are useful only to substantiate opinion, and if you cannot accept a man's deliberate opinion you are not likely to put faith in his cases. Cases can be twisted to prove anything. In such a position as that which, by the kindness of the Fellows of this College, I occupy, a little dogmatism may be excused, and I feel so strongly about this matter of the tube that I have ventured to deal with it in preference to some more brilliant or alluring topic. I beg you to believe that if I speak forcibly it is because I feel conviction, and when I argue for the total abandonment of the older form of tube I desire to assure you that any words I use are spoken with a full recollection of the gravity which my office attaches to them.

Of course the great difficulty to be overcome in acute obstruction is that of diagnosis, and even to the most experienced no finality is possible. There is no branch of surgery in which extended clinical observation and careful reasoning work better together. A simple process of logic will help the most trained clinician to a true conclusion. No cases afford more opportunity for the display of high surgical qualities than those of which I have spoken. Given the proper faculties of observation and deduction, the two qualities which combine to produce great surgical fitness are Thoroughness and Resource, and in the management of obstruction of the bowel there is the most ample opportunity for their development.

ART. VI.—*The Surgery of Hypertrophied Prostate.* By Thomas Eagleson Gordon, M.B., B.Ch., Univ. Dubl.; Assistant Surgeon to the Adelaide Hospital; Demonstrator in the School of Anatomy, Trinity College, Dublin.

The subject I have chosen for my Address is the Surgery of Hypertrophied Prostate. It will, however, be convenient, in the first instance, to briefly review what is known of the development, anatomy, and function of the normal gland—as far at least as these are of surgical interest or importance.

If the abdomen of an early embryo is opened there will be seen, on either side of the middle line, in the lumbar region, two long vascular prominences. These are the Wolffian bodies—structures

* The Presidential Address to the University Biological Association, delivered on Thursday, November 29, 1894.
composed of glomeruli and tubes similar to those found in the permanent kidney.

Leading from the Wolffian bodies there will be seen the Wolffian ducts, and these pass downwards to open into the urogenital sinus.

This sinus is merely the lower portion of the spindle of the allantois; the upper part of the spindle, it will be remembered, forms the urinary bladder.

Lying internal to the Wolffian body is another structure, the genital organ; and coursing downwards, alongside the Wolffian duct, is the duct of Müller, which opens like it into the urogenital sinus. The lower part of the duct becomes fused with its fellow to form a single tube. The upper end is open into the peritoneal cavity.

These structures—Wolffian body and duct, genital organ, and duct of Müller—are the rudiments of nearly all the future genital system of both sexes. In the male, the testis is developed from the genital organ; from the Wolffian body and its duct are derived the vasa efferentia tube of the epididymis and vas deferens.

The urogenital sinus becomes the first portion of the urethra. The ducts of Müller undergo atrophy almost to annihilation. But their upper part persists as the hydatid of the epididymis, and the extreme lower united parts are represented in the uterus masculinus or prostatic vesicle. Very different is the fate of the duct of Müller in the female. Here the upper part remains as the Fallopian tube, and the remainder, the united part, forms the uterus and vagina.

It will thus be seen that the uterus masculinus must be the homologue of the uterus and vagina, or of some parts of them. It seems to be the opinion of the best modern embryologists that it is most probably the homologue of the vagina alone.

The development of the prostate itself has been lately specially worked out by Griffiths of Cambridge. The conclusions he arrives at are these—The tubules are derived from the prostatic sinuses on either side of the verumontanum—i.e., from that portion of the urethra which, as we have seen, is formed from the urogenital sinus.

As the tubes extend backwards they carry with them a prolongation of the external circular fibres of this part of the urethra, and this muscular tissue is seen in the foetus spread out in slender fasciculi investing the developing tubes.