resulted from repeated tapplings if the apertures were closed. I may cite also the case of Wendelstadt, himself a physician in active practice, who, after an attack of empyema, daily, for thirteen years, withdrew a small quantity of pus from his chest without detriment to his bodily health.

The readiness with which the viscera regained their normal position, and the lung probably much of its normal volume, during the seven weeks of his convalescence, shows, I think, that permanent collapse and adhesions are very slow to form. In this case the lung had been more or less continually compressed for two years, yet it soon began to expand again when the pressure was removed, notwithstanding the occasional entry of air into the pleura. I was anxious in this instance to attempt to close the cavity in the pleura by exciting inflammation with caustic injection, such as tincture of iodine; but the patient preferred to let well alone, so that opportunity was lost of completing the cure.

This case is narrated to illustrate the great necessity of regularly withdrawing the fluid from the chest in all cases of empyema; moreover, that tapping and closure of the orifice, or even leaving it open for the fluid to drain away itself, is not sufficient. The entry of air is a matter of secondary importance if the pus does not stay long enough in the chest to putrefy; the products of putrefaction, not the atmospheric air, being the noxious influence in these cases. This opinion is borne out by the result of forty-six cases of tapping collected by Lacaze du Thiers, in one of which only did a bad result ensue from the admission of air, and in this instance the matter was retained along with the air in the pleura.

Weymouth-street, Nov. 1866.

REMARKS

ON

THE USE OF THE ENDOSCOPE.

By HENRY DICK, B.A., M.D.,

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THERE are some remarks in THE LANCET of October 20th on the use of the endoscope, by Mr. Henry Thompson, which left an impression on my mind, and very likely affected others similarly, that Mr. Thompson is not an admirer of the endoscope, nor very sanguine as to its future usefulness. I can pretty well understand the uncertainty which Mr. Thompson seems to feel on the subject, because I myself gradually passed through the same state of mind.

About fourteen years ago I began to work with the endoscope, and I had several conversations on the subject with the late Mr. Avery. With M. Desormeaux's instrument I did not succeed at first, because I used spirit of wine instead of gazogene. When I used gazogene the light was better. At the same time I found another inconvenience in the great pain which was produced in the urethra by the sharp borders of the tube, but when I used blunter tubes that inconvenience was obviated.

The results of my endoscopic researches nevertheless were not always satisfactory. Sometimes I could very well distinguish the colour of the urethra, and diagnose its condition, but at other times I could not get a good light at the desired spot, except by moving the instrument in different directions; and after many trials I came to the conclusion, that the essential thing for success in endoscopic researches is to get the rays of light well reflected on the spot we are desirous to examine. I therefore prefer Dr. Cruise's instrument to Desormeaux's, not only because the light is more brilliant, but because by his ingenious contrivance we can either raise or depress the tube, or give it a lateral direction. If we succeed in getting the light on the proper spot—even the light of an ordinary sperm candle is sufficient—a distinct view of the object will be obtained by means of the endoscope. A precaution I think it necessary to take is to have the endoscope placed on a stand, the height of which should be capable of alteration, as the involuntary motion of the hand renders the light uncertain. In fact, there are many precautions which it is necessary to observe, the omission of any one of which, though apparently of little moment, is quite sufficient to frustrate the desired result. Amongst them I found it desirable to have tubes constructed, with their side-openings capable of being closed, so that, when required, all the light can be concentrated on one spot, without any loss of light through the side-openings.

I quite coincide with Mr. Thompson's remark about *chronic inflammation* in the bulbous portion of the urethra. That affection was known long before the endoscope was in use; but we were in the dark as to the *extent* of that inflammation. Besides, it is not only the bulbous portion of the urethra which can be affected by chronic inflammation, but also the fossa navicularis can be so affected; and in three cases I found chronic inflammation two inches and a half down the urethra, and which I was only able exactly to diagnose with the aid of the endoscope. The touch alone is not sufficient for the diagnosis, because some parts of the urethra may be very sensitive when no chronic inflammation exists; and I have found, in *old cases* of chronic inflammation, pain in sounding is either absent or very trifling.

The term "granular inflammation" of the urethra does not seem to me one which we ought to accept; my reason for which I have stated in the preface and notes in the second edition of my monograph "On Gleet."

The orifice of a stricture can certainly be seen by the endoscope. It presents itself to the observing eye as a very small black spot; and may be overlooked by a *tyro*, or not found at all, because the end of the tube is directed towards the walls of the urethra. To be successful, we must by a little manoeuvring bring the opening of the stricture into the centre of the tube, as we have sometimes to do with the speculum in order to get a good sight of the opening of the os uteri.

I consider the endoscope a very useful instrument in impassable strictures. In a case of Civiale's, where no instrument could be passed, Desormeaux with the help of the endoscope succeeded. That the orifices of the ejaculatory ducts cannot be seen is to be ascribed to their anatomical position. If we could expand the tube at that particular spot, and dilate that portion of the urethra, I have no doubt the ducts could be seen; but I fear the sudden dilatation of that particular spot would produce orchitis.

In all disease of the bladder, the future of the endoscope is bright, and I am in great hope that the mysterious sac called the "*irritable bladder*," into which so many affections of the bladder have been thrown, and still are thrown, will be well lit up by the endoscope, to the great benefit of humanity and science.

There is not the least doubt that a foreign body can be seen in the bladder by the endoscope. Dr. Cruise has proved it in the presence of witnesses, and Desormeaux further actually gives exact drawings of stones in the bladder, as seen through the endoscope. The "*tactus eruditus*" of Mr. Thompson is certainly necessary; but the *oculorum acies* is still better in the diagnosis of disease. In fact, it is my conviction that the endoscope will be more useful in disease of the bladder than in that of the urethra, because a larger space for observation comes under the range of the instrument, and sooner or later lenses will be constructed to improve its practice and extend its usefulness.

Mr. Thompson's opinion about treating strictures by flexible bougies is very valuable, coming from such an authority; but it does not agree with my own experience, as I have found the metallic bougie more serviceable. But my own experience would be of little weight if it could not be proved that the pathological anatomy of stricture of the urethra shows conclusively that the metallic bougie is the one indicated.

Least I should be misunderstood, I should state that for passing a difficult stricture I prefer the finest and most flexible bougie; but for *treatment* I adhere to my above-mentioned opinion.

The presence of the tube of the endoscope cannot be more irritating than the sound; indeed I have always found it much less so, because the tube only penetrates a short distance into the bladder, and does not come in contact with its walls when in its injected state.

Mr. Thompson is mistaken when he says that we cannot make use of the endoscope in operating in the urethra. Desormeaux cuts strictures with the help of the endoscope, and I have removed a small polypus through its instrumentality; and in cases where only a very small portion of the urethra is affected by chronic inflammation I cauterize by its assistance.

But the last remark of Mr. Thompson about the use of the endoscope in disease of the rectum is very encouraging, and I am sanguine that the time will come when he will discover its equal usefulness in diseases of the bladder and urethra; because it cannot be logically admitted that if the endoscope can reveal a deep-seated affection of the rectum, it should not render equally valuable services in diseases of the urethra and bladder.

November, 1866.