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A MATERIALISTIC VIEW OF SEXUAL IMPOTENCE.

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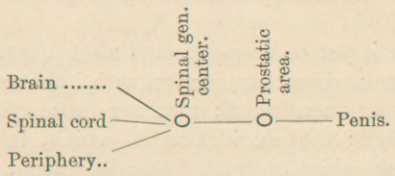
IT will be acknowledged without argument, I think, that impotence and allied sexual shortcomings are not generally viewed with any degree of precision or unanimity, and are not looked upon in the definite and distinctive manner in which intermittent fever, scarlet fever, locomotor ataxia, etc., are contemplated. Neither are they treated in any definite and purposive way, each physician having his own favorite aphrodisiac formula, which is brought out for each confiding patient who "is beginning to notice a little sexual weakness, a feeling that convinces him that he is not 'as strong' as he was some years ago." It is against this generalized, uncertain, and, in nine cases out of ten, erroneous estimation of this subject, based on lack of thought as to its pathology, that I would inveigh in this paper.

[1] Read before the Mississippi Valley Medical Association, at Cincinnati, October 12, 1892.

Physiologists teach us that erection—that change in the male organ that is prerequisite to copulation —is brought about by an active increase in the amount of arterial blood flowing into the penis, together with a coincident and abrupt decrease in the amount of venous blood flowing out of it, both serving to gorge the penis and to produce the required rigidity; further, that the influences that stimulate this active arterial inflow and sluggish venous outflow come to these respective vessels from the erigent nerves of the spinal genital center, situated in the sacral region of the spinal cord. Tracing these physiologic sequences still further back, we learn that such a nervous influence which goes out from the spinal genital center originates in one of three different localities of the organism: first, in the brain; second, in the spinal cord; or third, at some part of the periphery. Familiar illustrations of these three sources as originating centers of erigent influence are seen (1) in the man who gets an erection from looking at an obscene picture, in which case the originating impression is in the brain; (2) a painter falls from a house, sustains an injury to his spinal cord, and has a constant erection—priapism—for a week or a month thereafter; (3) the masturbator arouses his erections by friction of the penis, scrotum, or anus.

So, therefore, there are three sources of origin for erection, and, conversely, if either of these three sources becomes diseased, the organism is liable to lose that one as an erigent center. If the conducting mechanism becomes disordered, of course, the same effect is liable to ensue.

Therefore, diagrammatically, we might express the physiology of erection thus:



Our aim should, then, be to study the conditions that produce disorder of any one of these four parts of the economy.

To my mind the most rational and convenient classification of the several varieties of male impotence is that of organic, psychic, and symptomatic, according as the impotence is due to organic defect of the penis, to deleterious psychic influence, or to some diseased condition or agency acting on the organism. The present paper shall be confined to a discussion of the last variety.

That lack of sexual desire and capacity may result from such debilitating and depressing influences as loss of general health from any cause, such as tuberculosis, diabetes, fatigue from exhausting work, prolonged mental effort, etc., is readily admitted and easily understood; the physical and nervous forces are expended through these channels, and little force is left to be expended through the sexual channel. The lack of sexual vigor attributed to the deep-thinking philosopher is, as it should be, classical. The directly sedative effect of certain drugs, such as morphine, the bromides, lupulin,

antimony, arsenic, lead, etc., should come under this head—symptomatic; the impotence that these agents sometimes produce is symptomatic of their effect.

There is yet to be mentioned a set of causes that have a more direct connection with impotence than any so far mentioned; that are more commonly overlooked; the elucidation of which, in fact, is one of the chief objects of this discussion. I refer to such causes as masturbation, excessive sexual indulgence, chronic gonorrhea, and other genital affections. The *mode* of their production of impotence is especially important, as if that is not understood, a case having such an origin can hardly be brought to a successful issue.

In order to trace the connection between these affections and impotence, it is necessary to state that the prostatic urethra is now recognized as the sensitive area, the focal point of nervous impressions on the genital system. It is the seat of the pleasurable sensations in the crisis of intercourse. In this act the prostatic area is intensely congested and its nerves are at a high state of tension. It is, moreover, a kind of way-station, a junction for all of the nerve-telegraph lines connecting the various parts of the uro-genital system with one another; and, consequently, it bears the brunt of the injurious nervous impressions reflected from these various parts. If there is chronic irritation in the anterior urethra, from stricture located there, irritation from it is liable to be reflected back to this sensitive prostatic area. If there is excessive sexual intercourse, or repeated masturbation, or

persistent sexual excitement (ungratified, perhaps), just so often is there intense vascular and nervous excitement of this area, with possible ejaculatory convulsion. Naturally, under such circumstances we would look for disorder and disease of this area, and if we examine the part through an endoscope we shall find evidences of such disease in the deep congestion of the mucous membrane, in its acute sensitiveness to contact with an instrument, in the secretion of pus there, in the frequency with which the patient urinates, etc. These are demonstrable physical effects, showing the injury done this prostatic area by the abuse heaped on the genital system in the several ways mentioned. Chronic gonorrhea of the posterior urethra will also result in inflammation of the prostatic area.

Now, when we know that disease of this prostatic urethra is, in turn, capable of so deranging the spinal genital center as to deprive it of its power of sending out the nervous influence inciting erections—that is, that disease of the prostatic area is capable of depriving a man of his virility—then the key to impotence from these disorders and habits is at once furnished us, and the paths for appropriate treatment are also supplied.

The pathologic sequences are therefore these: Gonorrhea, masturbation, excessive sexual indulgence, organic stricture, narrow meatus, adherent prepuce—*anything* of the kind—through the close nervous relationship existing, arouses disease of the prostatic urethra; this, in turn, deranges the spinal genital center, interfering with its control over erections; impotence is the result.

A plan for therapeutic action is equally as plain: First, to remove the habit or the disease that is responsible for the inflamed posterior urethra; then to remedy that posterior inflammation, and in that way restore the health of the genital or erectile center in the spinal cord.

It so happens that disease of the prostatic area deranges the spinal genital center so as to arouse impotence in two very different ways: by causing either increased excitability of that center, or abolished excitability of that center. In the first case, the person begins the act of intercourse, but the genital center is so highly excitable that there is ejaculation before penetration can take place, and copulation is defeated. This is *relative* impotence. In the second case, because of entire lack of excitability of the genital center, no erection is aroused at all, and *absolute* impotence may be the result. Cases in illustration of both of these forms might be detailed, but for lack of time I shall not do this.

The distinction between impotence and hyperexcitability on the one hand, and abolished excitability on the other, should be rigidly maintained, as in treatment it acts as a guide as to whether we should attempt to arouse the dormant function of sexual excitability, or allay the exaggerated excitability of a too highly-strung genital organism. I believe that it is from the failure to make these fundamental pathologic distinctions that we notice such wide variance and reckless empiricism in the treatment of this affection. For instance, there is reason for surprise when we read the dia-

metrically opposed views of such authorities as Gross and Howe as to the propriety of giving potassium bromide in cases of symptomatic impotence. Gross strongly advises the employment of the remedy, "since the parts are to be kept still further at rest by the administration of agents which diminish reflex excitability of the cord, and suspend sexual desires and the power of erection." But in speaking on the same subject, Howe says: "I have no hesitation in saying that the administration of bromides in spermatorrhea and impotence is the source of incalculable injury to the patient."

With a pathologic basis and rational distinctions such as I have given, we are furnished with guiding principles; also, with the local measures properly applicable in different cases of impotence; and, from what has gone before, it certainly would seem that the agents most commonly in vogue, and most promptly prescribed for such patients, viz., aphrodisiacs, are not only least beneficial, but are most harmful; for we have learned that impotence, when arising from genital disturbance, such as masturbation, etc., is the product of inflammation of the posterior urethra; and we know that the manner in which aphrodisiacs cause sexual excitement is by causing congestion of the sexual organs. Hence, if we prescribe them under those circumstances, we are simply adding fuel to the flame by increasing the inflammatory congestion that is already doing the damage. The better plan would therefore be to employ measures that would allay congestion and inflammation of the posterior urethra, and thus re-

store its *health* and functioning capacity rather than goad it with unnatural stimulants into unnatural activity. The need of a rational mode of treatment, in contradistinction to the empirical modes usually in vogue, is, consequently, readily apparent.

In the present paper I could, of course, hardly go into the details of the treatment of such cases. Their principles are embodied and partly indicated in the pathology as sketched. They consist, as already mentioned, first, in the removal of the exciting cause ; second, in the reduction of the localized inflammation of the posterior urethra ; third, in the restoration of the sexual capacity and inclination, through a restoration of the health of the prostatic urethra, the spinal genital center, and the general health of the patient.

The subject of removal of the cause need not take time for discussion.

The treatment of the inflamed posterior urethra, I think, is best accomplished by the use of two series of procedures—irrigation of the entire urethra (anterior and posterior), with progressively increasing strengths of zinc-sulphate solutions, and, later, the injection of the entire urethra with progressively increasing strengths of silver-nitrate solutions. The zinc irrigation is performed, after the patient has urinated, by introducing a small-sized, soft rubber catheter well into the posterior urethra, and then injecting from a large syringe a half-pint of the solution ; on withdrawing the catheter, the patient passes out the solution, thus obtaining another and complete irrigation of his urethra. This is done, at first, every other day ; later, with intervals of two or three

days between treatments. The strength is gradually increased from ½ to 3 or 4 per cent. This is a preparatory measure for educating the urethra for the second series in the treatment, which is practised with the deep urethral syringe of Ultzmann or Keyes. The patient having urinated, the syringe is filled with a ¼ per cent. silver-nitrate solution; the catheter-stem is lubricated with glycerin (oil would prevent contact of the medicine with the membrane), and introduced until its end reaches the posterior urethra, denoted by the syringe presenting an angle of forty-five degrees with the patient's body. The solution is then injected as the instrument is withdrawn.

The first of these injections should not be stronger than ¼ per cent., so that the sensibility of the patient may be tested; this varies very considerably in different persons. The injections are at first given with two or three days' intervals, which are gradually lengthened as the strength of the solution is increased. I seldom use a stronger solution than one of 3½ or 4 per cent. If these measures fail, we may have recourse to the endoscope, cold steel sounds, the psychrophor, perineal douches, etc., which are all good in certain cases.

Systemic tonics are frequently indicated. If there is a tendency to hyperesthesia, continued irritability, etc., of the prostatic urethra, I should, perhaps, advise the use of the bromides; while if the opposite condition existed, abolished irritability or excitability of that region, I should not prescribe them. Aphrodisiacs, instead of being the first, should be the last of the medical armamentarium

brought to bear on the case. I believe that the field for their use in such cases is indeed very limited; that their only application could be in case the several restorative measures mentioned had accomplished the ends desired, the health of the parts had been reëstablished, and yet excitability had not returned; then it *might* be proper to stimulate the latent sexual function with some of the aphrodisiacs, such as phosphorus, cantharides, damiana, etc. These might then manifest a beneficial effect in a way that was not expected of them—that is, if there were any psychic element in the case, they might stimulate to one pretty good erection, which would have the moral influence of restoring the confidence of a timid patient.

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