the ureter, and this last-mentioned sound passes far up into the region of the kidney.

Kinking or spiral course of the ureter requires a flexible catheter. In such cases other phenomena occur, such as cessation of flow from the ureter for a longer or shorter period, with pain in the loin due to the impeded outflow of urine. This is followed by the sudden discharge of larger quantities of urine, with immediate relief from the pain.

In conclusion, a condition which may occur in the course of various diseases of the genito-urinary tract, *anuria*, may be mentioned. By this is meant the cessation of the flow of urine into the bladder. If a patient has bilateral renal calculi, it might happen that both ureters became obstructed at the same time. No urine would then enter the bladder, and bilateral hydronephrosis would be the outcome. If the patient has only one ureter (*one kidney*) this accident might occur more readily. Under anuria we include the conditions in which the kidneys do not secrete urine. If this occurs in severe renal disease, its cause is, of course, readily understood. Such cessation of secretion may also, however, be due to purely reflex irritation.

## CHAPTER XXVIII

### DISEASES OF THE PENIS AND VULVA

DISEASES of the penis require but little discussion. Benign neoplasms are of very rare occurrence, if we except the *gonorrhœal condyloma* which is frequently met with. Epithelioma of the penis should offer no difficulty in diagnosis, if the age of the patient, and the marked induration of the ulcer, both at its base and edges, are taken into account. The evident involvement of the surrounding tissues by extension—in marked contrast to the destructive progression of an ulcer—the shotty inguinal glands, and the duration of the trouble must also be considered. Sometimes epithelioma of the penis is found in the form of a nodule within one or both of the corpora cavernosa. It is at once recognised by its hard consistency. Frequently a primary cancerous growth of the glans is followed by metastatic nodules in the corpora cavernosa.

In cases of paraphimosis, remember to look for a thread tied about the penis, as cause of the trouble. Venereal processes will not be considered.

CAVERNITIS may result from trauma or from suppuration in the neighbourhood, followed by perforation into the corpora. It occurs, therefore, both in the form of a local, circumscribed, or a general inflammation.

The most striking symptom is the distortion of the penis, for, as a result of the excessive infiltration of a portion of one corpus cavernosum, the penis is bent toward the opposite side. If cicatrization then follows, the organ is bent in the reverse direction—i. e., toward the diseased side—by the cicatricial contracture. The most unpleasant after-effect is the resulting deformity of the penis during erection. If the cavernitis was bilateral and cicatrices form on both sides, the organ becomes erect as far as the scar tissue, beyond this it remains flaccid.

An acute cavernitis of considerable extent, with rapid pus formation, produces an alarming picture. The penis is enormously swollen as far as the perineum, and the skin of the penis becomes markedly edematous. A sharp line of demarcation—just as if part of the swelling had been cut off—is characteristic. The disease occasionally is seen during the course of a gonorrhœa which has been subjected to too energetic treatment. After fluctuation appears, incision is followed by the evacuation of large quantities of pus.

Functional disturbances, especially IMPOTENCE, require special mention. A common variety is due to *psychical* causes. To explain this phenomenon, an inhibitory centre, situated in the lumbar cord, has been assumed. This centre can be stimulated by the imagination, so that erection grows impossible in spite of the extreme desire of the individual. Not later than in the last century such cases of psychical impotence were judged to be the result of witchcraft.

There are other forms due to actual pathological changes. The physician must regard the matter in a very serious light when he is taken into the patient's



confidence, for the most varied psychical disturbances, and even suicide, have resulted from impotence. Sometimes the true condition of affairs is concealed from the physician, and patients afflicted with impotence will wander from doctor to doctor, complaining of various troubles, until they finally come to a physician who asks if they are potent. This physician at once gains their confidence. As most men are ashamed of their disease, the question must be put categorically.

A man who is able to have coitus and to ejaculate may yet be impotent if unable to inseminate. If the ejaculated fluid fails to contain spermatozoa, the condition is denominated *Azoospermia*. The cause must be an atrophy of the testicle, especially atrophy or obliteration of the lumen of any of the efferent passages, such as the vas or epididymis, following an attack of gonorrhœa. This condition should always be looked for. Another form of impotence is known as *Aspermatism*. Erection is normal and the patient can have connection, but no ejaculation is possible. If the patient never ejaculates semen, the condition is called *permanent* aspermia (so named by B. Schulz). If semen fails to be voided only during coitus, but pollutions occur, the condition is known as *temporary* aspermia. The latter is of lesser significance than the former, for it is purely the result of abnormal nerve control. Permanent aspermia is due to closure of the ejaculatory ducts, unless it is caused by stricture of the urethra. If the ejaculatory ducts are strictured, no spermatozoa can be found in the urine, but if the openings of the ducts are displaced, spermatozoa may be found in the urine. They signify that the semen has been ejaculated, but in a wrong direction—toward the bladder.

SPERMATORRHŒA still remains to be discussed. If semen is voided in the course of a difficult movement of the bowels, spermatorrhœa should not be diagnosed. This is a very common, almost a physiological, condition. If a patient masturbates and then comes to you complaining of spermatorrhœa, do not call it by that name. The physician should not beat about the bush, but should plainly ask, Do you masturbate? Another patient, at the sight of an attractive woman or at the slightest sexual excitement, at once has an emission, or may have ejaculation without erection. This is the result of disturbances of innervation. Other forms of spermatorrhœa are rarely encountered. In most of these cases normal and regular sexual intercourse with a congenial woman is the best remedy, just as in psychical impotence the diplomacy of a clever woman usually brings about a quick and permanent cure.

The vulva has but few functional diseases, but its visible and tangible diseases are numerous. Herniæ deserve our first attention. An inguinal hernia which has descended into the labium majus is known as a *hernia labii majoris anterior*. A hernia which appears in the posterior part of the big labium after descending along the wall of the vagina in front of the broad ligament is designated as a *hernia labii majoris posterior*. If the hernia descends posteriorly to the broad ligament, it appears externally in the perineum, and is called a *perineal hernia*. If the contents of such a hernia is composed of small intestine, the diagnosis may readily be made by the tympany and reducibility. Even if the hernia is irreducible, the impulse on coughing is sufficient to draw a true conclusion. If the contents is formed by the bladder, so that no true hernial sac is



present (by strict interpretation the condition is not a hernia, but rather a prolapse), the trouble is more important, as urinary symptoms arise. It must, therefore, not be omitted to empty the bladder by catheterization in order to avoid errors. In prolapse of the bladder the tumour will then diminish in size.

ELEPHANTIASIS of the labia is frequently not recognised by the inexperienced. If they see a large pedunculated mass, varying from the size of a fist to that of a head, hanging from the large labium, it is at once classed as a lipoma or fibroma. It is quite true that lipomata or fibromata of similar size and shape arise from the labia, but compared to elephantiasis they occur much more rarely. If the skin is intact, the structure of the tumour lobulated, and the consistency semi-elastic, the diagnosis of lipoma is justified. If the consistence is firm, the skin intact, and the mass is cystic in one or more spots, the diagnosis of fibroma may be made. If, however, the tumour is very large, the skin over either of the two neoplasms mentioned may ulcerate at the dependent portions of the mass, and the neighbourhood of the ulcerating area grow pigmented, fissured, thickened, and scaly. Over the central portions, however, the skin will remain normal, and both in lipomata and fibromata it will be freely movable over the tumour. In elephantiasis, the skin is thickened over the whole tumour, and at some spots, sometimes spots not especially exposed to irritation and friction, enormously thickened. The skin surface shows hypertrophied papillæ, and is warty, scaly, and covered by a cheesy secretion of strong odour. The tumour itself has a peculiar consistency. As the condition is due solely to a hypertrophy of the skin, and as the

blood and lymphatic vessels take part in this hypertrophy equally with the connective tissue, the tumour in spots has firm strands running through it, while in other parts hard lumps may be felt. The whole mass may be somewhat diminished in size by squeezing the blood and lymph out of its vessels, thus, to a slight degree, simulating compressibility. The history should be of value. The swelling may have appeared after an attack of erysipelas, or erysipelas may develop frequently, and each attack be followed by an increase in size. All these tumours may readily be extirpated. If a tumour of larger size occupies the pubic region and is firmly adherent to the pelvic bones, it most probably is sarcomatous. If its consistency is firmer and the growth slower, it is most probably a chondroma. Neither are very uncommon.

Most important of the *cystic* tumours of the labia are retention-cysts of the glands of Bartholin or of the Bartholinian ducts. The strict circumscription, the fluctuation, absence of pain, inability to empty the swelling, all point to its cystic nature. If the swelling is elongated and spindle-shaped, the ducts have been occluded; if rounded or lobulated, the gland itself is the seat of the trouble.

*Carcinoma* of the vulva is uncommon. The diagnosis differs in no way from that of cancer in other parts of the body.

## CHAPTER XXIX

### DISEASES OF THE RECTUM

DISEASES of the rectum are numerous and important. At all ages and in both sexes we have frequent occasion to make rectal examinations, essential for the purpose of diagnosis.

The chief instrument used in surgical exploration of the rectum is the finger, for digital examination may clear up many doubts. A relaxed condition, strong contraction, or spasticity of the sphincter can be recognised. In prolapse, the mucous membrane feels unduly relaxed; in submucous cancer, it appears fixed. A carcinoma opposes resistance; moreover, its open, ulcerating spots, its extent and boundaries, may be palpated. The prostate, a portion of the urethra, the bladder, the seminal vesicles, are open to our touch. We can feel an extensive stricture, fistulous openings, polypi. In the virgin, we resort to rectal exploration in order to examine the uterus; likewise in a multipara suffering with cicatricial stenosis of the vagina. Periostitis of the sacrum may be directly palpated, pelvic abscesses are discovered, fractures of the pelvis or tumours of its walls may be felt, also tumours lying in the pelvis, etc. The finger discovers much more than the mirror.

Although I have repeatedly alluded to the method