from the extremities of the transverse cicatrix on the dorsum of the penis. The anterior line is made to run parallel with the corona glandis, and about four-tenths of an inch from it. The posterior, starting from the same terminal points, is so drawn as to run behind the subpreputial tumor, which is now circumscribed by two curves forming an ellipse. An incision is now made following each line through the skin only; after which the subcutaneous mass, which is infiltrated and hypertrophied, is removed by a deep dissection. The edges of the wound are finally stitched together, and union by first intention almost always takes place.

CHAPTER VI.

FOLLICULITIS AND PERI-URETHRAL PHLEGMON.

These two affections resemble each other in their seat, but are entirely distinct in their anatomical characters, and demand different modes of treatment. The first is an inflammation of the follicles of Morgagni which open into the urethra; the second, inflammation, always resulting in suppuration, of the cellular tissue underlying the corpus spongiosum.

Folliculitis.—This affection is by no means common, but is occasionally met with in cases of gleet following severe attacks of urethritis. The mode of its production is as follows: The inflammation of the urethral mucous membrane extends to the cavities of the follicles, produces hypertrophy of their lining membrane and obliterates their ducts; hence the normal secretion of the gland mingled with pus is pent up in the cavity, which it distends in the form of a small tumor or intra-glandular abscess. These abscesses have been studied especially by Dr. Ch. Hardy,[1] who describes them as follows:

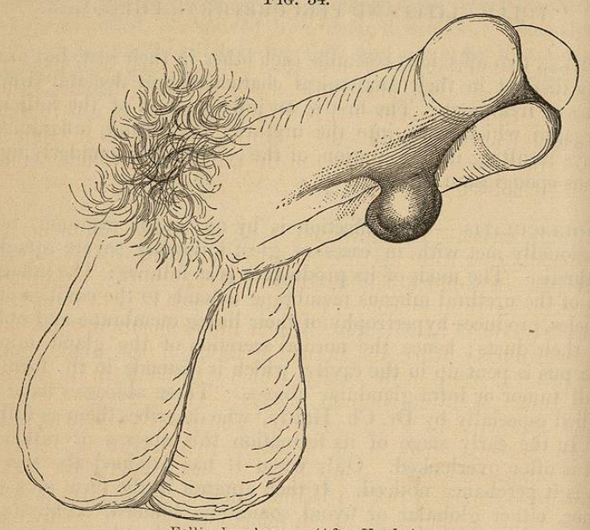
"In the early stage of its formation, this abscess or rather this cyst is often overlooked. Only when it has attained the size of a pea is it perchance noticed. It then appears in the form of a small tumor, either globular or ovoid, sometimes bilobed, occupying the lower surface of the urethra, to which it is attached by a narrow pedicle, which is nothing more than the obliterated and elongated excretory duct. This tumor is subcutaneous, hard, and movable under the skin, which preserves its normal appearance; it is little, or not at all, sensitive to the touch. When it has lasted for some time, and has attained the size of a small nut, it becomes soft, and possibly shows on palpation signs of fluctuation, which is rarely very distinct. These abscesses are often multiple. We have seen three in a patient who had had them over four months.

"These follicular abscesses pursue an essentially chronic course, and resemble very much, in their symptoms, and their mode of termination, the 'weus' that appear on the scalp. After remaining stationary for a long time, they suddenly become sensitive to the touch, increase rapidly in size, contract adhesions with the overlying skin, which, if they are not incised, they perforate and vent themselves by a narrow opening, which remains fistulous. They do not present the same danger as do abscesses of the peri-urethral cellular tissue: they show no tendency to open into the urethra.

[1] Mémoire sur les abscés blennorrhagiques, Paris, 1864.

"All that is required for the cure of these abscesses is to cut down upon the cyst and enucleate the whole of it, as is done with 'wens' on the scalp; or, else, simply cut out a portion of the fibrinous envelope, taking care to keep the wound open. Resolution of these tumors can never be obtained by ordinary means."

FIG. 34.



Follicular abscess. (After Hardy.)

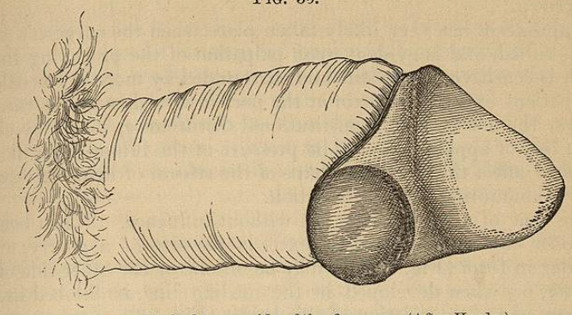
An extreme case of a follicular abscess, forming a pedunculated tumor on the under surface of the penis, is represented in Fig. 34.

Inflammation of Cowper's glands will be considered in a separate chapter.

PERI-URETHRAL PHLEGMON.—This affection, situated in the cellular tissue underlying the urethra, is much more common than the former, and is said to be met with in attacks of gonorrhœa which have been decidedly acute, or in patients who have indulged in excesses to the neglect of treatment. I have one patient, however, in whom it seems to be the inevitable attendant upon each attack of gonorrhœa. He has had the clap four times, and every time a peri-urethral abscess, so that he now predicts this complication whenever the first symptoms of a fresh clap show themselves. This affection may occur at any point along the under surface of the urethra from the glans penis to the bulbous region, but is much more frequent just beneath the fossa navicularis and at the peno-scrotal angle (in front of the bulb) than elsewhere. These are the two points at

which gonorrhœa is most likely to persist, but whether the frequency of phlegmons in these situations can thus be explained is a

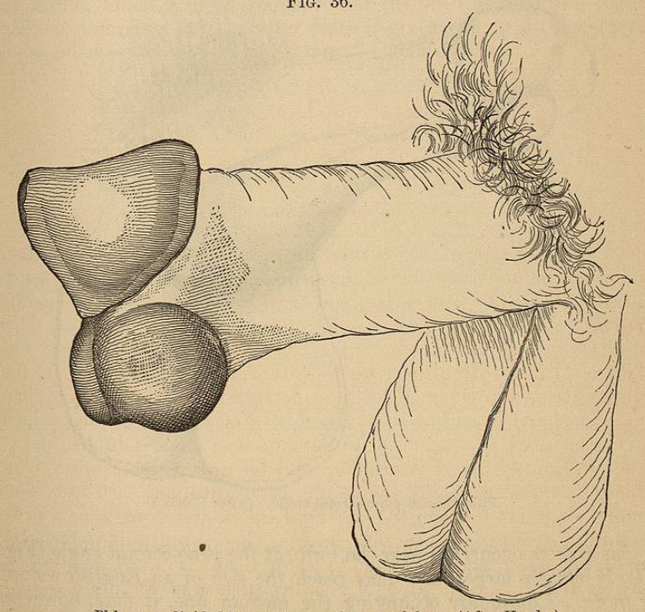
FIG. 35.



Phlegmon limited to one side of the frænum. (After Hardy.)

mooted question and is of little importance; the fact only need be noticed.

FIG. 36.



Phlegmon divided by the frænum into two lobes. (After Hardy.)

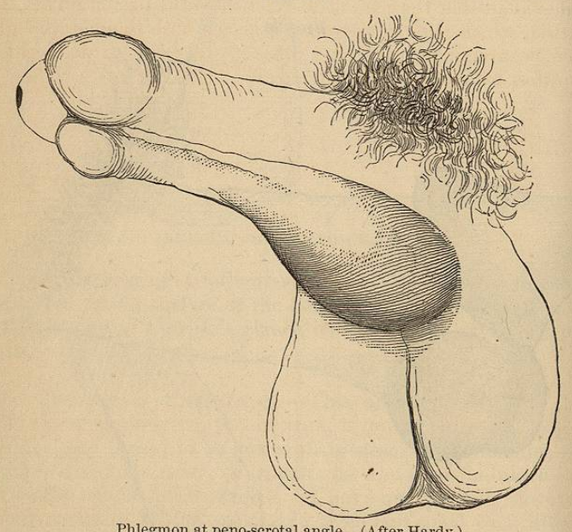
Any premonitory symptoms of the formation of a peri-urethral phlegmon are usually insignificant and are only recalled by the pa-

tient after the mischief has been done, when he will recollect (?) that he has felt more or less pain for some time at the point involved; this pain perhaps overshadowed by the more urgent symptoms of his gonorrhœa.

Suppuration has very likely taken place when the surgeon's attention is called, and is evident upon palpation of the projecting tumor, which is sensitive on pressure and surrounded by more or less œdema. The patient experiences pain at the part involved, and, in rare instances, there is general constitutional disturbance, shown by chills, fever, loss of appetite, etc. The pressure of the tumor upon the urethra may affect the force and shape of the stream of urine or occasion dysuria amounting even to retention.

The seat of the abscess is not without influence. When beneath the fossa navicularis, it rarely exceeds the size of a cherry, and is globular in form (Fig. 35); it may be on one or the other side of the frænum, or, when developed in the median line, be bilobed in consequence of the constriction of this bridle (Fig. 36).

Fig. 37.



Phlegmon at peno-scrotal angle. (After Hardy.)

An abscess occurring near the bulb, at the peno-scrotal angle (Fig. 37), is usually larger, and may reach the size of an English walnut or more. Commonly occupying the median line, it may, however, be lateral. It may extend around the scrotum and involve the perinæum, or, less frequently, it invades the penis. The skin covering

it is of the normal color. These phlegmons never undergo resolution; their only termination is suppuration.

The abscess most frequently and favorably opens externally and cicatrization rapidly takes place. Again, it may break into the urethra; in which case, its cavity is exposed to the entrance of the urine, and there is danger of urinary infiltration and gangrene of the cellular tissue of the penis and scrotum. Finally, the abscess may break both externally upon the surface and also into the canal.

Treatment.—These phlegmons should always be incised as soon as discovered, even if fluctuation is not as yet distinct, and the cut should be kept open until the abscess has completely emptied itself. If one has opened spontaneously into the urethra, the question comes up whether a counter opening should be made from without. Most authorities pursue this course. Fournier, on the contrary, prefers to wait, closely watching the case, and prepared to act in the event of infiltration, which, he says, is not nearly so common as supposed. "It is probable that the opening is often very minute and closes as the abscess discharges itself, so that the entrance of urine into the cavity is prevented."

It is evident that the patient is exposed to the formation of a urinary fistula, which is more frequent near the bulb than at the glans. "When occurring at the latter place it gives rise to an accidental hypospadias which is difficult to cure." (Hardy.)