URINARY AND PROSTATIC TROUBLES

(ENLARGEMENT OF THE PROSTATE)

By

Dr. WILHELM KARO


MAHINEMANN PUBLISHING CO. PRIVATE LTD.
CALCUTTA-12

URINARY AND PROSTATIC TROUBLES

(ENLARGEMENT OF THE PROSTATE)

By

Dr. WILHELM KARO

LONDON

HOMŒOPATHIC PUBLISHING CO. LTD

[redacted]

CONTENTS

PREFACE

My booklet appeals first of all to those anxious to have their troubles fully explained and to get some advice regarding treatment in urinary and prostatic affections. Furthermore, I hope that my colleagues will read it, the idea being to bring about a mutual understanding between Allopathy and Homœopathy. The two sciences are equally concerned in them.

In contradistinction to the usual homœopathic books I give a short, but exact review of the anatomical and pathological elements of the diseases, and of the clinical symptoms and the diagnosis, being convinced, that only on such a basis a correct treatment can be achieved. The patient has to learn how dangerous it may be to him, if relying only on his symptoms, he should thoughtlessly take homœopathic drugs. The same warning applies to the unqualified, who without any knowledge of the pathological conditions indiscriminatingly venture to treat these patients. In this my homœopathic colleagues will agree. I hope, that some of my allopathic colleagues may by reading my booklet take an interest in Homœopathy. My point of view is clear: Homœopathy and Allopathy have to supplement each other, both have to know exactly the limit of their efficiency; only by co-operation can the ideal medical art of the future be brought forth.

I would be happy if this short treatise is of service in that direction and I trust that it may be helpful to many patients.

Dr. Wilhelm Karo.

London.
June 1940.

URINARY AND PROSTATIC ORGANS—
ANATOMY AND PHYSIOLOGY

Bladder troubles of elderly men are of such frequent occurrence that not only the physician, but also the layman becomes familiar with them. It also is a fact generally accepted, that these troubles are due to an enlargement of the prostate. Whoever has to deal with such conditions, whether a general allopathic practitioner or a homœopathic doctor or the sufferer himself each should have an exact knowledge of the anatomy of the prostate, of its function and of the pathological conditions which frequently cause obstruction to the urinary flow.

Treating these patients no practitioner ought to rely on the homœopathic principles alone : " Similia similibus curantur " without a thorough examination of the patient ; since a reliance on the patient's symptoms alone may very easily prove to be fatal.

Considering these facts I review at first the anatomy and physiology of the prostate. Though it may be difficult to a layman to understand it, I hope he may get some idea of it, enabling him to judge the bladder troubles due to the pathological condition of the prostate, the urethra and the bladder.

The prostate is a glandular organ lying between the pubic bone and the rectum and between two lines going from the pointed end of the coccyx bone at the back to the upper and to the lower margin of the pubic bone in front. The longer line, a line joining the two, roughly defines the prostate. The basis of it lying above, the apex below. The urethra passes through the prostate in such a way, that the greater part of the prostate lies under the urethra, the smaller part above. The prostate embraces the urethra rather like a signet ring.

In the adult the prostate has the size and shape of a walnut, being about 1½ inches broad, 1 inch long and ¾ inch thick. Its average weight is set down in

text books as $4\frac{1}{2}$ drachms. This, however, represents the average weight of the prostate when removed from the dead body, covered by its " sheath ", which, as we shall subsequently see, is not in reality part of the prostate, being merely the envelope in which it lies. The real weight is less—probably about 3 drachms. The base is directed backwards and upwards towards the bladder, the neck of which it embraces, while the apex looks forwards and downwards. The posterior surface, which is smooth and slightly grooved in the middle line, rests on the rectum, from which it is separated by dense fibrous tissue, which forms part of the " sheath " of the prostate.

The prostate consists of two lateral lobes, between which the ejaculatory ducts enter from behind, before opening into the prostatic part of the urethra. A third, or " median " lobe was described by Sir Everard Home in the early part of the last century as existing in the normal prostate, and Sir Henry Thompson refused to agree. His contention has been almost universally accepted. Practical experience derived from numerous dissections of the healthy prostate and 1625 operations for removal of the enlarged organ in its capsule convinced Sir Peter Freyer, that Sir Henry Thompson was correct in his view and that the so-called " middle " lobe is merely a pathological product, derived from one or both lobes, and that it is non-existent in the normal prostate. There is, it is true, a median portion or bridge of tissue, sometimes forming a rounded prominence above the ejaculatory ducts in the normal prostate, but this is derived from both lateral lobes, which are in this position more intimately blended than in the rest of their course on either side of the prostatic urethra.

Structurally the prostate is composed of glandular substance and stroma made up of muscular and fibrous tissues. The glandular substance consists of follicular pouches with ducts lined with columnar epithelium. The excretory ducts, from twelve to twenty in number, open into the urethra beside the *verumontanum*. The muscular tissue forms the bulk of the prostate, its supposed function being to eject the glandular secretion or prostatic fluid to mix with that from the ejaculatory ducts of the testicles.

The function of the prostatic fluid consists in mobilizing the spermatozoids. If the semen does not contain the prostatic fluid the spermatozoids are devoid of motion, consequently such an individual is sterile.

The prostate has a general tendency to increase in size after the age of fifty, but not all these men suffer from any subjective symptom through it. From statistics, collected by the late Sir Henry Thompson and others about 33 per cent of men beyond 55 years of age are subject to enlargement of the prostate, but no more than 5 per cent ever suffer from symptoms. This percentage is rather too low. Anyway, as already mentioned in my first statement, the number suffering from troubles due to the enlargement of the prostate is very large. Every practitioner has to deal with them and is aware of the serious symptoms frequently met with in these cases.

What is the anatomical condition of the enlargement ?

The overgrowth may be uniform in character, the hypertrophy extending equally to both lobes, the gland thus preserving its symmetry. But in the fully hypertrophied prostate, as will subsequently appear, the pyramidal contour of the organ becomes reversed—that is to say, whereas in the normal prostate the apex of the pyramid lies towards the perineum and the base towards the bladder, in the hypertrophied prostate the base of the pyramid lies towards the perineum, the apex being placed in the bladder. The manner in which this alteration in shape is gradually brought about during the process of enlargement of the organ will appear later on.

The two lobes may be unequally enlarged ; indeed, one lobe may be enormously hypertrophied, the other remaining almost unaltered, except as to the shape impressed on it by the bulk and pressure of the other lobe. The surfaces of the lobes may remain smooth and uniform, but frequently nodular outgrowths project therefrom. These outgrowths are always confined within the true capsule of the prostate, they may form polypoid-like outgrowths projecting into the cavity of the bladder and connected with the main body of the organ merely by narrow pedicles.

In size the enlarged prostate may reach from anything

beyond the normal walnut to the size of an orange or even a coconut.

The urethra and the bladder will be altered in shape in accordance with the size and form of this overgrowth. The prostatic urethra is invariably lengthened and may attain to several inches, so that 15 or 16 inches of catheter may be introduced before the urine begins to flow. When the lateral lobes of the prostate are symmetrically enlarged, the urethra is compressed from side to side, and, one section resembles a vertical slit. When *one* lobe only is enlarged, the urethra being diverted to the opposite side, will be curved laterally. If there be a median outgrowth in the bladder, the urethra will be curved upwards towards the inner opening of the bladder ; and if this be very large, pyriform and projecting into the bladder, there will be a channel on either side, the urethra being Y-shaped. When the overgrowth assumes the form of a collar round the neck of the bladder, as it sometimes does, the urethra will necessarily be contracted at this situation.

The prostate being debarred from expansion below by the perineal ligament it gradually advances upwards in the direction of least resistance. The urethra is carried with it and the inner opening placed on a higher level than the base of the bladder, which remains stationary. A post-prostatic pouch is thus formed in the bladder, which is never emptied of urine during the acts of micturition. This remaining quantity of urine, which is termed " residual ", gradually increases, as the hypertrophy progresses and the muscular power of the bladder diminishes owing to the persistent overstrain to which the organ is subjected in order to overcome the obstruction to the flow of urine. In the early stages of the disease there is a compensatory hypertrophy of the bladder walls to overcome this obstruction, but in time, owing to the constant straining, dilatation ensues, so that the bladder often contains several pints of urine. The walls may become very thin or muscular trabeculæ may develop, between which the mucous membrane bulges outwards, forming saccules of various sizes. In course of time changes occur in the ureters and kidneys from backward pressure due to the obstruction of the urinary flow ; due to the disorders of the kidneys the whole

vascular system gets seriously damaged, resulting in high blood-pressure, heart troubles, hæmorrhoids and other disorders of the rectum.

We do not know the cause of the enlargement of the prostate. Many theories have from time to time been put forward to account for the enlargement of the prostate peculiar to declining life, none of which can be said to fit in completely with all the phenomena attending the disorder.

Guyon and the French School generally maintained that the enlargement of the prostate is not merely a purely local disease, but a local manifestation of a constitutional disorder which commences with general arteriosclerosis and ends in fibroid degeneration; that the genito-urinary organ—prostate, bladder, ureters and kidneys—are liable to undergo this change in a pronounced form, the muscular and glandular structures being replaced by dense fibrous tissue; these latter changes never being independent of general arteriosclerosis. The enlargement of the prostate and changes already described as taking place in the urinary tract behind are held to be coincident and not related to each other as cause and effect. It is pointed out that all the symptoms commonly regarded as the result of the hypertrophy of the prostate, may occur when there is no enlargement of that organ, merely as a result of sclerosis of the bladder.

Against this theory, though it may be very instructive from the homœopathic point of view, it is urged that though arteriosclerosis and enlargement of the prostate do occur together it is no proof that the latter is the result of the former—as well might cancer and other diseases which are liable to occur during the arteriosclerosis age be attributed to this degeneration; that enlargement of the prostate occurs, when there is no such general arteriosclerosis, that arteriosclerosis induces *atrophy* rather than *hyper*-trophy, that enlargement of the prostate frequently starts before the arteriosclerosis period and that this enlargement always commences as *adenomatous* overgrowth and not as *fibroid* degeneration.

One of the most important effects, from a surgical point of view, of the acceptance of Guyon's theory, if carried to its logical conclusion, would be to prohibit

the employment of any form of operative interference aimed at the radical cure of the disease, to limit the treatment, in fact, to the palliative kind.

Another theory is that propounded by Velpean, and till recently supported by some of the highest authorities in this country and America, that enlargement of the prostate is analogous to fibroid disease of the uterus. In support of this view it is pointed out, that a special part of the prostate, the so-called utricle—is the equivalent of the uterus (and vagina), that the structure of the prostate and uterus are somewhat similar, that there is a great resemblance in structure, position and mode of growth between the tumours of the uterus and the overgrowths that constitute enlarged prostate, and that the disease in both instances sets in, when sexual activity is on the wane and does not originate when the activity has completely ceased.

In opposition to this view are advanced the facts, that the utricle, which is the true analogue of the uterus, takes no active part in the prostatic enlargement and that the uterine tumours commence as fibromyomata, whereas the prostatic overgrowths originate as adenomata.

The theory that enlargement of the prostate is of inflammatory origin dates back to the days of John Hunter and Virchow; later on Ciechanowski was its ablest champion. He explains the sequence of events as follows: A catarrhal process occurs in the acini, producing active proliferation, desquamation and degeneration of the epithelium, at the same time a productive change takes place in the stroma, which compresses the excretory ducts of the acini, narrowing or obliterating them. The latter prevents the escape of the contents, the secretions accumulate within the acini and the lobules enlarge. The prostatic urethra is said to be the origin of the disease, which extends thence along the gland ducts from the urethra towards the periphery of the prostate.

The advocates of this theory hold that the disease is confined mainly to persons who have suffered from inflammation of the prostatic urethra previously, whether due to a gonorrhœa, masturbation or sexual excesses (whether natural or unphysiological). But they entirely fail to explain how it happens that the enlargement

of the prostate does not occur during that period of life, viz. early manhood, when these diseases and conditions, held to be the cause, prevail; except that the process remains latent for years, till even the existence of the provoking conditions has in many instances faded from memory.

My own experiences prove that as a rule patients who have been suffering from prostatic urethritis never get an enlargement of the prostate, whereas patients suffering from an enlargement of the prostate never have been suffering from a gonorrhœa. Anyway, the previous mode of life of the patient has nothing to do whatever with the advent of this disease. All we know of the disease is, that the enlargement of the gland is mainly, if not wholly, of an adenomatous character and that it occurs only during the decline of life, when the sexual functions are on the wane. Having fulfilled its purpose as an accessory sexual organ in early and mature manhood, as its function diminishes, the gland has a tendency in disease to "run to seed" as it were in assuming this unhealthy adenomatous overgrowth. *Why* it does so, has yet to be explained.

PROSTATIC TROUBLES, SYMPTOMS AND PROGRESS OF

Reviewing the symptoms of the disease we have to keep in mind that the progress of it is usually a very slow one. It may cover many, many years. We have to differentiate three different phases of the disease, which in nearly all cases repeat themselves with the greatest regularity: the first phase is the premonitory period, the second phase is the period characterized by retention of urine without distension of the bladder, the third and last phase is the period of the retention of urine with distension of the bladder. In each of these three phases there may be superimposed congestions or infections, resulting in altering the symptoms.

During the first period the symptoms usually are of such a slight nature, that only a few patients ask for medical advice. There is only a slightly increased desire to micturate during the day and the night; in some cases there may be a slight burning in the urethra, especially in its glans, some patients have to wait longer than before till the flow of the urine starts. That symptom, indicating that there is an obstruction to the urinary flow, appears more prominently whenever the patients for a longer period have not passed urine. Consequently it is more troublesome early in the morning. During the day, as soon as the patients walk around, the flow of the urine is much easier. The urine itself is clear, the general feeling of the patient good, but there is diminution in the strength of the urinary flow, which, instead of being projected in the normal curve, falls directly downwards from the meatus by its own weight. When during the day the patients have been lying or for a longer period have been reading, the micturition is more difficult than during walking about. All these symptoms are aggravated by each congestion of the pelvic organs: consequently constipation, excess in eating or drinking or sexual excesses, especially after getting wet through, when all these patients feel worse, the desire to micturate is increased. The patient strains to propel the urine onwards but his efforts have little or no effect in strengthening

the stream, on the contrary, the straining may arrest it completely. During the night the amount of urine is much greater than during the day. *But there is no residual urine in the bladder. During the first phase of the disease the patient is able to empty his bladder entirely.* This is an important feature in the diagnosis of the trouble.

That first period may continue for many, many years, till gradually an incomplete retention of urine becomes established and the second period starts. The symptoms of that period are the same as the symptoms of the first phase, but they are aggravated and increased. The frequency of micturition is raised; the patients during the night must get up six to eight times to pass urine, being unable to do so while lying down; the pains are intensified; local congestion or even inflammation of the mucous membrane of the bladder ensues and thus induces further frequency. Periods without any pains, so frequently met with in the first phase of the disease, are getting shorter and shorter, till they finally disappear entirely. These new aggravated symptoms are due to the formation of the post-prostatic pouch spoken of above, in which gradually an increasing quantity of urine is retained after micturition. This retained urine is, as we have already seen, termed "residual" and the manner in which it causes increased frequency requires an explanation.

RETENTION OF URINE

The bladder is a reservoir capable of containing a certain quantity of fluid, which is voluntarily discharged at convenient intervals. Let us assume, that the quantity passed during 24 hours is 50 ounces and that the capacity of the bladder is 10 ounces. It will thus be necessary to empty the bladder at least five times in the 24 hours. But if the actual capacity remaining the same, 4 ounces of urine in the pouch, formed behind the prostate, are retained, it follows that the *effective* capacity is reduced to 6 ounces, so that in order to get rid of the 50 ounces, that daily flow into it, the bladder must be discharged of these 6 ounces about eight times.

As the pouch enlarges and the bladder walls grow weaker, the quantity of urine permanently retained increases and its *effective* capacity diminishes, so that eventually micturition has to take place every half hour or even less. Indeed, this condition advances in the third period to such an extent that the bladder is incapable of discharging any urine whatever; and a serious symptom appears—continuous dribbling; the urine passing away by day and night as rapidly as it enters the bladder from the ureters, but the bladder always remaining full. The urine passing in this condition is termed the "overflow" and has to be distinguished from "incontinence", a rare occurrence in certain spinal complaints, in which the urine runs away from an *empty* bladder as fast as it goes in.

In this third phase of the disease there is always a remarkable distension of the bladder. The patients are not able to pass the urine voluntarily, or at best, if the bladder is over full, a few drops, but they can manage it only with the aid of the abdominal muscles. The patients kneel down, stoop low and forwards to find some position in which they are able to pass a few cubic centimetres of urine. In some cases the distension of the bladder is enormous. I remember patients, whose bladder contained more than 5 litres. In some cases there is the most astonishing fact, that the patients are

not incommoded at all by that condition. Though the distended bladder fills up nearly the whole abdominal cavity, there is no essential pain. Certainly the general condition of the patient has deteriorated, the patients are weak and emaciated, nevertheless they feel passably well. Especially patients, whose urine is clear, whose bladder is not yet infected. Some such patients still retain their good appetite.

The progress of the disease is not always the same. It is frequently complicated by the interference of an acute and complete retention of urine. The patient having been able to pass the urine without any difficulty, all at once is unable to pass a single drop of urine, in spite of the greatest strain, in spite of using the abdominal muscles, in spite of hot baths, in spite of taking all kinds of medicines, the flow of urine is entirely stopped. The earlier such an acute retention of urine occurs, the greater the pains, since in the early phase of the disease there is no distension of the bladder, the muscles of the bladder being unable to give way to the pressure of the urine. Consequently, while the filling of the bladder by the urine coming down from the kidneys increases, the most terrible bladder-spasms arise, in a word, the most painful and most tormenting condition to which anyone may be liable. Restlessly they move about, trying to get rid of the urine. Every few minutes they make the attempt, but everything is in vain. If there is no help and if that inflation of the bladder continues, the bladder gets violently overdistended and the most serious, often irreparable damage takes place.

Such a retention of urine is due to an engorgement of the blood vessels of the bladder and prostate. All circumstances, above mentioned, which increase the symptoms of a simple hypertrophied prostate, may induce such a complete retention. Consequently such a retention occurs during the first or the second phase of the disease, but not in the third phase, because there is already a remarkable chronic retention, which has stretched the bladder-wall to a certain amount of accommodation. As a rule the disease commences with such an acute retention or at least makes it manifest. To the slight symptoms, so often existing in the first phase of the disease, the patient does not pay any attention

at all, until suddenly such an acute retention occurs compelling the patient to send for the doctor. As a matter of course, the disease has been established already, perhaps for many years. The fact, that such an acute retention again disappears and that the patient later on is able to pass his urine just as before that attack, proves, that the retention is due to the congestion of bladder and prostate. But, unfortunately, we never know for certain whether or not the patient will be able to pass his urine voluntarily thereafter. Some patients, after a single acute retention, never again are able voluntarily to empty their bladder. But that is an exception. In most cases the congestion disappears and after a couple of days, or weeks or months the patients pass urine without any trouble.

But we are confronted with an entirely different condition in the cases in which *gradually* a *chronic* retention develops. Such cases are due to a permanent mechanical obstruction: either the overgrowths of the lateral lobes of the prostate have entirely compressed the *urethra prostatica*, or the middle lobe, spoken of above, obstructs the neck of the bladder like a valve. Such an obstruction is characterized by the fact, that the more the patient strains to overcome the obstruction, the stronger the valve-like tumour closes, and consequently the straining of the patient is ineffective.

The *acute* retentions are liable frequently to recur. There are patients who after the slightest irregularity of living or following a slight cold suffer such an acute retention. In other cases such a retention recurs only after some years. Finally and fortunately I have known patients, who had only a single retention and who for many years never again were ill.

But we are aware that an acute retention is the commencement of a *chronic incomplete* retention, that is to say: after the acute retention has gone and the patient is able to pass the urine voluntarily, there remains a certain amount of residual urine in the bladder.

As a matter of course, if such acute retentions occur frequently, or if there is a chronic retention for a long time, the constitution and the whole organism will be most seriously affected. At first disorders of the digestive organs appear—always presupposed, that there is no

infection of the bladder. The patients lose appetite, they do not care for meat or solid nutrition, preferring liquid food. These disorders are the symptom of a serious blood-intoxication due to the dysfunction of the kidneys. Owing to the pressure of the residual urine the kidneys, as above mentioned, being involved, they are not able to eliminate the products of metabolism from the blood.

COMPLICATIONS OF PROSTATIC ENLARGEMENT, ETC.

THE most frequent complication of prostatic hypertrophy is the infection of the bladder (cystitis). In some cases it develops even in the first phase, before there is any retention of urine at all, but in nearly all cases characterized by a chronic retention, the cystitis is present. It may be due to the most various causes.

In cases, never having been treated locally and never having been examined by passing any instrument into the bladder, we must suppose, that the microbes circulating in the bloodvessels or from the urethra or perineum reach the bladder, its congestion and hyperæmia being favourable to their development. Whereas in cases in which a cystitis develops in consequence of catheterizing, there can be no doubt, that the microbes have been carried into the bladder with the instrument. Certainly by proper and careful sterilization of the catheters we may prevent the bladder's infection, but. if the catheter has to be used for a longer period as in cases of a *chronic* retention, there can be no doubt, that in spite of the utmost precaution cystitis will develop. Owing to this "residual" urine its cure is difficult. Such a cystitis may be accompanied in many cases by an urethritis or even an inflammation of the testicles. Furthermore I must call attention to the inflammation of the prostate itself (prostatitis), always being a more or less serious condition, because it may develop into a suppuration (abscess) of the prostate. Such an abscess is always serious and may be fatal.

Stones in the bladder are one of the most frequent complications; most of these stones are phosphates, they develop around the mucus and pus of the residual urine; in some cases they do not give rise to any serious symptom, but in others cause pain and even hæmorrhage. We are confronted with hæmorrhage in many cases, where no stone is present. Such a hæmorrhage may be the consequence of a congestion of the blood vessels and rupture of them, due to an *acute* retention. Each hæmorrhage is a very serious complication, the more so,

as it often is followed by a complete stoppage of the urinary flow; the bladder may be completely filled with big blood clots, blocking the opening of the bladder. Such hæmorrhages may continue for several days. They arise either from the prostate, or from the bladder walls or even from the kidneys. Furthermore I must refer to the hæmorrhages, following the introduction of a catheter; these hæmorrhages are of the greatest importance. It is easy to understand, that if the catheter damages the serous and congested tissue of the *urethra prostatica* even only slightly, a severe hæmorrhage may be provoked. But there are cases, in which the catheterism if followed by a severe hæmorrhage, though the catheter did not hurt the urethra or prostate at all. There are hæmorrhages from the bladder veins themselves; we call these hæmorrhages "ex vacuo". The explanation for these hæmorrhages is clear; the bladder having been for a long time influenced by the high pressure of the retained urine, suddenly is rid of that pressure by drawing away the urine. Consequently the weak blood vessels too suddenly fill up with blood, resulting in a rupture of their diseased walls.

Finally I must mention the ascending purulent infection of the kidneys and their *pelves* as a most serious and fatal complication. Certainly not all cases of bladder-infection are ascending. I know of a great number of prostatic patients who have been suffering from infection of the bladder for over ten years without any involvement of their kidneys. But as soon as the kidneys are affected, we are confronted with the most alarming symptoms: rapidly progressive and increasing general weakness, loss of appetite, immense thirst, tongue very dry, scaly, coated, it really cleaves to the cavity of mouth, the patient being unable to move it. The patient may die under progressive cachexia. Such a *chronic* infection (urosepsis), sometimes accompanied by slight fever, is much more dangerous than an *acute* infection. To such an acute infection the organism replies with *high* temperature and reactions which purify the blood and after a couple of days entirely recovers, whereas in cases of a chronic infection a rapid recovery is the exception. A chronic infection affects the urinary organs, the blood vessels and the whole condition of the patient. There

are cases characterized by fever and disorders of the digestive organs, or with cerebral symptoms, while others again, are without any fever at all, but these chronic cases are most serious and too often fatal as the disease progresses. The septic character of the disease may have been for a long time latent, but, as soon as symptoms of the urinary organs appear, the true nature of the condition is easy to diagnose. In the great majority of these patients there are already very serious disorders of the whole organism, before any symptoms affecting the urinary organs appear.

DIAGNOSIS, TECHNIQUE OF PHYSICAL EXAMINATIONS

When the symptoms characterized in detail above are present the diagnosis of the disease is easy; it only has to be completed by the physical examination of the patient.

Technique. The patient is first directed to pass all the urine he can and we note the strength and general character of the stream. *After doing this*—He is then placed on his back on a couch; the glans penis and foreskin are thoroughly washed with an antiseptic and a soft (rubber) catheter is slowly and carefully introduced. Our choice of catheters will lie between a Velaton (rubber) or Thiemann vulcanized or a French coudé. This latter is, as a rule, the most easily introduced. In nearly all cases I usually anæsthetize the urethra by injecting a few c.cm.(3) of Novocain; by thus diminishing the congestion of the urethra, we facilitate the catheterism considerably. The quantity of urine drawn off, if any, indicates the amount of "residual" urine. This will vary from a few drachms to three or four pints, according to the phase the disease has reached when the patient first comes for examination. If the quantity be considerable, the patient may be surprised because he had just passed his urine and was of the opinion, that he had emptied his bladder. If the bladder is very much distended and the quantity of residual urine be very large, we have to be very careful. Some idea of the amount of the residual urine can be obtained by percussion of the area above the pubes. Dullness on percussion, especially in thin subjects, is a valuable guide. As above mentioned, if the whole of a large amount of residual urine should be drawn off too quickly the patient may faint due to the hæmorrhage from the blood vessels of the bladder giving away through loss of their habitual support. If the quantity of residual urine be moderate, a second or third subsequent and similar examination should be made to avoid error as to the real quantity of "residual" urine. By introducing the catheter we pay attention to the length of the urethra. *If there*

is considerable lengthening the diagnosis of an enlarged prostate is certain. The passing of a rubber *sterilized* catheter for the purpose of diagnosis should not set up any trouble whatever.

The next step of the examination is the rectal palpation of the prostate. The patient should be placed on his knees on the couch, with his head bent forward and downward. The buttocks are rendered prominent by the thighs being flexed on the legs. The forefinger, covered with an india-rubber finger-stall is lubricated and introduced slowly and gently up the rectum to avoid giving pain, and a careful survey of the prostate is made. The extent of the enlargement, if any, should be noted, whether it is general, or confined to one lobe or side more than to the other, whether the contour of the gland is smooth or nodulated. What is the consistency, whether soft, indicating adenomatous enlargement, or hard from inflammatory fibroid tumour; also whether pressure on the prostate is painful and, if so, to what degree. Severe pain with fluctuation will suggest the probability of an abscess, particularly, if the patient has had fever recently. Intense hardness with nodulation would suggest malignant tumour (cancer or sarcoma of the prostate); and a very hard nodule in the substance of the gland, accompanied by tenderness on pressure, the presence of a stone in the prostate. The finger should pass beyond the gland, if possible, and sweep the base of the bladder, to ascertain whether it is normally soft or hardened from malignant infiltration. Possibly a stone may be felt in the post-prostatic pouch. The examination will be facilitated by making counter-pressure on the abdomen above the pubes with the other hand. We can obtain no information at all by rectal palpation regarding the condition of the amount of outgrowths *in* the bladder. In fact, there may be a great outgrowth of the prostate into the cavity of the bladder, when no enlargement of the gland is recognized by rectal palpation. We have to diagnose such a condition by the cystoscope. The cystoscopy gives us a clear and instructive picture of the enlarged prostate. We see the outgrowths of the gland into the bladder, forming a narrow pass for the urethra, we find the so-called third lobe, referred to previously and we overlook

the whole condition of the bladder. Noticing the trabecula and diverticula (ridges, furrows, pockets, etc.), and any inflammation of the mucous membrane. We can discover stones in the bladder, especially in the diverticula, etc. I have to underline, that cystoscopy is indispensable for an exact diagnosis. If performed carefully by an expert, it is neither very painful nor dangerous. During my own practice of about 42 years I have performed many, many thousands of cystoscopies without any serious accident. Certainly, there are cases of prostatic hypertrophy, in which owing to the obstruction of the urethra cystoscopy cannot be performed. The question, whether or not in a given case cystoscopy ought to be performed, has to be decided by the expert. If cystoscopy should not be advisable, we have to resort to the X-ray examination of the bladder. To sum up: the diagnosis of enlargement of the prostate is comparatively easy. Nevertheless we have to differentiate between three different conditions. (1) Tumours of bladder, (2) the malignant tumours of the prostate, (3) retention of urine without enlargement of the prostate.

TUMOURS OF THE BLADDER

REGARDING the tumours of the bladder: the clinical symptoms differ from the symptoms of enlarged prostate and there are also differences regarding the rectal palpation. We never find such bulbous outgrowths in cases of tumours of the bladder. Finally there are differences in the cystoscopic aspect, the mucous membrane over the bladder-tumours never being as smooth and regularly laid down as it is over the outgrowths of the prostate.

Regarding the malignant tumours of the prostate, unfortunately we have to know that we may be confronted with them in a considerable number of cases. Among 3,000 enlarged prostates, removed by operation, there were 500 cases of cancer and 5 cases of sarcoma. We may find cancer of the prostate even in younger men. The malignant tumours progress more quickly than cases of enlarged prostate, the general condition of the patients is more cachectic and by rectal palpation we are confronted with great irregularity of the prostatic tumour; the malignant tumour as a rule involves the bladder-walls too, the inguinal glands are affected and the patients suffer from serious neuralgias.

RETENTION OF URINE OF NEUROTIC ORIGIN. CASES

REGARDING retention of urine without enlargement of the prostate. Here we have to deal with cases of different cerebral or nervous affections, or with arteriosclerotic conditions of the bladder. Furthermore I must call attention to the most interesting fact, that patients suffering from high blood pressure (hypertonic) are liable to get a retention of urine without any enlargement of the prostate.

All these cases are neurotic cases with a remarkable inferiority-complex in the sense of Freud's theory. I will give two cases :

Case 1.—F.L., 41 years of age, suffering for the last 30 hours from a complete retention of urine, the bladder overdistended reaches the umbilicus. The patient was extremely excited. While trying to introduce the catheter into the urethra I had most strongly to restrain and argue with the patient ; when touching the *glans penis* with the catheter the patient cried aloud, striking out with hands and feet. Only after getting tired, and after having convinced himself that he had sufficiently resisted, a thick catheter was introduced without any difficulty. Such attacks were repeated at short intervals. There was no mechanical obstruction to the flow of urine at all, the prostate being rather infantile. Through examining the patient's history thoroughly I learnt, that before such an attack occurred, there was always something of a disappointment : either a conjugal conflict, or a disappointing contemplated law suit, etc. There was quite clearly an escape into the disease and the unconscious intention that by such an annoying retention of urine he would be able to withdraw from difficult situations. For a long time the sexual power of the patient had been greatly diminished.

Case 2.—S.K., 72 years of age, has been castrated 20 years ago in consequence of a tubercular infection of both testicles and a few years later became entirely impotent. At the same time very peculiar retentions of

urine appeared. The patient always predicts such a retention, he gets evidently more and more excited, till at last the retention occurs. While under clinical treatment everything took place very sensationally. All the other patients had to participate in the affair. The patient, if there is no retention being able to empty his bladder entirely, at each such retention asks to have the catheter given to him. As soon as he touches the glans with the catheter the urine flow starts voluntarily at once. There is no stricture of the urethra, nor is there an enlarged prostate. The patient physically and mentally has the characteristic eunuchoid feature.

I desist from giving more cases. They all are alike, having nothing to do with an enlarged prostate. According to Freud's theory we may comprehend such retentions as a compensation for an inferiority complex, i.e. for the extinguished sexual power, keeping in mind, that sexual function and bladder function are innervated by the same nerves.

POLYURIA AND OBSCURE CASES OF RETENTION. CASES AND TREATMENT

As already stated the diagnosis of an enlargement of the prostate is a very easy one, if the patients suffer from symptoms of the urinary organs. But there are prostatic patients suffering from a chronic uræmia due to a chronic retention of urine without any symptoms pointing to a prostatic obstruction of the urinary flow. On the contrary most of these patients suffer from a polyuria, the main symptoms pointing to the digestive organs. Nearly all these patients have been diagnosed and treated as cases of malignant diseases of the stomach, of the liver, the bowels or of diabetes insipidus for many years without any success, till finally an experienced urologist is able to make the correct diagnosis. The following case may illustrate my statement :

G.M., 64 years of age has been suffering for the last 11 years from progressive cachexia ; loss of appetite, increased thirst, polyuria, constipation alternating with diarrhœa, flatulence, vomiting, pain in the stomach and in the region of the liver. He lost 18 kg. of his weight, and for the last four years he could not do any work at all, always suffering from serious headache, sleeplessness and heart troubles. He has been treated by a great number of allopaths and homœopaths, each of them producing for him another diagnosis. One diagnosed cancer of the stomach, another spoke of tubercular enteritis, others diagnosed chronic nephritis, pernicious anæmia, etc. The patient never complained about bladder troubles, none of his doctors did ever blame his urine in spite of his polyuria. Finally his physician, diagnosing chronic Bright's disease, asked me to see his patient. The patient was in a terrible condition, emaciated, his skin dry, yellowish, the eyes sunken, the tongue extremely dry, reddened and coated, pulse very hard, irregular, blood pressure 206. My first impression was : chronic uræmia due to a chronic retention of urine. When I told the physician my idea, he and his patient were very doubtful of my diagnosis, saying there can be no

retention of urine, there is no bladder trouble at all, on the contrary the patient passes too much urine. Indeed, when I gave the patient a big glass he passed about a pint of clear urine, specific gravity 1010, *no* albumen, *no* sugar. Paying attention to the diminished strength of the urinary flow I told the physician that I have now no doubt regarding my diagnosis, but neither the doctor nor the patient could believe me. After the patient had undressed I called his doctor's attention to the lower part of the patient's abdomen. There was a distinct prominence above the pubes reaching nearly to the umbilicus. "Well," I asked the doctor, "what do you think about that tumour?" "I'm sorry," answered the doctor, "I never examined the abdomen, I do not know what that means." "I will tell you," I replied. "That is the distended bladder of the patient, full of residual urine, as I informed you previously." Without any difficulty I passed a Thiemann catheter into the bladder, emptying more than two pints of urine. Now it was my turn. They could not understand the condition. By rectal palpation I found that the prostate was hardened and enlarged. My diagnosis was right. I explained the whole condition and both the doctor and his patient were satisfied and pleased with the diagnosis. I advised the patient to have clinical treatment for about three weeks. He confidently agreed. The treatment was successful. I immediately put a permanent catheter through the urethra into the bladder, irrigating the bladder twice a day with a solution of *Arnica*. Every morning and evening an enema with *Natrum muriaticum* followed by a *Gophan* suppository.* The first two days only liquid food, mineral water, juices and *Adinolan* tea.† Twice a day *Arnica* 6*x* and *Nux vomica* 6*x* alternating. During the first week the tongue cleaned, became moist, not coated at all, appetite excellent, blood pressure 195, pulse improved; general feeling of the patient much better than ever before during the last ten years. At the end of the second week the patient felt quite another man. All his troubles had gone. I removed the catheter;

* *Gophan Suppositories* can be obtained from Messrs. John Bell & Croyden, 50 Wigmore Street, W.1 (and no doubt from other chemists).

† *Adinolan Tea* is supplied by Messrs. Lewis & Burrows, Ltd., 146 Holborn Bars, E.C.1 (and no doubt other chemists), at 1s. 6d. and 2s. 6d. per package.

though the function of the bladder was much better, there were still 1½ pints residual urine. The congestion of the prostate was also much better. I taught the patient how to use the catheter, suggesting that he should catheterize every evening before going to bed. During the following weeks the recovery of the patient continued, he was able to work, he gained 18 kg., his general feeling of content was excellent, his appetite increasing from week to week. He passed his urine three times a day, using every evening the catheter and slept the whole night without any interruption. After eight months his bladder was strengthened, containing only a few drops of residual urine. Blood pressure 175. Consequently I discontinued the use of the catheter, giving the patient vegetarian diet and asked him to continue taking *Adinolan tea*, *Gophan suppositories* and prescribed *Sabal serrulata 2x*, three times a day, 10 drops. That prophylactic treatment proved to be a great success. The patient never had a relapse of his disease, but neither he, nor his doctor could understand the miracle of such a perfect cure after such a long period of a progressive cachexia.

I intentionally give that case in full because it ought to be most instructive to all my readers. It underlines my statement in the beginning of the book, that it would be the greatest mistake to rely only on the symptoms of the patient. I desist (for reasons of space) from discussing that statement thoroughly and will only mention, that the case just reported is no exception at all. I met with other similar cases and there can be no doubt, that every experienced urologist has met cases resembling it.

FURTHER DIAGNOSTIC TESTS

CONCLUDING my statements regarding the diagnosis of the disease I will refer now to two very useful tests, helpful to individually indicated treatment.

I.—The patient may tell you that he is not constipated, that every morning he has a spontaneous, smooth and copious stool. In order to test the action of the bowels, we give the patient 0·5 gr. *Carmin* in a wafer immediately after lunch. If the action of the bowels is normal, the stool of the patient ought to be reddened after 18-20 hours. But there are many cases in which the reddening of the stools appear only after 40-60-72 hours. In spite of the fact, that these patient's bowels act regularly every morning, the test proves that they suffer from a serious atonic constipation. The condition is similar to the bladder condition of prostatic patients with a chronic retention of urine: though these patients may pass a great quantity of urine, their bladder always contains a considerable amount of residual urine.

II.—In each case of prostatic obstruction to the urinary flow we have to examine whether or not the urine contains coli bacilli. The following test is a very simple one; we want two test solutions:

1.	Acidum sulphanilicum	3·0
	Acid acetic dilut.	900· c.cm.
2.	*x* Naphthylamin	1·2
	Hot water	120 c.cm.

The second solution must be filtered, after being heated, into the first solution.

If we mix 3 c.cm. urine with 1 c.cm. of that test-solution, the mixture will be reddened, provided that coli bacilli are present in the urine. We can rely upon that test in men. As a matter of course the test glass as well as the urine glass must be scrupulously clean before making the test.

Note.—1 cubic centimetre (c.cm.) = 1 gram (a little more than 15 grains in weight or $\frac{1}{4}$ of a fluid dram).

TREATMENT. DRUGS OF HOMŒOPATHIC USE

The treatment of prostatic patients is a very difficult task, requiring exact knowledge of the pathological conditions of the urinary organs as well as of the whole constitution of the patient. Much patience must be exercised on the part of the physician and of the patient himself. Remembering that there are many prostatic patients who for their whole life never experience any trouble from an enlarged prostate whatsoever, we must take the greatest care to keep away from the patient all injurious treatment which might result in congestion of the prostate or of other parts of the genito-urinary system. We should advise him concerning catching cold, cooling, especially of the feet, excesses in meals, alcohol, too much of the armchair and too long holding up of micturition. The right diet is of the greatest importance; for many cases a lacto-vegetarian diet is the most suitable one, but it depends upon the whole constitution of the patient. The dietetic directions have to be given individually. Leguminous plants and spices are forbidden.

Regular action of the bowels and regular gymnastics are necessary. Independent from these prophylactic measures the real treatment of the prostatic patients has to be adapted to the special conditions in each case. We have to differentiate between cases to be treated homœopathically and between cases in which a local treatment either catheterization or the radical operation should be applied. The conscientious homœopath should consult an experienced urologist before starting the homœopathic treatment. I repeat and underline that in dealing with prostatic patients we are not justified in relying on the symptoms of the patient, but must know exactly the anatomical and pathological conditions: these conditions alone indicate the suitable treatment in an individual case. I do not for a moment undervalue the homœopathic treatment—on the contrary I learned by an experience from more than ten years the valuable effect of the proper homœopathic treatment upon the various conditions in prostatic patients, but

on the other hand we have to realize that no homœopathic drug whatever is able to cure a patient suffering for example from a considerable amount of residual urine in an overdistended bladder. Here local treatment has to support the homœopathic drugs.

Regarding the local treatment we have first to answer the question, in which cases and under what conditions catheterization is indicated. As a matter of course each case of an acute retention of urine has to be catheterized, provided that hot hip-baths or hot compresses upon the abdomen or upon the perineum have not relieved the retention. The greatest care in using the catheter is to be taken, especially in patients suffering from their first retention and in patients with high blood-pressure. As already mentioned, the bladder has to be emptied very slowly, otherwise a fatal bleeding from the bladder-vessels or even immediate collapse of the patient may occur. I always combine the catheterization with a dose of *Arnica 2x*. I use a soft Thiemann catheter. Before introducing it I anæsthetize the urethra by injecting a few c.cm. (3) of a 2 per cent solution of *Novocain* or *Alypin* into it. By doing so we diminish the congestion of the urethra, enlarge its canal and facilitate the passing of the catheter. If we have to deal with a patient in which fruitless attempts to catheterize have resulted in severe damages of the mucous membrane and hæmorrhage it is much better to desist from further attempts and to empty the bladder by capillar punction above the pubes. An absolutely harmless procedure and we may repeat it for several days, till the injury of the urethra is cicatrized and healed. Then the catheter as a rule passes without any difficulty.

Furthermore the catheter is indispensable in cases of *chronic, complete* retention as well as in cases of chronic *incomplete* retention, if there is a considerable amount of residual urine. If in such cases the introduction of the catheter is very difficult and painful, it is advisable to treat these cases by a permanent catheter, especially in cases complicated by an infection of the bladder. In cases without any infection I would rather desist from a permanent catheter, because the permanent catheter too often sets up a suppuration of the mucous membrane, resulting in a cystitis.

What amount of residual urine indicates the use of the catheter ? It is impossible to answer that question by a generally valid quantity. It depends upon the quality of urine as well as upon the distension of the bladder. We can only say : the disproportion between the capacity of the bladder and the amount of the " residual " urine is the most decisive factor. Each practitioner, according to his own experience of it, may have a different point of view.

As soon as an acute attack of complete retention of urine has passed, enabling the patient to urinate voluntarily again, the proper homœopathic treatment is called for, either supporting the effectiveness of the catheterization or replacing it.

Independent from the question of the use of a catheter the homœopathic treatment of prostatic patients demands a thorough discussion. I have already stated that the homœopathic treatment has to be based upon an exact knowledge of the anatomical and pathological conditions of the genito-urinary organs rather than upon the symptoms of the patient. Accepting that point of view the homœopath ought to give the most valuable help to his patients. The homœopathic practitioner in dealing with prostatic patients has to consider the following :

Is the condition : (1) A chronic or acute enlargement (congestion) of the prostate.

(2) Sterile or infected residual urine and what kind of infection ?

(3) Constipation due to mechanical obstruction on the part of the prostate or a spastic or atonic constipation.

(4) The pulse of the patient ?

(5) The condition of the blood ?

(6) The condition of the bowels regarding flatulence ?

Apart from these questions the homœopath has to improve the function of the liver of all his prostatic patients. Due to the congestion of the abdominal blood-vessels nearly all prostatic patients suffer from liver disorders. The most suitable drug for these conditions is *Digitalis purp.* 6*x*, twice daily, 5-10 drops. In my own experience its effect upon the liver and the constitution of many patients is striking, especially if it is

combined with the use of the *Gophan* suppositories; these *Gophan* suppositories containing *Chinin*, *Æsculus* and *Carduus mar.* in homœopathic potencies improve the circulation in the portal veins and in the pelvic vessels, resulting in removing the congestion of the prostate as well as of the abdominal organs. If the urine is infected, we have to consider other drugs according to the special indications of the case. I refer at first to *Berberis vulgar.* 4*x*, acting upon the liver as well as upon the kidney-pelvic and the pelvic blood-vessels; it acts especially upon the left side and is indicated in prostatic patients suffering from stones in the urinary system, from infection of the kidneys and their pelves due to the coli-bacillus. Furthermore I must mention *Coccus cacti* 2*x* which, according to Rademacher, is one of the most effective drugs in improving the function of the kidneys.

Sabal serrulatum 1*x*-3*x* ought to be given in nearly all cases of prostatic enlargement; it is called "the homœopathic catheter" because many homœopaths are of the opinion that it improves the muscular power of the bladder to such a degree that by giving *Sabal* we may not need to use the catheter. I do not underrate at all the good influence of *Sabal*. I give it regularly to all my prostatic patients, but I must state, as repeatedly pointed out above, that it would be fatal to rely on any homœopathic drug whatsoever in cases characterized by a considerable amount of residual urine. The most effective dose of *Sabal* is three times daily, 5 drops, *Sabal* 1*x*.

Cannabis sativa 6*x* and *Olœum terebinthinae* 2*x* are indicated in cases of infection complicated by hæmorrhage.

Acidum boricum 4*x* is the most powerful drug in cases of coli infection. I am surprised that in the homœopathic textbooks *Acid. boricum* as regards the prostatic diseases is not mentioned at all. It may be of interest to my readers to associate it with the drug picture. The principal symptoms are sleeplessness, thoughtlessness, diminished psychical energy, congestion of the blood vessels, especially in the skin and mucous membranes, pains in the soles of the feet and in the knuckles as well as in the loins. Skin very dry and itching, eczema seborrhoicum or psoriasiforme, loss of hair; dysuria,

pain in passing the urine, albuminuria or even blood in the urine. Disorders of the stomach and of the bowels, aggravated after eating. Meteorism due to intestinal intoxication, inflammation of the rectum producing very viscous mucus, complete the drug picture which covers the symptoms of many prostatic patients.

In such cases *Acid. boricum* will be a success.

Ferrum picrinic 4*x* is indicated in younger prostatic cases, the prostate smooth with attacks of acute congestion resulting in acute retentions of urine. The *Ferrum* patients are sexual-neurasthenics, resembling the *Nux vomica* patients. Considering that fact, I combine *Ferrum picrinic* 4*x* with *Nux vomica* 4*x*, giving it twice daily alternating.

Aurum jodatum 3*x*-4*x*, or *Aurum metallicum c.* 30, acting upon the prostate itself is suitable, if the prostatic tumour is hard like a fibromatous uterus, but only in cases presenting the well-known mental symptoms of *Aurum* (depression, suicidal ideas, etc.).

Baryta carbonicum c. 30, indicated in cases of frequent micturition, in arteriosclerotic old patients, degenerated, stupid, indifferent.

Conium maculatum 6*x* is recommended for extremely hard prostates. I never had any success at all with it.

Populus tremuloides 4*x*, *Ammonium carbonicum* 4*x*, *Strontium* 6*x*, *Sulphur* 4*x*, *Capsicum* 6*x*, are indicated in cases of soft, slack prostate, while *Staphisagria* 4*x*, *Iodum* 6*x* and *Oleum juniperi* 2*x* are suitable to the more compact and firm prostatic tumours. In the *Staphisagria* cases we are always confronted with depression and similar mental symptoms; there is always burning pain in the urethra, most of these cases having suffered from gonorrhœa.

Pulsatilla 30*x* may be given in cases of bladder-pains, frequent micturition, cystitis due to a cold, if the well-known *Pulsatilla* modalities are present. Urine in these cases always cloudy and purulent.

Hydrastis 4*x*-6*x* is especially indicated in cases of hæmorrhage. *Gelsemium* 10*x* and *Causticum* 6*x* are suitable to cases of Ischuria paradoxa.

Pareira brava 4*x*-10*x* influences the bladder itself; it is indicated in cases of painful spasms, cystitis and renal colic; it may be of use in cases of an acute retention of

urine (every hour 20 drops), or in cases complicated by uric-stones or by suppuration of the kidneys.

Sarsaparilla 4*x* and *Polygonum sagittat* 4*x* are useful in prostatic patients, suffering from hæmorrhage and infection of the right kidney. Other suitable drugs for these patients are *Chimaphila umbellatum* 4*x*, *Cantharis* 6*x* or *Phosphor*, 30*x*, according to the modalities of the special case.

Finally I call attention to *Equisetum hiemale*. It is one of our most effective and reliable drugs and ought to be much more frequently given in urinary cases ; in some textbooks it is not mentioned at all regarding bladder troubles. Its effect is related to all parts of the urinary organs ; its best effect is upon the bladder, less upon the urethra, the least upon the kidneys. It acts especially upon the right side. The pains are burning, piercing or cutting, worse in movement, excitement, and in sitting and during afternoon, better when lying down. The modalities differ in the different parts of the urinary system : (*a*) KIDNEYS : we find pains in the region of the right kidney, worse by touch, pressure, accompanied by frequent micturition and dysuria, pain radiating to the right groin. (*b*) BLADDER : the whole region of the bladder is very sensitive, especially on the right side. The slightest pressure is very painful, worse during afternoon and by night, micturition very painful without any relief of the bladder, polyuria ; incontinence. (*c*) URETHRA : burning and severe pains independent of micturition, especially in the glans.

Equisetum is especially indicated in prostatic cases, complicated by stones and cystitis as well as in cases of infection of the kidneys.

Regarding the treatment of cases, complicated by spastic or atonic constipation and by the very worrying flatulence, I would refer to drugs like *Nux vomica*, *Opium*, *Sulphur*, *Carbo vegatabilis*, *Lycopodium* and *Natrum sulphuric.*, according to the special symptoms of the patient. In all these cases the diet is of the greatest importance. I always insist upon a lacto-vegetarian diet containing a great quantity of All-bran.

SCHEME OF MEALS FOR PROSTATE PATIENTS

The following scheme of meals may be helpful to the most of these patients :

BREAKFAST : 4-5 tablespoonfuls of All-bran with hot milk, 1 poached egg on toast, 1-2 cups of Adinolan tea, 2 slices of Ryvita with butter.

LUNCH : All-bran with hot milk, any vegetable, rice, salads with lemon, from cress, lettuce, beetroot, radish, cucumber, etc., without vinegar, 1 scrambled egg on toast, any fresh fruit, walnuts, etc., cheese on toast, 1 glass of milk.

TEA : All-bran, as before, 1-2 cups of Adinolan tea, 2 slices Ryvita with butter.

SUPPER : All-bran, as before, vegetable soup, macaroni or spaghetti, 1 boiled egg, fresh fruits, 1 glass of milk, cheese on Ryvita.

SUMMARY OF TREATMENT

Summarizing the homœopathic treatment I must state that the drugs above reviewed are only a part of the many, many homœopathic drugs which may be the simillimum to a special case. It is impossible to give a complete list without counting down nearly the whole Materia Medica Homœopathica. I am afraid the great number of drugs above mentioned may be confusing to the reader; it may be difficult to him to select the right remedy. Therefore I repeat again and again, that no homœopathic drug should be given without the advice of an experienced homœopathic practitioner familiar with the anatomical and pathological conditions of the genito-urinary organs of the patient as well as with the Materia homœopathica.

Furthermore, we have to turn to all other biological remedies. There are leeches, herbs, etc. Regarding leeches, I must say that their application in cases of an acute retention may be very useful. I remember cases in which the application of three leeches on the perineum and two above the pubes was followed by a striking effect; the patients were able to pass their urine so that I did not need to catheterize. If the case is not too urgent I often apply leeches before I use the catheter. The application of leeches may be very helpful also in uræmic cases as well as in cases of congestion of the abdominal organs, especially if there are hæmorrhoids. Anyway, I would not like to miss the leeches in treating prostatic patients.

Regarding the herbs the homœopathic materia medica makes use of them to the utmost limit. I refer only to the many herbal drugs already reviewed above. But independent from the homœopathic potencies each practitioner ought to study thoroughly the effectiveness of our medicinal herbs as well as of our victuals. Their effect applies (1) to the heart (*Digitalis*, *Cratægus*, etc.); (2) to the kidneys (*Berberis*, *Equisetum*, etc.); (3) to the chemistry of the blood and protoplasm; (4) to the hormones of the organism. There can be no doubt that the strengthening of all these organs may be of decisive influence in treating prostatic patients. Considering

these facts I give all my patients a special herbal tea, i.e. the *Adinolan Tea*, above mentioned. Its chief constituents are *Guaphalium*, *Juniper*, *Betuline*, *Scilla*, *Rhizoma graminis*, *Ruta graveolens*, etc. Some of these plants are impregnated with *Natrum benzoicum* and *Urotropin* in homœopathic potencies in such a percentage that each cup of *Adinolan* tea contains one dose of *Natrum benzoic.* 4*x* and *Urotropin* 3*x*. Its stimulating effect upon the urinary organs, as well as of the digestive canal is striking; owing to its antiseptic action it prevents the development of bacterial infection of these organs. *Adinolan* tea ought to be the daily beverage of each prostatic patient.

OPERATIVE TREATMENT OF THE ENLARGED PROSTATE

In conclusion I have to say a few words regarding the operative treatment of the enlarged prostate. Certainly the radical extirpation of the prostate (prostatectomy) is the only way to remove radically the mechanical obstruction to the urinary flow. If performed by an experienced and skilful surgeon or urologist the danger of the operation may be reduced to a minimum. On the other hand we have to consider some after-effects of it and have to think of the shock upon the system and on the psychically weakened patient. Therefore, the question whether or not the operation ought to be performed in a special case must be decided very carefully, the more so as we know that many prostatic patients do not suffer at all in spite of their enlarged prostate. Furthermore, there are many patients who, under the suitable homœopathic treatment, with or without the regular use of the catheter, are going along fairly well, though their bladder always contains more or less residual urine.

In my own practice during the first thirty years, I performed the suprapubic prostatectomy more than fifty times, the mortality being low and the results excellent. Many of these patients were over seventy years of age, nearly all of them entirely recovered without ever getting a relapse. Nevertheless with progressive age and with progressive knowledge of homœopathy, my point of view changed. In the last twelve years I operated only on three cases. Certainly even now I do not object to the operation if there is no other possibility of relieving the patient's suffering, but I am happy to say that conservative treatment during that period in nearly all cases has been successful.

HEADLEY BROTHERS
109 Kingsway, London, W.C.2
and Ashford, Kent