CHAPTER XVI.

GONORRHŒAL INFLAMMATION OF THE VESICULÆ SEMINALES.

GONORRHŒAL INFLAMMATION of the seminal vesicles has been described by several authors, as Cruveilhier, Andral, Mercier, Velpeau, Lallemand, Gosselin, and Prof. V. Pitha,[1] upon whom I must chiefly rely for its description.

It is unnecessary to dwell upon the mode of its occurrence, since this is so readily explained by extension of the inflammation from the urethra through the ejaculatory ducts. It may also be caused by any mechanical or other irritation of the prostatic portion of the urethra. The symptoms noticed by the patient are much the same as those of prostatitis. A constant, dull, pressing pain is felt in the rectum, shooting from the neck of the bladder to the sacrum. This pain is increased by the passage of the fæces, especially if they are hard; also by micturition, by erection of the penis, and above all by any attempt at coitus. The calls to defecation and micturition are frequent, and the latter is attended with dysuria. Erections of the penis are frequent and may amount to constant priapism. Involuntary emissions occur from time to time, which are excruciatingly painful, and the semen is found to be reddened with blood, or of a yellowish color due to the admixture of pus. Even between the emissions a slimy secretion mixed with blood and pus may be discharged from the urethra, and, under the microscope, be found to contain spermatozoa.

"Bloody semen" is not an uncommon occurrence in men who have for some time suffered with a chronic gonorrhœa, or gleet. They usually discover it by the stains on their bedclothes after a wet dream, or by the color of the semen in a condom which they have worn *in coitu*, and they are naturally frightened by it. It does not always indicate that the vesiculæ seminales are involved, but shows that some inflammation still remains in the prostatic urethra or ejaculatory ducts. It is not serious, and often disappears spontaneously. Its appropriate treatment, if any be required, is a deep urethral injection of a few drops of a solution of nitrate of silver, either by the author's deep urethral syringe or by Guyon's method.

Physical examination is somewhat difficult; but with a long finger and some adroitness the vesiculæ seminales may be reached through the rectum. They lie directly above the prostate, not more than a finger's breadth apart, and one or both of them when inflamed may be felt as an oval, sensitive, hard or fluctuating tumor, which, with

[1] Handbuch der speciellen Pathologie und Therapie, redig. von Virchow, 6 Band, 2 Abtheilung, p. 132.

care, need not be mistaken for an abscess of the prostate. Pressure upon them excites a dull pain.

In some cases this affection is said to be of short duration and to leave no traces behind it. In others the cavity of the vesicula becomes enlarged, even to twice its normal size, and is transformed into a puriform sac, which may either break in the perinæum, giving rise to infiltration of the neighboring tissues and the formation of a fistula, or it may empty itself through the urethra. Again the walls of the vesicula may become ulcerated and the sac itself obliterated, in which case, according to Gosselin, the vas deferens and even the epididymis share the same fate.

When the acute inflammation terminates in a chronic form, we may have thickening and induration of the walls of the sac, with chalky deposits, or,.especially in scrofulous subjects, deposits of true tubercle. Usually such tuberculosis accompanies a general affection of this character, but occasionally it is limited to the vesiculæ seminales, or at least to the urinary organs, especially the kidneys, in addition to the seminal vesicles.

Prof. V. Pitha reports a case in which the left kidney and the left vesicula were infiltrated with numerous coarse masses of tubercle, partly pulpy in the centre, and a portion of the prostate gland and the membranous part of the urethra were the seat of large tuberculous ulcers. The patient was a day-laborer, aged 50.

Velpeau observed a case in which vesiculitis terminated in an abscess, followed by peritonitis, which proved fatal. (Tarnowsky, op. cit., p. 330.)

In spite of the nearness to each other of the two openings of the ejaculatory ducts, both vesiculæ are rarely attacked at the same time. If both are involved, resulting in such changes as those described, impotency must necessarily follow.

Inflammation of the vesiculæ seminales can rarely be diagnosticated with absolute certainty during life, and we can only say of its treatment that symptoms must be met as they occur, and that, in general, the same remedies are applicable as in prostatitis.

An interesting case of hydrocele of the left seminal vesicle is reported by Dr. N. R. Smith, of Baltimore.[1] It appeared as a large pyriform tumor, occupying the cavity of the pelvis and extending above the umbilicus. It was regarded at first as a distended bladder. A catheter being introduced, an ounce of perfectly normal urine was obtained. On pushing the catheter upwards and forwards the tumor glided upwards. The finger in the rectum found a normal prostate, and on its left an elastic tumor, pressure on which caused motion of its fluid appreciable on the abdomen. It was cured by two tappings.

[1] Lancet (Lond.), Oct., 1872.

CHAPTER XVII.

GONORRHŒAL PERITONITIS AND SUBPERITONEAL ABSCESS IN THE MALE.

ONLY a few cases of these rare complications of gonorrhœa have ever been reported, and I am indebted for the material of this chapter to the valuable paper, appearing in the October and November numbers of the *Archives générales de médecine*, 1877, by Dr. A. Faucon, who reports a case of subperitoneal abscess occupying the internal portion of the internal iliac fossa, and extending upwards four fingers' breadth above the inguinal cord.

Instances of gonorrhœal peritonitis had before been reported or briefly referred to by Hunter,[1] Ricord,[2] Gosselin,[3] Dr. Peter,[4] and Godard;[5] one of perinephritic abscess, by Dr. Laforgue,[6] of Toulouse, all of them originating in the extension of the inflammation, first from the urethra to its annexes, and, second, from the latter to the subperitoneal cellular tissue, or to the peritonæum itself.

Dr. Faucon's conclusions at the close of his paper give a summary of what is known of this subject, and I shall quote them verbatim:

1. Peritonitis and subperitoneal abscess should be ranked among the possible complications of gonorrhœa.

2. These accidents are only distant effects of the gonorrhœal inflammation, extending from the urethra to the peritonæum or the subperitoneal cellular tissue through the intervention of the vas deferens, vesiculæ seminales, the prostate (possibly the bladder, ureters, and kidneys), and the cellular tissue surrounding these organs.

3. Their appearance is, therefore, always preceded by the more ordinary complications of gonorrhœa, resulting from the preliminary inflammation of the tissues or organs which serve as intermedia (inflammation of the vas deferens, vesiculæ seminales, etc., etc.).

4. Gonorrhœal peritonitis may appear at different points; thus it has been seen to commence in the pelvic region opposite the recto-vesical *cul-de-sac*, while at other times it starts from the internal orifice of the inguinal canal.

5. It may remain localized at the point where it commenced, and

[1] Ricord and Hunter on Venereal (Bumstead's translation, 2d ed.), p. 90.
[2] Ibid., p. 96.
[3] Clinique chirurgicale de l'hôpital de la Charité, Paris, 1873, t. ii., p. 364.
[4] Union méd., Paris, 1856.
[5] Gaz. méd. de Paris, 1856.
[6] Rev. méd. de Toulouse, Dec., 1876, p. 355.

terminate favorably, or it may become general (or at least extend to a more or less considerable portion of the abdominal cavity), pass into a purulent stage, and result in death.

6. The gonorrhœal subperitoneal abscess has been observed in the lumbar fossa and at the lower portion of the internal iliac region, and of the anterior wall of the abdomen. It may terminate by resolution or by suppuration. Its influence is less mischievous than that of peritonitis.

7. When a subperitoneal abscess has formed, it should be opened as soon as possible. Decided antiphlogistic treatment, the prolonged use of ice and early incision may arrest its development and prevent its passage into suppuration.