minces easily. The tongue, that persisted in remaining very coated and unpleasant for many days, is now quite clean and moist. Gaining weight rapidly, her weight being now 9 st. Is going home to-day.

For details of feeding by glucose, see the Temperature Charts.

December 23.—Letter from patient states: "Very satisfactory; have gained a further 9 lb. Swallowing well."

January 29, 1932.—"Getting on wonderfully." Weight is now 9 st. 10 lb.

May 2, 1932.—"I am going on wonderfully, and feel ever so much better since my operations. I can eat anything now and have no trouble whatsoever in swallowing. The wound has healed beautifully and one hardly notices it."

All toxic foci should be removed first, viz., dental and tonsillar in this case. I think that I delayed too long between Stages 1 and 2, viz., fourteen days, thereby allowing the unavoidable adhesions to become too firm and extensive. Great care must be taken not to injure the recurrent nerve.

It would seem to me the wiser plan not to open the sac.

I enclose two radiograms of the neck.

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**A SHORT NOTE ON ENDOscopic RESECTION OF THE PROSTATE.**

**BY TERENCE MILLIN, M.A., M.CH.DUBL., F.R.C.S.ENG., F.R.C.S.IRE.**

Hon. Assistant Surgeon, All Saints' Hospital for Genito-Urinary Diseases, London.

The limited applicability of the older "punch" and other per-urethral procedures for the relief of prostatic obstruction has led to a strong feeling of distrust in this country towards all such methods. That such a view is to-day unwarranted we are convinced. Many who, in the past, have been strong in their condemnation of attempts at endoscopic resection are now whole-hearted in their enthusiasm. A timely word appears desirable during this phase of over-enthusiastic resection lest an excellent procedure become discredited through misdirected zeal. Let not judgment be warped by enthusiasm!

The endothermic resection of to-day enables us to deal adequately with 75 to 80 per cent. of all prostatic obstructions. There is virtually no limit to the amount of prostatic tissue which may be removed, and instead of a major operation carrying a mortality of 10 to 20 per cent. the patient may be relieved of his urinary obstruction by means of a minor procedure with an estimated mortality-rate of but 1 to 2 per cent. in skilled hands. Confinement to bed is usually limited to one to three days, and the hospitalization ten to fourteen days. The post-operative absence of pain is remarkable, and it is seldom that any analgesic whatever has to be administered. Correctly performed, resection leaves the ejaculatory ducts intact and, a point not unimportant to many, sexual function is not impaired.

Broadly speaking, the main indications for the method are: (1) malignant prostatic obstruction, and in such micturition per urethram may be maintained for periods extending often over several years, so avoiding the alternative of permanent cystostomy with its attendant discomforts, nay, miseries. In such malignant cases, of course, repetition of the resection may be necessary owing to further growth of the neoplasm.
(2) The early benign case where the symptoms are not such as to warrant the major operation (few surgeons seek early radical surgery for their own commencing prostatic symptoms!). (3) The advanced "bad risk" case where the renal and cardio-vascular systems are so damaged as to preclude a reasonably safe prostatectomy. (4) The small fibrous prostate—that bugbear of the operator. In my judgment such groups are definite indications for per-urethral surgery. We must await the verdict of time as to the desirability of applying the method to the large so-called "adenomatosus" type where the general condition suggests a relatively safe prostatectomy.

Our experience of prostatic resection now dates back three and a half years, and we have satisfied ourselves that the endoscopic operation, skilfully applied, will give lasting relief in the great majority of cases. We have carried out the procedure seventy-three times with but a single death, and that a malignant case with metastases where the tenesmus associated with a cystostomy done elsewhere was rendering life a misery. Excluding six malignant cases, sixty-seven resections for benign enlargement of the prostate have been performed without a death. No selection of cases has been made and not a single case refused resection. The ages have ranged from 54 to 88, and the blood-urea figures have been as high as 136 mm. gms. per cent. (and that after three months' drainage!). In only three instances had a subsequent cystostomy to be carried out, twice for haemorrhage not properly controlled on the operating table and once for infection; all recovered. These three mishaps occurred in the first dozen cases whilst working with varying experimental technique. Since adopting our present standard technique, over sixty operations have been carried out without mishap.

In conclusion, we must stress the dangers of an imperfectly performed resection. It is essentially a procedure for the trained urological surgeon who is thoroughly conversant with the endoscopic appearances of the bladder neck and posterior urethra.

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**Hospital Appointments.**

The Editors do not accept responsibility for the accuracy of this list which is published to give applicants the general idea of what is required in applying for any of the posts mentioned. These lists will be published in each issue and indicate the appointments for the ensuing three months, but as many of the appointments are renewable post-graduates are warned that, before applying for any post, they must ascertain if there will definitely be a vacancy on the date mentioned. Except where otherwise stated the salary is pounds per annum.

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<th>Experience</th>
<th>Women</th>
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A Short Note on Endoscopic Resection of the Prostate

Terence Millin

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