PERINEAL DRAINAGE IN INVETERATE STRICTURE OF THE PENILE PART OF THE URETHRA.

BY C MANSELL MOULLIN, M.D.OXON., F.R.C.S.ENG.,
SURGEON TO THE LONDON HOSPITAL.

IT is a mistake to suppose that strictures of the penile part of the urethra are invariably, or even frequently, the result of cicatrisation. Occasionally the mucous lining is destroyed by injury for more or less of its circumference, or eaten through by ulceration; but nearly always, as Berkeley Hill and others have shown, if the urethra is laid open, the membrane can be dissected off, thinned and discoloured, it is true, but intact, and capable of being unfolded its whole width. The first beginning of a deep-seated stricture is usually either a granular patch on the surface or an inflammatory deposit in the substance of the mucous membrane—sometimes the one, sometimes the other; and it steadily increases little by little as fresh lymph is poured out around and beneath it, involving first the urethral and then the peri-urethral tissues, until at length it forms a definite obstruction. The problem in the treatment of stricture is how to ensure the absorption of this deposit without causing the addition of more.

Temporary relief may be obtained by division or dilatation; and occasionally, if the lymph is still soft and cellular, so that its absorption can be effected without loss of time, this leads to permanent cure. But such good fortune is exceptional; nearly always a hardened patch or an open ring is left in the substance of the wall, less elastic than the tissues near, and unable to yield smoothly and evenly when the folds of the mucous membrane are straightened out by the passage of the urine. There may not be sufficient obstruction to cause any difficulty, but there is enough to keep up irritation and make the stricture relapse. Each act of micturition strains and pulls upon the tender tissues around; fresh lymph is thrown out, and organisation begins and contraction is well established before the original induration has had time to disappear. Strictures relapse and recontract, not because they are formed of scar tissue (with a few exceptions), but because the remains of the old and hard inflammatory deposit act like the little thickened patches, or the papillary granulations that are left after gonorrhœa, and begin again the old vicious circle. What is wanted is something that will hasten the fatty degeneration of the old exudation and help the tissues to remove it before the irritation of its presence can lead to the formation of any more, or cause any fresh trouble.

Unhappily, the means at our disposal for hastening the disappearance of chronic inflammatory exudation from other parts of the body are useless, or worse than useless, when the urethra is involved. Counter-irritation, for example, is impossible. Pressure cannot be employed. If a tight-fitting catheter is introduced and left, the stricture tissue softens, it is true, and appears to melt away in the same way and for the same reason that dense fasciæ and ligaments become softened when a joint is acutely inflamed; but the effect is quite as transient; and clinical experience has proved that strictures treated by rapid continuous dilatation alone are usually the first to relapse. The only method is to free the tissues from every source of irritation, and secure for them a long period of complete physiological rest. If this can be done the hardened lymph will slowly disappear, and the walls of the urethra become soft and yielding again. In other parts of the body the absorption of the products of chronic inflammation begins as soon as the irritation that gave rise to it ceases to act, and if only strictures can be placed under the same conditions the same result will follow; at least, in those of them in which there has been no destruction of the mucous membrane. The curability of stricture has been denied. I have already shown[1] that it is by no means uncommon after external urethrotomy, and I am prepared to go further, and assert that not only is this possible, but that, under certain circumstances, strictures of the penile part of the urethra (or at least some of them) are capable of undergoing a process of spontaneous absorption.

The occasional success that attends extreme dilatation after Otis's plan, and after free internal urethrotomy, is probably to be explained in this way: thorough stretching or division of the stricture places the part at rest for a sufficient length of time, and the inflammatory products in the wall undergo fatty degeneration and absorption before they can give rise to sufficient obstruction or irritation to lead to the production of any more; but the result is very uncertain, even in comparatively recent instances. In older ones, especially in those in which there is more than one stricture, there is only one plan by which sufficient rest can be ensured, and that is by opening the urethra behind, in the perineum, and allowing the whole of the urine to escape without coming near the affected part. It is true the measure is a severe one, giving rise to considerable inconvenience for some length of time, but it is not intended to make use of it unless the conditions are severe.

My attention was first drawn to this by noticing the way in which strictures of the urethra sometimes disappear spontaneously in cases of extravasation of urine. In August, 1887, a patient suffering from this complication in an extreme form was admitted into the London Hospital under my care. The history, so far as could be ascertained, was of the ordinary character—several attacks of gonorrhœa, increasing difficulty of micturition, complete retention, and then suddenly, a week before admission, rupture and extravasation. The patient's condition was deplorable: the putrid fluid had spread far above the umbilicus, back into the lumbar region, and even into the ischio-rectal fossæ, Colles' fascia having given way by sloughing. The pulse was very feeble, and it seemed doubtful if the patient could survive the night. However, an anæsthetic was given, the stricture examined, and found to be impassable, at any rate at the time. Free incisions were made wherever the fluid had penetrated, the first in the middle line of the perineum, with the view of opening up the membranous portion of the urethra and giving free exit to the contents of the bladder. Six weeks later, when the patient had rallied and the incisions were closing in, it was thought that the time had come to examine the condition of the urethra. The whole of the urine still passed through the perineal opening, and there was no sign that the obstruction had yielded in any way. However, on trying a small black bougie (No. 2, English) it slipped through almost at the first attempt, and by the end of a week, passing a catheter every day, all obstruction had disappeared and the walls of the urethra were as soft and flexible at the seat of the stricture as they were elsewhere.

I admit the altered behaviour of the stricture may be accounted for, to some extent, by the subsidence of spasm and congestion. Before the rupture occurred the mucous membrane must have been subjected to an extreme degree of pressure and irritation. After the operation, for six weeks it was absolutely at rest. But I do not think, in such a case as this, spasm and congestion are factors of much moment. The real change was in the dense gristly mass that surrounded the urethra and filled up all the interstices in and around the submucous tissue. Left absolutely quiet for six weeks, without anything to irritate it, it had gradually undergone a process of degeneration and been absorbed, so that when at length a bougie was passed the narrow part of the urethra could be unfolded and opened out at once. Whether the cure was permanent or not I am unhappily not in a position to prove; but it may be admitted on *a priori* grounds that even if the chance of this at any time is not very great, it is certainly greatest if the stricture tissue is thoroughly removed by fatty degeneration and absorption, not merely stretched and left.

Such a measure as this is, as I have already said, a severe one for ordinary cases, although, if the patient will spare the time and put up with the inconvenience, he will, I believe, be amply repaid in the future; but it is not uncommon to meet with instances in which a perineal incision is rendered advisable, and even necessary, by the presence of complications, and in which it can be made to assist in the absorption of the indurated mass. All that is required is that it should be kept open for a sufficient length of time. In one case, for example, that was under my care in 1890 there was a number of false passages spreading out in all directions, so that it was scarcely possible to find the orifice; and the urethra behind was so dilated that when it was incised a long cul-de-sac was found running in the corpus spongiosum, far beyond the stricture itself, almost into the glans. In another the median operation was performed for the purpose of extracting the broken end of a bougie. In a third the bladder was drained for severe cystitis and strangury; and in a fourth the whole length of the penile part of the urethra was affected more or less, and there was already the beginning of a peri-urethral abscess.

[1] THE LANCET, Sept. 19th, 1891.

In two of these internal urethrotomy was performed at the same time; in the others the stricture was simply left alone, and all the urine allowed to escape through the perineal wound. The length of time this was kept open varied from a month to six weeks, but I regard the longer period as usually necessary. In no case did any fistula persist—the difficulty is rather in the opposite direction. It is not easy without maintaining a drainage-tube, or occasionally employing dilatation, to prevent the opening contracting prematurely. In all the stricture tissue disappeared of itself, so far as could be ascertained with a bulbous sound. It was not stretched or dilated; it was merely left alone, and when a catheter was passed it apparently did nothing more than open out again the folds of the mucous membrane, which were still collapsed owing to the way in which they had been so long pressed together by the inflammatory exudation.

Wimpole street, W.

THE VERNACULAR MEDICINE AND SURGERY OF JAPAN.

BY BENJAMIN HOWARD, M.A., M.D., F.R.C.S.E.

IN aptitude, adaptation, and enterprise the Japanese have shown a decided superiority over all other nationalities of the Orient. These qualities added to great delicacy of manipulation have made them in art conspicuous throughout the world. It is but natural to expect, therefore, that they should be found to have arrived at something, both in medicine and surgery, which the nations of the West might find to be an acquisition. The earlier Japanese medicine dates back to the "Shindai," or divine age, many centuries before Christ. The Chinese, as early as 218 B.C., found their way amongst the Japanese doctors with medical books dating back, it is alleged, to 2737 B.C, and the influence of Chinese medicine upon Japanese medicine has continued to be a controlling one up to the recent introduction of European medicine now in vogue. As it is difficult to disentangle that past which is of Chinese origin, I include in the vernacular medicine and surgery of Japan all which pertained to its general practice, say, forty years ago, and which still pertains to the practice of about 30,000 out of the 41,000 physicians now practising throughout the Empire. Of the 30,000 of the old vernacular school one of them is still on the list of the Court physicians and maintains a high reputation.

The impression throughout Europe that coloured papers, exorcisms, &c, are the basis of Chinese and Japanese medicine is erroneous. I have myself seen nearly 2000 books by these people, covering most of the departments of medicine, but amongst which materia medica occupies altogether the leading place. In these books are the doctrines of the successive schools, strikingly like some of those which in past centuries existed amongst our own ancestors. The successive medical colleges have always had a professor of astrology, but the solid fact remains that the materia medica has included amongst its several hundred remedies a large number of those used by ourselves, and these are not only vegetable, but animal and mineral, in the latter class mercury being prominent. Surgery became a separate branch as long since as the seventh or eighth century. Tube acupuncture needles, so comparatively new with us, have been in use here since A.D. 1688. Centuries ago one of their authors wrote: "When medicines are ineffectual as well as acupuncture and the cautery, the abdomen and back may be opened, the stomach and intestines be washed, &c." A narcotic mixture employed on such occasions contained datura alba, aconitum, &c.

As the history of medicine in Japan once included so much which seems substantial I have inquired with much care amongst practitioners of the old or vernacular school—all of whom were in practice before 1876,—hoping to discover something in their practice now which would be a veritable addition to the medical resources of our European brethren. I am sorry to have to say that the result of my search has not met my anticipations. As far as I have been able to discover, the vernacular practice of Japan to-day, over the entire length and breadth of the empire which I have traversed, is entirely empirical. Rachitis being unknown, and the life led by the women being so much more natural than in Europe, obstetrics may scarcely be said to be needed, and certainly does not exist.

Syphilis, which came here from China in 1630, is treated in a manner which is the same in principle as the treatment I have seen practised in Nubia, where the patient for several hours at a time buries all the parts of his body except his head in the hot sands of the desert. In this excessively volcanic country the various hot springs which abound, and some of which are exceptionally hot, are the sovereign remedy. In these baths, some of which are fully exposed to public view, whole families, entirely nude, pass a large part of the time during their visit to the particular spa. In several cases I have not seen, but I have been told by the patients of results from them which certainly seem remarkably good. In acupuncture, which, as I have said, has been practised by the Japanese for many centuries, they exhibit very delicate manipulation. For six seng (3*d.*) one of the blind practitioners of this art will, without pain, insinuate a long needle into your stomach, intestines, arms, legs—almost any part except the eye and the brain. The conditions for which it is held in particularly high esteem are flatuence and colic; next, perhaps, in order for neuralgia and rheumatism of the joints. From my own experience I can say it is almost absolutely painless. The points to be penetrated are not entirely arbitrary, but are determined by astrological indications. It is a noticeable experience to see one of these poor blind men take from the folds of his "kimono," or robe, a case of beautifully bright long needles of gold, steel, or silver, and with the *nonchalance* of the Oriental, and without the slightest pause in his conversation, to see him burying his needles two, four, or six inches in various parts of your person in a way which would astonish a European professor of surgery. I mention this practice only as a pretty display of manual dexterity, not as a practice to be imitated. There is one medical procedure, however, in which the Japanese can teach us something in every particular. I refer to their manner of practising massage. For reasons sufficiently apparent, the number of blind in Japan, as in all Eastern countries, is enormous. Every blind boy or girl is expected to join the one guild which is exclusively their own and be an "ammah." With their small hands and supple limbs they give to massage a variety and a delicacy not approached even in India. To what extent anatomy enters into their training I do not know, but no duly qualified surgeon could seem to be more intimately acquainted with the formation of the joints and the course of the nerves as a guide to manipulation. As to percussion, they obtain it by a semi-rotation of the hand with a velocity so great as to make the movement almost invisible. The deeper structures external to the joints they get at with the olecranon process of the naked elbow, which, by an equally rapid movement of the forearm, reaches every interstice with a force regulated with the greatest delicacy. For the muscles of the back, as in lumbago, the "ammah" frequently use their feet, with which they are almost as dexterous as with their hands. When great force is desired this is very efficient. Plain rubbing, which is the principal part of massage in Europe, would be beneath their dignity. Nearly every one of their various manipulations includes some delicate manœuvre which excites one's surprise and admiration. So common is massage in Japan that on arriving at an hotel—next to the tea, which is always immediately brought—the "ammah" is the individual who will surely appear. For the superficial or general massage at such time the tariff price is six seng (or 3*d.*); but a European is expected to pay two or three times as much as that, unless he can talk Japanese, in which case he generally does not. I have had massage in Sweden, which I thought perfection; I have had it in Turkey, which I thought otherwise; I have had it in India, and found it in most instances too rough and indiscriminate; but with a good "ammah" or masseur in Japan I have had but one regret, which is that my friends at home could not share my advantage.

Another lesson we might learn from the Japanese with probable advantage is the more general use of the moxa. For almost any pain whatsoever, if persistent and if at all deep-seated, the remedy throughout the country is the moxa. Whereas with ourselves the moxa is, even with a surgeon, a very unusual remedy, its use here is one of the female accomplishments in almost every household. A cone of cotton-wool previously saturated with a decoction of the Artemesia vulgaris latifolia is placed upon the part concerned, and being lighted is allowed to slowly smoulder to ashes. It leaves a superficial eschar, which seems to heal without special attention. The performance is often seen going on in passing a house, a woman operating on a man, woman, or child, and dressing the patient's hair, perhaps, at the same time. I have therefore inferred