ALLEN (G.W.)

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OF

ACUTE URETHRITIS.

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THE TREATMENT OF ACUTE URETHRITIS.[1]

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I HAVE no new contribution to genito-urinary therapeutics to offer, but merely wish to make a few general observations on the treatment of acute urethritis in the male, based on my own experience.

The internal treatment is of some importance. The value of copaiba, I think, is apt to be underestimated, and, because it is disagreeable to take, some physicians discard it from their formulary. Many persons take it well, and it undoubtedly has a marked influence on the disease in a large proportion of cases. Where internal treatment is indicated, copaiba should be considered, but, of course, must be stopped when found to produce gastric or intestinal disturbance, or a cutaneous eruption. Sandalwood oil is perhaps even more efficient and is less nauseating. It is expensive, however, and most preparations of it are unreliable. Its action on the kidneys should be looked out for. My experience with salol is small and somewhat disappointing, as far as it goes.

[1] Read at Meeting of the Surgical Section of the Suffolk District Medical Society, March 4, 1891.

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For diuretics, acetate of potassium and liquor potassæ are perhaps as good as any. The latter combined with compound tincture of cardamom makes an agreeable preparation, but where there is severe pain on micturition, it works better if given with hyoscyamus.

Local treatment, however, is the most effectual, and although many advise the postponement of injections until the third week or later, it seems to me that the sooner we begin with them the better. If we are to use simple astringent injections it may be well to wait until all acute symptoms have subsided, but I think the time has come when we should consider the question whether it is not better to eliminate simple astringents from the routine treatment of gonorrhœa. They are doubtless useful in certain cases and should not be wholly neglected, but it seems to me that we now have more reliable agents, namely, antiseptics, which should always be used when practicable, beginning the treatment as early as possible. In cases of extremely intense inflammation or of phimosis with long œdematous prepuce we must, of course, defer the use of injections until a more favorable opportunity presents itself.

For injecting the urethra it would seem hardly necessary, now, to speak of the importance of using a large syringe, holding about half an ounce of fluid and having a blunt point, yet the small, sharp-pointed syringes still seem to be the favorites with most patients and many physicians. It will be found of ad-

vantage to carefully instruct patients in the use of the syringe.

Among the substances supposed to have antiseptic properties, that I have used for injections are hydronaphthol, sulphate of thallin, peroxide of hydrogen and pyoktanin, which have been on the whole rather disappointing, seeming to have few, if any, advantages over old-fashioned remedies. Permanganate of potassium and nitrate of silver make useful injections. The former is comparatively unirritating, but the latter should be largely diluted in the acute stage, a solution not stronger than from 1–4000 to 1–2000 being used. Corrosive sublimate, according to my experience, is more reliable. As an injection, in solutions of 1–8000 or 1–10000, or even weaker when irritating, it may, I believe, generally be depended upon, if not to limit the duration of the disease, at least to reduce the discharge to a thin, milky oozing from the meatus, devoid of the most disagreeable and painful symptoms.

The best results in the use of corrosive sublimate, however, are to be obtained from irrigating the urethra with a hot solution of this substance. The strength of the solution should be from 1–40000 to 1–10000. The latter is too irritating for most cases, but many patients bear 1–20000 very well, and 1–30000 is strong enough to be effective. The irrigation may be carried out by means of a fountain syringe, syphon or any other more convenient arrangement, and the solution introduced into the urethra through a soft

catheter or other irrigator passed down to the bulbous portion, or through a blunt nozzle, with either a single or double current, held at the meatus. I have generally used and preferred a simple, blunt-pointed glass nozzle. Adjusting it so that the lips of the meatus fit snugly about the tip the current is turned on. As soon as the urethra seems to be fully distended, the nozzle is very slightly removed, allowing the fluid to escape, and immediately replaced. By alternately filling and partially emptying the urethra, it is thoroughly washed out, and by distending it with the fluid all the folds of the mucous membrane are laid open. I have not found this operation painful when carefully and cautiously done, sudden and violent distension of the canal being avoided. Many surgeons, however, prefer retrojection through a catheter; this is probably quite as effective, and, if the passage of the catheter is not painful, it is open to no objection. The danger in carrying gonococci into the deep urethra, even beyond the sphincter, either on the end of the catheter in retrojection, or by the force of the current in simple irrigation is probably slight, for any microörganisms would be rapidly destroyed by the solution. The chief objection to corrosive sublimate is that it is irritating. Micturition is apt to be painful during treatment. The meatus sometimes becomes very sensitive, requiring the use of cocaine in order to continue the irrigation.

To obtain the best results irrigation should be repeated two or three times a day, but this is generally

impracticable. It should at any rate be done as often as possible while there is hope of aborting the disease. During the intervals and after the irrigation has been discontinued, ordinary injections of corrosive sublimate in somewhat stronger solution, say 1–8000 or 1–10000 may be used by the patient. Or, what is still better, he may use an instrument called the universal injector, which is described by Prof. Keyes in his book. It is a hollow rubber ball, holding an ounce and a half, with a blunt nozzle on one side. It makes a good substitute for the irrigation apparatus.

Notwithstanding all that can be said, however, in favor of this treatment, we cannot, I think, feel at all confident of really cutting short the disease unless we see the case very early, that is, within twenty-four hours or perhaps within twelve hours of the very first symptom noticed by the patient. In a few cases I have succeeded in obtaining very satisfactory results. Unfortunately none of them were first attacks, but each had a purulent discharge coming on after a regular period of incubation of from three to five days. In the cases in which the discharge was examined it was found to contain gonococci. The disease was apparently aborted in these cases within a week, and did not recur.

Of course, a few isolated cases like the above do not prove much, but the results were satisfactory to the patients and to me, and I think indicate in a general way, that the antiseptic treatment is the best. For every such quick result as this there will be a

number that, as I said before, if not aborted, will at least be so modified that the disease will run its course in a mild, subacute form, causing comparatively little inconvenience to the patient, and less liable to be associated with the painful and sometimes serious complications that often accompany the disease.

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