an anæmic, poorly nourished man, thirty years old, whose antecedent history is pointedly marked by two operations for osteomyelitis, eight years apart. His previous venereal history includes a great deal of ungratified sexual excitement, and one attack of urethritis of short duration, one year before. The urethritis of which he complained at the time he came in consultation, had been in existence three months. His symptoms were, a scanty urethral discharge, some frequency day and night, marked urgency, pain in and tenderness of certain joints and bones, loss of appetite, and general absence of well being. Early in the course of the urethritis he had been treated with intravesical irrigations for three weeks. Sounds had been passed every third day, a stricture having been discovered. No progress toward recovery having resulted, he became so discouraged and run down that he abandoned all treatment and went away for three weeks. He returned greatly improved in every particular. Attention having become centered on the insignificant stricture, to the total exclusion of the significant cautionary signals, dilatation had been resumed and more frequently than before. As a result, the frequency and urgency of urination had returned.

The following case may further illustrate not only the ease and frequency with which the general condition of the patient is overlooked, if not neglected, but also the futility of urethral irrigations as a routine measure in acute specific urethritis, and the traumatism they are capable of effecting even in experienced hands.

CASE V.—The patient was a spare, poorly nourished, anæmic man. Both sides of his neck bore the legible, pathognomonic scars of extensive dissections. With evident conviction and without qualification, he stated that he had had a great deal of sickness in his life. Certainly his looks did not belie him. He had every appearance of a man requiring supportive treatment. During the first four days of his urethritis he had allowed the disease to take its course and was fairly comfortable. He then consulted a well

known advocate of the so called irrigation treatment, who promptly instituted urethral irrigations and two days thereafter essayed an intravesical irrigation. It was not very successful. The reason given was the fact that the patient was "very sore and sensitive, and not used to it." This was preeminently the fact; it was the patient's first urethritis. That evening, the patient had terminal bleeding and noticeable frequency of urination developed. The second intravesical irrigation was undertaken the following day, with the same consequences and results. The treatment was then reduced to anterior irrigations.

He presented a profuse, dark yellow discharge, marked inflammatory swelling of the urethra, and considerable engorgement of the whole penis. There were slight frequency, urgency, and tenesmus. Under treatment that made general measures as important as the local means, the gross inflammatory signs entirely disappeared before the eleventh day; the discharge almost ceased—was sometimes absent altogether; his rest was broken by only one nocturnal urination; his diurnal frequency became normal; and only a small number of gonococci could be found in the scanty smears. Several days prior to this, his appetite and general wellbeing had returned. He had not lost a day from his office.

Case VI.—A second illustration in the same class is furnished by a hearty, vigorous, well nourished man,—physically the direct opposite of the patient in the preceding case. Comparison is further favored by the fact that both infections were virulently specific. His treatment had been begun with a potassium permanganate irrigation of the anterior urethra three times daily. No improvement resulting, a change had been made to a 1 in 6000 solution of mercuric iodide. This scalded intensely, and at once frequency, urgency, and severe tenesmus developed, with feebleness of the stream and terminal bleeding. The symptoms had almost reached those of strangury. Thereupon the potassium permanganate irrigation had been resumed, and hand injections of weak solutions of argyrol added. The prostatitis had culminated in an abscess. It had already ruptured into the urethra when he came under my observation, eight weeks after the onset of his symptoms.

Notwithstanding his history of a previous severe, probably specific urethritis, with a sharp involvement of the posterior urethra, and notwithstanding his inability to take any rest during the present attack, as also during the preceding one, it is fair to assume that potent but less violent

local treatment, with a hand injection of one of the silver albuminoid salts, for example, would have saved him a great deal of valuable time and an amount of suffering that is unpleasant to contemplate. Largely, if not wholly, because of the complications he had suffered, his course toward recovery was slow, though progressive.

The instillation of a strong silver nitrate solution into the urethra or bladder is a not uncommon error.

Case VII.—A young man had apparently recovered from a second urethritis of six months' duration. Five months later a frequency of urination developed, undoubtedly in consequence of the effect of beer drinking and excessive use of tobacco and coffee on a chronically inflamed, imperfectly treated urethra. Probably his physical and mental fatigue were contributing causes. After the frequency had persisted for about a month, he noticed a redness around the meatus. Soon thereafter a urethral discharge appeared and gradually increased until, at the end of a week, it was profuse and greenish yellow. By the end of another week he was having very frequent and painful erections. When giving me this history, he voluntarily summed up his condition as it then was by calling it a worse attack than the one of six months' duration from which he had completely recovered, as he thought, five months before. Overlooking the patient's faulty mode of life, the attempt had been made to cure the urethritis by irrigations alone. The discharge, being a secondary one, so to speak, was promptly checked by the effect of the daily irrigations on the inflamed mucous membrane, but they failed to clear up the mucoid morning drop, though continued daily for two months. Apparently in his zeal to cure his patient, the physician then instilled into the urethra a ten per cent. solution of silver nitrate. The immediate effect need not be described. When he was brought in consultation four days later, the discharge was again moderate, thin, and purulent, the inflammatory signs were conspicuous, and both urines were almost equally cloudy. Gonococci were absent.

Case VIII.—An elderly prostatic patient, seen in consultation, illustrates still another common error, and also one similar to the foregoing. To relieve his first complete retention, the physician had properly passed a catheter, but had suddenly drawn off the total quantity contained in the over distended bladder, without injecting a compensating volume of fluid. Finding that the supervened cystitis was not being alleviated by a daily lavage, he finally

injected into the bladder a solution of silver nitrate, gr. ii in oz. i. This excited so much tenesmus that further catheterization was withheld, under the erroneous assumption that the catheter was to blame. The bladder soon became overdistended again, and added the pain of its expulsive efforts to the sharp irritation caused by the silver nitrate solution.

Examination showed an enlarged prostate, now greatly swollen by congestion, and a tender bladder overdistended with bloody urine. A greatly moderated line of treatment on a systematic plan was advised and followed. Three days later the patient was able to go out driving as formerly.

The experience of the patient in this, the final case, includes both overtreatment and uncertainty in treatment. In the latter may be found a significant commentary on the still unsettled conception of the histology and pathology of the urethra.

Case IX.—A middle aged man, decidedly neurasthenic from protracted business cares, had a slight urethral discharge soon after he had established a mistress. The discharge, scanty at first, had gradually increased. No effort had been made toward stopping his sexual indulgence, which had become excessive, nor toward modifying his mode of life in any way. At the outset, no gonococci had been discovered. Three months later, with the more abundant discharge, gonococci were reported.

He came under observation six months after the development of the discharge. The treatment given him during those six months included methylene blue, salol, and sodium bicarbonate; ten injections of argyrol; irrigations of bichloride, in strength from 1 in 6000 up to 1 in 4000; irrigations of potassium permanganate 1 in 4000; instillations of silver nitrate 1 in 20 (five per cent.); irrigations of protargol solutions from 1 in 500 up to 1 in 200; and, finally, an injection of resorcin (4 per cent.). Some of these means had been used conjointly, notably the five per cent. instillations of silver nitrate, followed by the 1 in 500 protargol irrigation, and that by the 4 per cent. resorcin injection. The combination in use when he came under my observation was a daily irrigation with a 1 in 4000 potassium permanganate solution, followed by the four per cent. resorcin injection. It is interesting to note that under this *comparatively* simple combination the first appreciable improvement in his symptoms had taken place. Aside from

stopping his alcoholics as soon as the gonococci had been reported, no general treatment had been given. He had continued his sexual excess and his very liberal use of tobacco.

After two weeks of absolute sexual rest and the use of a very mild hand injection at lengthening intervals, he was able to report: "No drop of pus has appeared, and really no true drop of mucuslike fluid."

The common errors in the treatment of the urethra and bladder, may be summed up as errors of omission and errors of commission. Under errors of omission, may be grouped: Neglect of a prostatitis or seminal vesiculitis, or both; neglect of the patient's general condition; failure to insist upon sexual hygiene; failure to regulate his habits as to alcoholics, tobacco, and coffee; inattention to the dietary and the quantity of water drunk.

Under errors of commission may be placed: The use of the sound in the face of contraindications; overfrequent dilatation and overdilatation; the unscientific use of urethral irrigations in general (in particular, the use of intravesical irrigations before the chronic stage of a urethritis); the use of strong, i. e., caustic, injections and instillations; the sudden emptying of a chronically overdistended bladder; the administration of methylene blue except as a *placebo;* and, finally, the use of undistilled water in making up a solution of silver nitrate.

I have ventured thus to indicate the common cause of our failures in the ordinary cases in this sphere of practice, hoping to aid in urging a more careful analysis of them, to the end that our failures may be diminished and our successes multiplied. It is admitted that many cases are complex, but a detailed history will often simplify them, and, when supplemented by a proper physical examination as a working basis, will usually direct the treatment aright.

20 East Forty-sixth Street.