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CHRONIC GONORRHEA IN THE MALE.*

The Difficulties of Cure by Ordinary Treatment.

By Victor Cox Pedersen, A.M., M.D.
New York.

With the invention of urethroscopes a generation ago, a step forward was taken in the diagnosis and treatment of urethral conditions. In these urethroscopic tubes, the first defect of importance for remedy was inadequate light, which was removed by the introduction of practicable small electric lights of sufficient power to illuminate lesions at close range. Another difficulty with the straight urethroscopes was that the mucous membrane pouts into the transverse objective end in a manner to defy the control of the operator. Obviously, the next step was an instrument, which, either by the aid of air or of water, would enable the operator to dilate the canal, push the mucous membrane more or less away from the fenestrum, and smooth it for study and treatment. The greatest advance in this detail was the Goldschmidt instrument, which was introduced a few years ago. The error of which this ingenious device is guilty is that of having an undue amount of urethral wall presented in the instrument, that is, of having an unnecessarily large fenestrum.

The latest and greatest gain in the direction of dilating instruments is furnished by the Buerger urethroscope, which has like the Goldschmidt a lateral instead of a terminal opening, but reduced in size, so as to prevent undue prolapse of the mucous membrane into it. The system

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of lenses magnifies about five diameters, so that the lesions which under the old style straight tube entirely escape diagnosis, are readily diagnosticated, studied, and treated. The Buerger urethroscope is sold with a curved and a straight tip, interchangeable at will. The writer, however, has totally discarded the curved tip and uses only the straight instrument. This straight tube is manifestly a little more difficult to introduce than the curved, but practice, patience, and gentleness soon teach one how to overcome this trivial obstacle, by remembering two important details, to keep the beak of the instrument against the pubic arch, so as to avoid the bulb of the urethra, which, in many of these chronic cases, is redundant, deep, and hangs below the opening in the triangular ligament, so that the beak readily catches in it. Should the effort to pass the instrument high in the pubic arch fail, a finger should be introduced into the rectum as a guide. These two manipulations combined almost invariably secure the passing of the instrument without incident.

The advantage of the straight over the curved instrument is that, beginning with the neck of the bladder, one may continue the examination systematically, step by step, half-inch by half-inch of the entire urethra until the meatus is passed.

The writer is of the opinion that no case of gonorrhea should be discharged as cured without precisely this form of deliberate and thorough examination. Perhaps above all, those patients who give a history of long continued discharge, and of prolonged and persistent treatment in the hands of competent physicians, should always be thus examined. One might multiply the number of cases in proof of these simple statements, but the following are, perhaps, worthy of note.

Case I. N. W., United States, white, eighteen years old, single, clerk. Denied all venereal infection, other than gonorrhea fourteen months ago, which was severe and persistent, with much chordee, but without complications. Relieved by private treatment with internal and injection methods. Treatment stopped by patient himself without preliminary examination by physician. Sexual habit irregular and very moderate. Present trouble began four weeks ago without known exposure to infection. General complaints were a thick, scanty, purulent discharge, with smarting in the anterior urethra. Urination every three hours by day and once by night. Difficulty of control, some urgency, moderate tenesmus. Had been under treatment by his family physician for three weeks prior to his first visit.

Physical examination negative, except in corroboration of the foregoing symptoms. The usual expectant method of treating acute gonorrhea was employed after a cultural and microscopical verification of the diagnosis. When the discharge had ceased, the urethroscope revealed the following interesting features: On the roof of the deep urethra near the sphincter, was a large cockscomblike hanging papilloma. On the right of this was a large pocket, apparently an abscess cavity in the prostate, which might well explain the recurrence of his gonorrhea without exposure to reinfection. The bulb of the urethra was deep, unhealthy, and boggy looking; while in the roof of the anterior urethra were very numerous and enlarged follicles.

Such, then, were the features of this case, why it was obstinate to cure, and also why the history was probably correct in asserting that the patient did not have a fresh infection.

Case II. J. B., Ireland, white, twenty-seven years old, stoker. Denied syphilis, acknowledged chancroid six years ago. Cured by the usual methods at a dispensary. Complicated with bubo, which was incised and evacuated. At the same time, he was circumcised. Last attack of gonorrhea, four years ago, treated chiefly by himself by internal measures. No examination at that time. Second attack of gonorrhea began seven days after intercourse, was accompanied by a thick scanty, purulent discharge, with much burning throughout the entire urethra. Urination by day every two hours, otherwise no important symptoms. Treated for a while by a private practitioner, and at a dispensary for a few visits, by internal methods, then he consulted me. He had much pus, but no gonococci on

microscopical investigation. He then disappeared from view, during which time he was treated by four or five physicians in private and public practice. Underwent an operation for so called stricture in the office of a well known advertising specialist, and was otherwise energetically handled. No urethroscopy was done, however, by any one until, after the lapse of nearly three years he again returned to my care.

At this time, he had a frank discharge, for which he received the standard conservative management. At this time the discharge did contain gonococci. As soon as the symptoms were in abeyance, I did a urethroscopy and found the following conditions: Almost the entire posterior urethra from the sphincter to the colliculus was in a state of cystic degeneration, especially dorsally in front of the verumontanum. On each side were two distinct warts or papillomata.

Here, then, in this case are the reasons why the man had a gonorrheal discharge for three years, which defied all methods of treatment. In the urethroscopic examination no signs of stricture were discovered, so that one may hazard the opinion that he never had a stricture, but that the foregoing lesions gave the symptoms of pain and stricture of moderate degree.

Case III. J. H., Ireland, white, twenty-seven years old, valet. Denied all venereal infection previous to the present attack of gonorrhea, which began three years ago, after a four days incubation. His sexual habit was regular and moderate, and for three years he had never been free from slight urgency and tenesmus. Had been thoroughly treated by a number of physicians, without urethroscopy. In my hands, this procedure revealed the following: Fine granulations on the left and front of the colliculus and in the left prostatic sinus. On the dorsum of the prostatic urethra, back of the colliculus, was one large papilloma and many unusually large cysts. The mucous glands on the roof of the anterior urethra were numerous and greatly enlarged, and discharged pus on pressure.

In this case, we see how simple was the recognition of why the man for three years has suffered distress at the neck of his bladder, and why moisture and pus have been more or less constant at his meatus. His general appearance would

suggest that excuse for a real diagnosis, namely, sexual neurasthenia. As a matter of fact, the man had real pathological lesions accounting for all his symptoms.

CASE IV. W. McC., United States, white, twenty-five years old, single, clerk. Denied all venereal infection, excepting the present, which dated back five years. Sexual habit moderate. Present disease began a few days after intercourse with a thick, scanty, mucopurulent discharge, which still persisted, accompanied by a definite burning. Urination normal in all respects. Was treated irregularly for the past five years by physicians, druggists, and himself. Treatment stopped by himself without examination. First urine showed shreds, second one clear. The patient's appearance was one of a thin skinned, girlish man, hypersensitive, nervous, overworked, so that one's first inclination was to regard his assertion of ardor urinæ as a sign of his nervous depreciation. Urethroscopic examination showed that in this case, also, the man had a definite basis for the symptoms which he honestly described, namely, on each side of the colliculus, in the prostatic sinuses, were two ulcerlike areas, larger on the right than left. In the anterior urethra were a half dozen or more inflamed patulous follicles, so that we were able to prove that he has a real ground for the burning of his urine, both in the posterior and the anterior urethra.

CASE V. E. L., United States, white, forty-five years old, married, manufacturer, referred by Dr. T. J. McGeary, of Jersey City.. Denied all venereal infection, except a gonorrhea twenty years ago. Had had no sexual intercourse, excepting with his wife, since marriage. The feature of this case was that he had not in these many years, at any time, been free from a morning drop, which had defied efforts at relief in the hands of a number of experts. Seemingly, no urethroscopy with modern instruments had been attempted until the patient came under my care. It revealed in the left prostatic sinus, far back, a large papilloma, and a small one on the right side of the colliculus towards its front. In the dorsum of the anterior urethra, just in front of the bulb, were five very much dilated and diseased mucous follicles. These papillomata were of sufficient size to cause the irritation and uneasiness of which the patient complained.

His mucous drop might be due to the papillomata alone, with or without the follicles, or due to the follicles alone.

Case VI. R. G. I., United States, white twenty-seven years old, merchant, referred by Dr. R. S. Morton, of this city. Syphilis and gonorrhea denied. Admitted chancroid about three years ago. Treated in the well recognized methods by a physician. Sexual habit active with a young woman, whom he subsequently submitted to examination, and who showed culturally the presence of gonorrhea. Present sickness, namely, gonorrhea, began six or seven months ago, with a brief incubation. At the present time, he had a thick, scanty discharge of mucus and pus, otherwise was without symptoms. Physical examination showed a small stricture at the mouth, admitting only 21 F., but easily dilatable. Urethroscopic examination showed that the source of his gonorrheal discharge was a distinct row of bleeding granulations in front of the verumontanum, and a distinct, wartlike growth on the left side, back of it; also a few enlarged follicles in the anterior urethra. Culturally, the discharge showed gonococci.

Case VII. T. P. D., United States, white, thirty-seven years old, married, waiter. Admitted four attacks of gonorrhea, without adequate treatment in any of them. Gave sypmtoms of stricture reasonably well marked, and complained of persistent gonorrheal discharge. Wife seemingly not infected, but no examination was permitted. Urethroscope showed the prostatic urethra inflamed as a whole. Surrounding the forepart of the verumontanum were four or five large granulations, presenting a kind of crown to the verumonatanum, making, in the instrument, a particularly interesting feature. The left prostatic sinus was large, deep, and filled with unhealthy granulations. No stricture, strictly as a cicatrix, was visible.

As more and more cases of this kind are observed with the urethroscope, it will be interesting to note how many individuals give the symptoms of so called soft, dilatable stricture, precisely as this man did. It may be possible that this form of stricture is commonly due to similar lesions.

Case VIII. J. B., Ireland, white, thirty years old, single, elevator conductor Denied syphilis. Admitted one attack of gonorrhea, successfully treated by conservative methods by a private physician, who discharged him cured after examination. Had gonorrhea about two years ago. Sexual habit, active and promis-

cuous. Had been troubled, off and on, for the past two years with his second attack of gonorrhea, which began three days after intercourse, with all the typical symptoms, showing severe infection, such as frequency of urination by day and night, difficulty of control, urgency, chordee, and the like. Was referred to me by Dr. W. D. Tyrrell, of this city. Gonococci were easily demonstrated in this case, but disappeared under the usual gentle and conservative treatment. The discharge persisted in an aggravating manner, which led to a urethroscopic examination. It was very easy to demonstrate a thin, delicate, lacelike papilloma in the right prostatic sinus, extending almost the entire length of the verumontanum. This was burned away with strong silver nitrate, which was followed by immediate recovery.

Case IX. S. A. H., United States, white, forty-three years old, insurance agent, referred by Dr. F. Spencer Halsey. Diagnosis, chronic anteroposterior urethritis. Denied all former venereal history. Present venereal history, divorced from wife and without regular intercourse. Had had present symptoms about two and three quarter years, beginning about ten days after a carousal and intercourse with his "divorced wife." Showed a moderate, thick, mucous discharge, normal urination, otherwise negative. Bacteriologically, no gonococci, but frequent Gram positive bacilli. Though the man denied gonorrhea, he had a stricture which dilated with some pain to accept the Buerger urethroscope, which revealed a small, lacelike papilloma on each side of the roof, just back of the colliculus. Many enlarged mucous follicles in the bulb, and a very large lacuna magna.

Case X. F. C. L., United States, white, twenty-six years old, single, salesman, referred by Dr. L. K. Tuttle. Diagnosis, third attack of chronic anteroposterior gonorrhea. His first two gonorrheas were apparently without feature, excepting that the second was of long duration. At the end of it, his urethra was dilated to 30 F. and he then ceased treatment. His present infection began four days after intercourse. When first seen, he showed thick, scanty, purulent discharge, otherwise negative, excepting for a decided lump in the midpenile region, with many shreds and some pus in the first glass. Twenty-four F. bougie-à-boule passed the node easily down to the bulb. The gonococcus was found in scattered fields. Without other instrumentation, epididymitis developed on the right side, which lasted for many weeks. After it ceased, an anterior ure-

throscopy was performed, showing the lump to consist of a stricture, behind which were bleeding granulations, which seemed to be the source of his discharge and symptoms.

CASE XI. F. S., United States, white, twenty-six years old, single, engraver. Diagnosis, second attack of anteroposterior gonorrhea. First attack was eight years ago, followed by rheumatism in the ankles, knees, and shoulders. Present attack dated back fifteen months, after three days' incubation. Showed a thick, scanty discharge, normal urination by day, occasionally disturbed at night. Had long noticed shreds in his urine, especially after squeezing the penis. True gonococci found in the shreds and discharge. First glass filled with small shreds. Urethroscope showed, seemingly, a normal, posterior urethra and bulb, with, however, a very unusual number of enlarged patulous follicles on the roof of the anterior urethra, from which pus could easily be extruded while the instrument was in place.

CASE XII. H. J. C. S., United States, white, thirty-nine years old, single, clerk. Diagnosis, chronic anteroposterior gonorrhea. Former venereal history denied. Present attack began from ten to twelve years ago. At present and since originally infected had never been free from discharge, which was thick, scanty, mucous, and purulent. Urination was normal. First glass showed shreds and considerable pus; second glass small pus shreds, third glass pus. Bacteriological investigation showed gonococci at each examination except the last, about four months after beginning treatment. Urethroscopic investigation was most interesting, in that it showed a mucous membrane more or less damaged from the sphincter to the bulb. In the depth of the bulb was a distinct ulcer, as seen in the instrument, about the size of a lead pencil top, with edges overhanging and an indolent, unhealthy, boggy looking base. I had never seen its like before. Mucous follicles everywhere in the regions of the prostate, colliculus, bulb, and anterior urethra were manifestly involved. The lining of the urethra seemed generally affected. One can hardly hope for much result in such a case.

CASE XIII. H., United States, white, thirty years old, married, draftsman. Diagnosis, initial anteroposterior urethritis. Referred by Dr. T. K. Tuthill. Former venereal history denied. Acquired present infection five years ago after six or seven days incubation. Had never been free from discharge. Wife apparently not infected. Numerous relapses, independently of any exposure, had occurred. Diurnal urination every three hours; nocturnal, twice. Urgency, tenesmus, and

chordee moderate; control fair. Both glasses of urine were rich in pus. Uranalysis negative; culture of pus negative for gonococci, but showed a large Gram positive diplococcus, both intracellular and extracellular. Gonococci not found by culture or smears. The local treatment of this case was along modern lines with ascending hand injections of zinc sulphate. The particular features of the pus, however, impressed me with the feeling that the patient had overdone the treatment. I, therefore, submitted him to a careful urethroscopy and found the urethra, from end to end, presenting a peculiar shaggy exfoliation, as though there were largely a medicinal urethritis present. Moreover, a number of prostatic ducts were patulous and seemingly infected; the verumontanum was covered with unhealthy granulation tissue; the bulb was almost entirely excoriated; and in the anterior urethra were the usual enlarged follicles. In virtue of these findings, the patient was taken off all local treatment and submitted only to internal sedatives, with the result that in about one month all visible discharge had disappeared, with the sole exception of a few shreds. The source of these shreds would probably be corrected by giving, in due course, attention individually to the lesions named.

Case XIV. M. J. W., white, thirty-eight years old, married, policeman. Referred by Doctor Pasternack. For many years, the patient had had a chronic urethral discharge, which had defied the efforts of his family physician and several first class specialists. Seemingly, no end to end examination of the urethra was done previous to my examination of June 28, 1912, which revealed enlarged prostatic ducts, chiefly in the left lobe; a very distinct papilloma on the left side of the verumontanum; a thin, cordlike stricture stretching across the urethra in the midpenile region, with two large mucous glands proximal to it. A number of other mucous glands were present, from which pus could be squeezed. Under the treatment hereinafter described, this patient greatly improved.

This is not a favorable case, however, for complete cure on account of the distinct nervous tendencies, although the patient is muscular, athletic, and well built. In searching for the source of this nervous defect, I found sugar in the patient's urine, which only illustrates the wisdom of step by step investigation in these cases. Treat-

ment for the sugar in his urine has improved his nervous condition.

Having presented a few cases illustrating why chronic gonorrhea may be so persistent and intractable, we next inquire into the causes of these conditions and their appropriate treatment.

The causes are anatomical, physiological, and pathological. The anatomical causes are inherent in the fact that the various portions of the urethra more or less tend to invite infections of the gonorrheal type and its corollaries. For example, we know that the prostatic urethra is normally the widest part of the urethra in diameter and is bounded behind by the sphincter and in front by the verumontanum. In this pouchlike cavity, therefore, the gonorrheal pus may lurk, and there set up those changes in the mucous membrane that are seen everywhere in other mucous membranes as the signs of persistent inflammation.

Passing forward to the verumontanum and the right and left prostatic sinuses on each side of it, we again find a complex anatomical arrangement, in which the inflammation may very easily reside and from which it is not easy to drive it. The posterior extremities of the prostatic sinuses, called the prostatic fossettes, may be so shallow that they are difficult to recognize, as offset from the floor of the urethra on either side of the crest; or they may be so deep as to be difficult to illuminate and inspect with the urethroscope. This form of prostatic sinus usually has its floor thrown into folds, which only complicate the difficulty.

Where the verumontanum rests against the lateral prostatic lobes, the sinuses are long, narrow, and relatively deep, and invite the formation of granulatons therein, with or without papillomata.

The fact that in these special parts of the urethral tract the walls are in apposition, much more closely indeed than are the walls of the urethra itself as a whole, tends to invite and augment those changes in the mucous membrane which the disease produces only too actively, even where there is no such close contact. If one may draw an analogy of this condition, it would be the persistence with which the victims of eczema suffer from eczema intertrigo wherever the skin makes an angle, is folded upon itself, and remains more or less in contact, as behind the ears and in the cavities of the armpits, elbows, groins, buttocks, knees, and interdigital spaces.

The great frequency of prostatic ducts along these walls invites the penetration of infection therein by the imprisoned pus. The roof of the urethra in the prostatic region frequently possesses a number of folds, from which proceeds the fact that cysts of the roof are so common.

The membranous urethra is a little less apt to be involved on definite anatomical grounds. The bulb, however, which is the next important part of the urethra, is far otherwise in its anatomical relations. It may be a slight or an extensive pouching of the ordinary passage. In the former case, lesions of its floor seem to be relatively infrequent. In the latter, however, one not uncommonly finds an interesting variety of conditions. The circular fibres of the urethra about the bulb are sometimes seen to throw the floor of the bulb into transverse folds, precisely like a miniature of the bladder. The mucous membrane as a whole may be rough, shaggy, or the mucous crypts may be infected. Ulcers and strictures, strictly as such, are sometimes seen at this part.

In the anterior urethra, the normal arrangement is the presence of numerous mucous folli-

cles along the dorsum, any one or few of which may become involved and go on indefinitely to chronic suppuration.

Most anatomists assert that the anterior urethra has normally large mucous crypts, whose mouths are visible to the naked eye in the adult. It would be interesting to make a study of this fact, because I have recently urethroscoped one adult who never had had venereal disease, whose urethra showed at no point, an enlarged mucous follicle, excepting the lacuna magna. He was subjected to this examination for its moral effect upon his neurasthenia, which had a sexual basis. It is a well known fact, however, that mucous crypts are not only of simple, but also of complex types, so that they do not only constitute little cuplike depressions, but may pass along under the mucous membrane, so as to form more or less angulated cavities. In such cavities as these crypts then form, the gonococcus may abide for life and defy all human skill in eradicating it.

Last and not least is the anatomical fact that the urethra at rest is a closed, collapsed tube with walls in apposition, which only tends to imprison discharge somewhat and grant the gonococcus still more opportunity to penetrate.

The physiological causes of the chronicity and persistency of gonorrhea embrace the two features of the normal activities of the various glands throughout the urethra, and the normal sexual activity of the various organs comprising the general external genitals. Thus it is that irritation and hypersensitiveness which accompany chronic involvement in a more or less degree tend to stimulate the sexual activities. This disturbance, in turn, inclines to invite penetration and prolongation of the trouble.

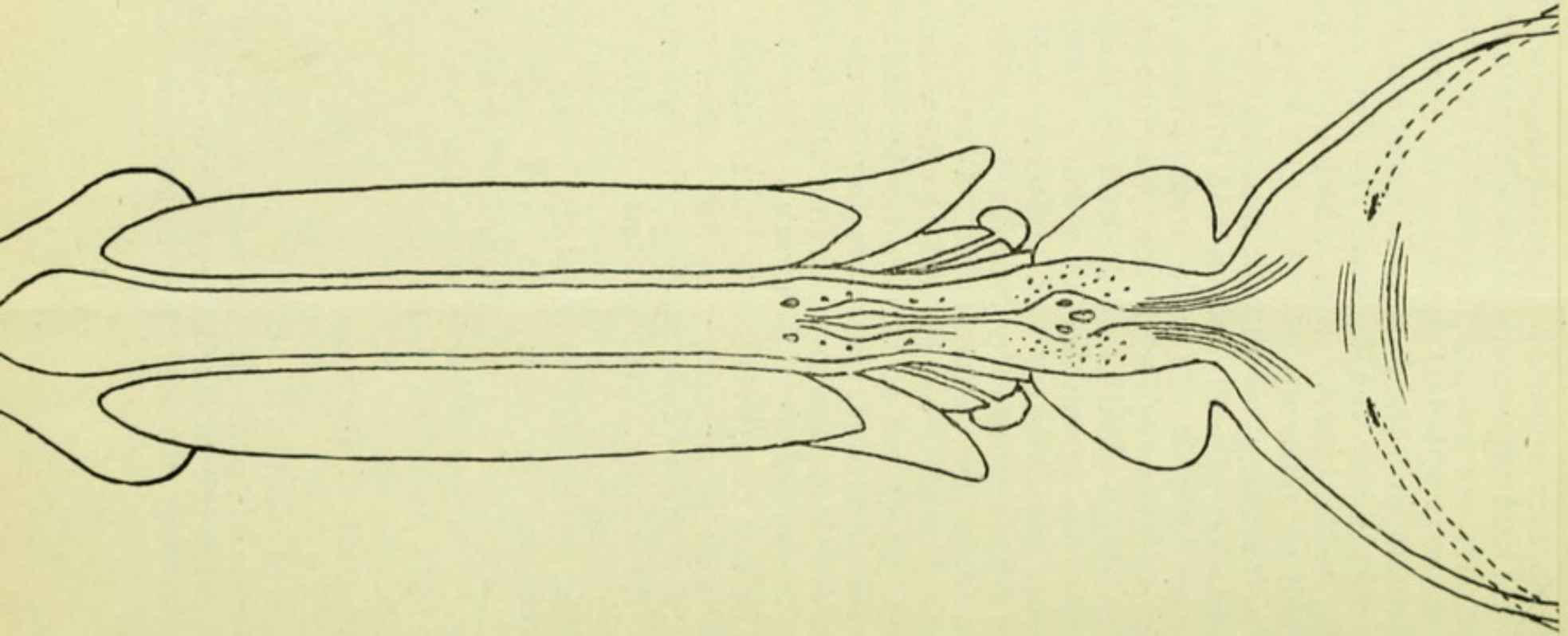
The pathological causes rest particularly in the nature of the gonococcus and the germs which frequently accompanying the gonococcus to pene-

trate into the deeper regions of any portion of the body surface attacked. Therefore, when the anatomical and physiological conditions have played their part, we find the disease has penetrated into the mucous follicles, the prostatic ducts, the seminal ducts, and the outlets of Cowper's glands (to say nothing of the seminal vesicles, vasa deferentia, testes, etc.), from which it is extremely difficult to eradicate it.

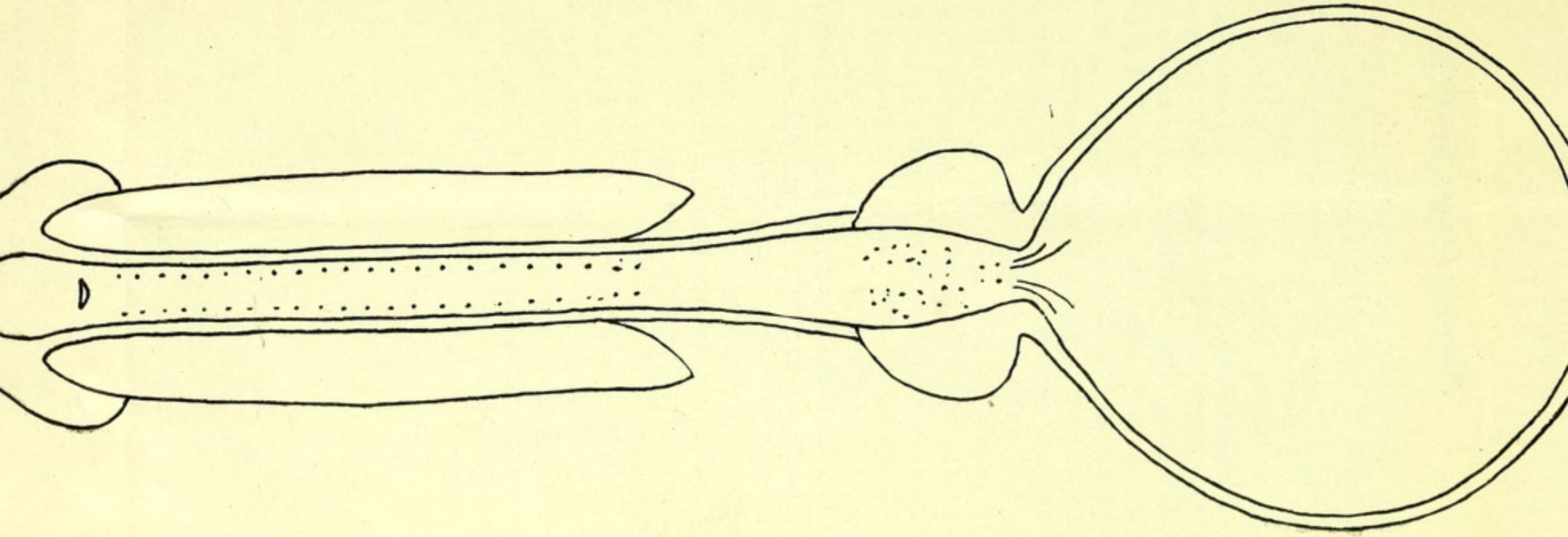
The pathology of chronic mucous membrane inflammation is well known and differs in no degree or detail in the male urethra from the pathology of every other mucous membrane, in male or female, in child or adult, namely, thickening of the mucous membrane as a whole, cystic degeneration, involvement and obliteration of the mucous crypts, unhealthy granulation tissue, in spots or more or less disseminated. Where folds occur, these granulations go on to the formation of warts, which act as foreign bodies and produce a chronic discharge, germ-bearing or not, as each case develops, and not infrequently to the causation of symptoms of stricture.

The last consideration is the treatment of these conditions when once they have been recognized. Many of these cases, particularly those that show the thickening, granulations, papillomata, and other changes in the mucous membrane, are those which, in the less refined and older methods of treatment, frequently do well under perineal drainage, rest of the part, and occasionally curetting. In a few of these cases, also, well balanced, carefully observed dilatation with sounds or the Kohlmann dilator has been of great value. The instillation of a few drops of strong silver nitrate, from 2.5 to five per cent., has in the past also been of great remedial benefit; but, after all, these methods of treatment are more or less blind. Today, with the modern urethroscope and electrical applications through the fulguration wire, it is

Anatomical diagram for office histories for noting diagnosis of cystoscopy and urethroscopy, and recording results of treatment.



Anatomical diagram for office histories for noting diagnosis of cystoscopy and urethroscopy, and recording results of treatment.



often possible to accomplish wonders. The strength of the current may be varied from mere desiccation to true cauterization, and one may have the pleasure of seeing cysts disappear, granulation tissue clear up, warts drop away, mucous follicles shrivel and close, and the entire situation improve. Through the urethroscope, after recognizing the situation of definite lesion, the surgeon may use the writer's light carrier, and make any form of chemical application he chooses. Thus is gained the advantage of first recognizing the exact situation of the lesion, and then carrying out upon it a selected method of treatment.

It seems to the writer that in the majority of cases, the chronic, gonorrheal conditions, which in the past have for so many years vexed patient and physician alike, will hereafter be accessible, tractable, and curable.

Inasmuch as these refined and advanced forms of treatment are carried out by stages and steps from one to two weeks apart, so as to allow the mucous membrane to recover fully from each treatment before another is undertaken, the recording of the diagnosis and lesions is of great importance. Hence, for office records the following chart is suggested. It is an accurate anatomical diagram of the important features of the bladder and urethra as to floor and roof, and will be found to be of great convenience in remembering the lesions and in noting results of treatment.

The following chart is elastic, adaptable to almost any variation in the cases, and will be found serviceable. It needs no individual description, as the specimen record speaks for itself. It will be noted that on some dates occasionally treatments of the posterior and anterior urethra may be carried out, if, obviously, neither is very severe. As a rule, however, it is best to proceed slowly, permitting one operative field to heal

before undertaking another. Otherwise, a reaction is excited in the mucous membrane which is very difficult to distinguish from the condition under treatment itself.

PEDERSEN'S CHART.

Name, X, Y, Z. Diagnosis, chronic anteroposterior urethritis.

Dates and results of treatment.

Lesions and means of treatment	July, 1912 1	8	15	22	29	Aug. 5	12	19	26	Sept. 3	10	17
Cysts prostatic urethral roof	+	>	>	=	?							
Acupuncture												
Curette	yes											
Silver nitrate				10%								
Follicles of anterior urethra	+	>	>	?	+	>						
Silver nitrate	5%											
Fulguration (as below)					yes							
Caustic (mild)					yes							
	to 3 near bulb				to deep one near stricture	seemed cured		only small scar left				
Papillomata of colliculus						+	+	+	>	>	+	
Snare												
Curette												
Fulguration						yes						
Sparkgap						¼"						
Switchpoint						3						
Seconds' duration						5						
Dessication						yes						
Caustic												seems to have dropped off

In speaking of the cure of these obscure lesions, sight has not been lost of the fact, that if the mucous membrane anywhere in the body is damaged beyond a certain narrow limit, recovery through any means whatever within our present knowledge is impossible.

It must also be remembered that any one undertaking this thorough investigation of obscure cases must be prepared to devote much time and patience to it. This recalls to mind a case referred to me by Dr. Jerome M. Lynch, that of a physician who had had a rectovesical or rectourethral fistula. My duty was to find, if possible, the vesical or urethral end of the fistula,

and I was asked to get in and out quickly, which was manifestly an impossibility. This fact, however, seemed incomprehensible to the patient, who was much disappointed because this could not be done.

In closing, I would lay down the principle that it is neither just nor wise, on the one hand, to discharge a patient from treatment of a gonorrhea, nor, on the other hand, to accept a case giving a history of long continued symptoms, without a most careful, persistent, and painstaking examination with the urethroscope If this is not undertaken, we may well expect the case to remain much as it was when first presented to our care.

The day is passing, and the field is getting narrower and narrower, in which any methods of blind treatment are acceptable. Hence, in this as in all other fields of medicine, careful diagnosis in chronic gonorrhea is the key of the situation.

45 West Ninth Street.

Note: So many inquiries have been received that it seems well to add that the light carrier of the author alluded to in this article was described in the American Journal of Urology, for August 1911, p., 312, and is manufactured by the Wappler Electric Manufacturing Co. 177 East 87th St., New York City.