tenacious, and strings out as the thumb and finger are separated, feeling scabby as they are again rubbed together; or, on the other hand, the drop may be quite watery and thin, but it is always somewhat sticky and never has a seminal odour. This flow when abundant is thick, but does not stain the linen, and it may come away in greater quantity during straining effort, as at stool, during exercise, or after micturition. If the discharge be due to surface urethral congestion it is quite watery, clear, and only slightly sticky. When the secretion of the glands of Littré and Cowper is mixed with it or constitutes its main bulk, it is thick, cohesive, and tenacious. Patients generally think that it is spermatic fluid. The microscope shows it to be composed of single flat epithelial cells and clusters of the same, mucous corpuscles, films of striated mucous, granular debris of various kinds, no pus threads (unless there be also a patch of chronic anterior granular urethritis, which is quite possible as a concomitant), no prostatic bodies, no spermatozoa, no leucin bodies, no Böttcher's crystals.

The causes of this affection are prolonged, ungratified sexual desire, constant impurity of thought, a sort of mental masturbation through the imagination, often indulged in by weak-minded youths, as well as by old men who are regrettfully conscious that they are getting beyond the potential stage of sexuality. Another cause is delayed orgasm during intercourse or withdrawal before emission, pernicious practices which occasion sexual strain. Masturbation if excessive, or too much natural sexual exercise under the stimulus of mental provocation—all these and the like, being a violence to the various urethral mucous glands and to the circulation of the urethra by prolonged, sustained, excessive nervous tension, lead to passive congestion and lack of tone in the circulation of the urethra and in its mucous glands and follicles, and thus occasion an excess of mucous secretion all along the line, together with more or less desquamation of pavement epithelium—and this is the malady and the whole of it.

The natural history of the meatus during intense sexual excitement is physiological. It is equivalent to the watering of the mouth when one is hungry and smells appetizing food.

Whether it is fair also to denominate urethritis that form of mucous oozing following chronic anterior urethritis in some cases, notably in the strumous, goitre, and debilitating, after the pus and shreds have disappeared, may be questioned; but it is much the same thing, being a mucoid oozing from congested surfaces which are not

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**CHRONIC URETHRITIS AND PROSTATITIS**

infamed enough to yield pus, and it gets well, not by local treatment, which indeed may maintain and prolong it, but by improved general health, change of air, etc., with lapse of time. I well remember such a case, which came to me thirty years ago, a solicitous young man who had been under continuous treatment for a year at the hands of one of New York's most noted surgeons without avail. I stopped all treatment and sent him to Bermuda. The vessel had not been twenty-four hours out of port before his mucoid drop diminished notably. It promptly disappeared and never returned.

Many a time a little, final mucoid drop of this sort is entertained for weeks or months by excess in local treatment due to unnecessary solicitude on the part of the patient and inordinate zeal on the part of the surgeon.

But the true urethritises, be it due to whatever cause among those enumerated, gets slowly better upon doing away with the continued action of that cause—be it lust, masturbation, excess, or what not which has occasioned it—and by insisting on urethral and general hygiene aided, perhaps, by a monopoly of comfort 30 centigrams 2 times a day, if creations be insistent, and such tonics as seem indicated, notably iron and strychnine. A minute dose of strychnin, sufficient to dry the mouth slightly, assists. I think it also somewhat dries the urethral and prostatic secretion. Massage of the urethra by the passage of a large steel sound every two or three days through the anterior canal, or by the double-current cold-water metallic sound (Winterwirte) with fixed water, is sometimes helpful, with perhaps a light injection of the non-alcoholic fluid extract of hydrastis 5%, or elixir and water 50%, once or twice a day. Strong injections irritate, and any injection may do as much harm as good, notably in those self-centred cases where morbid intrusion in the salient feature of the malady. Here anything that keeps the patient's mind upon his genitals harms him, and any local treatment may be mischiefous. A cold morning douche to the external genitals has a tonic effect. The patient's mind must be disabused of his morbid fancies. Horseback exercise is helpful, unless there be also chronic prostatitis, when it might do harm.

For treatment, see page 140.

**PROSTATORRHEA**

This malady may occur alone, in which case it is not inflammatory, not a prostatitis—but it is almost universally convulsed, nor yet a urethritis—but a sexual malady, and, like urethritises, due to some form of sexual strain.
But prostatatorrhea may very well be engrafted upon an already existing surface or follicular prostatitis, and in the declining stages of the latter may form part of the picture—or a person with prostatorhrea may get chronic follicular prostatitis as a sequence of gonorrrhhea—but the point is that true prostatorhrea is a local sexual weakness due to strain and not a sequence of local inflammation.

Chronic spermato-cystitis is distinctly a sequence of gonorrrheal inflammation after the latter has invaded the prostate sinus, and this vesiculitis may yield some of the symptoms of prostatorhrea; indeed, the two may also coexist. So that, clinically speaking, a true case of uncomplicated prostatorhrea is very rare, since it is likely to be affiliated on the one hand with chronic inflammatory follicular prostatitis, and on the other with chronic seminal vesiculitis. It may also be associated with urethrorhrea, and share some of the symptoms of the latter.

Sturgis¹ has made an admirable study of the malady, differentiating its individuality in a very concise manner.

Prostatorhrea is a sexual weakness due to strain or sexual perversion of some sort. It is a local lack of tone due to deteriorated nerve force from prolonged nervous tension, and is not an inflammation.

It consists in an intermittent discharge from the meatus of thin, white milky fluid of acid reaction, sometimes neutral, not sticky, not opaque to the feel, and when uncomplicated containing no pus cells, spermatozoa, or leucocytes. It does, as a rule, contain prostatic bodies (spermatozoa), cubic and pyramidal epithelia, and upon the addition of a 1% solution of phosphate of ammonia, a drop of which may be added to a portion of the discharge upon a microscopic slide, it does produce the peculiar star-like angular collection of pointed and crossed back-saw crystals known by the name of Bütcher, not found in any secretion from any portion of the genito-urinary tract except the prostate. It contains also clumps of lecithin granules.

This distinguishing mark is notable, but unfortunately there may be a combination of prostatorhrea and chronic spermato-cystitis; and then sometimes the Bütcher's crystals are found in the discharge expressed from the meatus without the addition of the ammonia solution, because the secretion of the inflamed vesicles is alkaline.

The prostatic secretion smells like semen on account of the lecithin which it contains. It is acid in reaction in the normal state.

¹ Sturgis, J. A. C. and Gen., Univ. Dis., 1886, xvi, 260.

but Lohnstein; recording recently his 542 examinations of the prostatic secretion, carefully obtained by massage from the prostates of 80 patients, noted certain variations from Führbringer's doctrine as to the reaction of the normal secretion. For even in these pathological states the fluid was 404 times (75%) acid, 30 times (5%) neutral, 108 times (20%) alkaline; but it was not always the same in the same patient, being in 5 cases alternately acid and neutral, in 8 neutral and alkaline, and in 15 acid and alkaline, while the proportion of moving spermatozoa was equally great in both cases. This mixture of spermatic elements in the fluid would, however, indicate either that Lohnstein was dealing with cases of spermato-cystitis as well as of prostatitis, or that his massage included the vesicles as well as the prostate.

These investigations, however, establish the fact that the secretion in prostatitis is generally acid, as the fluid of the vesicles alone is known to be freely alkaline. Führbringer says of these vesicular and testicular fluids that they become easily alkaline.

This, then, being the quality of the fluid—acid, thin, watery, white (opaque)—the question is, Does prostatorrhrea ever occur as a distinct malady independent of prostatitis or spermato-cystitis? In my opinion, although possible it is very rare—so rare as a distinct malady that it may be almost disregarded, being better considered as an associate symptom sometimes with urethrorhrea, sometimes with prostatitis, sometimes with chronic spermato-cystitis.

Symptoms.—In a true case—always a masturbator or one given to perverted or excessive sexual exercise, most often a neurotic or neurasthenic subject—the patient finds a whitish, thin, watery drop at the meatus, and notices that the same is extruded in greater quantity at stool, and sometimes after urination.

He believes this to be a seminal loss, and is on that account excessively despondent. He is likely to have obscure neurologic sensations along his membra, a feeling as if he is cold, occasionally a hot drop were trickling down the arm at odd times. There may be a little vesical irritability not noticed by a man in health, for raro myangitur cantus is as true now as of old. Every physical and functional evidence of sexual lack of tone may be present. The penis may be long, cold, and flabby, blue at the glans penis, notably about the corona glandis. The testicles may be flabby, soft, neuralgic, or at least oversensitive to handling. There may be pain in the back, radiating down the thighs or in the perineum, and various other reflex pains. There may be dyspeptic symptoms, a white tongue, a soft

² Guynn's Annuals, 1890, xiii. 1188.
rapid pulse, dilated pupils, cold, moist palms, headache, tendency to mild vertigo, loss of memory, inability to concentrate the attention, or to sustain prolonged mental effort, as in study or even in reading. With this there may be premature ejaculation during intercourse, and excessive sexual desire with diminished power—possibly functional impotence due largely to self-contum and to neurotic causes.

The patient may be melancholic and dependent to the verge of mania, incapable of consolation; and this all the more if with his prostatortorhea he has spermato-cystitis, a perfectly possible combination. In fact, all the evidences of the so-called sexual neurasthenia may be present in any or every combination.

But it is not a fact that true prostatortorhea alone or true chronic spermato-cystitis alone necessarily gives rise to these symptoms of despondency, sexual incompentence, or precipitate ejaculation, for a considerable number of patients have both spermotortorhea and spermato-cystitis, and are not subjectively conscious of it, unless by the physical signs of pain and local discomfort to which the inflamed vesicles give rise. I have again and again found spermatozoa constantly in the urine of patients being examined for another malady, and have not communicated my information to them because the seminal less occasioned no symptoms whatsoever, and I preferred not to arouse the attention and fix it on this very delicate sexual centre. Yet the combination of prostatortorhea with spermato-cystitis is more likely to be associated with this train of symptoms than is either malady alone, and I ascribe this to the fact that in these cases there is often a combination of inflammatory action with sexual exhaustion; and that the patient, usually a neurotic, is unable to withstand the combination. The symptoms are neurotic rather than physical. They occur in neurotics who have no local disease, neither prostatortorhea nor spermato-cystitis, and conversely, patients with prostate-cystitis and with spermato-cystitis may be entirely devoid of this combination of symptoms.

It is proper, however, to note the frequent combination of the symptoms with the maladies, and the fact that the cure of the local symptoms may and often does greatly improve the neurotic state, probably by calming the mind and doing good by the process of suggestion.

In true uncomplicated prostatortorhea the prostate is not necessarily sensitive, either subjectively to the patient or to rectal touch; but as prostatortorhea is often a part of the general picture in which another malady (prostatitis, spermato-cystitis) is concerned, the prostate may be subjectively and objectively excessively sensitive where there is true prostatortorhea.

The malady is of long duration, but is always capable of betterment, often of entire cure.

For treatment, see page 140.

**SPERMATO-CYSTITIS**

Spermato-cystitis, inflammation of the seminal vesicles, is a result, early or late, of posterior urethritis, and as such is almost always of gonorrheal origin.

There is, however, a very chronic form of vesicular dilatation (usually bilateral), due to masturbation, to sexual irregularity, to excess, or to prolonged, ungratified desire. This occurs particularly in neurotic subjects, and is accompanied by prostatortorhea, with or without a little chronic surface or follicular prostatitis. These patients are often afflicted with sexual neurasthenia and complain of so-called spermatocystitis.

The frequency of spermato-cystitis as a complication of gonorrhea is a matter in much dispute, and cannot be determined until our methods of diagnosis become more refined. This is due to the fact that in a certain indefinite proportion of cases of gonorrheal posterior urethritis, and in all cases of epididymitis, there is subacute spermato-cystitis. This passes unrecognised, as it yields no special symptoms, calls for no particular treatment, and subsides spontaneously with the disappearance of the greater malady which it complicates. Therefore Von Petersen's estimate of the relative frequency of the complication (14%) must be considered much too low.

Spermato-cystitis may be acute or chronic, and in either case may run a mild or a severe course. The mild cases, whether acute or chronic, yield no symptoms other than those of the prostatitis which they accompany; and while such cases may be recognised by careful examination (see Diagnosis) they require no treatment. But the contrary is true if the symptoms become intense.

**ACUTE SPERMATO-CYSTITIS**

In mild cases there are no symptoms, except the objective one of moderate distention of the vesicle with extra sensitiveness, recognised by rectal touch.

Severe cases may be accompanied by considerable fever, and have for local symptoms pain in the perineum, anus, rectum, or hip.
This pain is of an aching, a throbbing, or a burning character, and is increased by urination (which is urgent and frequent) and by defecation. There may be partial priapism, and emissions may be painful and frequent, the semen bloody. The urine contains free pus, usually a little blood and shreds, as in acute prostatitis, the shreds often entrapping symptoms of spermatozoa, and free spermatozoa may also be found. There may be epididymitis.

**Chronic Spermato-cystitis**

Octave Gueriot restricts the symptoms of chronic spermato-cystitis to those of a not infrequent complication — i.e., recurrent epididymitis. This is far too narrow a view, but it emphasizes an undoubted fact — namely, that chronic inflammation in a vesicle is often entirely overlooked, being dominated perhaps by a more obvious disorder in the testicle, or often shrouded by and mistaken for prostatitis.

**Symptoms.** — The symptoms of chronic seminal vesiculitis are often definite, and evidence themselves in one or more of the following three ways:

1. Pain, often with more or less vesical irritability and functional sexual disturbance.
2. Gleet, pyuria, pyospemra or hemospemra.
3. Recurrent epididymitis.

The pain is usually neuralgic in character, and resembles the pain of chronic prostatitis or of urethral neuralgia; or it may be reflected to various regions, notably the testicle, where it may manifest itself as a neuralgic pain of more or less intense. Pain may exist in the back, low down, may radiate down the sacral nerves, or along the front of the thigh (more marked if the testicles and cord be sensitive). Pain in the hip, said to be pathognomonic, but often absent, has led to confounding this malady with hip disease. Defecation may be painful and may leave a dull aching sensation high up within the rectum, which may come on spontaneously at night, awakening the patient. It recalls fissure pain.

Ejaculation, often unsatisfactory, may be painful, and is generally premature. There may be feeble erection and functional impotence from lack of desire; but desire is usually increased, while capacity is lessened. Nocturnal emissions may be frequent, the sperm may be bloody or chocolate-coloured; there may be symptoms of cystitis, even retention.

As in prostatitis, there may be slight but obstructive urinary discharge. The pus in the urine or semen shows macroscopic and microscopic characteristics distinguishing it from pus from the prostate.

**Chronic Urethritis and Prostatitis**

(See Diagnosis.) Occasionally, however, the pyuria is intermittent or remittent, resembling the urine of pyelitis-nephritis rather than that of prostatitis. If the blood mixed with semen comes from the vesicles, they are intermingled, if from the prostate it occurs in streaks.

Epididymitis may be the sole symptoms worthy of attention. Melancholia, depression of spirits, and all the symptoms of sexual neurosis (see Prostatitis) may be also present, notably in neurasthenic and exuberant patients.

**The physical signs of spermato-cystitis are essential to the diagnosis.**

**Diagnosis.** — The symptoms are so variable and so non-specific, including as they do many of the symptoms of posterior urethritis, prostatitis, prostatorrexa, and even neurasthenia, that careful examination of the vesicles and of their secretion may be necessary before an accurate diagnosis of the malady is possible. In every case of gleet or of persistent urethral or perineal pain the vesicles require examination, since they may be the chief or the sole seat of the disorder. A history of hemospemra, priapism, seminal colic, or recurrent epididymitis strengthens this probability that the vesicle is the corpus delicti.

**Rectal Examination.** — The vesicles like the prostate are reached by the finger in the rectum. The procedure has already been described. Suffice it to say that the normal vesicles cannot be felt unless overdistended. If inflamed, the finger passing up over and beyond the prostate meets with no resistance in the middle line, but laterally, instead of slipping around the corner of the prostatic lobe, it meets a prolongation of this lobe upward and outward in the shape of a boggy, tense, or soft, fluctuating, elongated, sausage-like tumour, often exquisitely sensitive, and always more or less tender. The tip of the finger cannot reach the upper limit of the vesicle. Indeed, in some cases it can scarcely reach the lower part of it. A full bladder and counter-pressure on the lower abdominal wall are aids in examination. The surgeon need not hesitate to crowd his finger into the rectum as far as it will go, but he should fear the exhibition of any roughness, for it is easy by too much pressure still further to inflame a vesicle not yet quite out of the acute stage, and bring on active symptoms of irritation of the neck of the bladder (cystitis) or acute epididymitis, bloody emissions, aggravation of urethral discharge, etc.

Two questions arise here: Are all enlarged vesicles inflamed?

[1] The rubber-tipped finger-stall does not interfere with the exploration, protects the surgeon's finger for other surgical work, and possesses an aesthetic advantage.
ACUTE UROPHLEBITIS AND PROSTATITIS

ABSCESSES OF THE SEMINAL VESICLES

Occasionally the inflammation goes on to abscess of the seminal vesicles, the ejaculatory duct becoming occluded. Such abscesses, while giving rise to the symptoms of acute prostatic abscess (p. 88) —being differentiated from it as to position by the rectal touch—may burst into the peritoneum, or, infiltrating the pelvic and periurethral connective tissue, go on to post-urethral, ischiococcygeal, or pelvic abscess (p. 90).

Such abscesses usually point spontaneously into the bladder or the rectum. Very exceptionally a fatal peritonitis or a burrowing periurethral abscess may result (p. 91).

SPERMATORRHEA

Methods of modern diagnosis, aided by a broadened common sense, justify the surgeon, I believe, in dismissing spermatorrhea from the catalogue of diseases. There is no such disease as spermatorrhea. The alleged malady is a fetish created largely by La belle—fetish to which its worshipers, young and old, bow down throughout the community morning, noon, and night, offering to it the insane of their distorted erotic fancies.

Spermatorrhea exists surely as a symptom, not as a malady. As well call cough or pain a disease.

Spermatorrhea is the intermittent or constant involuntary escape of seminal elements (spermatozoon) without orgasm, and not in nocturnal emissions. This escape occurs during the urination act, during defecation or rectal straining, sometimes during walking, sometimes in slight constant discharge mingled with prostatic and follicular secretions. It means that the ejaculatory duct is patulous, either atomic and relaxed, or catarrhal.

The duct may be atomic and relaxed and even catarrhal from the debility of age when there is enlarged prostate. Sometimes it becomes relaxed during the weakness following prolonged fever (tuberculosis). Sometimes it is relaxed by the congestion and strain of masturbation, or more often by excessive and prolonged sexual excitement without relief, aided by erotic fancies and imaginations, but in such instances a prostatitis or a spermatozoon is the malady that gives the symptoms, and not the escape or loss of semen.

I have known men having sexual intercourse nearly every night of their lives for years, and often more than once in a quiet, not only from a point of any sexual malady, and surely, if an ex-