White (J. B.)

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ON THE

DIAGNOSIS AND TREATMENT OF SPASMODIC STRICTURE.

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PHYSICIAN TO CHARITY HOSPITAL.

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ORGANIC strictures of the deep urethra are very rarely met with, as all surgeons assure us, but contractions dependent upon irritation reflected from the anterior canal are of common occurrence. The presence of a stricture in the pendulous urethra, or the existence even of a contracted meatus urinarius, often occasions, as a result of reflex irritation, a contraction at the membranous junction so resistant that a filiform bougie cannot be passed beyond it.

Such spasmodic action of the muscular urethra may result from other causes than the existence of organic strictures in the anterior urethra. A spasm is occasionally produced in the membranous portion by the simple passage of an instrument along the urethra, which acts solely as an irritating medium to the mucous membrane, precisely as an irritation may be occasioned by highly acid urine.

Voluntary retention of urine for a prolonged period is also capable of exciting spasm. Diseases of the rectum and all irritations about the anus, as well as derangements of the digestive or cerebro-spinal system, may produce urethral spasm.

A slight urethral discharge is, generally, an early and constant symptom of stricture. Such a urethral discharge might arise from causes independent of stricture, but the continued presence of a gleet may be justly regarded as symptomatic of a contraction in some part of the urethra.

Among other important symptoms of stricture may be mentioned a more or less frequent desire to urinate, associated with lumbar pain, sometimes extending from the back around both sides to the inguinal regions and down the scrotum, following the course of both ureters and the spermatic cord. Pain is also referred, occasionally, to the supra-

pubic region, or in the perineum and along the urethra before, during, or after urination.

A sharp pain is not infrequently experienced at the end of the penis after the bladder has been emptied. This is, I think, oftener observed when a spasmodic condition of the membranous urethra exists, or rather has a tendency to be excited to spasm as the result of a permanent stricture anterior to the bulb.

The stream of water is more or less altered in size, momentum, and form. It may assume a spiral shape, may be expelled from the meatus in two or more distinct streams, or the patient may be obliged to make strenuous efforts to urinate, without avail. This symptom is more likely to be present when permanent strictures complicate the spasmodic, but the symptom may also be an indication of the latter condition alone.

When urine manifests an ammoniacal condition, the presence of stricture may be suspected. A partial retention of the urine is thus occasioned by the incomplete emptying of the bladder, and the retained portion is prone to decompose, thus exciting troublesome cystitis if the obstruction is not removed promptly.

Prof. F. N. Otis has often demonstrated the frequency with which strictures of the deep urethra are found to co-exist with a contracted meatus urinarius only. They have been shown to be dependent not infrequently upon the presence of strictures of large or small calibre in the penile urethra. No surgeon merits more credit than Prof. Otis for recognizing and proving the correctness of these facts by the results of many such operations for the relief of spasmodic strictures.

In the course of my experience I have met with not a few instances where a contracted orifice or stricture of large calibre situated in the penile urethra was the sole cause of what seemed to be an impassable stricture of the deeper portions of the urethra.

Some eminent surgeons believe that, in accounting for deep strictures, the possible influence of spasm as an exciting cause does not as frequently obtain as is claimed. My personal observations and experience have led me to think differently. The reflex character of such deep strictures is not so often recognized as its importance and frequent influence demand.

The two following cases will afford good examples of the subject under discussion :

Case I.—Julius A., aged 24 ; single. Has had repeated attacks of gonorrhœa, the last occurring about six months ago (October, 1885). At the time the patient was seen, there was some slight urethral discharge. Complained of pain on urination along the urethra and especially at the end of the penis. Passes a very small stream of water, with some effort at times.

Upon examination, the circumference of the penis measured three and

one-half inches. The calibre of the urethra should therefore be 34 F. to represent the normal proportionate relation as advised by Dr. Otis. At an inch and a half from the meatus there was a stricture of 14 F. and one also at three inches of 10 F. The meatus itself was 24 F. In the deep urethra a stricture was discovered which resisted the passage of a filiform bougie. It was thought that the deep stricture was of reflex origin. Dr. Otis, who was invited to see the case, was of the same opinion, and advised the division of the anterior strictures with the meatus to 34 F., which was performed. The operation confirmed the diagnosis concerning the deep stricture, as a 34 F. sound was readily passed into the bladder. The patient convalesced rapidly and satisfactorily.

CASE II.—Frank R., aged 26, single. Has had several attacks of gonorrhœa. After the last attack he experienced some pain on micturition, especially over the suprapubic region and at the extremity of the penis. Sometimes he had difficulty in passing water, being obliged to make an expulsive effort to do so, and afterwards for a little while the urine would dribble away. He had found it impossible sometimes to urinate at the time he felt the inclination to do so, but never had retention, so that instrumentation became a necessary resort for relief. Has been suffering from a gleety discharge for a long while, and when he urinates the water flows out in several streams.

An examination revealed a contracted meatus urinarius. The circumference of the penis measured three and one-quarter inches which would indicate a urethral calibre of 32 F. A stricture of 14 F. was discerned at three and one-half inches by Otis urethrometer and a filiform stricture in the deep urethra was also discovered. As in the preceding case, the deep stricture was thought to be spasmodic, and in accordance with Dr. Otis' advice, who also examined this patient, the meatus was enlarged to 32 F., and with the dilating urethrotome the contraction at three and one-half inches incised to correspond with the normal urethral calibre of 32 F. After the operation a 32 F. sound was passed without obstruction into the bladder, although a filiform bougie was arrested prior to the operation.

These two cases, among a number of others in the experience of surgeons, afford important examples of the fact that deep strictures are sometimes entirely dependent upon contractions in the anterior urethra and indicate the expediency of first removing the anterior obstructions before resorting to the more serious operation of external urethrotomy.

I have thought that a deep stricture, when spasmodic, imparted a peculiar, elastic resistance to the expert touch when an instrument was carefully pressed against it, which would tend to characterize the nature of such strictures, but, after all, the surest way of corroborating the diagnosis would be an operative procedure, respecting the anterior contractions, when any exist, and afterwards carefully attempting to pass a full-sized sound. Unless the stricture tissue has been thoroughly divided, the spasm will not be wholly relieved, therefore due caution, to render the operation successful as to results, is advised by attention to the importance of a complete division of the anterior contractions.

One of the above patients (Case II.) had two severe hemorrhages following the operation—one the second day and the other the third day after, but they were readily controlled by the introduction and retention of an endoscopic urethral tube aided by pressure upon the perineal portion of the urethra. The urethral tube was worn for three days without causing any irritation worthy of notice.

It is said that an important diagnostic feature of spasmodic stricture would be the suddenness of its appearance or the possibility of passing urine at some time previous to the attack during the previous twenty-four or thirty-six hours. I cannot agree with these views entirely, for I have seen patients suffering from organic strictures with the same experiences above noted. It may be, however, as stated by Rynd, that "when there is complete retention of urine, and the patient applies, writhing and straining with painful and continued efforts to discharge the contents of the bladder and not a drop appears, the presumption is that he is suffering at present from spasm, no matter what his other troubles may be." In other words, spasm is almost always an element present, or likely to be present, when there is a contracted meatus or a stricture of any calibre along the pendulous urethra. Sometimes spasm is relieved by a warm sitz-bath, followed by a full dose of opium. The patient may be etherized and an attempt be made to pass a catheter if the symptoms are urgent. Should instrumentation be determined upon, I would advise the injection of a four-per-cent solution of cocaine before passing the catheter, as the pressure of an instrument in the urethra may irritate the mucous membrane and aggravate the spasmodic condition to such a degree as to baffle the most skilful operator in its introduction. The sedative effect of cocaine in such emergencies is very positive, whether the spasm be due to irritation reflected by anterior pathological conditions or is purely idiopathic.

I have seen the good effects of its use in both conditions, when attempting to use the catheter or pass sounds for diagnostic purposes. The use of this solution, however, with the ordinary relief which the patient may experience from this treatment can be only palliative and of temporary duration, when an organic stricture complicates the condition of spasm. The only means of permanent relief must be the removal of the organic lesions, which should be done without hesitation when all other means of relief are without avail, and before the extreme measure of puncturing the bladder is resorted to.

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