On Diseases of the Rectum

A Thesis

by

John Isaac Thurn M.B.
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Old Hall, Surbuce
Introduction

At the commencement of this Thesis, I feel it to be necessary to offer some apology for its excessive length. And briefly my declaration is as follows. Since my publication in 1876, it has happened—whether by mere accident, or from some unconscious personal bias—I cannot say—that my experience has been more in cases of diseases of the bladder, than in those of all other diseases combined. Any reading, therefore, though somewhat exclusive, has been almost wholly confined to the Pathology of the Bladder. I have had experience in diseases of this region, not only in England but also on the continent—France and Italy—and have met with ample opportunities of comparing English and foreign modes of treatment.

I have considered only those diseases with which I have been brought most into contact. Wanting the confined facilities formerly to women, partly from that cause, and partly from the idea that they belong more fittingly to a treatise on diseases of women, my Thesis is chiefly that of Blenorrhages, Fistula of the Urethra and Bladder; Polypus; Uninelines; Irises; Eclampsia, and Fiddle.

I have also described a disease, a description of which I am proud to have made my 'Multiple ulcer' of the Bladder. Whether it will prove to be a distinct disease, is left to an accurate study of a 'general alteration of the pelvis,' leave those having authority to decide. I record two cases.

I pass on now to the structure of the Bladder. I have been collecting, revising, cataloguing, and considering this tissue for two and a half years! Its study has been a most absorbing task, but it is hard to find any summary of the whole which is not a brieve epitome of my past experience, and, at least, a foretaste of my future field of research.

Frederic Dvorak
Hemorrhoids.

Hemorrhoids or piles are more commonly met with in this region than any other disease affecting the rectum, and, happily for mankind generally, though the sufferings caused by their presence are very great, they nevertheless yield to appropriate treatment, and in the majority of cases, where they are not a manifestation of a constitutional disease, arising from some organic lesion, in which it is technically called "a radical cure."

A pile or hemorrhoid signifies a node or ovooide tumor, varying greatly in description and size, multiple or single, situated around the verge of the anus, external, or internal to the Jelatinous Zone muscle, if a pledge or pad of skin or boil of skin; and growing from their surfaces a venous, or nervous discharge. They consist, either of a varicose, or enlarged condition of the veins, or vessels, especially those situated in the subcutaneous, submucous, and subadjacent cellular tissues; or they are formed directly from the skin, or mucous membrane which has taken on a nodular form, presenting a more complicated texture, their chief characteristics being an erect, stiff, fleshy structure, and filled with blood. They have been divided into internal, and external according to their situation within, or without the perineum: both, Blind or Bleeding piles, and Into - external piles external.

Hemorrhoids

Causes

There are divisible into two classes: (1) excising, and (2) predisposing. The former being due to anything acting in the nature of an irritant, which causes at first an increased redness of the skin, and this irritation, unless the irritating cause be removed, will cause an acute active inflammation, an inflamed hemorrhoid being the result. One of the most common causes, due to the want of cleanliness upon the part of the patient, this is greatly aggravated by the use of alcohol or tobacco. So much walking, whereby pressure is indirectly increased, the joints of the anus become painful, and intense inflamed piles arise. There have been several cases in which the cause succeeded, or could possibly have done the mischief, which resulted in pain as from other ailments had been void. The irritation arising from the wearing of tight-fitting coarse clothes, causing congestion of the perineal skin, a clot is formed therein, or by some surrounding inflammatory products, the
Easily became blocked up. After a time, this subsides, and all that remains is a true fist of fluid, for each fistulous space on into subphrenic. Anything which induces local congestion will give rise to fistulae, i.e., abscess of the fistulae of the stomach, oesophagus, duodenum, or the rectum, and other organs. The frequent use of purgatives, this, thanks to the blood of fistulae of the stomach, oesophagus (particularly in the case of patients), is apt to be the cause of the occurrence. Purgatives, without "slimy or roessen" required or otherwise, occasioning loose stools and diarrhoea being very subject to the effect of the parasitic faeces, and abdominal tumours by their pressure, interposing with and attacking the portal circulation. \textit{C}yphtaea in the large joint; habitual constipation; sluggish liver; excessive smoking, tobacco, alcohol, beverages, champagne, coffee; lack of moisture of the intestines musturine; all these may be called as being exciting causes of hemorrhoids.

Here are very numerous indeed. And this is 127 to be considered all when we look at the peculiar anatomical characters of the fistula, their dependent position, the continual irritation to which they are liable, and the influence which the thoracic and abdominal organs exert upon them. It is necessary for a moment to glance here at the Anatomy of the Rectum. The longitudinal bands found in the skin are absent, and the fibres are scattered on its surface, and whilst the walls contain a number subserous, muscular, and peritoneal coats, we find that the two first layers—serous and subserous— differ characteristically from the other portions of the intestine. The peritoneal covering also differs, it surrounds the whole of the first part, is absent at the posterior part of the second, and is altogether wanting in the third part. The lower part of the rectum, and the anus are composed of a transversal or superficial, and a deep or circular bands of fibres, lying in two planes. The circular fibres are welded together towards the pelvic and from the sphincter muscle. Here is placed an intervening space, which is filled up with dense connective tissue, and it is in this space that the vein forming a freely anastomosing network, vessels are situated. They are devoid of lobes, and thus applied to the fascia, and anastomosing vessels to a slow circulation. The blood supply is derived from three sources, the superior, inferior, and inferior haemorrhoidal vessels. They anastomose freely in the course and of the rectum, the superior haemorrhoidal running five or six branches to
The sphincter muscle, which, after passing through the muscular coat, surrounds, between it and the mucous coat, and inclines to form a circular circle, immediately within the internal sphincter muscle. The arteries here being joined at the same branches as the human pleura. The superior hemorrhoidal then communicates directly with the vein below; and posteriorly, they open into the internal heel vein, by these means a free communication is established between the two great human systems - portal and systemic - conjugation thusly being very little to occur.

From these anatomical observations, the prevalence of hemorrhoids among all classes of people, rich and poor, is not to be wondered at; on the other hand, we are inclined to ask, how it is that any one escapes the disease altogether? Of necessity, any disease, organic or viscerous, that interferes with the free circulation in the portal system, must cause local congestion in the hemorrhoidal veins, and the same observations are to a certain extent applicable to the systemic system. How is it that phlegm does not preponderate to a greater extent? I think the answer lies upon the fact that there is a direct channel in the hemorrhoidal vessels between the two great human systems; and that the one relieves, to a greater or less extent, the other; and in time of danger helps to avert evil by its direct current for a time. Careful observation will show that the branches of the middle hemorrhoidal vein, simply the branches, join the internal heel vein. Therefore hepatic, gastric, intestinal obstruction, local accumulations, abdominal tumors, and even those forms of disease which frequently work on the liver for an hour or two together - all conducive to become angiosis of the veins, with the eventual formation of piles. Whatever tends to encourage dilatation, create a great deposition of piles, and under such circumstances the occasional hemorrhoidal disease in men has been regarded as a voluntary evacuation. Another cause is the use of clothing small in opening, in place of the old fitted ones. This is perhaps due to the greater degree of pressure which the corset has to bear, and this downward pressure, the overbearing causes congestion. The most obstinate case of hemorrhoids have had and in which the sufferer were very severe, in a local suffering from constipation. This has been noted long ago; hard Osborne that should detect, after repeated, and careful examinations.
Your message text here...
III. Hard, inflamed tumours. And

IV. A sac, formed of hypertrophied cutaneous tissue, inflammatory reaction which has undergone organization, and in which no natural cavity is seen. In fact it is an adherent to the class called cutaneous piles. In this variety belongs to cutaneous and subcutaneous, perhaps better called intercutaneous, and which is an external tumour. It consists more in this

I. Simple varices not forming tumours. In this class of piles the tissue have undergone dilatation, marking their course under the mucous membrane by this dark blue varicose or bluish, presenting numerous dilatations. The mucous membrane is of a deep purple color, and frequently adherent to them, and the cutaneous tissue is not affected. The walls of the vein may be hypertrophied, or thickened. The blood is more or less stagnant and having lost color under the effects extremely white in inflammation. They are rich with its pasteurian worms; in cases where subcutaneous veins displace, prolapses etc., press upon the vein in such a state, and the cavernous, and cause congestion of the external veins. If their swelling cause be removed, they may subside, but if not they swell up, and pass into the more prominent varieties which we are about to consider. They are in fact the initial expression of haemorrhoids. They are very apt to bleed, and often to a very serious extent. In women who have had a large family, they usually remain as a permanent disease, only removable by surgical interference.

II. Tumours, soft, firmly composed, and uplifted, having one external cavity. These vary greatly in size from a small pea to a walnut, and are as a rule very numerous; in some cases three or four, whilst in others the dilation may be completely filled with them. They are soft and spongy and present a peculiar cellular appearance, lying either in the cutaneous tissue, or ranging from perineum, or latter arise from the repeated irritation and chronic abscess of the face, which causes them to become detached from their position, and hang down into the cavity of the rectum. The cellular tissue is filled with blood, but this stasis varies greatly, and depends entirely upon the amount of irritation present. If this be small the cavities are inflated, and the tumour shrinks to a small size; but if the cause increases in severity, blood is forced into their tissue, they enlarge become hardened, and finally divide themselves by haemorrhage. From this peculiar nature the
French have looked upon them as stimulating the cellular tissues, and one peel French pathologist found that the veins could be injected from the arteries, should their cells be not filled with coagulated blood, (Chassereau). His cell-like appearing has caused a large amount of conflicting opinions as to their formation, some have relied upon them as being formed "by a section of the vascularised, and denuded vein", whilst others have considered them as formed by the transformation of blood into the another tissue, or some not warranted in accepting either one or the other of these opinions as holding, or as the sole cause, and formation of every pimple; the former at one time, the latter at another, take into their functional formation, in a frequency with one combined.

Attention may be made here of vesicular swelling, caused by enlarged proteolytic cellular structure, or consolidation. Owing to the chronology of these diseases, and the age at which they appear, this form of hemorrhoids is very frequently found in elderly gentlemen who have lived "not wisely, but too well", and who have succumbed to the sedentary feeling of their overwearying minds. It is easy to follow the natural course, under these conditions, through the stages I have mentioned, and as the causes here are immutably, we have the opportunity of following them through their later stages.

III. Hard inflamed tumours. After the former variety of hemorrhoids has existed for some time, the length of time, and been subjected to continual irritation, it gradually approaches the chronic and, during obliteration, is thought not to be eliminable at first, but eventually it is provoked in the form of the contracting vessels, inflammation sets in, and we have the hard inflamed tumours. The changes which have, or are taking place, are an increased thickening of the vessel walls, the surrounding cellular tissue becomes inflamed, the tissue is converted into a thin, fibrous, material, becomes organized, and hypertrophy, thickening, and hardness of the tissues accordingly occurs. If an incision is made into them, to find the cellular structure locked up with coagulated blood. This form of piles made be called inter-saccatal (Cope).

IV. A sac formed of hypertrophied cellular tissue, or plastic exudation, which has undergone organization, and in which no thin opening is seen. The difference between this and the preceding form, is that in the former the inflammation has subsided, the tumour has become internal, the vein has become occluded, and the cellular structure obliterated, leaving only a sac-like appearance. It is the final stage of all, and represents a truly
chronic haemorrh or hemorrhoidal prolapsing

I am quite aware that except the may be taken as to this classification, but to my mind I can see no real objection, and certainly structural appearances warrant it. Although these four varieties are but the different stages of haemorrhoids, we must expect to find the one combined with the other, and in some cases, all four exist together. We see the variety being by far the most common.

We have seen that haemorrhoids are divided into two great and distinct classes, internal and external, and that I have added another the the internal or submucosal. Broadly speaking, the internal are vascular (plump) and the external cutaneous. But since the external are merely a later stage of the internal, we must look upon them as having at one time possessed the structure and characteristics of the internal, and that it is only the alteration of position, the coming in contact with external surroundings, that the differences arise, and exist between the two kinds.

Exteranal piles are situated on the external aspect of the sphincter ani and are extremely common; few adults being free from them. They are of a pale colour, presenting a unique cutaneous appearance, while, as elongated, rounded, or flattened, simple or multiple, hard and hypertrophied or soft flaps of skin. They are formed little from the skin which they are simply hypertrophied folds, or they are are hypertrophied part of the veins. These vessels being without valves are very liable to enlarge and become varicose. As a rule external piles are merely the remains of internal piles; and their cutaneous appearance is due to the lasting effects which their presence has subjected them to. From this it will at once appear that external piles are divided into two classes, i.e. varicous and cutaneous, and their appearance will depend on whether they belong to one or other of these classes. The varico haemorrhoid is a tumour from a point to a pulpous hump, a protuberance, having all the appearance of a small varicose veins. The cutaneous one or any other cutaneous, resemble tumours covered with a very delicate skin, resembling the surrounding integument. After a time the tumours will gradually ensue, reabsorbs and reabsorbs, the cutaneous, until they merge into one common aspect.

This process acting like a foreign body sets up a local irritation and
Symptoms

This causes at times, spasm of the external sphincter, with its accom-paning discomfort. In many cases, the patient is unable to void at all, and, as a result, the bladder appears distended and the discomfort and deciliation of urine is apparent as small liquid issuing. Unfortunately, they are very susceptible to inflammation, and if under such circumstances they present themselves before us, let us not fail the patient's complaints of great itching, and is known to the necessity of scratching himself; this if taken matter worse, and is followed by cystitis, heat, spasm of the sphincter, and dull achy sensation, often especially in the effect — commencing as the fingers glide along the staples, up the iliacus, attacking the lumbars, and sacral region, and ensuing great agony. Often he is unable to rest upon his back, which he says is "fit to spin," loses sleep, is unable to ride, or ride, unable to pain rest or care. If he sits, or is in an wheelchair; to sit, he is unable, the pain is the nails, and the ribs present this; so that he is unable to rest for any space of time in one position. He is unable to depurate without the greatest pain, and is continually migrating. Most of his sleep by night; he becomes restless, feverish, and his indigestion causes great suffering. Some of my cases the patient could find no rest unless doubled up in bed upon his side, with his knees upon his chest, and his hands clamped between them. Then he would lie resting from one side on to another. These are of course serious symptoms, and fortunately rarely met with.

Examination

Upon examination, they are seen to be very greatly in size, ather, and external covering in each case. Some a longitudinal fold surrounding the anus, and radiating from it as a fold in a wheel, to the size of a walnut; reddish purple, tender, engaged, throbbing, leading to the external tooth, and extremely painful. This tissue is found, tough, contracted, afraid to depurate, and when he does the cylinders is tagged with blood. The pain which accompanies and follows such contortions, lasts for some time after voids, and is of a dull achy character. These two latter symptoms are pitifully annoying.

Treatment

Bile may, or the care require. It is very simple if the case is taken at the outset. Diet, and cleanliness, with a continuity of diet, will effect a cure. Seldom are we so fortunate in obtaining so early a case. If inflammation has set in and we find the patient in pain, the prompt and shortest method is surgical interference, so recommended by William Hay and Lichtenfert. Have the patient on his side, if a male, preferably lying on the back.
Surgical

If a chair is present, cross the foot edge of the seat with both hands - and apply the tension one by one with a hook or by the fingers - and of all instruments, take care to cut them in a direction radiating to the center, and not to take away too much. If this caution is neglected, structure - an irremovable complaint - will result. Should we have to deal with a benign pile, we must transfuse the base with a curved sawing and cut outwardly laying the tumour completely open. Having squeezed out the contents, rounded off the edges, placed a piece of lint soaked in a solution of boric acid, and adjusted a T bandage, remove the patient to bed, and keep him there for a few days. Sometimes the application of a warm poultice will do good; at other times, cold applications effect the desired end. This a disputed point whether inflammation should not be first produced before operative interference is to be resorted to. If so Clark is very emphatic upon this point, he says, "an operation should not be performed, when the part is swollen." I think it depends greatly upon the severity of the case; always remembering that one is preferable than the other in obtaining a cure.

It is seldom patients consent to this simple operation; we must then have recourse to palliative treatment. This consists in keeping the patient in bed and applying warm poultices, or ice, on the one or the other sides best. A very good ointment, which I saw my friend Prof. Sapolsky use in Italy with great success, consists of Sal Pella adamsis 37. Pals: Opia 37, Lign: falsa 6: 37. It is dressed over the piles, and then a biscuit poultice applied; the ointment being renewed with each poultice. Ulcers of Opirne opined, and the poultice affects comfortable relief. If the inflammation be great, then 4-6 litters will relieve it. They should not be applied directly to the pile, but sufficiently near without actually touching them. The diet must be simple; cold aleatick liquors must be abandoned. Fowl, green vegetables, water in small quantities, soft fruit should form the staple of his diet. Gentle exercise, cheerful society, and the abandonment of coarse tight-fitting clothes. Frequent attention with warm or cold water to the anus. Keep his bowels gently moved once or twice a day, but strictly avoiding all drastic purgatives. Castor oil, or the Emetic Syrup, with Sulfur are by far the best. The patient should be given a saline purge, and ordered to sleep on a mattress. If he experienced an irregularity of his
Internal piles are situated within the rectal muscle, and their external surmise a mucous membrane. They may be divided into:

1. Tissue, these seldom existing are called Blind piles. And
2. Fistula, or Bleeding piles.

I have previously considered the anatomical characters of the Rectum; but improperly omitted entering into the peculiarities of the mucous coat, so I thought it should be more in place to describe when considering Internal piles. Besides its increased movability, and regularity, it presents, when the bowel is contracted numerous cavities, cavities, hollows, or cavitations, hollowing their convexity, letting upwards. Near the nerves, longitudinal columns are seen, and are called the columns of Morgagni. The thin fold of the aorta extend some distance up the bowel, and the one opposite the bladder on the front of the abdomen, and the vena cava, on the right, and the vena cava the left side of the pelvis. They act in all probability in aiding the bladder, to close up the cavity of the abdomen, and support the floors in the polyperiod bladder, thus preventing the bladder becoming irritated by the continual presence. In healthy or hard pile is generally found situated between these folds, hanging partly in the colon, providing and texture from a hard reddish brown to a dark erysypelas-like feeling. In very raw, from a red, to a hard, and the other differs in their proportion. They are uncommonly small, and seldom bleed; covered with smooth shining membrane, or presenting somewhat a cutaneous appearance.
The causes have already been enumerated. Allingham says, they are very frequent after parturition; and are hereditary, as they seldom bleed, the patient is frequently ignorant of their presence. At first, the complaint consists of a sense of weight, and oppression, this always being accompanied after having been slight, as the patient first feels, and dragged down the piles with them posteriorly during defecation. At first they arise upon the substance of the piles, but in time they remain chronic, and form lumps into external piles. This latter result is due to a prolonged irritation of the central veins, when healing occurs it is small in quantity, flows in quantity, and frequently affords relief, some surgeons alleging, if this is the case, advise leaving it alone, and allowing the opening to the external surface.

Patients frequently complain of a something retaining their lives, and alarmed. This is a term more than an increased secretion of stools, now times more-painful is character; and although the secreting plants are very few about the lower part of the gut, and caused, the secretion in many cases, may assume a formidable appearance, carrying great

Constitutional

Treatment

The system being generally being for below pears, the rectal becomes relaxed, but in those parts which are more dependent, and subjected to the greatest amount of strain. As such, it participations in the debility, and protracted is the consequence. The administration of this, with irritants, that, with local antiperspirants will effect an attainment of all these. An application made of the infusion of black pepper, with sulphur, and bitter bark of Potatoes, and taken every alternate night, will ensure a regularity of the bowel, with a stimulating effect upon the
Abdominal

Abdominal obstructions. Their removal is imperative. If the liver be the offending organ then tonics in the form of medicinal acaulis will prescribed or, should it prove a very useful pill by Plummer in which one or two can be taken for a close every other night. A short course vein must be the ushering of the expelled organ.

Constipation

Constipated let's avoidance of alcoholic liquors, the substitution of mild soiled meals; and gentle exercise. Plenty of exercise and very lean, a light diet on a hard matters, will do much to restore this state of things to a very common cause. Build regularly with regularity in diet, exercise must be enforced. A pipe of tobacco often brings in action of the bowels; with some people; whilst with others a glass of cold water the first thing in the morning has the desired effect. Increasing the meal upon its constitution will well repay a careful persons. It is impossible to make further mention of it here.

Local Treatment

In addition to the constitutional treatment, the local use of mild astrignents as warm perchloride of boric, alum, nattate ete may be beneficially serviceable. They will remove all hemorrhagic tendencies, and clearing the irritability of the surfaces. I have had wonderful results attending the use of the Perchloride of boric, and can strongly recommend its use. I apply it either in the form of an application to the pile – having first held the patient sitting on a hot stone bath for a few minutes, when an ordinary amount of retaining will postpone the tumor; or as a lotion injected after each evacuation. Ablutions must be strictly enforced, leaving the parts night and morning with cold water. Themselves if not like, they abraded the

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book so much, and in one or two cases they have actually ruffled service of
the cheeks. Dr. Burne (Cyclog. of Practice of Med.) endorses the use of warm
sweat, he considers they relax and determine the flow of blood to the divided
parts. Horse cresses may be recommended partly because after the
parts has something to do with it, acting in the manner of a spring pad
or bandage.

Have so far only been speaking of piles that are not inflamed, if by any
chance such a state of things should set in, then the hiccups around the
cheeks, nostrils, etc., warm plump, sofontations are to be applied, at the
same time securing a gentle motion of the bowels. Complications of, and
operations for piles should have for future consideration.

Bleeding piles are of for the most distress and difficult to treat. They
are globular in form, pedunculated or flat, and vary greatly in size, some
are as small as a pain's head, others as large as a strobeg. For these
ends, and with one that sounds nice it is certainly
in every case, they present differences as to their structure. Some are like
the subtle tissue as hair, composed of a network of capillaries, spread
continuously by a delicate surface; others are more solid, fibrous, and if
cut into, one or more arterial taps will be found opening into them, the whole
covered with a variety of the muscular membranes, relatively delicate, and
easily explored.

In sepsis, they range from a dark to a deep purple
smooth, and gray, or alternated, and manual, within reach, can be
pressing on their surface, surrounding, and pushing. In arteries leading
with these tumours are of unusual caliber. Ellis in the Dublin Hosp. Rep.
1757 p. 142 thus describes them "If filling up the section, saw three hard
beads each as large as a crospid, running for some way down the lobe;
and these dividing into a number of branches; there were, some, very
pointed, and each lined by interweaving of its branches to form
three of these tumours. The trunks, and branches, were covered only by the
lining membrane of the intestine."

... have then less distinct joints one hairy in form, and the other
'circular.' The latter being undeniably formed from the former, having under
some superficial attack of inflammation, the capillaries becoming dilated
and the anterior termis hypertrophied and thickened by the organization of
the repeated evaporation of lymph, and fibrous matter, corresponding.
is the change, observed in all cases of the skin that have undergone inflamm-
ation, and suppuration.

In the first variety we have first and foremost hemorrhage, which is generally very alarming, the repeated, and frequent attacks reducing the patient partly or wholly to bed, he becomes bloated, aueremic, chlorotic, heavy, with an anxious expression of countenance, accompanied with headache, palpitation, and syncope; complaining of great pain across the lower part of the lumbar region, and across the loin, often extending up the spermatic cord, and into one or both testicles. After some accident but I have more frequently seen the right testicle attacked than the left. There is an irritable feeling "just within" the scrotum, if not in the scrotum itself. In women, if the repeated "losses" are allowed to continue, the uterine and vulvar become irritable, and leucorrhoea sometimes sets in, leading to menopausal symptoms. Should inflammation set in these symptoms change; the hemorrhage becomes greatly reduced. Defecation is extremely painful, with dripping tenesmus, or tearing down a continual desire to go to stool, and a passage of the hemorrhoidal swelling, this may occur, or become one marked by the profuse and bloody stool of matters remain, the pain becoming inflamed and constant. A constant secretion of mucus is poured out of the rectum, staining the stool and alarming the patient. A constant crying to micturate occurs and aggravating the disease by the straining with which the patient is put to. The pulse is quick, hard, and contracted. If the patient is constipated he is afraid to go to stool, and when he does the act of defaecation is extremely painful, hard to accomplish, and involves the "after pain" to such an extent that he rests from side to side upon his bed in "perfect agony."

Hemorrhage, the first and chief symptom requires a more than passing glance. It varies partly in quantity and colour, sometimes being very profuse, at others moderate. If the former it becomes explosive to the sufferer, and his general health rapidly gives way; if the latter it affords temporary relief. It is necessary to discriminate carefully, between hemorrhage arising from piles, and intestinal disease, the origin of which is a stool, even scarlet-stone, liquid, and contains the faces; whilst the latter is leucocolic, black, and mixed up with the stools. In latter it may range from a slight streak to
The termination is four ways. 1st They may subside without much injury, because, if the inflammation has never ceased, nor hydration, if the ulcers or necrosis have taken place. Even however, these latter would have attached the tumour, when C, contraction, a direct result of the effects of inflammation, suspense, and the Swelling became hard, and then prevent the moving to the consolidation of the Plastic Division. Such termination may be slow, advance further, and in turn by the whole of the swelling, becoming absorbed, and the envelope assuming the appearance of a second skin, or suppurative may set in, and the tumour be destroyed. In the latter case, if a cure by drying an internal pile immersed by repletion. The tumour disappeared, and the tumour surface healed by an irregular民警 of a granular substance, have on rare occasions been found in the tumour. (Sec). They are formed by a crustaceous process with the epithelium, fibrous and carious elements, and a phosphatized substance, coalesced together by a gelatinous matter. Carious elements are more frequently, and in a suppurative than in an internal, they being more liable to influence. Again the third internal piles, more frequently suppurative, than the 2nd internal hardening pile, when an internal piles declines, and becomes contracted outside the subcutaneous, and, being rotten, turn hard, and painful; in a few days, it expires to the touch. The is off the ulcerated surface, granulates, and the pitted is cured. In cases in which the constitutional treatment and the local applications mentioned have failed, it is necessary that we should have recourse to operation, means to effect a cure. This may be obtained in one of three ways, as follows: 1st culture them away, 2nd excision, and thirdly, by clamping, and cutting. In these cases, the uses of excluding nitric acid, will furnish us with this calametted fluid. At the time the application of nitric acid has been used upon us as a panacea for all diseases affecting the kidney, and moving to the internal excrescences, it fell a victim, to which no case was really benefited by it, whilst so many it failed altogether. So this form of pile is commonly benefitted. I attribute to the urine of leucine, from which especially the principal pile been so frequently in women. They are seldom multiple, there being but one or locally treated. The acid is easily, with caution, applied to the tumour, itself. When known they are not external, or protruded, a digital examination will reveal a soft, knot-like tumour, feeling when touched and a little. Then examined by means of a speculum is seen to be entirely.
eces, and sozting stick, if the pile be properly, as sufficiently low down to become so by a little obtaining, and then be cut out, or almost this small red like tumour, then the acid freely applied by means of a piece band, taking care not to touch the healthy tissue, will do all that is required. But, generally, these red tumours are accompanied by a large gappy mass of internal tumours, which require a more radical treatment. After the acid has been applied, the tumour must be well dried, and provided with a calculated quantity of bicarbonate of soda or powdered chalk and water to neutralize the acid, and returned into the patient. In all cases, the pile must be thoroughly dried, before the acid is applied, and the surrounding parts oiled. Dr. Lee and Dr. Webster have strongly recommended this mode of treatment. It seems to act by destroying the pile, and leaving an elevated surface; for opulation takes place, and the contraction caused by the increase lessens the cavity of the section, the external surface of which we have seen to be a prime factor in the production of piles. This risk an almost nil.* It is altogether known to follow the pilonidal and where a lipoma can be applied to it. But there the pile is not this cannot be done.

When venous membrane is required, the lipoma must be used, where the opening to contain the knife is decisive, and on fresh. This may be laid down or a cone. Having then adapted the rim of the knife to entering internal pile, he had many fatal cases; and found the bleeding exceedingly difficult to arrest in many. (I will not mention) As an authority, Oliver, Bollie, & Castle, Lobor used the same plan, until Sir Benjamin Bollie observed that the much condemned lipoma covered the sinus, and was altogether an easier method. Bollie and Bollie used to transpose it at the base, and the two parts, allowing the lipoma to ulcerate through tumours. This is a very painful mode, and has been greatly improved upon by Dr. Salmon of St. Luke's Hospital London.

The patient's bowels must first be well cleansed out by administering a close of Castor oil the previous evening, and an enema about an hour before the operation. It should be done. Steaming water being well chosen is as to protrude the pile for a few minutes, before operating. Place him on his left side, in the natural position, and raising the lumbar vessels near with a tube, put in a loop of rope, draw it well down; then with a pair of curved scissors cut the skin, and then make the

* Since writing the above, Dr. McElroy records a fatal case in which

Supplements set in after the use of the acid.
The resection of the mucous from the submucous surface, and carefully devised up the mucous coat from the submucous and muscular layer: in such a manner that the division runs parallel to the vessels, leaving the pole distal, connected by a network of vessels, and mucous membrane only. Being distended up the pole in this way, take a strong twist of ligature, well seated around it, so that it will prevent the base of the pole in the process thus made; traction being made up the tension, the ligature is drawn or tight as possible, thereby contracting the pole tight up, and including all the vessels. Should the decapitated mass be of a large size, two may safely cut off the distal part, within a reasonable distance of the ligature, before returning it into the rectum. This is by far the best plan of resection by ligature. The first division is decided of how for the hemorrhoideal tenesmus under the pole at the upper part. Running through the mucous membrane; in that as long as the wound remains untouched at the upper part there is no danger of hemorrhage occurring. This must be done to both hemorrhooids, separately, removing any superabundant skin which remains, though all to the sublentum of producing tension of the anum. A part of lint or a stout is placed over the anus, and retained in place by a T bandage. Should the pain to occur after the operation, an injection of opium may be given. The bowels are to be unfixed for three or four days, and the diet must be simple - mops, milk, broth, or bread and butter. No alcohol or any form, whilst the hemorrhoideal portion must be included up. Until the fourth day is well opened as to be pain, warning the patient that it may suffer some pain, and pass some stool. The ligatures will come away about the fifth day, and the remaining surface will generally be healed by the sixth. Should the ulcerated surface present any unhealthy appearance, a solution of laurert. Bic. applied one or twice will remove.

A very common afterpain is apt to occur in some of the submucous veins, and a hypodermic injection of morphine will relieve it; the solution of iron is prolonged for more than ten hours after the operation. Retention of urine frequently occurs, resorting to the introduction of a catheter, or a warm NW. bath. Pellets may be given to avoid constipation. Should thr demurrage of the catheter of the bladder is too small a canal. A bongal passed may might well be. Usually this intervenes itself.

As regards the removal of internal piles - should they exist - at the
Same time is a matter of controversy. Dr. B. seems to have a head of the same idea. He says, after the point that it is "a question of the length of the operation," and reminds the reader that "we should therefore not try the internal one and then the abdominal," as "the abdominal one is a large one.

It is better to leave alone, but be sure it is done correctly.

The risks attending the operation are reduced to a minimum. Venous and arterial damage have resulted in some cases. But what about the abdominal? It is not held to be attended by a lesser number of these serious complications.\n
Removal by Sclerosing Injection

Smith's Operation

The risks attending the operation are reduced to a minimum. Venous and arterial damage have resulted in some cases. But what about the abdominal? It is not held to be attended by a lesser number of these serious complications.

Trapping or Treating, or Both. Perhaps no operation has been more lauded by its advocates, than the removal of hemorrhoids by the clamp and electric cautery. The clamp is a recent invention, and was not constructed for this use originally. In cautery and its many years, then applying trichloroacetic acid to these tumors, I am not of opinion. I believe that the operation of the cautery of destroying the tumor and the cautery of the clamp and cautery, I am not of opinion. I believe that the operation of the cautery of destroying the tumor and the cautery of the clamp and cautery, I am not of opinion.

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but likely to be "tame & death" by its own friends. In my humble estimation, Salvarsan injection is infinitely too preferable, and I think all who have performed it will agree with me.

The operation is performed in the following manner: The patient must first have his alimentary canal well cleared out; then, alternating an enema, and till he has to form stool; the tumours will collapse, when they must be ligated with a bulldog, or horse, drawn, clamp, and the clamp firmly applied. In this case, if the pile is with a covered four prongs - sufficient being left to fasten it - and to the clamp he applies the actual cautery at a chill red heat. In some cases, that in which the part to be removed are not large, and not very vascular, Smith's hot needle instead of the cautery. The clamp remains to be closely removed in order to maintain whether any bleeding points are left; if they are, then they must be touched again, and sealed firmly up. The parts must be returned well within the sphincter line, and any superfluous skin which remains cut off. The after treatment consists in giving an injection of turpentine. Injections are an abuse of old stature - or a destroying at the time of the operation, keeping the patient quiet; and the bowels infusid for three or four days. Save the patient that when his stools are more for the first time, he will suffer much pain, but that a warm potato applied for a short time will assuage this.

Two cautions must always be borne in mind. 1st. that the clamp must fasten the innermost part of the pile as the cramps, rule the tumours, one which fasten the cautery must be well applied. And 2nd. the 30th allow the clamp to be touched by the cautery or pain will be caused.

In avoid the first difficulty various alterations have been made in the clamp. Dr. Smith invented one with a spring that could be pressed in from within outward - the name of Smith's improved. Dr. Smith's stress, adapting it to Smith's instrument. However is very slight to occur, it should be carefully looked for and especially noticed, either by means of shaving rope, and by the cautery, or by inserting a probe of a little, not usually with a membranous tube, and subsequently disturbing it with cold water. In some cases when the injection has a fully prepared the edge of the tumours at the base, if the patient will form stool, you may be able to seize the pile, before the reddening point and apply a cautery.

A laterly person, however, if it is an alarming point, sometimes
occur, and require prompt and expeditious treatment. In most instances, the plan is to apply the solution well with a tooth and syringe, these having been saturated with peroxide of iron, and leave them in the vagina for a week or ten days. Dry cold applied coodly to the patient; fan gently alternately, and a banehame bath will remove these cases. I care when the lozenges have not been used for an期限, remove them in a manner that will prevent injury to the patient. A test to determine whether the lozenges are in a state of equipoise, and try them to a piece of paper; if loose, they are in a condition to be properly applied. Before leaving this trouble, it is necessary to say one or two words concerning the complications that will be connected with it. If symptoms of internal piles, when you are called on to such a case try with first place to press them by tampons, but where, either from the cost of the patient, it is not possible, then, or from inability, apply the patient's back to suffer for teaching them, or in case to reach rotten to press the flaxen slip, which the patient's position for proper use in with each cold, the back will be time enough to return them. Place the patient upon his side, and raise the pelvis by means of pillows, so that the pelvis will not move towards the navel. If the cold cannot be cured, pain, apply hot fomentation, or poultices. In this may be used. In case of operating for piles, with the patient chloroform, the patient sometimes of the patient. The cold, either with the solution with the fumigation, properly named, and then by means of a tube, the piles can easily be drawn off, and again, when this occurs in women, by passing the finger up the vagina, and forcing the walls of the vagina close, the difficulty will be more easily overcome.
Ulcer of the Rectum.

Any ulcer of the rectum Loko are divided into definite causes, of which I shall have more to say hereafter: I simply refer to internal ulceration of the mucous membrane, that of a large bowel, appendicitis, or otherwise. I am an adherent of the theory which holds that ulcers in the bowel and dependent, in most cases, upon a constitutional diathesis, or hereditary trait. It is frequently associated with Bowen, or the ulceration, and then its treatment depends entirely upon the method used for curing this complication.

Ulceration of the mucous coat of the rectum is seldom large in extent, certainly the size of the ulcer, and the suffocation of the patient are incompatible. If the ulcer, of course, to those situated on the left side of the base, or situated to the right of the base of the colon, is situated to the right side of the rectum, I have seen a few cases, both in men, in which several ulcers existed, but of these hereafter.

Rectal ulceration may be classified as follows—

Primary ulceration, a disease for itself, unaccompanied with any constitutional or hereditary disease.

Secondary ulceration, arising from a general diathesis, which may be either relapsing, or malpignant.

Trivial ulceration, due to the administration of a local application of some poison, drug or essence etc.

These ulcers are situated within the sphincter, either immediately above the anus, or some distance up the bowel. These are many symptoms come to all, the differences alone being their cause and treatment.

The symptoms of ulceration of the rectum are very characteristic, and almost identical in every case. The patient comes to you only after the mischief has been done, and he is worn out with suffocation. The complaint is of a constant varying pain, becoming worse during, after defecation. A continual desire to tolerate his bowels with more or less irritation about the perianal organs. The badder symptoms often manifest the real disease, and leading the surgeon to imagine the patient is suffering from hemorrhoidal or prostatic disease. If you question him more closely you will find he has had a more or less purulent discharge from his anus of a peculiar character. The amount of these instances being quite remarkable.

Diarrhea is always present, and depends upon the stage in which you find the patient. As follows: it should be have an early evacuation as the
Anomalous Symptom

Later Stages

Acute

Last Stages

Causes

morning the disease is only in the rectum, but if in a constant dull pain, with a frequent desire to go to stool, the disease is of long standing. In states of themselves in character, resembling "coffee grounds" mixed with jelly-like mucus, pus, mucus, and "emulsion". The suffer greatly from it also, and their ears present a brown, haggard appearance.

Sympathetic pains arise in the chest, back, thighs, and legs. At night, his feet is bitten with pain, and after he is bed ridden, he suffers greatly from neuralgia in the chest, and back, bladder, bladder of his abdomen. These symptoms gradually become worse, the diarrhoea is repeated, until his health entirely fails, and he is reduced to a miserable existence. At the latter stages constipation often sets in for a few days, but the diarrhoea soon returns, and continues until another attack of constipation, when the old pain is played upon again. The hardened faces hang down, generally, one hand upon the other, and the act of defecation causes a great deal of pain. Many of the defecation was bloody, and the patient - if diarrhoea lasts - is often unconscious of the passing of his stools. He is compelled to watch himself carefully. Should constipation be present, he is forced to use enemata, or his life is miserable. "If I do not use an injection, I feel as though there was something there, which must come away. I am in agony, until it is removed." Said a patient - time. The diarrhoea now less their power, and the continual dripping of the fluid, irritates, and influences the external parts. Still the disease is altered. Even the full course, the stool will finally make its appearance internally, by setting away - if heavy use the retention in the clausura. If the right or the blood" will exist, and nothing but a common opening is seen, then once was a closed and healthy anus.

I find the appearances are exactly the malignant disease.

General debility or cachexia, infected state of the intestine is one of the most common causes of the ulceration. Pains, and rectal. Division of the rectal, and lumen, either poisoning, or arise from injury to these walls. Depription, has been said to be a common cause, but this I deny, much doubt as there have been a case of rectal ulceration due to it, or have seen in a degenerative case any appearance of ulceration, and I have seen many cases of these diseases, at home, and abroad. Malignant ulceration occurs in women, it is generally found to effect the anterior walls of the ecstomy, probably due to the infiltration of the prostate.

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walls of the vagina, with the tonsils, and the spreading of the cervix to the os. Unbendable of the rectal tubes may perhaps take place, and then the break down when fluid.

Examination of a rectum afflicted with ulceration at its earliest stage, will disclose a rough, ragged, round surface, extremely sensitive, easily washed to bleed, and situated, either to the anterior or posterior walls, some distance from the rectum, ranging from an epidermis of a vessel to an eroded wall in latter. Upon it to the eye a reddish purpura appearance, with solidity of tips, and a modulated state in the descending muscular membrane, due to the thickened plantar.

In muscular, and sometimes tumors are thickened, and there is a narrowing of the gut in the immediate vicinity of the ulcer. Or the disease being close to erosion, become deeper, the ulceration of the glandular mucosa, and the muscular membrane by time. The attempt at healing have partly removed the ulceration, and structure is more or less present. In the mucous are seen intestinal, and external; intestinal usually after are seen running to anus, and perforations little into the bladder or vagina may occur. The patient may complain of pain; tenderness of the lower part of the back, with epigastric dilatation; a.indication of a low form of peritonitis, notable in one way, as the thickening occurring, and the adherences forming these with the bowel, perforations taking place.

The question now arise as to the cause of these appearances, and the history of a syphilitic lesion must be carefully looked for. Before acting as a final diagnosis, in the favor, and treatment depends entirely upon this point. A difficulty may arise as to the nature of the ulcer.

Differential Diagnosis.

Syphilitic ulcer. The history of a syphilitic lesion must be considered. If the ulcer is in a early stage, and not yet altered in the course, or well. The history of a syphilitic lesion. If the ulcer is in an early stage, and the ulceration of the ulcer may be accompanied by the infiltration of the neighboring tissues. Syphilitic ulcer is more yield to treatment, and besides the pain is very bearable, their tissue is jagged and irregular, the plans are not infiltrated, the muscular membrane is perfectly healthy, looking, whilst the ulcer has a scabby outward. There is no discharge from the cut surface, but in the cavity the ulcer appears dry. If lossless there is none.

With respect to the third class, or Pus, no ulcer, they are rare. As stated above, of little accord an occasional ulceration of the anus, on the Bulletin Initial 25.
the blood, owing to the patient having used a press paper - which was
intended for bills - locally, the remaining matter was the cause of blisters.
They disappeared on the patient ceasing the use of the paper.

Thus far, I think, I have clearly and sufficiently enumerated already
its only remain, therefore, for me to mention the most common by name -
Vitiligo, Melanosis, psoriasis, abscess of the scrotum, perforations into the bladder,
avia, and perineal fistula (1).

In the earlier stages, before the ulcer has attained a large size, when
the glands are enlarged, and before much thickening, and ulceration has
taken place,cool and milk chills will generally suffice to cure the disease,
but when the ulcers in the ulcers has come up to a parallel situation, surgical
intervention must step in. If it is syphilis, then the antiphlogistic course
of treatment must be pursued. In the final stages, lumbar artery may
be performed, but a mere temporary relief is the only result, the patient dying
soon afterwards.

Rest, and milk chill. Absolute rest in the recumbent position must be
enforced for ten to eight weeks on a hard mattress, and the diet must
be strictly simple, consisting of milk only. Everything must be avoided
that would in any way tend to irritate the parts. Nitric injections
containing corrosive sublimate, or Co 2 O 3 are to be given at night time. Aparite
made of Quina, Eupatorium, Brodovalc of Staph, yield good results. Especially,
we care here. The severity of this treatment is soon apparent, the ulcer begins
to contract, the wounds become regular, and, although the patient is considerably
reduced in strength, the parts both more healthy, the pain gradually
diminishes until I finally cease. when the ulcer has healed, you may
allow him to take gentle exercise, and very gradually to assume his
usual diet. In this way a perfect cure may be obtained without
suffering and annoyance, beyond the restricted diet, and wanting of
sleight.

I use the word 'sleight' here in a broad sense, and not confined to the
sleight manipulation of syphilis. I also include tertiary syphilis
ulcers. Special ulcers bearing for their history a syphilitic claim, have
been much debated, and very perplexing opinion exist as to their
treatment, and prognosis. Small ulcers are found covered on the
side - the one advocating the use of Monohloride of mercury, and inside
of Potassine with phinone results, the other extirpating the ulcerated-

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all together, saying nothing to disturb post. I may either a sufficiently clean extract of the same by the best means. Secondary and tertiary alterations have been described together, treated alike, with the nearest approach to it. In my part, I am fully convinced that if we had of potassium and perchloride of mercury to steadily poisoned with an ordinary alkali in a pot small well disposed below, not that they are tertiary, that very little acid, may be derived by this treatment is nearly always

Local Treatment

Potassium, sulphate, salicyl, or Balsam of peru, Balsam of Peru, perchloride of mercury, sulphate of lead etc., may be judiciously applied locally as joiners with alcohol and oil. Such mixtures may be derived in many cases, and for some it may be necessary to mix. It is always the function to apply what appears to be a cold, to make of them, patience, and perseverance will only be required in these. It behooves all surgeons to apply what appears, they can command, perseverance being the key to a successful cure of treatment.

Very little can be said under this head, as they are decided and sick, and on a purely pathological curiosity. In withdrawal and avoidance of this cause will in all that is required to remove a cause of course combined with oil and milk chil.

Structure

Nature has been said to be a very frequent complication. It is in fact a natural sequence. In use of a tincture three times a week for several months will greatly relieve the obstruction. In some cases it will be found necessary to make two or three, to make small incision in the contracting band, and while these at first with the fingers, then after using a tincture regularly.

Syrupums, or a hawthorn decoction to facilitate may be advised by administering internally the brother of bismuth, and charcoal, and
Bland. The ulcer will bear these, especially made of hot, Belladonna, or Bismuth, and prompt after being kept containing made into an ointment and introduced into the ulcer will act well. Early use of a powder containing Belladonna, Camphor, and Abscissal of lead can be strongly recommended.

Chemical ulcerations is a frequent complication, and must be combated by perfect care, warm compresses on the part, with guaiac, and Carbonated Spirit administered, and a milk diet. For symptomatics and tonics from repeated dose of Camphor and pilule p. v. x.

If these means fail, what then? Tincture, such as Nitric acid or better still Dilute of nitric, applied to the ulcer will remove their infected appearance, and cause a healthy action to set in. When this fails, the only resource we have left is Excision intervention.

Having cleared the ulcer and skin of pus, and placed the patient well under Chloroform, transpose the base of the ulcer with a curved bistoury, and cut outwards. To describe the operation more in detail:— annex the highest point of the ulcer by means of the finger of the left hand, and when the point of the bistoury will close in the margin of the same, carrying it well up through the base of the ulcer, with the point makes the leaf-face fringes marking the extreme edge of the ulcer, then by pushing it a little further upwards so as to include a portion of the healthy mucous membrane, complete the operation by making an outward incision. In some cases, the excision is of long standing, and the base of the ulcer is hard and resistant; while another incision, made at right-angles with the one above, across the ulcer, and exactly in the same way, may be advisable. The after-treatment consists in keeping the wounds dry and mild lotions applied when necessary. It is advisable to watch the ulcer, and six times bismuth, as it may acquire to apply; cancer, this materially curtails the healing process. First must avoid any milk and wine; and clots and coagula in the ulcer, and partial maintenance, for sometime afterwards, very fair and pure diet being allowed up to the extremal parts of the limbs. A weeks time this, and prevent some away.

In the worst stages of all, when the ulcer is of large size, and extremities and numerous sterile sores, then the above means are of the greatest, and lumbar celiotomy is the only means we have of prolonging life. Incapacely,
Like a few months, but Allingham in St. Vincen Hospital reports for 1899 gives three very successful cases, and both the patients were living two years after the operation. Is doubt the section when all signs have ceased coming through it, and irritation is therefore reduced to a minimum, will experience a great deal of the lost tone, and the vessels become well-adapted for the cure; the tumour growing may then be closed*. Very much question the possibility of a perfect closure.

Rodent ulcer has been mentioned during the consideration of the foregoing disease, and a word or two concerning its treatment, and proposals may not be out of place here. The pain accompanying this disease is sometimes extreme, and it is to the alleviation of this that we must almost confine our attention; the ulcer itself being removable. Some have advocated the excision of the ulcer, but it soon returns, and the end is worse than the beginning. Others may be led to trace it out, such as iatric acid, Eclectic, Ipecac, etc., the actual cautery, freely mention them. Solid of Potassium, and lodic oil, may be administered internally, and salve their externa applied locally.

* Dr. Allingham reports a successful closure of a "facial fistula in the lip" (see p. 37). It occurred in girl who had been subject of appendicitis, ulceration of the section. It was under the care of Dr. Alfred Erasmus.
I append the two following cases of ulceration of the rectum and from their peculiarity I have termed them "Multiple ulceration."

A. K., at 22, male, unmarried. Had been suffering from a burning pain in his rectum for the last four months, but thought it would pass away. Defecation did not cause any reappearance of his symptoms. He had never suffered from pain; nor had he passed any blood. His stool was black by a smarting itching pain, which he said was "just inside" and he could not get at it. Sometimes the scratching made him "cry out." His stools were regular. Had never had diarrhea, or any discharge from the rectum. Family history very poor. Had never suffered from a feverish affection (after this point, subsequently made a very careful examination but failed to elicit the faintest trace). Had always enjoyed good health. A appearances he was a clean, muscular man, but looked nervous, and harried. Internally the anus presented no lesion; it had a "pore" appearance, but this was doubtless caused by the incessant scratching. Took no discharges. Upon inverting the finger into the rectum, felt one or two small soft surfaces upon the anterior, near posterior walls. They did not cause pain when touched, though he could tell when the fingers were upon them. There was no ulceration, or narrowing of the rectal caliber. The bleeding showed two small, solid, sharply commissured sound areas about the size of a pea, upon the anterior walls; the like number on the posterior wall of the rectum. Had no discharge. A appearances, I ordered absolute rest with milk, milk, and a small injection (3/4) of sulphate of copper 2 p.m., till the 7th night and morning. I touched them with a point of nitrate of silver at the end of the class from the commencement of the treatment. He made a rapid recovery, and at the end of three weeks he reported himself "quite well. Have better in his life."  

In June 1877 Dr. A. at 38, a gentleman, came to me suffering from great pain in the rectum during the day, especially after defecation, with an acute itching within the anus at night.
time. He did not feel relieved after evacuation without using an injection, for, as he said, there always seemed as though some forces had been retained, and when he did feel relief, the "burning neuralgic" were moderated a large sized pea in dimension. The history was somewhat remarkable. For 15 years he had suffered from an affection of the bladder which had been treated by twelve medical practitioners, each in his turn diagnosing a different disease — from hemorrhoids to syphilis, cancer of the bladder, but without the smallest shadow of relief. Six years ago he placed himself under the care of Sir Henry Thompson, who found he was suffering from a large ulcer of the bladder, rather larger as he said — than a five shilling piece. This he — Sir H. D. got abated upon and cured; but the habit was so long established that each tablet and which he had contracted after 15 years of daily use, he could not dispense with. He was now persuaded that the old ulcer had returned on a new one had arisen. He had been seen at one time of a lifetime addicted to excess drinking; but had never suffered from any specific disorder. His appetite was fairly good, but he was practically losing flesh and growing weaker. Examination revealed an involution condition which was evidently due to the scratching which he subjected himself to all night to relieve the internal annoyance, on the posterior perforation from the exit of the rectum there was a small friable growth standing. The feculae showed the existence of five separate well defined, round, smooth, very hard foreign bodies, and with the mucous coat, three on the posterior, and two on the anterior walls of the bladder, each about the size of a small pea, and between the mucous and submucous coats, and one rich within the sphincter. There was not now had been for five years any discharge from the rectum. The pain during defecation was of a burning nature, but insufficient to compass to that coming on afterwards. Although the case was decided a chronic one, I determined to try a palliative treatment here, and give the hemorrhoid injections with Belladonna pills, as recommended by Professor, a familiar. His chief I did not interfere with, as it was already sufficiently severe; but he had to avoid all fatigue. If this latter he had taken home for 3 years, and so he was "far below par" I ordered him Surgically. The six weeks of treatment, one day almost well, another worse, the ulcers on the anterior wall had completely disappeared, as well as two on the
posterior wall, but those remained one, which although much diminished in size, remained patent. This stretched the times with Temar cautery when it healed in ten claps. The former known required somewhat additional treatment by a solution of Cupri sulphur as a lotion. At the end of two months he was entirely cured, all the symptoms had disappeared, and he pronounced himself "quite well. Perfectly better." Soon advised him to get rid of the excrescences but this I found most difficult. All that they were a necessity included a custom, a habit. He had no uneasiness after defecation; at the duration of using them for 15 years had really settled into "grand nature," and the bare idea of "doing without them" seemed to him an infringement upon his "necessities of living." However he was often in convulsion, and before the end of September he had ceased using them.

Early in the case gave him Dr. Megnac's 15 love daily, which I continued for six weeks. Afterwards he took it: 10 per

Portland: 10 love daily for two months.

At the outset of the case had very little hope of the palliative healing being effectual; but my doubt was speedily removed, as after a week's trial, the pain after defecation was sensibly diminished, and the "aching" greatly reduced. As I was still in doubt, and I am convinced the ache was entirely due to the internal ulceration, as is clearly shown by its cessation when the ulcer was healed. Further the pathological appearance of that ulcer was totally absent, I can suggest nothing as to the nature of the ulcer, its cause, or situation. Have heard of such things as "fusiform ulcers" (Byers). He certainly had never suffered from any specific disease - dyspepsy, duodenal ulcer like - the fact that he had ever been the subject of cardiac ulceration, and also during the early period of manhood "used a lot worse but still well," while his habits for the past five years had become markedlyicterian meal, as point to "excessive exhaustion" could this prove productive ulcers? In last case past such little complications did not exist. His family history was good, and no hereditary taint was traceable. Could the ulceration, caused by the nozzi of the contraction have been the "preceding cause"? Finally are we warranted in considering this a distinct form of ulceration - A new disease for us? Attempt to.

* March 1878 he continues perfectly well.
Fissure, or Painful Ulcer of the Rectum.

In this most distressing disease, we arrive at the minimum of cause, with the maximum of pain. The disease in many cases being simply suppurating, and if allowed to continue, will reduce a strong healthy man to a mere shadow. By the term "fissure," we mean a small rent, split, or chink, chiefly situated on the closed aspect of the anus. Small, superficial, elongated and narrow ulcers, between the Villar's folds of the anus. Dr. Boyer was the first to describe this disease, about 1820, and called it fissure, or fissure of the anus; and he was of the opinion that fissure is the true cause, the frown being merely a complication, or an accessory of that disease. Dr. Pechere, also described the disease in 1838, and since then it has attracted the attention of many surgeons of note. Dr. Ballet of Paris considers the disease to be "a spasmodic neuralgia of the anus, with or without fissure."

Whatever may have been the obscurity of opinion entertained by the earlier writers upon this subject, I think the generally accepted opinion now is that the frown is the primary cause, and anal fission is due to the irritation of sech-up. The extreme pain, and spasmodic contraction is clearly owing to the fact that the rectum, especially in the towns partly, is sufficiently supplied with nerves from the pudic, and posterior and anterior rami. The fistulae form beneath the mucous membrane, and between the stricture fibres of the sphincter, those being readily affected upon the slightest loss of tenacity of surface, and when irritated as they must be, set up fission of that muscle. After this has gone on for some time, the muscular fibres become hypertrophied, and this alone is sufficient to prevent healing of the ulcer. The clear understanding of this we shall see better, when we come to consider the treatment.

A true instance of the cause being will be found on the posterior, internal aspect of the anus, and we shall presently see. They thus should be the case. It occurs at all ages, from infancy to old age, but is found as the female more frequently than in the male. Paroxysms are especially liable to occur in menstruation, and when the head of the child, especially of the woman, from the perineum, passes, and the to escape backwards: the tear, and muscular membrane surrounding the part become greatly stretched, small rent.
on formed as above, thus laying the foundation of a future service, which
only require the perpetual irritation of the social discharge to prevail
their healing, when complete service is formed. In women, if necessity
habit: the social discharge is insufficient of itself to cause the closure.
First passage is another common cause. Immediately within the bladder,
the rectum becomes dilated, and forms several sinus or pockets, into
which the "head" of the ascending feces is forced, and as the clay
bind, a suppurative focus of the site, and rupture continues, the head
becomes exceedingly large, and its calibre five parts in diameter
than that of the dilated sphincter. Now what is the consequence of
all this? Immediately the bowel are opened, the enlarged head of
the cylinder less press, difficulty in passing through the narrow
opening; the skin and mucous membrane are torn longitudinally, and
on the forward, through the eye, these skin is the outlet, and, owing to the
intimal irritation caused by the passing of stools, the ulcer never
heal up. They become edematous, the submucous have become sequestrated,
causing the painful spasm of contraction of the sphincter
and the expiring pain. The crack, a linear fissure has become an
ulcer. Hemorrhoids, on a very fruitful source of fissure, indeed
it has been said by some one, but by whom I cannot recollect, that
one ever have a fissure without a hemorrhoid having formerly
existed, going ease to the idea, no pile, no fissure. They present the
free passage of the feces, and accumulate in small particles in their
folds, the surrounding parts become irritate, inanne, and excoriate,
giving rise to the formation of fissure. Sometimes, a very characteristic
small and pile reacts the position of the fissure. Sphincter; a careless
introduce point of a syringe; the fistula arising of any foreign body.
Solitary; the suppurating hemorrhoids of an internal ulcer; No. 8 of
a cachectic state of the sphincter, have all been known to produce this
disease. In some cases the cause can not be ascertained.

The fissure may be either without, or within the sphincter; it
may pass from the bowel to the outer side, and across the skin of
the external. It is found chiefly in the posterior part of the anus at
may occur at any point of the long, and it may exist separately
or in connection with others. In one case I had under my care, over
in less than five, and they were arrayed down the anus. One
Complications

Postoperative

Papilla

Fistula

Protrusion

External dot

Symptoms

Acute Differinige is a disease of the nose characterized by the presence of a pus-like discharge from the nostrils. The symptoms include a burning sensation, a sense of pressure, and a discharge that is sometimes bloodstained. The disease is most common in individuals who are exposed to cold and windy conditions. Some patients also experience a sense of dryness in the mouth and throat. The symptoms can be acute and may persist for several weeks or months. The treatment is usually a combination of antibiotics and decongestants, as well as lifestyle changes to reduce exposure to cold and windy conditions.
or even during defecation; or it may set in for some time afterwards. This difference depends upon the fact of the nerves filament being irritable or not. If they are, the pain sets in at once coming to their being strictly excited; if not, the pain only commences some time after evacuation when the muscles begin to contract. Patient suffering from this disease, reason is say, allow to run on for some time before seeking advice; appeasing their sufferings, and increasing the disease by so doing; allowing their bowels to become constipated, and alleging as their excuse, that the pain is so bad we are afraid to let it stop. They will tell you they have visited doctors of tried in their names, and that perhaps, they have passed "corruption and stool" for some time.

Anomalous pain sets in after a time, and frequently, whether from a source of constipation, or rectis -ments, the patient will details, sensation, a sense of pain in the body, less pain [as a woman in the interim of spacing] with a frequent desire to evacuate; whilst in some this latter will amount to spasmodic motion; being right [1] at the while of the pain situated in and around the anus, under those circumstances it is not to be wondered that the Surgeon makes a wrong diagnosis, and treats for a disease, to which the patient can lay no claim, whilst the latter is proving worse. The general health begins to give way; constipation increased; weak dyspepsia, dyspepsia kept; loss of appetite, flat dyspepsia, and the subject is reduced to a very short time is positively helpless to action - his face expression of intense suffering, and dulness to his. I have frequently visited how some patients, suffering from salivation in hypochondriasis. After all, they are one of the view, as they do their medicines without effect for four months. Some noted case I had, the pain arising from defecation absolutely drove the poor fellow delirious for hours.

When you come to examine the anus, tincture, you will find it extremely difficult in many cases to obtain a thorough view under for administering chloroform, the very act of separating the bowels besides contraction of the sphincter, and a return of the pain. Place the patient on his right side and gently separating the body; advance your finger gently towards, at the same time gradually separating the anus. The finger may tell to the right, where the being hidden behind a hernial cord, a little further, or to the being situated within the sphincter, and not of right. In these cases, the best plan is to give chloroform and dilate the anus. The finger then reposed will be seen to be red, engorged, round, oval, or triangular, with cells,
Treatment

Palliative

Palliative treatment consists in subduing the intense sufferings. Stifling a healthy action of the mucous membrane of the bladder, and laying a quiet rest, evacuation. To indiscriminately treat every case of gravel by palliation, and thus failing, operatively, will only bring great calamity upon the head of the surgeon. A sufficient amount of purgative drugs, and diuretics, will avoid all this. I have been accustomed to take the following rules — if I may call them so — as my guide, and to act accordingly —

1st. If it be a syphilitic case,

2nd. — — permanent.

3rd. — — red, and to a great extent.

4th. If the subject be a woman, and

5th. — there be no indication, or by pretense of the physician,

then under me, or mine, or any of those circumstances, feel myself justified in resorting to local stimulants, and palliative means to drain a case.

Next seek to obtain a thorough evacuation of the bladder, and to maintain a moist and free passage daily. Diuretics begin morning and night. An emulsion made of Capsaicin, Nux vom., calomel, washing, and followed by a good draught of Foderickshall bitter very morning early, will cleanse the system. One lemon, with or without my patience, i.e., leave lemon on evening evacuation; should they do so, and you form one stone or broken, and then lose heart — the agony of one night enduring the repairs of a month. — The remarks made concerning gravel when speaking of hemorrhoids in these matters, will be applicable here. Hence I differ in this aspect, — natural evacuations — from many eminent surgeons, yet I speak from experience, and experience is that. Having stood this and I seek another the fever, and pain, the obstinate; or a little containing quin, belladonna, and opium is very efficacious, or an injection of opio
Upon a person of cold stomach after each evacuations may be used. The application of ointment at night, or a mixture of honey and pepper-bread rubs on the stomach, sometimes, of the action. By these means a cure is frequently obtained. Stool in the rectum, frequent position must be maintained, and a mild emollient diet resorted to.

In France a pledge of linen cloth saturated with chloroform and chloroform as recommended by Chapelle, introduced into the ears, is often practiced. But this causes much pain, and seldom does any good. Sommavilla strongly recommends the injection of chloroform, in fact inspired by Bichat. I have tried it with much success in many cases.

The following is the way I have used it, as first recommended by Bichat, with slight alterations. Cause the patient to clean out the bowels well with an injection of hot soapsuds water, and having waited about an hour, give the injection, if the patient is within the physician, or wash the hands if it be external with the following mixture:

- 1/2 oz. potassium 37
- 1/2 oz. potassium 37

Add to the distilled water.

Apply the enema in the water in a Florence flask, and when cold add the tract. In four ounces exactly take up the 37 of the enema, and the chloride is reduced to its minimum bulk. If this be done after each motion, a wonderful change will take place in the patient; what indigestion, thirst will gradually disappear, and the mucous membrane of the stomach again be restored. At first the injection may cause pain, but such cases are rare, and when met with, the pain soon vanishes. It is however always advisable to warn your patients that such may occur.

In internal administration of Bichat's enema is followed by Bichat's and his disciple Sommavilla. It is not always necessary, and very seldom use it, in the case of the case. It may be given in pills every night, and taken containing 37 of a grain of the enema. Alternately with the injection solutions of sulfuric acid, 2 parts to 5 parts of water may be used, eight and ten minutes, repeating the practical to three times daily during the cure of it. Sommavilla's enema is also very useful, and it is frequently used in the course of its administration an invaluable drug. A very useful internal wash of soap and chloroform, and in the stomach, may be considerably affected with
much benefit. I do not know the exact nature of the metal, but it is applied very in many cases.

Surgical treatment is the best, quickest, and most method of curing cases of the anus or rectum. It should always be preferred in cases in which the patient is not opposed to operative measures. For any operations, however, which is not immediately successful, and the remedy does not occupy many days (3-14) I have already seen the rude "riddle" which I consider sufficiently encouraging to warrant an attempt at curing by alleviation means; then the applicability here would be superseded, equally to their "cures".

The surgical operations are divided into two 1st forcible dilatation, and 2nd section through the base.

This means of thinking the base of a fissure, or dilating the contractility of the sphincter for a certain length of time, is a very good and practical one at times. It was first advocated by Dr. Bocciarell, and Dietze of Paris still hold the performance of the knife. This is certainly a mode of treatment to which the French surgeons are extremely partial. They have several operations, but they will not like them. Dr. Dietze's practical recommendation is, that the patient's own injuries not. The pain of the operation is very great, and can not be borne unless Chloroform is given. The operation, as performed by Dietze, is the same as in the case of Dr. Bocciarell, by introducing, either the two thumbs, or fingers into the anus, and forcibly dilating it. By this means the fossa is torn open, the sphincter muscularis paradoxicum, coming to the surface of some of the fingers, and thereby the ulcer bed. Alas! the blood is very profuse. We have seen that Dietze considers the closure to be of a peroperative nature, and he says, when speaking of the manner in which this operation is to be performed, that there is a closure on "and the argument in favor of the spontaneous nature of the closure." He after treatment consists in the application of some simple ointment, and the careful regulation of the bowels. The greatest draw-back to the operation, however, is that the sphincter loses its form, and maintenance of feces is the result. Perhaps this indirect dilatation by means of traction of the fibers, is a tension, and painful method of cure, and certainly unsatisfactory as its results. The Italian surgeons have a theory for their mode of treatment; but I have seen any real lasting benefit arise from their operations.
Mr. Royen was the first to introduce this manner of treating oral pyorrhea, but he considered it absolutely necessary to thoroughly cleanse the gums. Dr. B. Brodie, however, gradually limited his mission, until he found that by carefully dividing the bone and the fibers of the muscle immediately beneath, the same successful results are obtained. Royen's deep incision caused an ugly wound, which took long to heal, and this troubled the patient considerably in health. It was M. St. Amant, M. Dupain, M. J. S. Moore, and others, all now admit the limited mission of Brodie. So little is so bad – in time some perhaps more than too much. So unless you thoroughly divide the bone and obtain theewing for some time, I acting, the operation will have to be undertaken a second time.

The operation is performed as follows: introduce the periosteum of the left hand into the wound, and pass along it on the flat surface, a straight and pointed bistoury. When the knife has reached the highest point of the ridge, turn the cutting edge down upon the periosteum, and withdraw the knife at the same time cutting downwards, and outwards, thereby the bone to about the depth of an eighth of an inch. If a pyorrhoea, putty, or bone, it must be removed at the same time by the knife; but occasion may be used to cut off any inflamed tabs of skin which mark the site of the external inflammation of the periosteum. So dressing is really required; but a small piece of cotton wool may be placed in the wound, and retained there for a day or two. Such: lori: packlet is: should be given to or three times a day during the healing of the wound. When the jaws were kept confined for the first three or four days, when a stone of the jaw may be given. It is all necessary for the patient to remain in bed; but his exercise is to be limited, and he should at least keep his head for a week. Until the wound is healed exactly, it may be touched along its white line with lignint. Yet:

Dr. Redko suggested that instead of cutting close upon the bone, trim perio for rather, and then cutting afterwards towards the mouth is a better plan. He begins by cutting the point of a curved bistoury dull under the bone, and carrying the knife upwards until the point occurs, and then its natural margin; when he finishes the operation by cutting upwards, downwards, and outwards. His after treatment is identically the same as in the former operation.

It remains to say that one or two words upon the syphilis: it: firm.
Forms of this disease. They are very common, and very accessible to acquire, being readily under the finger. Ointment may be applied to the affected parts, and the diseased skin will be found to be very successful. By such treatment a very slight one, and ugly ulcer will heal, and scar tissue will be avoided. It certainly requires a little time, and patience, but a cure is almost always effected by these simple means.

Protaspous Ani.

Small obliquity of Opium praecox regarding the true, and accumulated that just arise to this particular form of rectal disease. Some surgeons clothing upon it as a mere protrusion of the mucous membrane only; others both both these, and call protaspous muscular bulwark into protaspous Ani (Brodie etc.), while others are still farther, and unless I am very much mistaken, in the construction they would have placed upon their classification, nothing short of inscription of the rectum in their opinion can constitute protaspous. However much they differ they all agree to a certain extent. Doing protaspous in this treatment I am, as the principal of protaspous I mean it full, or take forward; to pasture this with prosidant - proceeds - to fall down or forward, and we find the two words, protaspous, and prosidant - which we shall here directly are the two words on which a real deal of the engineer devoting in this case has revolve - bear exactly the same meaning, and are as applicable to each all the various forms, and differences of this disease as they stand. So my mind the true objeet is not in the word protaspous, but in the word "ani", and in speaking of this disease, I shall use the word "ructi" in preference to it; locating as on single instance, and that the widest, simplest, and most common to the forms, i.e. Protaspous of the mucous membrane. Protaspous Ani or Ructi to distinct to three distinct forms.

1st: A simple protrusion of the mucous membrane of the bowel situated at the lower part or Protaspous Ani.

2nd: A protaspous sten of the mural, submural, external, and internal tissue of the rectum (sten), being too all of the 1st, 2nd, or 3rd point.

3rd: Salivous anis, or inscription of the upper part of the rectum,
which has occurred through the shock part.

It is imperative that we clearly understand each of these forms of the disease, and discriminate upon the matter of a doubt in any case before operating, as the removal of the mucous membrane would be good treatment in the first form, but would lead to fatal results if the action were divided in the first portion, and the peritoneal cavity opened.

I propose to distinguish two postapone Recti from postapone Recti by applying the former term to the simple protrusion of the mucous membrane and the latter, to the bloat form as above. Some authors call the one postapone Ani, the other Posterior Ano. I prefer to avoid this, and I retain the word "postapone" referring only the former, as the one or the other portion of the intestinal tract is implicated.

A simple protrusion of the mucous membrane of the small intestine is very commonly associated with, and caused by, the presence of internal hemorrhoids, and I draw particular attention to this fact when speaking of that disease. It is also frequently found in ill-nourished, weakly, nervous children, and in old people, especially in women who have borne a large family. Diet in those, dyspepsia, constipation at stool, ascariasis, phthisic renal, calculus, etc., will all be found to predispose to the disease, although more frequently the rectal portion of them are the cause of postapone action.

This is a very simple disease, the patient generally having it when a child by its parents, or when it newly itself. It is only when other signs are associated with the absence of the mucous membrane that we are called into a case. The simple rectal protrusion presents a bulge, soft, pulsating back, and somewhat tender. If a careful examination be made the protruded surface will be found to be continuous with that coming the sphincter muscle. The protruded part may be contended by the sphincter, and the vascular supply is cut off; more commonly however it is found that the usual contracture is relaxed. The protrusion at first only takes place after or during defecation, but as the case is allowed to go, the parts come down upon the slightest assumption of the closed position, more especially during walking, or long standing. The patients complain of a feeling of fulness with a dull dragging pain, an inability to evacuate the bowels, with modified symptoms of aneurism. Should the protruded part be allowed to remain protruded intussusception may arise, and the parts slough away, a mere band being effected. If hemorrhoids are present, then the
postulated mass will have the appearance of a number of distinct humming of a polyhedral or present it will be seen hanging by a pedicle.

When the polyhedral or pedunculated with tail, polytely etc., the postulated mass may be gently removed by rolling the part, and gradually capsicum, it will then pull off. If the pedicle be contracted be removed it in a hot bath for 15 or 20 minutes before attempting its reduction. The patient must then be put to bed, and the recumbent position maintained for some time. Antiseptic injections such as calamine, alum, menthe, oil of turpentine, or small fragments, may be used. Inபாச்தர் containing the same drug may also be given. It is also advisable to follow the plan given in Vani's Surgery of having the trunk forced in the abnormou sedition in bed. Potash oxide is to be given, and burning evacuation encouraged. Without pain, or polytely be associated with the disease, they are to be removed, then the postulated mass membrane will generally be removed.

In all children cold, loin oil, and a nourishing, easily digestible diet are to be given. Numerous cases report anti-ulcerous treatment — suppositories along with chloral, and Inunion of iron.

Some cases refuse to yield to this palliative treatment, and the removal of the humerus membrane is then necessary. This may be done better by applying the fuming nitric acid on the whole of the postulated mass, or by ligature. Excision should not be practiced, as the part is too irregular, and hemorrhage is very profuse and difficult to arrest.

When applying nitric acid the humerus must be held still, stationary, and theachine plucked with sharpness. The burn closed, and the legs bound together with a sheet. The trunk are to be kept inflect in for a few days. Sometimes — especially after alcohol form — the trunk begin to inflect, and the flap is forced out, to avoid this a thick pad of lint is to be placed at the anus, and a T bandage applied. After a few days a dose of Castor oil may be given, when the flap will pass out during defecation.

Though this disease in children is terrible, in adults is very difficult to alleviate. Children are frequently allowed to sit, upon a low chamber stool for an hour together, the body being well thrust forwards, and the separated force of the chaperons being exerted upon the abdomen of the patient. This practice must be discontinued, and a high stool used.

When ascariads, chiliasm, calamine, oil of turpentine, and the means to lessen them be used. In adults, the use of nitric acid is to be deprecated. It
Pelvis accomplishes a cure, and the sufferer being nearly always a person of weak and constitution, if he alter his form and alarming hemorrhage were reducing the patient to a great extent. Many Carbolic Acid, is the acid solution of silver nitrate may be applied in place of the nitrate and a powder passed up the anus, and retained there by a wire or candle, may be tried. In use of poultice counter are very likely to cause within the cure being worse than the disease.

I shall also operate numerous I stand one until have considered them in severe forms of prolapse recti.

Prolapse of the Rectum is by far the most serious of all. A portion only or the whole of the mucosa of the walls may come down, and it may be that the portion that is also protruded. The tumor, therefore, remains in some cases common (as) Sivyer reports a case in which it was larger than a fatal lead. This disease is more frequent met with in females children than in adults when it is met with in female, it is generally among women who have had large families, and is when the bowel movements have been greatly altered.

Piles; ulcers, ulcers, along with muscular heave of the rectum, regurgitation, habitual constipation occurring in people of inferior constitution. Structure of the rectum, disease of the prostate, hemmorhoids, chronic constipation, constipation, and long residence in the stools, all tend more or less to give rise to this disease.

In female generally prolapse during defecatory movements, and the straining arising from any of the causes just enumerated. The patient complaines of a dragging down painful sensation, of a fullness around the pains, and a difficulty in defecation. The symptoms may approach very near to those of stricture. As soon the stricture is relieved, and the surrounding integuments relaxed he feels free from the sense so from a cancer, strictures, and prosthesis, they being downward, and are felt to be intense. Of the finger be just into the canal offically, it will be found to be dilated, and placed. In such circumstances prolapse will take place at any time the patient assumes the seat position, and what at first only seemed during defecation will now have become a per-manent disease.

Strangulation, later sets in, and the tumor becomes hard and swollen; the patient
complaints of great tumours, and pain; in a short time the change takes place, the surface begins to alter, and soften, and finally the whole mass disappears - the tumour having undergone a spasmodic cure.

When the tumour is rapidly reduced, the surgeon is seldom called in, it is only when a large solid jet of thick has come down, and its reduction difficult that we are called for. The tumour will present an oval, filiform, or cylindrical appearance; hard, and pulsated at times, the surface is rough. Compare this change. The oral mucous membrane will be found to be continuous with that covering the pharynx, and one finger can be passed into the natural canal. Afterwards, the softer will also a lamellated appearance.

**Treatment**

**Palliative**

When called at a case of spasm of the neck, our first care is to reduce the mass. This may be an easy or difficult task, depending upon the state of the sphincter, the extent of the protrusion, and the length of time it has been there. If the sphenicter is in spasm, and pressing it with a finger, or at its central and lowest part, and pressing gently upwards, will effect its reduction. But when the mass is either large, congested, and manipulated, the sphincter must first be divided before you attempt to remove the jet. This may be done by passing a claret between the tumour, and the sphincter, along which a silk-poled cautery is carried, and the muscle divided. The tumour is then to be well held, and death twice made upon it, by pressing the neck with the finger, and pushing this upwards until it has passed the sphincter, and the portion is then to be reduced in like manner, and so on until the whole is removed.

**After Treatment**

(1) In children the after treatment consists in hot, cold, or tepid, or injection, and regular gentle action of the bowels. The mention treatment for spasm is applied with equal force here, and need not be recapitulated. The rectal cause must be very case to be first removed, when the prostatic will readily yield to treatment.

We have a relieved condition of surrounding parts, and a tendency to protrusion of the bowels. The vein around the base of the tumor is loose, and those into radiating fields, and the sphincter intumescence. The palliative treatment in such cases is certain to fail, and operative measures must be adopted. We seldom find a case is a child of 1/4 with all these true conditions of external parts.
In Operative Treatment, the cutting away of those loose folds of mucous membrane would reduce the contraction caused by the cicatrisation, and the adhesion arising from the inflammation set up by the operation might happen the patient, and cure the disease. The folds are to be removed by a close pair of curved scissors, to a direction radiating from the anus. It is advisable at the same time to remove a small fold of the integument covering the sphincter. Some cases known to indicate any such interference, and an only remnant is a protoplasm tissue.

The removal of the loose flesh having formed adherent, the separation by ligation of the mucous membrane; in the use of the actual cautery may be tried.

The patient must first have his bowels thoroughly cleared off the day previous, and a warm saline purgative the day of the operation; he should also be kept in bed, and warm, to facilitate evaporation. The wound being dry, the operation, by which means the protoplasm will be well done. The position is now to be kept at its line on one side with a pair of shears, drawn forward, and a strong ligature tied firmly round it. The same being done on the opposite side of the anus. The ligation is cut short, the loose flesh folds of skin adhering, the tumour reduced, the patient put to bed, and a full dose of opium is to be given to confine the bowels for a few days. The transplanted portions will separate, leaving adherent surfaces. This will readily heal. The treatment is safe, prompt, immediate, and complete relief, and leaves no operator's. The pain caused by the operation is very slight, and can be allayed by the administration of chloroform.

Henry Smith strongly recommends this mode of treatment, and considers it to be far preferable to any other operation. It is applied in the same way, as described when treating of hemorrhoids. Portions of the fistula are clamped the parts cut off, and the cautery applied. Van Heerden has introduced the cautery in stripes down the protoplasm section, and to the base of the anus. But this does not place, and a cure effected.

Lining nitric acid is a most efficacious remedy, a precautionary course of which often cures permanently. Instead of applying it to the whole of the surface of the fistulaled mass, it is better, and does equally well, if you divide it in lines - four to six in number - down the fistula. Similar to Van Heerden in his application of the actual cautery. Nitric acid is avoided, and a very satisfactory cure results.

Inception, and Subincision of the Reclaim has been used with
Stricture of the Rectum

Stricture of the rectum, uncomplicated with ulcers, is a rare disease. It is rarely met with, and difficult to understand regarding its exact cause and development. Simple strictures - when not associated with malignant growths - fit the rectum, like stricture of the oesophagus, with similar wide hollow tubes, must have for its repair some serious disease sufficient to reduce a powerful, and usually narrow, lumen of the tube, before the existence of an impediment to the passage of the feces is suspected or this noticed. As a congenital disease it very rarely occurs.

Stricture of the Rectum may be classified as follows:

I. Simple, uncomplicated Stricture.
II. Malignant strictures, or carcinomatous strictures.
III. Syphilitic Stricture.
IV. Hernio-rectal Stricture.

The stricture may be confined to a limited extent of one side of the bowel; it may surround it, as a ring, or a single, narrowing the whole instead of the tube; or again, the whole of the stricture may lie in the posterior coats of the bowel, and their contracting upon the lumen, contract its calibre.
When a patient suffering from this disease is examined by the fingers, its diameter will be found to be normal on the lower part of the structure, but in fact, somewhat suddenly, and to assume its natural diameter again above the diseased part.

It may occur immediately within the anus, from one third to one eighth inch above that aperture, and near to the Jacob's promontory, the latter position being the one in which it most frequently occurs.

When the disease is met with in children, more often among women, and seldom in children. In women it is, as we shall shortly see, frequently the result of parturition, the infiltration of the rectal wall with theophile, the veins of the vagina, and the result of constipation, which is a common complaint among young girls.

I. Simple or rectal stricture. This fibrous thickening of the structure is generally found situated about five or six inches above the finger, and it may be superficial in its nature. Old women are the most frequent victims of it when it is found; but it may be met with in young, healthy young females. They have generally had children, and the stricture or double division from syphilis; ulceration of the action caused by parthenium, or by the contraction of the external coat following inflammation.

The mucous, muscular and cellular parts are greatly thickened, and indurated, the intercellular tissue having undergone similar changes. The stricture may complicate the whole circumference of the bowel, so it may be nearly circular. W. H. Insull fact given attention to the diseased condition of the mucous membrane in the neighborhood of the stricture. Inflammation may be going on, and the walls complicated, and thickened up. Even when these are absent, and no disease with the exception of the stricture, can be detected, the mucous membrane is wrinkled and has lost all the folds which it presents in the healthy state.

Abscess and fistula are frequently formed with alone, and those complications, this translation of veins outside opening internally, in others into the vagina, or bladder. There are caused by the ulcerations, which, forming sinuses in the dilated portions of the bowel, the submucous and muscular tissue being to suppuration, discharges copiously into the sinuses thus formed. Sinuses are made, and these cut their way through the stricture, thereby forming fistulose openings from the right to the lower parts of the structure; so they communicate with the
Causes

Dysuria, bladder, or pain. Ectymially.

Ectymially, dysuria, or bladder, is the most common cause of
this disease. In ectymially, the surface of the bladder, being
inflamed, tends to swell and become inflamed, and the
the lining of the bladder is removed. After each attempt at
repair, the bladder becomes painful and tender, until the
passage of some foreign body
or the passage of some hardened substance in the stool, causing
an inflammation of the parts. Sometimes lumps of hard, yellow
matter become lodged between the folds of the mucous membrane,
and
the inflammation of the body of the intestine, either by the introduction of something foreign
or
the passage of some hardened substance in the stool, causing
an inflammation of the parts. Sometimes

Syphilis

Syphilis is a prime factor in this disease; especially among
women. The virus infects the wall of the intestine from the vagina
down to the anus, and the attempt at repair which takes place causes
induration of the connective tissues.

In some cases it is absolutely impossible to ascertain any
feasible cause — the history of a previous attack of inflammation in
the parts being unanswerable, and everything tending to render
the history absurd. Have noticed that these cases are frequently
among young females, and it has seemed true that abolition of
some irregularity in the menstrual functions may be the cause —
and at least uterine disturbances are always present.

No attention of the patient is first drawn to the gradually decreasing
size of the cylinder of the stool, and the increasing straining effort during
defecation. The complaints of pain, whilst at stool, and suffering
from dysuria, attack of diarrhea, failing in relief afterwards. The
next day the stools become small and hard masses of bloody
matter, and
this is again followed by diarrhea. Stools have large quantities of
pelengous, looking matter. Diarrhea arising from this
continued irritation, with the pain is greatly increased, much suffering.
obstructions take place, pendulous matter is evacuated; and he complain of abdominal flatulence, and distension of bowels or the back and fore limbs along the penis, down the thighs, across the abdomen, and in the pelvic region. His objection is badly arranged, the whole of the alimentary canal being affected. He soon becomes stiff, and one or none of the heavy 'intestinal distress', and he loses or quantities of water.

The vital powers suffer greatly from the discharge, and it wastes; he loses flesh rapidly, and has all the appearances of one suffering from a cachetic disease. Extreme inactivity with little motion, and if the abdomen, or the belly, gives into the intestines in portion and the peritoneum. Cows are accreted (Saliva) in which protrude teeth,ITION, and upon postmortem examinations no perforation could be found. This was evidently due to the contraction of the intestinal irritation towards the peritoneum.

As the condition proceeds towards complete exclusion of the bowel, symptoms presenting all the appearances of strangulated hernia exist, and the patient dies. The condition in these cases has been described as being filled up with hardened stool, giving rise to the acute, and rapidly fatal symptoms. The progress towards these ends is very gradual, and continuing for a considerable period of time. The patient may live some days, or even weeks after complete exclusion has taken place.

like a patient suffering from any of the above symptoms present himself to our notice, a careful examination should be made, first externally, and if we find to ascertain any obstruction, then a well-modified knife, carefully formed, maybe had recourse to.

In Mr. Salmon's cases the condition was by far the most frequently found about five or six inches from the anus, whilst Dr. B. Land's point to the lower part of the rectum as the most common site, from a half to two, and a half to three and a half miles above the joint, orifice. Mice may occur as or near to the internal stricture.

When it is within reach of the fingers, the bowel below will be found dilated and flaccid, and upon continuing the examination higher, a sudden narrowing will take place, having only a small opening, and through which one or two fingers will pass with difficulty. The joint above will be found partly dilated, and generally containing hard plugs of jelly-like, about the size of marbles. It is then disturbed.
Examination by bougie injection.

Abnormalities of the Bougie

At the time any disengagement of the intestinal canal was the official, and search for passing tracheal, postaural, orifices, etc., was made. If the bougie is felt to be in the region of the Trachea, a stricture, and a bronch is necessary, it must be in our conscious, pre-existing and cautious, must be used, or our results will be negative or disastrous.

In the first place, we may think we have discovered the existence of a stricture, when the bougie has only become caught in the floor of the trachea, without the actual, or, if any resistance, we may force the instrument through the septal wall into the pericardium, cavity, and cause death. Again, the bougie may meet with a stricture, and we may feel aware of its site, the instrument having become fixed upon itself, and its point turned downward towards the anus. To avoid these errors, I propose to trace the course of the stricture by the following means, the course of the floor of the trachea, membrane, and the wall of the bougie. The tracheal stricture must be kept in mind. The bougie tube may be forced up, and walls injected through the supposed stricture. We should always be tried when we have to depend upon a bougie for the information of our choice.

Treatment.

This points towards the importance of having a bougie slowly introduced through the stricture, thereby dilating it, and administering mild agents, to cause a
Casting oil is an excellent agent for the treatment of constipation, and in regulating the function of the bowels, the patient is at no inconvenience. By its help, the bowels are kept in a state of regular action, and the patient is relieved from the pain and distress caused by the presence of an enema. The oil is administered by means of a suppository, and its effects are usually noticeable within a short time.

Before proceeding to dilate the bowels by the introduction of a suppository, it is important to ensure that the patient is not suffering from any underlying condition that may make the procedure unsuitable. In cases where the patient is unable to tolerate the suppository, alternative methods may be used to relieve the constipation.

Sir B. Barrie, in particular, was known for his expertise in the treatment of constipation. He believed that the use of suppositories was essential for the effective treatment of the condition. Sir B. Barrie's recommendations for the treatment of constipation were based on his extensive experience and knowledge of the subject.

Sir B. Barrie's approach was based on the principle that suppositories are a safe and effective means of treating constipation. He emphasized the importance of regular usage, suggesting that suppositories should be used daily or every other day, depending on the severity of the condition.

In conclusion, the use of suppositories is an effective and safe method for treating constipation. However, it is important to consult with a medical professional before using suppositories, to ensure that they are appropriate for the individual's condition.

Sir B. Barrie

Extensive use of suppositories

Sir B. Barrie

Extensive use of suppositories

Sir B. Barrie
and abscesses have formed, a cure is rarely achieved. How much more then are we to despise when we find that they very rarely occur in which the stricture have only been added to, and rendered inexcusable an already existing one.

The plan most strongly to be recommended, may be explained by the following rules. A sponge in a barrel is to be used when irritation is reduced to a minimum, and the stricture is within reach of the sponge; it may be introduced every second or third day, and should never be allowed to remain in the stricture longer than two minutes. If after that time being absorbed, should the sponge cause pain it must be withdrawn immediately. The sponge should be either of steel or Junior, elastic, having a groove corresponding to the concavity of the stricture, and its head mounted with a wad. The introduction is greatly facilitated by these means, the wad especially, as you know immediately it has passed through the stricture. They shall first be well immersed in hot water, and then rolled, and oil may be injected into the barrel before introducing the instruments.

As the stricture becomes dilated so must the size of the sponge become large. Sponge ties may be substituted for the graduated sponges. Simply, to those for stricture already mentioned. The barrels must be kept regular during the use of the sponge, by prompt operation, and constant examination. After the stricture has been overcome, sponge must be introduced once a week or ten days — for some months afterwards, so the part will contract again.

If the stricture will yield under these measures in many instances but slowly, is there it returns to its original condition immediately, the sponge is withdrawn, which is to be done under these circumstances?

In the first instance, you may have recourse to two sponges, either by introducing into the stricture, after the withdrawal of the sponge, a sponge tied, or one of Barnard's dilating bag, and retaining it for some time, thereby subjecting the stricture to a more continuous process of dilatation; or you may divide the stricture into two or three places with a knife, and do as done by Sir W. Lister. The sponge tied or bag is left in during the night. The air bag is inflated with air after it has been placed within the stricture, and the patient slowly removes it by letting the air out. Sponge ties are best introduced through a speculum, for two reasons — you can direct, and have better control on their insertion, and the oil, or paste with which they are injected is not removed by the passage through the sphincter. When the stricture is seen to a linear or bridge one its tenacity may be overcome by cutting the
edge to a slight extent.

Sodium salicylate can be advantageously used. The instrument is protected by a vulcanized india-rubber sheath, is introduced closely, and when it has passed well into the STRICTURA, by pressing the trigger in the handle the blades are expanded forcibly, and the STRICTURA dilated to the requisite extent.

After the STRICTURA has been "nicked" by the knife, care must be taken that the incision do not heal up immediately, and the contraction return. Tissue, or pieces of tissue saturated in a weak solution of hydrochloric acid, and placed within the STRICTURA will effectively prevent this. Great discrimination must be exercised as to whether the cutting of the STRICTURA is opportune or advisable.

In one case I can see no hesitation in adopting it. I mean that in which a perceptual narrowing of the calibre of the part has, either from over-tightness of the sutures, or reflex, been allowed to progress to such an extent that its presence can no longer be used. Now the knife certainly can be used and is to be infinitely preferred to any other treatment. But when fibrous obstructions have taken place in the submucous arterial tissue, and the STRICTURA is clearly due to a clotted action in the walls of the rectum, causing induration, and thickening of its coats, the use of the knife should be withheld as long as possible, in short a deference must be shown to the instinct of the animal, the mind of the doctor to the mind of the patient. The acridiated material composing the contracting band presents the appearance of white fibrous tissue, and possesses great elasticity, and resilience. It generally accumulates, it may assume a semi-fluid nature, but must frequently the sooner. In cartilaginous STRICTURA the resistance to the knife is very great, intestinal absorption is induced in the coils of the bowel, and they gradually return to their normal state. But in cartilaginous STRICTURA, so much resistance exists, and affects the opportunity of a cure by these means it is necessary to divide thoroughly their hardened base first, before they will partake of the elasticity, so the contraction yield to treatment. For the dilatation, or incision made into them by a knife will affect the duodenal mucous more might be said upon this subject, but I think sufficient has been stated to warrant ample room for deductions to be made, and suitable hints guided for any case.
cells, presenting a flat cauliflower appearance; or sometimes, large, close from the surface, membrane, and surrounding tissue.

We have seen that simple structure of the bowel may arise from contractions identical to the fist. So we may have here cancer beginning in the surrounding muscular, and sub-serous tissue, which in time can produce the bowel and narrow its calibre. Then this occurs the consideration of the nature, and formation of the cancer, becomes of great importance as a means of diagnosis. So long as the structure is formed of the cells of the fist directly, we shall find that the cylinder is round, however small it may be; but immediately a tumour pressure upon the structure, they thereby flattening it, the rounded formation is lost; and the fascia present a tape-like shape to the tumour an enlarged prostate, a misplaced uterus, a fibroid polypus or a Serous tumor.

The causes of local cancer are very obscure. As by far the public majority of cases they remain a hidden mystery, we know the important that the 'building-ground' plays in cancerous process generally, but how it does its effect, I hold it possible to believe the potency, and feel indeed the cause in which is a previous family history of Cancer or attainable. In cancer at present are unknown, and the pathology less determined in gravity.

Some holds upon cancer as 'substantially a new secretory organ formed to eliminate removed material from the system in which it has been generated.' I cannot accept this, being more inclined to raise the origin of Cancer — and I use the word in its broadest sense including of the bone — as resulting from the prevention of natural processes taking place within a cell, leading to the production of peristaltic waves. Fascia latera, essentially a natural product — undoubtedly, changes a first place of attention than it is less to be received, and it will be found that it plays a very important part in the production of new formations in the cells of secretory glands. As the process of cells becoming arrested, the products are different, the solid post-tumorous matter becoming a better plastic one. In this way new materials are formed, and among them, I think, we ought to class Cancer.

If these ideas concerning the origin of Cancer be correct, we are still as ignorant as ever respecting the cause which results in these 'peristaltic' waves of multiplication in Fascia latera. Of one thing we are certain, that the cells produced from the post-tumor by an independent process, scirrhous in very much the primary part of them the vital powers become weakened, this process of cell multiplication being...
presented by force, as by a blow; new formations spring up, cells and phlegi are de-
veloped which posses the power of self-multiplication, and formation to an
unlimited degree. Until a cancerous disease exists previously to the perforation
of the natural process, then the disease is aggravated, increased so to speak, and
the local growth is nearly the expression of the constitutional trait. Whilst the one
point to the local origin of cancer independent of a constitutional trait, the
other bears witness to the fact that it requires some external force to be brought to
bear upon the wound vital force before the disease can be developed. Do the
constitutinal traits suffice in itself to cause a deviation of the natural
process? It may. To decide one way or the other we must wait until we have
sufficient bases upon which to found a clear and sufficient answer. Until
that time are the local Constitutional traits - cancer local origin will
exist and occur.

Injury to, or injury of, a part, seems to be sometimes the starting cause
of cancer; and especially is, when the irritated surfaces are epithelial. Deceptable
of Fauca has pointed out this clearly in his lectures upon. Histology of the tongue,
the continued irritation of that organ by tobacco, dying chickens, or spices,
are ways, seem to cause an abnormal increase and development of the
epithelial elements; the part of the cancer epithelial, and germinal layer.
As found. May not something of a like nature take place in the mucous
membrane of the rectum, and account for the origin of cancer in that region
is there cancer in which we are unable to describe any cause? I think we are
justified in saying that it may.

Having purposely entered here into this consideration of the mode of origin of
cancer, partly in the hope that it may not be considered out of place, and
eclor to its place. Our knowledge touching the local causes of cancer, is alimited,
unprofitable, and what little light may be thrown upon it by future dissection
and research, must, I think, be obtained through the means I have statet.
The cause of cancer is so intimately associated with the origin or process
of epithelium, arising as it most frequently does in parts where epithelium
is the principal tissue, that the consideration of the one is incidental to the
consideration of the other. Billroth, Virchow, etc., maintain that the
epithelial cancer cells can only originate from pre-existing epithelium; while
Brock, Virchow, etc., denying this, assert that they can also be
formed from connective tissue cells.

Cancer of the rectum is generally met with about three or four inches
from the anus, but any portion of the tract may be affected. It spreads, from
bouts upward, and by hardening, and contracting the bowls, the interior
becomes narrowed and sometimes occluded. Then the disease is of an
epithelial nature; it is found at the margin of the anus, and admits of the
possibility of relief for some time afterward by means

It attacks both sexes. It has been said to be more frequently met with
in women; perhaps owing to the presence of cancer in the labia or vagina
and disease has spread to the pelvis, but as a primary disease, is it
nearly equally distributed between the sexes. After middle age, and advanced
life, it is found to occur most. It may arise in young subjects, when it is
usually lymphoid.

The forms in which the lymphoid disease of the rectum assumes are

- Sarcoma
- Visceral
- Inflammation
- Tumor
- Hard, thick, or smooth, and contractive

Some of the forms are lymphoid, others are hard, thick, or smooth, and contractive: the

- Sarcoma
- Inflammation
- Tumor
- Hard, thick, or smooth, and contractive

The sarcoma differs from the lymphoid only in having hard, thick, or smooth, and contractive

Colloid Cancer differs very greatly from the other forms of cancer both
microscopically and in the malignant character. It is accompanied
by ulceration, or inflammation, it does not produce secondary parts,
its organs, or parts, are contaminaled by lymphatic cells, and, being
attached by infiltration, ulceration, or inflammation, there is no set in as it does in the
inflammatory parts, neither does it give rise to a sarcoma cachexia. It is very
rapid in its progress, and advancing to some extent large clumps.

Malignant Cancer occurs in the anal orifices, in the mucous and
intestinal surface lining. It is a cancer from the parts, thickened, and
contractive, having a thickness that, and yielding readily to pressure, separating
into immense portions. As it advances further with the increase of the bowel,
it becomes softer, and more ulcerated. It does not contaminaled the lymphatic
channels, for sometime after it has invaded; Ulceration is there the cachectic state
of the intestine, as characteristic of the other varieties of Cancer.
Symptoms

In the early stage of cancerous diseases the symptoms are very occulting, the disease proceeding insidiously, and the patient frequently is merely suffering from hematuria, dysuria. It is from the latter indeed that the reeds seldom see cancerous diseases of the bladder in their early manifestations. Perhaps a slight pain during, and a burning sensation after urination is all the patient complains of. This of course incurs in the case, for in, and now slight attacks of diarrhea, or a continuous desire to urinate begin to manifest themselves. He may also notice the motion are slightly diminished, with a more compassing discharge; and the bladder he had an accosted sensation of the affection in a now altogether abnormal, and in its place a feeling of ease taking up the action itself. Another peculiarity regarding the bladder itself is noticed, they have lost their normal contour, and although devoid of the usual form, their cylinders appear as though it has been forced upon, and presents very much the appearance of a "frothy stick," irregular and indented.

Night difficulty in coming the stools with a wanton increase of the pain, points to the fact that some impediment exists, and that the surface of the bowel are ulcerated. If an examination of the bladder be now made, you will find the former portion normal, perhaps ulcerated, while above the sphincter, in contact with the abnormal parts. In cases when seen through a speculum presents a raw ulcerated surface, irregular, indented, and the bladder, both contracted.

The general health is poor, the severe symptoms not in, caused by the intense suffering, death, and uncertainty. Adhesions make the features, and clamps them as those of one suffering from cause. The due of all desire for food, his appetite has gone, and his digestive apparatus is totally unfeeling. No rest is taken by continual pain, and frightful dreams. The pain now short above the thigh, upwards toward the chino, and through the pelvis to the hips, and later. He declares the one thought of going to sleep; consequently, abstaining from his food, as long as he possibly can, only to reject it, and to rise again. The fatal adhesion is characteristic of the disease, how much it manifest to anyone in the poor suffering patient. Ulcer is a continual cause of pain, and anxiety, and when expelled a
Nothing further.
Examination into every case is at least the patient has advanced in years, and complaints of increasing pain in the abdomen, or in the pelvis, who has a history of dyspepsia, and by whom a certain quantity of discharge is proved to have by eating more in the gullet will be avoided.

Before finally leaving this portion, Dr. Gray remarks, there is one or two points regarding the pathomonic characters of malignant disease of the uterus, they are worth a moment.

1. it infiltrates the neighboring parts.
2. The glands into which the lymphatics of the cervix join on the seat of Carcinoma, persist.
3. Secondary deposits take place in distant organs. And

Gray says, in proportion as the bladder has suffered itself to undergo a fibrous transformation, in such measure became to recognize that which is distinctly Carcinoma, and malignant. Accepting this to be true, we must not imagine that because disease is mainly confined to fibres, we are warranted in removing it, believing that by doing so it will be got rid of. On the contrary, the fibrous structure is merely passive, and actively around to manifest alarming proportions, and the Carcinoma persist may become identified into Carcinomata.

Our supposition in cases of malignant uterine disease, must always be a bad one; and this from the fact that it is a constitutional disease, not merely a local affection, and our opinion will be increased, confirmed by the nature of the Carcinoma may be have been that disease have a long course, existing perhaps for years; while fibrosis is a speedy fatal. Gastrocnemius arises from cancer generally, strong to say it is able some once refer to it in two words. It is always found growing from, and intimately associated with structures, or tumor surfaces, may develop from the epithelium of the vein, or tumor, membrane, often from the epithelium of the walls in the immediate neighborhood. It has the seed malignancy, which Stevens and Zuckerman possess, extending locally, sometimes involving the lymphatics, but rarely forming secondary deposits in other parts. By its removal the disease may be kept for some time in abeyance, or even cured. Likewise means to save a salutary result more, and to do malignant as Carcinoma. As lastly mentioned a case before the Patho. Dr. T. in 1854, in which a patient of 27, female, had died from the effects of a uterine cancer in March two years after the study had been performed. The specimen showed that the white of the
level up to within 1/2 inch of the artificial mass, the pus gets increased, and part of it may, with the aid of a lung force or suction, be removed from the natural. In some cases, our operation will be still more favorable to the patient than the surgical removal of the mass. An electric shock has been tried, and the tumor is removed. When they rapidly break down and slough. Shortly, then our operation must be a surgical one in all cases of cancer, with the exception of squamous.

Under such fearful, and hopeless circumstances, what must be our treatment? Can we assert that we are exploring the disease, if only for a month or two, by removing the tumor? With the exception of squamous, our answer is no. The disease is a constitutional one, and unless we eradicate it from the system, we can have no hope of so doing by simply removing the cancerous mass. It is possible that the disease of squamous to awaken a dormant focus, cancer creeping up in all directions, and in these with a power of re-vegetation almost irresistible. Again, the symptoms of the disease are so great that unless we remove the whole, it will surely return. How can we expect to do this in a part? How can we then procure only average the sufferings by palliative means, admit to poisoning, and form a futile mass in the least likely region of the disease. The use of hot pires must be absolutely avoided, as it was to be recommended in squamous structure. They only increase the disease and aggravate the sufferings.

Large and frequent doses of quinine are to be given to relieve the sufferings. Materia with squamous may be injected by systematically. Difficulties containing quinine, or injections of tincture and quinine afford much relief. Then cause the contained, then the ulcer and so on is quinine. This may be given in large quantities. Dr. Bonney advocates the local and general use of Calamine of potassium to Cancerous ulcers. They afford relief and. Hence it first by burning the cutaneous and with the poisons for a few days until the irritation is removed, and then using the crystals for they seem to have more influence than the poison. The last P. Bennett suggested the use of nitric acid, but there does no good. It certainly aggravates the pain. He also advocated the inflammatory of the Calamine Eutectic. It has no effect for the disease.

The application of carabolic to Cancerous masses within the mouth, only causes the evaporation, causing great pain, and directly forming a superficial slough. But when the the tumor protrudes through the mouth, damage is caused by the application of a weakly poisonous mixture containing acetic acid. This is danger, and the pain is nil. Here, permitting masses should always be removed.
in they cause great pain, either as above, only the Perineal Cavity, or what otherwise well, cutting them off with a pair of scissors. Perineum, and can be seen following the removal of blood stains of skin do not take place here.

Here is one form of Carcinoma rectal disease, which Carcinoma rectum, V.R., cases in which the tumour is so too close that it is outside the pool of the bladder, and situated actually. By threading the needle through the healthy side, immediate relief is given. Should the Carcinoma soon surround the whole of the rectum, then far may divide the tumour at any point.

An isolated cancer of the mucous of the ileum the decision is then taken will of be followed by satisfactory results. A liquid solution of Chloride of Lime must be well spread on the base surfaces, to ensure as far as possible the destruction of the disease, and set up a healthy action. Many cases will do well, living for years after the operation. Should it then the result an unsatisfactory operation, we are advised in removing the disease, affecting so it does the only chance of curing or prolonging life. The patient will suffer from a certain degree of his operation, as a result of the operation.

Sedative measures are to be administered, and the diet must be simple, and nothing, the patient maintaining the recumbent position as much as possible.

An partial, or complete destruction of these beds it will be proposed to remove, and maintain that this should be done in every case of Carcinoma of the ileum, at an early period of the disease. The sufferings are greatly reduced, and life is certainly prolonged.

Operation, or the operation for opening into the ileum, is certainly a new one, and, until someone at personally performed it in 1839, it had received little attention. The operation known as Heuson's is known merely the one suggested by Bochus in 1794, with certain modifications. In 1794 Heuson proposed opening into the sigmoid ileum of the ileum. In 1794 Heuson's plane opened into the ileum; and in 1797 some of these cut down into the tumour, and in 1797 the ileum cut down into the tumour. Heuson's operation is known the one to be preferred, as it permits us to cut into the bowel at a point when the intestine is less movable by peritoneum, and we therefore avoid the risk of perforation with this short incision. I pass on to the operation, first describing it, and then mentioning the long intestine likely to arise during after the operation.

Placing the patient in the recumbent position upon a table, with the left side of the knee and back raised, the operator stands in front, and carefully maps all the space which lies behind.

64.
The face also, and the rest of the pleura. Having assumed the longitudinal, of the anterior and posterior superior processes of the spine, and measured the distance from the one to the other, he marks upon the crest of the spine, the mean distance being three points, and then marks another point half an inch posterior of this mean spot, and under which he will usually find the site in that any difficulty. An incision four inches in length, extending from the middle point to the median point to this spot, is to be made. The skin, fat, and fascia divided. As understood, layer by layer, the abdominal wall, consisting of the transverse, oblique, internal and external abdominal muscles, are then separately divided upon a direction. The peritoneum, and the border of the quadratus lumbarum muscles are then carefully looked for and, having passed the direction under the internal border of the muscle, are then freely divided; the fascia being divided to the full length of the incision. A large quantity of loose subcutaneous tissue is next seen, covering the chest, by the placing here the towel will be brought clearly into view unaccompanied by division, and recognized by its peculiar greasy nature. The surgeon can provide himself with a large curved needle, carrying a strong piece of thread, passes it through the jug of the esophagus and main opening of the incision, and securing it firmly there by passing the sutures through the chest on each side of the mark previously made in operating. A trace of lint may be now passed into the wound, and a small opening made to admit the finger. The two sutures are then to be opened last, and the four made, clearly tied. The towel is next opened to the full extent of the incision, and its contents evacuated. Fluid saturated with a weak solution of carbolic acid is all the dressing required. The sutures are not removed until forty-eight hours after the operation.

Such then is the operation. But are the complications likely to be met with? First case must be associated with every step of the operation. Slight wound, complication, and complication to death. Every vessel must be secured to the one next with, and the toekines divided to the full extent of the contumex incision, of the latter be neglected, a casual incision will be made, and great difficulty experienced in the further stages of the operation, when the bone is reached, and before the incision is incised. Make certain of the position of the penetrum, and avoid wounding it. A fat becomes a difficulty is not to occur here, owing to the depth of the wound, caused by the large quantity of the loose subcutaneous tissue. This may be overcome by dividing the deeper branches, evenly, and widening the space again the site may be hollowed, and difficult to find, by distracting the wound with our thumb with excellent, and
in them easily seized. Some inject fluids to obtain this end, so they are allowed to escape into the peritoneal cavity, and - when the jet is opened into - cause foul peritonitis. In opening into the jet, begin at the midst of the peritoneal interior of the wound, and carry it carefully forwards. Then the bowel is exfoliated. Other with gravel matter, or because an indigo-carmine tinge shall be passed into the bowel, and the matter flows gradually away. Form the depression of the opening the gravel matter are rarely expelled, and little risk is seen of their passing into the peritoneal cavity. If I find the bowel 1st. Clearly ascertain the peritoneum, and avoid wounding it.

2d. Sneeze the :)5, firmly to the skin by the sick patient before proceeding to it.

3d. Prevent the escape of gravel or other matter into the peritoneal cavity.

If it be carried out methodically, and carefully in the manner before stated, and the complication avoided, but be kept in them, and promptly yet exactly done, the operation is a simple one, and the result highly satisfactory.

The after treatment is simple. If the bowel have been long infused, either the gravel matter is to be removed by means of a tube, more recently used, the great soft-filling is to be placed up the section, the patient should keep in bed, and the diet consist of bread and milk. At the end of a month the patient may be able to walk about, as may the latter, unless a simple paste is used. Support is the position by a cravat, or a mechanical apparatus adapted for the case.

If patients be have had none matters after the operation, the bowel passes through the opening. This is unavoidable. It may be prevented by means of a small or large.

The caun a coarse division of the section, and in which the dressing has been prepared, the patient complains of great tenesmus, and pain. This arises in part from the effect of the pressure caused by the confined bowel, and in part by forces of gravel matter slippery stone into the section. Unless an excretion will remove the latter. Nor their support will prevent it.

The patient should encourage the bowel action in the morning, it can then go about in daily incisions with comfort and cleanliness.

III. Syphilitic structure of the Section. Many diverse opinions prevail against the exact appearances. Such specific structures of the Section present: Sir W. Brodie noticed upon the small flat incisions, which would seem once syphilitic, as rarely a peculiar form of simple structure. O'Leary of Dublin writing in the Dublin Medical Journal of Medical Society on February 1854.
less at the opinion of Dr. Benjamin Brodie; whereas in December of the same
year, Jodocelin published in the Archives Physiologica de Medicine a descriptive
and illustrative tractate on the disease, adopting the syphilitic doctrine of
Jesuit, but priding it was a local disease, and not an infection of the so called syphilitic chasseris. His paper was founded upon two cases of the disease occurring in women, and also incidentally followed the treatment of Jodocelin. We again have another point of divergence
some authors affirming that this disease is more common in males than females
southern cases, not of 10, thirteen were amongst men. Lastly, whilst many
authors look upon this disease as yielding readily to anti-syphilitic treatment.
Thus, regard it so eminently venereal, and with just cause so we shall see
If Jodocelin considered this disease was almost exclusively confined
to women, that it originated from the continued irritation, the solicitude of the
primary inflammation, seminal to the uterus, to the venous membrane of the
uterus; this inflammation after having destroyed the venous memlne retained
and through its muscular coat the fibro-circular tones. The process is
slow in its course; palpable, at first, and afterwards growing, causing pain and
various complications. The less of the surface thus caused can only be explained
as the exposure of the surrounding parts; therefore when attempts at sealing
set in, and cicatrization begins, the blood contracts, and the passage becomes
narrowed; when a patient suffering from this disease is examined the circumference of the anus, and the seminal skin will be seen. The rectal
cartilage elevated, flattened, point bearing incens, and in the intecles or spaces between these, formations and fistulas will be noticed.
They resemble very much in appearance seminal glands, differing only in their being moist, and of a cartile line.

If we now examine the interior of the bowel, we shall find the put to
become suddenly narrowed, about 1/2-1 inch within the palpable,
the extent of contraction will depend upon the severity of the previous
alteration, and the length of time since the first symptom set in. The
section will be felt to be fibrous in its nature, and to arise from the
muscular walls of the bowel. By means of exhibition the mucous surface
will be seen to be more or less ulcerated, the raw surfaces appearing of a
yellowish cast, and to present the appearance of having been cut out; the
mucous membrane being also covered with 37-38 papillate, papil-
The condition of the pit above the structure is generally dilated, rendering an apuritic discharge from the red dilated surfaces. The dilatation of the tissues is well marked, extending as some cases several inches up the trachea, when the ulcerated surfaces have ulcerated, apuritic formation will be found arising from them.

The course of events have usually been as follows: the patient has been attacked by a chill in the immediate neighborhood of the region, the purinuric inflammation has caused, by irritation, the growth of uterine tumors, and ulcers around the anus, these in time have joined to form two or more ulcers within the abdomen, the tissues become dried, cicatrices set in, and the ultimate result being ulceration of the bowel - ulceration.

The symptoms of this specific form of structure differ very slightly, indeed from those given in the "simple structure," the one applying with equal force to the other. Certain differences, however, do exist, and I think the most important is the almost total absence of constitutional, and the prevalence of charcotosis. The patient in the early stage seldom complains of the disease, nearly always referring her symptoms to the uterus. Instead, she will tell you her stools are sometimes formed with blood, and there is a more purulent discharge from the anus. The history of the case will guide a diagnosis; the ulcerated siphon, uterine, vesica, rectal pain in the limbs, vesica, and the scar of old ulcers will reveal the true condition of affairs.

As I have already said the value of anti-utricular treatment has been much disputed; the general weight of opinion is that specification of very little use. While of quinine, and the prophylaxis of fever, may be given; the structure being at the same time well dilated, with torpor, spongy, thick, or even tough, the line, - laminaria, Elizabeth, small, large, or tubal. If the structure does not yield sufficiently, these means, then a few small incisions may be made into it, and the use of the tonics continued. The principal point to be attended to is the administration of powerful tonics, including food, chiefly animal. This oil, and the maintenance of the alimentary portion together with the local application of epibras to relieve the irritability of the pit. Unless the use of tonics be continued at regular periods, or intervals, for some length of period after the structure has been reduced.
all the old symptoms will return, and the case become as bad as ever. I am inclined to believe that it is in such cases as these that Dr. Joyntson, Allen, Beals, and others have failed to effect a cure, and refer structural cases of a simple nature. Allen, who seems to join major, venous, and patent vein, says "there are no cases of any importance or lasting effect on permanent cure in a single instance." If this reasoning in his practice be correct, it is that if "one thing is certain, it is that you have tried the worst fortune to make the my patient from upon whom I have been afflicted with this disease. As it had been cured by another surgeon," it will doubtless prove, at least, a relief.

Then on side of the body is only affected, and the disease in its acute stage has not been extensive. I am judging from the case. Have seen myself inclined to believe that much permanent benefit in the current case the life of treatment I have marked out. But when the disease is chronic, and the pure extenuated absence, a little like of affecting anything the cure can be substantiated, and the formation of an artificial anus in the left lumbar resection can not be too strongly insisted upon.

Spasmodic Stones.

Spasmodic Stones if the diaphragm is in 10 cases an occurrence that many very eminent surgeons have, and its being in Poland, I think we are entitled to look upon the following cases as an example of this rare disease. I make no comments upon the cases, but put it from my table, in Poland.

A. B., at 15, if his occupation was bought. One of my assistants, complaining of great pain in the region of the prostate and bladder of comini, and an inability to defecate. He is a thin, fair complexioned youth, listless, but a free evidence of disease and prostate suffering. Hence, since he was 2 years old (14 years ago), he had always complained of pain during and after micturition, which increased in intensity as he grew older. Of late years then attempting to mitigate having recently voided his feces spontaneously, and, to some extent, lost the power - when the pain in the bladder was present - of defecating them. The urine did not come away in a continuous stream, and he had always to place himself upon his heels and knees
To relieve the bladder sufficiently to relieve his suffering. He complained of great pain in the bladder. The prostate was large, and irritating from his continually "dragging at it." Pressure in the suprapubic region caused intense pain. The bladder had not been moved for a week, and he said he could not feel them move. The pain in the bladder was continually present, and nothing relieved it. Upon examining the section I found nothing externally, but when attempting to insert my finger within the bladder I found a piece of resistance, and this became complete obstruction about 1/2 an inch inside the internal sphincter. In the state he was in I could do nothing beyond ordering a hot bath, a full dose of castor oil, and some chloroform. I gave him an enema, and 4 hours later, when I found him again, the bladder was very sensitive, and he complained of burning on passing urine. The condition of the rectum had been very tender, passed off, and I could now admit my finger without any pain. The bladder did not appear to be "hollow," and I did not think much of its existence. I ordered a good dose of castor oil, and an enema. The latter was never given as he could not be made to approach it. and it was with the greatest difficulty in passing. I succeeded in getting him to take the oil. Three hours after taking the oil, the pain in the prostatic region returned, he was injected with frightful pain in the lower portion of the bladder, and his stomach was very distended with pain. After much perseverance I succeeded in again examining the section when I found the fistula completely excluded about 1/2 an inch within the internal sphincter. I then administered chloroform, and keeping my finger in the section felt the constriction gradually subside. I attended the case of a local calculus, and the mucous tissue of the section to deal with, declared immediate operation for the stone.

In June 1877, local lithotomy was performed, and the stone removed together with a band, resembling chain links, were removed. He made a good recovery, and is now quite well, but is very busy and able to do any quantity of hard work. The prostate is essentially now returned after the operation.

X March 1877.
Polyposis of the Rectum

Polyposis of the rectum have frequently been confounded with hemorroides, and other local diseases. They are certainly hardly met with considering the frequency of these diseases in this region. They bear a very alarming influence upon the general system, moving to a great extent, and sometimes alarming attacks of hemorrhage from going over to more remote places, pain in the bones and joints, causing great nervous irritation, and being nearly always accompanied by the most distressing feelings, e.g. nausea, hemorrhoids, etc.

When speaking of polyposi, I draw attention to the celebrated mucous folds of Houston, and there said that they had been frequently mistaken for polyposi and vice versa. This very complication should always be well remembered, and their differential diagnosis fully borne in mind. Patients with sometimes say they are the subjects of polyposi of the rectum, and unless a careful tactile examination be made, we shall be very prone to judge of the same conclusively, and in all cases be disposed to believe the one only appears, and to confuse the other.

Polyposi are met with at all ages, and in both sexes indiscriminately. In children, the nature of the polyposi differ somewhat in character from that found in adults, being softer, more vascular, and particularly in appearence, whereas the converse is the rule in adults. A number they range from one to twenty or more.

Dr. Lebert records an instance in a girl of nineteen, in which the latter number was found.

In shape, a polyposus resembles a pear, possesses a well-marked pedicle and forms a peduncular portion of a much shorter appearance. The peduncle varies in length from a quarter to an inch and a half, its thickest a mere in the very slender, and rarely broken off from the main mucous lining from which it sprouts. When it is very long, the tumor becomes prolapsed during straining at stool. The stalk itself has been compared to a goose to a strawberry, mulberry, chanterelle, raspberry, and pippin, its color being of a more or less bright red. So much for its appearence.

These tumors arise from the mucous membrane, and are generally situated about two and a half from the anal line. Their position is usually in the posterior part of the gut, but they have been found in the anterior as well as lateral walls. They sometimes arise higher up in the bowel (2-3 inches) and when multiple, or if any large size, they almost fill up the entire cavity of the section. The external "see and seize" has led to their being subjected to various operations, pain, hemorrhage, and anxiety. Of the peduncle is long and slender, they.
Varieties

I. Soft follicular tumours. And

II. Hard fibrous polyps.

In addition to these there is another polyp very commonly met with at the upper end of a fleshy, mucous, cutaneous in appearance, and pedunculated. It is usually called a true polypus, although it is a polyroid polypus. It is termed sufficiently, when speaking of viscera.

I. Soft follicular. These polyps are very vascular, often having a hanging peduncle, and are by far the most common. They are almost entirely confined to the oesophagus, being seldom seen in the age. In infancy they vary from a spurt to the fifth or twenty.

Other histological characters consist, according to Libbrecht, of a large aggregation of fibrous and cellular tissue, in the lumen of the, with numerous trabeculae, which pass delicate walls, and dip into the interior of the follicular mass, which they supply; being crossed externally, by cylindrical epithelium, and present numerous minute papillae into which the bloodvessels pass. In action they are acrid, granular, and resemble a variety of appearance.

Symptoms

So the haemorrhage being ascertained above, hamorrhagic will be observed in the leading symptom. The swelling of the follicular, the thinness of the walls of the polyps, and the superficial position to which they are exposed, make them exceedingly liable to cause haemorrhagic placers. They are usually found in delicate children, and cause a good deal of irritability. (acting as they do on foreign bodies) in the neck of the tumours, a continuous desire of discharge, anaemia pains in the lumbar regions, across the neck, and down the stomach. Diarrhoea, diarrhea, always occurs, and the child ceases. Induration. An ichorous, disagreeable, bloody discharge is invariably present, which assumes a mucous brownish appearance, or a blood clots, if it does not amount to a bloody haemorrhage. Then the polypide is long, the tumour is steeper, the food through the follicle as debris, discharging dysphagia, and the patient passing little, for a time to alterations of the tumours, and progress of the polypide; idiota is the size increased, and the diarrhoea augmented. The diarrhoea, reducing the strength of the child, and if the disease has lasted any length of time, the function of the alimentary canal are prevented, which causes a turn to the stomach. The appetite is poor, and the child Ennecel reduced in size etc.
Vesical hemmorhage issue. It happened to Mag. once, and the death was
extremely sudden. (Will outline of Human Pathology.) The liquid will escape
along with the remainder of the tumor, and be expelled abunto, in a few days.

Excise, as at one time employed, should never be practiced, but tumors
being very vascular, vesical hemmorhage from the base surface will take place
and the patient life placed in great jeopardy. Besides the pain of the operation
is very great.

II. Hard, or Adenoma polyposa. The soft polyposa are peculiar to children, in which
one sees the body and character of the adult. The tumor is composed
principally of fibrous tissue, and it occurs in either female or male. The
peculiar appearance may be so exaggerated in one instance that the tumor
prevents the modulation of the Cauda vera, and anus. The polyposa
is from time to time, and varies greatly in size from a raspberry to a melon.
In some cases it is harder than the soft variety, and not so vascular, hemmorhage seldom
taking place from it. It may arise from any point of the rectal wall, the posterior being
perhaps the most frequent site.

In adults, the symptoms are unique. The patient never suffers from any
premonitory symptoms in the absence of the first intimation in loss of its substance in
its posterior during a stool. The symptoms are different if the polyposa is to some
extent of its prostate. The patient has an uneasy, restless feeling, after the
frequentation, the feeling as if something were there which is "certainly not a piece of"
rectal discharge is present, but the stool tinged with blood. This sensation of a
foreign body will give the clue to the nature of the disease.

When the polyposa is irritable, and the rectal is long, it may be liable to become
engorged, and extremely painful, when protruded through, and passed by the stool.
Such cases are more frequent among women, hysterical habits, than the
"stomach cases", and require prompt treatment.

Any difficulties experienced in childhood are wanting here, and a
diagnosis is easily arrived at. A little confusion might arise as to whether the
case is one of hemmorhage, or not, but the absence of the onset of the disease
which is characteristic of polyposa will at once dispel the difficulty. In adults
polyposa are frequently associated with stones, intercornition, and polypus,
perhaps the cause and as the effect of these complications.

This consists in applying a strong ligature round the neck of the pedicle
cutting off the tumor, returning the channel, and rejoining both tubular, and

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body for a few days; then a dose of H. Vice will stop its discharge, and the
wound is completely healed.

Some have recommended the use of the Clamp and Canthury, others the
wire tension. Both are equally good, and may be employed. But I found the
use of so much anguish "chew", when a simple piece of Silk is all we require. My
conclusion is that we possess any advantage, rather to accelerate a cure. The
bedchamber is best for the treatment of these cases, and standing, knee-strap is
unnecessary to me.

Rest is absolutely necessary; and an opiate should be given after the operation
to induce the patient for a few days. If danger is likely to arise in such cases as
these, convulsions, and dysentery. The former can be avoided by the patient
remaining in bed until the discharge is gone away. Dysentery is fortunately a
rare termination and is seldom encountered in private practice. It seldom occurs in
patients of healthy constitution, and requires for its prevention - a rich subject-
free Ventilation, wholesome food, and stringing. The patient's health should always
be raised up as far as possible before the operation. During the first
weeks after the operation to ensure a healthy state of the general
constitution.

Fistula in Recto.

Fistula in anus is a most common, it is more correctly operating Fistula in recto,
the anus being a mere cleft, and to quote Blacklock, is "affected without health." The
first stage of Fistula is the formation of an abscess, deep or superficial, and by
proceeding to consider the former, I shall first direct my attention to the latter
form, and especially to those forming in the rectus-rectal space, as they are by far
the most important. Such abscesses are called "Peri-rectalitis." The inflammation
extends to the submucous or perirectal, to form, and the matter exits its
way by tumbling out the bowel, or fuses serosally. Abscesses are of two kinds:
Acute, and Chronic.

Dr. A. P. Peri-rectalitis. Sir B. Brodie, the late Medico, devoted especial
attention to this subject, and it was mainly to their lesions that we are indebted
for our present knowledge regarding the Pathology of this truly disturbing disease.
It commences in the form of subrectal inflammation with extremely acute
symptoms; the pulse is rapid and full; the skin is hot and dry; the temperature
in erect, varies from 10° to 30°: or even higher, and then a great constitutional change. The inspiration stage is ushered in by shivering; the patient complains of severe pains, of throbbing, throbbing, pulsating nature, in the region of the ears, which extend upwards into the neck, and downwards along the periosteum, suture, to toe, and stifle. Then we become the future seed, a hard swelling in the interior tissue of a reddened form, the central being of a bright red, making the point of inspiration. If allowed to proceed without surgical interference, this will burst, and the patient experiences instantaneous relief of all his symptoms, and finds himself that he is better.

Such acute abscesses are found in strong healthy men, of a robust nature, and usually between the ages of eighteen to thirty-five or forty. The abscesses are either direct injury to the part, irritation, or anything tending to cause irritation will not be inflammatory symptoms. The abscess runs a rapid course.

Dr. B. Bridge was of the opinion that ulceration of the mucous membrane always existed in the first instances, that from direct irritation of hardened faces formation of a tubercous or fistulous, or other foreign bodies transferring it by a trophic. An ulceration is set up in the submucous connective tissues, little limited to one side, or of the entire circumference of the part, and followed by suppuration. This is true in the majority of cases, but abscesses do form independent of any opening in the mucous surface. Such abscesses occur in persons of a cachectic phthisical constitution, or in those taken down by intemperance; the abscess arising insidiously, accompanied by pain, local or constitutional distension. As the abscess is evacuated, we find a bumpy swelling, putting upon pressure, and expulsive. It is in such cases as these that we have most to fear; extensive hemorrhages along the sides of the part in the true tissues, taking place in many directions, and these from inter-communicating channels, until the whole resolves into a network of canals. These ill results arise from the inability of the abscess to open spontaneously. When such does take place, it bursts through the mucous membrane into the bowel, or through the vein with the fishe-pectoral force. Here may be one or more of these fistulous openings.

Immune causes may give rise to these abscesses, and besides these I have mentioned, may be intraneural such as sitting upon a damp seat, or smoke, press, dress on table, while; by standing upon ice; injuries to the part, as gashes, cuts, etc.; abscesses commencing around the prostate and spreading to the tissues around the bowel; acute and chronic inflammation of the bowel, typhus, caries of bones of sacrum & coccyx, scrofula; and in bulge the osseous
of Caruncula, or boil.

When the abscess commences after the formation of a caruncle, the induration of the parts is usually perceptible, the urine is deeply colored, sometimes being actually purple. The constitution is also at a low ebb. Infarction is very frequent, and small in quantity, but the subjacent vascular tissues are extremely destroyed, and often from the pressure of the abscess. These cases are those in which the ulcer is blotted by intemperance, and are the subjects of a cachectic disease. When abscesses arise from a low constitutional state, they depend mainly upon a Sluggish State of the Blood (Dr. A. Cooper), which tends to promote the character of the intestinal secretion, cause irritation of the hemmorhoidal veins, and set up an inflammatory action in the tissues surrounding the "core." Again abscesses is a very productive source of the disease; the hard, and indurated mass, change and irritate the mucous coats, whilst the opposite condition, diarrhea accompanied with some tenesmus, has also been credited with causing this evil.

But the distress accompanying the abscess also attack and cure sympathec tone the bladder, kidneys, bladder, etc., in the shape of irritation, often at the neck of the bladder, hemmorhoids, posthumea coat, tenesmus and diarrhcea arise, and aggravate the sufferings. Hemmorhoids are more frequently the cause than the effect of this disease; and in these cases the abscess arise very insidiously, progress slowly, first symptomatically, leaving a fistula.

As regards the site and formation of the abscess, it may be seen that it is generally found in the intestinal tract, it appears to be unconnected with it in any way. Sometimes, though rarely, this is the case, but as a rule the intestines have suffered the matter having broken at one or two points towards its extremal part, and by ligature or destroyed those that the bowel has been destroyed by this process of time.

If one of these abscesses be allowed to run its full course without being either fixed both, shall work symptomatically, and the matter be expelled, this will still take place into the bowel, symptomatically as the abscess, into the peritoneum, or there may be with an internal, and intestinal opening. The intestinal action of the Ascending Air, as well as peritoneal processes, these provide healing, extrusion certainly, does take place, but the inflammation are constantly called on again, the latter, and the exigencies necessary for their admission, and abscess is about, they are therefore destroyed, rendered unhealthy, and build a more permanent discharge. The edges, and base become indurated, callos, and thickened; in fact, the sitable fistula is erected, is formed. Such then is the ultimate end of
Treatment

As the Early Stage

In the Early Stage of the disease, and before matter has formed, some remedy or other is to be applied to the parts. If these in past years a few leeches may be employed to relieve the patient. Leeches are to be given to agitate the bowels; sulphur with a mixture of pepper being preferable. Then the rolling around the carbuncle, in the carbuncle is taken on the swelling and lateral nerves, surrounding the fistula and completely eliminating it. The same remedies apply to these cases in which the inflammation is of the suppurative nature.

The most approved way of operating in these cases is to place the patient upon that side on which the abscess is, and, the figure upon hand, well oiled, is gently pressed up the fistula, at the same time, being applied to the more affected part of the external base; then, making gradual downward pressure with the forefinger and upward pressure with the thumb, we have the abscess forced into a small compass, and carefully mopped out. Into this space, a curved trephine, and make the incision as already described. The abscess, voided by these abscesses is extremely offensive, emitting a very strong offensive odor. This foul smell appears to be characteristic of abscess in abscess.

The after-treatment consists in keeping the patient in bed, and the bowels confined for a day or two. The wound is to be dressed with a piece of lint or better, with a thumb in between the lips and a warm poultice applied over all. The lint is to be left in place for four and twenty hours, and then changed. In a few days, a stimulating bath, consisting of water of sulphate of zinc, or copper, may be used.

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turate the cut, and applied as a dressing. Every morning, great care must be taken to assure the healing of the incision thoroughly, and from the base. The dressing can be retained in position by a T bandage. It is advisable to keep the patient in bed for the first five days, and then, after he may take slight exercise. When the constitution is weak, pare, mineral, still, tonics, etc., are the poison, and complications treated as soon as possible. In this way, an abrasion of the colon often heals without further trouble, and the intestine escapes uninjured. Unfortunately, however, the mesocolon surface will usually be found injured at one or more points, when the operation for fistula in ano. To be beneficent, it must be performed.

Operating in cases of abrasion, the same caution to be observed. If cutting is a radiating direction from the anus, must be subcutaneously carried out. The incision must be so made that the discharge can free escape, and the patient to be placed in bed that the wound is on a dependent side possible.

Some have argued that the peculiar smell of the discharge is due to the surface of an opening in the mesocolon; through which the liquid free passes. This is rejected by the total absence of any peculiar matter in the discharge, and further the abscess is sometimes far removed from the interior of the gut, so that the suppuration of the occurrence at the height of itself. Nothing is so redolent of a poison as a poison.

The pain attending the perforation is very acute, and therefore advisable to Chloroform the patient. It is more securely under control, and complete union of the abscess, and division of the Fothergill is readily insured.

We have seen that rectal abscesses, have allowed to burst of themselves, form deep ulcers, and constitute the common fistula in ano. Two important points in removing these abscesses are: consideration here, before proceeding further with our inquiry, viz. 1st. The anatomical arrangements of the parts - ophio-colic fossa. And 2nd. The manner by which various do not heal without operative interference.

The ophio-colic fossa, is that space which lies between the subserous of the ischiium, and the side of the colon, and extending from the perineal cartilages to the rectal muscular muscles. It almost to a cone with the apex pointing towards, and the base towards. A hole, the base is an inch in width, and two in depth. The space is filled up with a large quantity of loose peritoneal fat, together with the lumbar and hypogastric nerves and bloodvessels. The boundaries of the pouches are

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muscle, which, passing inwards to support the section, causes the narrowing and limitation of the process at its innermost extremity, and the very fine and filiform muscles, together with the anal fascia (portion of the pelvis) forming the levator muscle. In the side of the pelvic, the obturator muscle, with its long obturator fascia, also derived from the pelvic fascia. These two fasciae—anal and obturator—bound the innermost extremity of the space so as they are reflected upon the two muscles, as the recto-sacral, rectal, and obturator recumbens muscles together form the apical boundary. The local or rectal boundary is formed by the skin, and in part by the rectal sphincter, and pelvic muscles.

The space, thus described, is seen to be limited throughout by these fasciae, and which present only two strict limits: 1st the anal fascia becomes externally firm and cellular above the sphincter muscles; and 2nd, at its basal or rectal side. The limit being the thinnest. When an abscess, therefore, forms in the fossa, we find that it would pass through either one of these fasciae or points.

II. I have not for to look for the cause which resulted in more correctly filling the vesicle, then forced into the area, again becoming viscid, and heated up. I begin with, we have been given direction of the space, the large quantity of loose fasciculae, which unite, and fill up the fossa, and in which the hemorrhoidal polyps, and nerves are embedded. Further, we have been told that the intestines is supported by the levator ani, and of the muscles, and that the hemorrhoidal veins are devoid of valves. Add to these the intestinal movements, which take place at the jel and we see: 1st, the internal motility of the parts; 2nd, the surrounding tissue, for support, of the polyps arising from their dependent position. 3nd, the intestinal action of the bowel itself; 4th, the effects of the levator, and sphincter muscles, acting upon the viscera; and 5th, the less motility of the true muscles, that may vary.

In addition to these anatomical arrangements, we shall have reason to refer to them when speaking of the pathological appearance of the disease.

A fistula may be defined as a vesicular ulcer, in the form of a long sinus, channel possessing one or more openings,oris to heal, and emitting a thin, jelly-like mass, pale, with discharge from the surface.

I have already been mentioned. Fistulae are generally found in middle life, seldom appearing in the aged or very young, being by far the most common subject of this disease, fistulae being male, and females are its women.

A fistula varies in extent from a mere slight to a little over half an inch in length, in a long tortuous tract, extending far up the sides of the bowel, the walls of which have been pierced at one or more points, and only to the number of lateral
the pons will follow the oblique side of the section, and assume the same direction. The deeper the closure is placed in the pons, the straighter, and the longer, will be the sine.

Ponista are divided into two great classes - complete and incomplete. The first produces an internal and external opening, the last, but one, and this may be either an internal, or an external one. They have therefore been divided as follows:

1. Blind internal.
2. Blind external.

By the term "complete" we understand that there exists an external opening passing the spot at which the pons burst through, and an internal opening resulting from the same cause. This variety of ponista is by far the most common, easily detected and harmless. Sometimes, however, happens that the pons instead of terminating at the internal opening, passes still further of the side of the pons, and ends in a dead space. This of recently complicated diagnosis, and due to what has led many to imagine that instead of the ponsista being complete, it is incomplete, naming their diagnoses regarding the frequency of the latter cause considerably, as if practically as high as the former. The external opening does not always correspond directly with the internal one, but in the case of the existence of an "ultra" wound here in the tract of the pons, the term angular has been given as best describing this variety. This is a term of embarrassment in making our diagnosis. When we pass the pons into the external opening, it does very far as far as the point at which the pons bursts upon itself, the point becomes suddenly expanded, leading to the idea that it is a case of blind external. However, we have thoroughly explored the interior of the pons without the least damage of the fibre, and with the aid of a speculum, we shall have discovered the existence of an internal opening, and remembering the erratic course and various other divine movements, we shall avoid being misled by such tautology of nature.

At any rate, there may be but one internal opening or sometimes two, with two internal openings. Such cases are then less given to a lateral branch, which has an internal opening into the pons. Cases of two internal openings are also met with, and can be accounted for in the same way. When the pons is in the form of a triangle, difficulty exists in following the true cause, but by the introduction of the speculum into the brain at the time we are exploring, we shall find much aid to us, and the point of suspension will be felt, the site of the internal opening being, and after this idea, as to the cause taken by the pons will be arrived at. Again the tract of the pons, owing to the amount of indication it has undergone, feels somewhat like an artificial opening, acting on the pons as if it were a nerve. Such cases are those are "bad enough", but what can we say about the "ultra" ponista? By the term we mean a pons in which one opening is at one side...
fact, any of them as a rule. For the primitive human society, there is no...
margin of the anus. The deeper the internal opening must be looked for. The papillary area in such cases having commenced in the inner rectal fornix, and come away from the rectal wall, we shall see, after considering the facts in connexion with Pott's disease, that more than one internal opening generally exists.

The two following rules, which have laid down for my own guidance, then testing the internal opening, will afford excellent material assistance, and facilitate the search: 1st. When the internal hiatus is situated in close proximity to the anus, the internal opening may safely be looked for immediately within the sphincter; the fistula being then short, and straight. And 2nd. When further the Your opening is from the anus, to a proportion, will the fistula be longer, more irregular, and passing higher up the wall of the rectum.

Blind external. By this time we understand a fistula having but one opening—an external one. Next to complete fistula, this form of fistula is the most common; but a careful examination must be made before a surgical decision is made, and the possibility of an internal opening being set aside. The above has been sectionally, and the whole of the discharge is forced out through the opening. Staining the patient's linen, not injuring the surrounding cutaneous surface, and causing irritation by peculiar properties. The character of the present discharge is different; instead of the branch being met with in complete fistula, denoting the allurement of sculent matter, it is thin, profuse and thin, or scanty and thick, depending partly upon the external state of the patient—the former being generally associated with a smaller discharge. But for this there is a hard, and soft tissue. Then the disease is slight. The form of fistula may be allowed to exist for some time without operation until, palliative measures being adopted it is the hope that a spontaneous cure may take place; but, when the wounding is the case, and more especially if the opening is close to the sphincter, the issue the tract is laid open, and the fistula opened into a fissure, the stone will a cure be obtained.

We have an internal opening only, in very few cases it is truly remarkable. They may originate either from the branching of the intestinally, or from the action of the intermittent, and, or from the formation of the opening that at one point there is more sustenance, such as a fish or a liquid bone, or a blood as much adherent matter has become lodged in it, and by the irritation thus caused has deepened, partially, finally becoming a wound. The cutaneous surface remaining the intact part of the discharge is if a tearing one, and whose patient is made upon it, the patient suffering pain. The discharge is evacuated through the anus, and orgasm of the sphincter is
As we should suspect, the opening is commonly situated in the prehernal cavity, which may be, a small ulcerous tumour, and by pressure the fistula is found. This may be seen through a speculum, the aperture large, regular, and ragged, and the discharge is seen oozing out. The larger these cases are allowed to grow, the more definite is the base. Laterally serous is formed in the loose and adherent tissue, spreading round the bowel, usually dorally. This discharge results from the pus accumulating in the little vesicles in the posterior walls of the sinus, leaving the second part posterior, which gradually becomes large, and large, and finally assumes the character of the purulent sinus.

Early operative measures are therefore imperative, not only to prevent these complications, but to remove the suffering of the patient, which is sometimes intense and always severe. The aperture being large, feces are easily admitted, and the bowels, caused by their presence, are sore to the patient's finger. The patient may also complain of loss of appetite in some cases, that instead of the tissue spreading towards the caecum, it spreads laterally, and being disposed of this "cork mark" on diagnosis assuming the direction of the tract, and the subsequent operation are rendered difficult. This will be further considered when speaking of the treatment.

The causes of fistula have been mentioned, we must now consider the pathological appearances of the disease. Whatever may be the cause, the intestinal system of the sphincter, and local tissue, and the passage of food, the disease, through the fistula, the sinus contracting sufficiently to render a complete closure impossible. The discharge coming from the abscess gradually becomes thinner and watery in consistence, changing from the thick purulent to the more watery and fluid. The intestinal action of the muscular apparatus continues the healthy peristaltic movements, setting up a large deposit of irritation, the interior walls of the anal become irregular and an unhealthy discharge proceeds from these. This irritation is not confined merely to the sinus, but it spreads into the surrounding tissue, which, by the action of lymph into them, becomes dense, and thickened, whilst the walls of the sinus become more contracted, and hardened, and the interior becomes very smooth and strong; thus being at one time called the myogenic membrane. It hardens indeed many times, and is said to be, that they resist the cutting force of a bistoury, and break its blades.

The less degree of vitality of the adjacent caeco-colic tissue, the continuous discharge which is thrown off from the cavity, together with the irritation caused by the passage of flatus, is, through the sinus, all tend to aid the formation of the fistulous tract. Again, fistula are commonly associated with perianal abscesses, especially hepatitis, and the...
Nasal cavity situated in the nose, contains the nasal bones; a powerful ally of the above cavity consists.

Obstructive:

Inflamed when complicated; irritation, ulceration, and ptosis are always seen.

To reach the nose of the cause, than an unexplained one. They sometimes are less severe, as an example: between the fibrous of the external sphincter, the latter two forms frequently in a simple before, and then great care must be taken to cut the base of the union; the remaining fibres of the sphincter will continue to act on the great vessels.

When a sinus is completely formed, it presents under the finger the feeling of:

If a short one had been formed under the surface of a pimple, and penetrated it: the external surface is marked by a small round mass of more pronounced hardness; and the internal cavity is better conceived and更好, it forms a small papillary patch which by:

The latter renders prompt assistance in making our diagnosis.

The chief of suffering in this disease, arises greatly in some, beyond the cæcum, and the corona of the discharge, the patient suffers in pain, and issues caused it all:

The discharge to last some time before seeking medical aid; whilst in them a continuous

Inflammation, chronic, or acute, in general, the sphincter is chronically contracted.

If pus, forms, passes through the tubular canal, the constitution becomes affected:

The state of the alimentary tract is disturbed; sleep is broken, and disturbed by

The discharging becomes; the discharge is offensive, and the patient, in short, presents to:

Suffering from a cachetic disease. Happily these severe symptoms are rare. Should:

A case of the kind, when the disease had run its course, the constitution had become:

Greatly impaired, that the recovery was slow, and retarded. The patient did eventually:

Regain his health, and is now (179) a strong, healthy man.

There is always a certain degree of pain, or annoyance during defecation, which:

Persists for some time; and should the patient have suffered from piles, this symptom is:

Usually lauded. It is, inflammation must be in any part of it, the means of pain amounts to:

Suffering. It is known to the prevent that prudent, readily discharge that we have to:

Look for a diagnostic symptom; for it is present in many cases, sometimes before;

Often times usually, attended or unattended by pain. The patient's face is always:

Stained by it, and the cutaneous surface (especially of the brow), and region:

Is shown, are involuted by it, the skin, and nervus superficialis being red, and sore.

The pain attending fluid intestinal infection is always present, for as we have:

Seen, the opening is frequently delayed and short, allowing the passage of small

pieces of feces into the anus during defecation, the pain following each evacuation:

Being extremely prolonged, and severe. There is no intestinal opening through which it can.
be expelled, and in consequence it occurs in them, until, should I be hands, it has either been expelled by the discharge, or it has been expelled by the contractions of the jet. The symptom of same is absent in rectal fluid fistula, and in which we arrive at the minimum of St. George.

Complications, such as fissures, haemorrhoids, ulceration of internal rectal mucous, and ulceration of the walls of the bowel, from internal neoplasms, are all associated with this disease, and will be considered when speaking of Treatment.

Regarding the mode of examining a patient suffering from proctitis in "one" - how are we to proceed? Various methods, and positions have been recommended, with which it is needless to enter, as they all depend more upon the dexterity and genius of the respective surgeons, than upon any real advantage they may possess. The following is the plan I always follow - having armed myself with a pot, syringe, speculum, and oil, I cause the patient to lean forward upon a table, or chair, resting upon his elbows in such a manner, that his body is at right angles to my body, an assistant standing at his left - the patient's right side, gently separating the nates, then the lateral parts are thrown clearly into view, there are first removed to maintain the rectum and side of the rectal orifice, any extraneous obstructions, because if the sexes, feces etc., and then, by passing the tip of the second finger around the neighborhood of the anus, I ascertain the presence of any indication of inflammation. Should an extraneous opening exist, I then pass a probe gently along the track, until I meet with some resistance, or it has passed into the bowel, when drawing my right-hand finger into the pot, I ascertain the rectal portion of the fistula. By following this plan the internal orifice of the sphincter is avoided during the passing of the probe. If the probe has not passed through an internal orifice - a frequent occurrence, then by gentle manipulation the position of the orifice is to be carefully noted for, having always around the common situations in which it is to be found, the exposed opening, or the filling up the finding it, then I have clearly satisfied myself upon the existence, or non-existence of such a fistula. I next separate the anus as high up as I can with my finger, to ascertain the condition of its walls. Would bottle feed limbs, I pass up a syringe, in the way above described, if the presence or absence of structure etc. is much for complete results. For the incomplete forms they are as we know it; but in this case it is the position of the internal orifice with which we are concerned, and so we are supposed to have failed in its discovery. That next? If a strain of the sphincter is present, two straws are given to me, or better to debar further examination on that day; or place the patient upon the side upon which the fistula is (or supposed to be) with the knees drawn up towards the abdomen, and chloroform...
Treatment

administration. In former operations, and unhesitatingly stated, in the examination is absolutely
is without case. The operation is well made, and passed into the mouth, and the internal
aperture is closed for. When it is found, offers a probe into it, to ascertain the direction
or direction, and the extent of the urine. As regards the passage of the probe into the
internal aperture — this is by no means a long task, especially when the veins are
always directed towards the cause, and it is situated high up in the pubis. In some cases
then be bent upon itself, and great care must be exercised in the dissection. If the
aperture may be situated midway in the course of the veins; or sometimes they enter in a lateral direction.
In this case the veins must be held steady, and great caution in necessary.

This shortly consists in carrying from the fossa of the breast to its whole length. In the
case of the inefficient this is easily and readily done; but in the incomplete case more
deliberation is required, and we should first consider whether the knife should be
used or not, and the chances of a spontaneous cure taking place considered. With this
incomplete, I think all are agreed, that the sooner it is laid open, the better, but in
the more seminal cases, and when the bladder is some distance from the anus, I think
we are warranted in delaying operative measures.

This now brings me to the consideration of treating fistulas complicated with
other diseases. They may be arranged, and considered as follows.

1. Fistula complicated with uterine.
2. Fistula complicated with uterine.
3. Fistula on account of tone.
4. Fistula of the bowel — including sprue, and syphilitic diseases.
5. Fistula of the bowel, and uterine diseases, surrounding the pubis. And.
6. Fistula of the bowel, diseases of the liver, — fistulas.

In short, bite diseases for future consideration.

In spirit of our thesis has been more particular attention to this subject one:
which is, than any writer known of. The silence that has mantained by myself in this
applies strange, when we comprehend how imperative it is to cure these before we
attack. I read the other; the frequency with which they are associated, and the
consideration of the cutting of the fistula, when the fistula has been
in the above, or injured. But then the wall is the primary disease, or the fistula an
extent of the fistula, is a matter of no practical importance. It has been how
frequently, fistula arise in veins, structure of the pubis, and there can be no doubt
but that the persistent irritation arising from the presence of a fistula, can and
understandably, do induce to the formation of stricture. But this matter of Sensitivity
The success of localized hemorrhoids

Carina

Record of

80.
The incision must be made into the parts, the diseased structure exposed, and extracted. This done, the disease will heal permanently.

Such complications are chiefly remarkable for the great similarity which exists between their symptoms, and those of fistula. But in these cases the use of the speculum is so indispensable. Operative complications must be anticipated constitutionally before proceeding to act for fistula. Both for the case in squamous, and the case of the lining is clearly indicated; but for chief considerations are the discovery of the fistula, and the select from ulceration. Hold the fistula be obliterated, and the case of the prime divided, the patient will be relieved for a time, but the symptoms return, and a fresh operation is necessary, which would easily have been avoided had the true state of matters been laid at the first examination. As both divers depend on a pointwise to the contractions of the sphincter muscle, the division of the muscle, though the disease is admitted, should, on all hands, be sufficient to cure both, without dividing the indicated case of the prime as well. When you find a prime in a patient complaining of a persistant discharge, receive no notice, until you are in a fistula is closed; when both prime, then operate in above.

In dwelling upon this subject, reference may also be made to the features which sometimes result from operations performed upon fistula. Non-success may follow operations upon the injunctive form of prime, so we shall see hereafter.

When the sinuses are very hemorrhagic, removing the tissue in a supple
sine or temporizing manner, proving high up, and involving the suppository terms to a great extent, it is advisable to leave the case alone, or, without laying upon the whole and very branch of the fistula duct, no one could be assured; and in this union, the lumbar character of the operation, and the probability that in that case with the most careful future, at least one prime will be overlooked, sufficient in itself to undo all that might be done. It is exactly in such cases in these, that failure attending operative treatment are encountered. But in these indications present in all these cases, are so great that a substitute is useless, and where can only be used, and in the same operation be imperfectly performed. Such cases are of long standing, and, as a rule, meet with in elderly men, the have held "morsoe in cut." They are one times. In a younger subjects. The very nature of the disease teaches the man, soon, and demonstrate more forcibly than the clearest mental description can, the uselessness of operations. So much for those fire complications, for certain "obstructionists" to operative success, unless unusual and, combated, and overcome.

This may be either by "cutting" or "treatment without cutting." The former used one time a very fashionable remedy in the posthantarian chart. Whilst the latter
Treatment without Cutting.

Although advocated by Dr. Alliuphaus of St. Martin's Hospital London, is almost exclusively confined to pamphletists, and empirical. This is to be regretted, as many cases, especially amongst nervous subjects, are met with in which the lesion does as well as the knife. One does not like to follow the practice of surgeons. There is a repugnance about it; not alone in one's own, but in every profession.

Nothing at once spontaneous case, which are fast and far between, and then only after several months of life and pain, the treatment without cutting consists of stimulating the interior of the posterior lesions by the application of caustics, as distils of salic, nitric acid, suie, mentum etc., or forcing a wire to the interior to soften through the tract and allow it to cut its way through the walls of the veins. As unity observed a plan of cutting through the indicated walls by using a small piece of knife, and a steel triumfl. The pain accompanying this method is peculiar than that caused by the suction, and renders pain giving the knife. It is evident, that such palliative measures, if may so call them, can only be used when the situation between the bowel and the interior of the veins is thin, and soft, before it has undergone inflammation. The distills of salic acid nitric acid, can only be applied to solid frontal fistulae, when there are slight and I ave no lateral surfaces. Such cases are more likely to be affected, when the frontal fistula is situated some distance from the anus, and consequently, too under the irritating influence of the diaphragm. So the round and solid lateral fistulae by any of these means, would only meet with partial failure.

So far are the cases in which a cure is effected by these means, and so entirely do they depend upon the tact and judgment of the surgeon, that, with these remains leave the subject.

This consists in laying open the whole tract of the veins, together with any lateral branches or branches, there may be complicating it. The former affords somewhat in the two varieties - Complete, and incomplete - but as to what it may be described as follows.

Adymetite - a dose of Caerula or the preceding evening to insure the thorough cleansing of the bowels, and also cause a diaphoretic to be given a few hours before the operation in the following morning. It is advisable to chloroform the patient, it is better under chloroform. Place him upon his side, in the common bicalculation position, but resting on that side upon which the fistula exists, the tract of the veins having carefully been known beforehand, a probe pointed directly to the fistula, passed through the veins until it meets with the tip.
of the fingers or the cuticle. Along the base of the cuticle a curved blunt point is inserted until it reaches the finger, when the cuticle is withdrawn, and the tip of the finger passed over the point of the bistoury, by pressing down upon it (the point) with the finger, and at the same time raising the handle of the bistoury. The blade is made to cut through the walls of the wound with the cuticle, and by a downward sweep it finally emerges through the limbs. We have by this operation divided the splint-like muscle. The lateral branches are next to be laid open, one by one, and, as has already been pointed out, unless all of these are separately treated alike, and the whole of the limbs retracted from hind to hind, we cannot expect our treatment to be efficacious. Much caution, and patience is requisite at the stage of the operation; seldom - especially in chronic cases - do we find the fistulae without a "branch"; and, this fact alone, should make us extremely careful, before we dismiss the patient from the operating chair to this bed.

It will be found advisable in many instances to cut off the super-abundant edges of skin, thus may be safely done by means of a pair of common scissors. By so doing we are enabled to see how the healing process is progressing, and can apply our dressing more effectually. In our operation we should always endeavor to divide the splint-like muscle, as direct as possible. The more effectually we make our incision through the muscle, the more shall be left of overhanging flaps of skin - always detrimental to the healing process. It has been mentioned that we often find the sinuses situated above the internal opening, forming a cul-de-sac. Though it is preferable to divide this also, rather than risk the possibility of its healing by contraction. Though many times it is thus finds as they consider by so doing, a large, and extensive wound is left. Better this than our operation should fail, and all have to be undergone again.

Should be as simple as possible. Chloroform, or carbolic acid, moistened in oil containing a small quantity of Carbolic Acid, should be inserted into the white of the wound. A bandage should be applied to retain the dressing in place. The patient placed in bed and a full dose of laudanum given to relieve the constipation for 48 hours.
A cone-shaped pledge of oil had better be placed between the bandsaw and clamps. It acts materially in preventing the latter from becoming misplaced, should the patient show restless. At the end of the second day a dose of Castor oil can be given, and the dressing left to come away upon the bowels acting. In dressing the wound afterwards, should be confined to simply keeping it clean, and healthy; and being that it heals up thoroughly without leaving "a false base". Should it appear unhealthy, or show in healing a mild tremulousness; at the third week, a weak solution of Chlorides of Bichlorid of Juret, 1 per cent., may be used. Otherwise, interference is to be deprecated.

A great quantity of hammerheads, and secondarily, it is to be quickly checked. All bleeding points should be carefully sought for before applying the dressing itself. Sometimes secondary hammerheads of an alarming character come in; after the sixth of the operation, has passed off. All the dressing is to be at once removed, and, if the bleeding point is seen, it is to be immediately tied with a small oblique suture, if the wound be applied to the wound, and a piece of gauze saturated as directed. When a wound is thus applied — the insertion of an oblong pledge, covered with lint, is recommended by Brooks as an admirable support — and the patient replaced in bed, and kept cool and quiet.

If, however, hammerhead has taken place, a full diet may be given after the oil has acted, but a course with diet during the first two days should always be enforced. The beds are 15 minutes bated, and defecation is more easily controlled.

The operation upon one of the thick varieties is modified only in the inciting stage — the after-steps being identically the same as described. In many of these cases the external osseous structure often once open into the cavity by cutting directly into it, and completing the operation; but this is sometimes absent, and the capacity, and vitality of the tissue, which depends upon the elasticity, and manipulation of the Sinus. A hard pointed instrument, bent at an acute angle is to be passed up the cavity, and guided by the surgeon into the internal opening, the wound then being fixed down and closed, and the incision, until it can be felt externally, and the operation completed.

The operation differs only in one aspect from that of complete perforation — the cutting through the wall of the first at the upper or bishop end, this close the two operations are identical.
Fistula in Recto and Phthisis.

It matters little whether we regard the fistulous discharge of the rectum as a symptom of phthisis, or vice versa. My duty is to examine the opinions held by competent authorities upon the point—should we call for fistula in cases of pulmonary diseases? To elucidate this point I shall content myself with stating the opinions of others, and then briefly stating my own convictions.

Fistula in its exhaustive, and admirable treatise says, "as far as my experience goes, I deplore emphatically against interference in one class or the other, unless what is rare, that be wasting discharge from the urine and sinus local, and general suffering. Have more than one known the pulmonary disease preceded in activity by successful operation for fistula. As much as these abscesses are lined with a coating of cheesy, tuberculous material, it is not illogical to regard them as Thamy, a patent beneficial drain." He considers this particular complication to be more common amongst males than females.

Dr. Henry Smith says, "In my observation, teaches me that as a rule, an operation is far better avoided in such cases." He concludes by saying, "that when the tuberculous abscess is extensive, operative interference should be withheld as the in the majority of cases the wound will not heal, and the abscess in the lung becomes accelerated. But when the mischief in the lung is slight, and the rectal discharges are great, then an operation may be performed with much benefit."

Dr. Lusain agrees entirely with Dr. Smith, regarding all cases of fistula, in which "the lung are troubled with abscesses" as decidedly those in which we should not interfere, but in early cases it is different. He concludes by saying, "In fear of throwing the disease upon the lung, has almost died out, and we no longer hesitate to relieve a tolerably healthy patient from a fistula, and depressing malady."

Dr. Sinclair, after acknowledged that the fact that fistula in rectum is of common occurrence in pulmonary diseases, says, that great caution must be observed before venturing to operate upon the fistulous tract. He confirms and still less in advanced fistula, no operation should be performed as the wound will not heal, and the increased discharge from it surfaces only tend to hasten destruction.
Dr. Lyon

Dr. Lyon was of the Opinion that Fistula is very Frequent in Phthisical persons and "is of course incurable."

Dr. Jos. Clark says, that Fistula complicating Phthisis should not be avoided with.

Dr. Bonnemay holds, that Fistula in Phthisis should not be cured in persons of tuberculous diathesis, and that the relative ability of the patients arising from the fistula is to them a protection against the sudden onset of "tuberculous accidents." - See also Op. Cit. p. 98.

Dr. J. B. Baskie held, that no operation should be performed upon the section, for the Fistula, if laid open, will not heal, if it should, the disease will be greatly accelerated. - See also, Ibid. p. 19.

Dr. J. Thomson considers that the very existence of a Fistula is beneficial in pulmonary diseases, that it seems to hold it in check, and greatly accelerates its progress.

Dr. Bruce says, "From the frequency with which the disease under consideration (Fistula in lung) is associated with disease of the lung, one can be said to be properly treated when the State of these organs is controlled. If Phthisis be far advanced, I should advise some interference locally for the relief of Fistula; but when there exists only the paroxysm, a good result may be obtained, and constitutional benefit may be derived from the cure of Fistula."

Dr. Louis

Dr. Andral

Dr. Andral

Dr. Burke and Mr. Allingham

Dr. Burke and Mr. Allingham agree entirely with Dr. J. Thomson, that the healing up of the Fistulous track is to be avoided, that the very existence of a Fistula accelerates the pulmonary disease and therefore we should not operate.

Dr. C. A. Taylor, bears testimony to the common occurrence of Fistulous ulcers in pulmonary disease, and avoids committing himself either one way or the other.

Dr. Allingham says, that if no other means is employed in selecting cases for operating upon, he cannot say "any clinical fact, to show that the operation for Fistula in Phthisical patients renders the long affection worse, or makes it more rapidly progressive."

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It is remarkable, that so few of our men of eminence in the profession give this subject all it's due. It cannot arise from their want of experience upon the subject, for, as Dr. Allingham points out, the percentage ofifton cases suffering from phthisis is at least 12 per cent.

Encouraging operations have been performed with great success on every case would be the rule of the day, but I think we are warranted in withholding in those cases in which the pulmonary mischief is of the low progressive form, and only as it were, in its infancy. But even then, we are urged to be desirous in many things, i.e. in endeavoring to save the standard of the patient's health as much as possible before它是, and choosing a fitting time of the year. It should never be kept too bed, postsurgical subjects require all the exercise and care they can, consistently with their strength, obtain, besides the accidental position is unnatural standing, to it does not exhibit the patient, and the almost certain occurrence of the hystica, and pulmonary disease.

We Allingham's large head which upon another point, the more and constant cough often with a many cases of consumption we see very much, infected with his remarks upon this point; it certainly is worthy of the highest consideration. It aids greatly in retarding the healing of the sinus after an operation.

Finally, we frequently find that patients the subjects of untreated phthisis, differ most from the symptoms - mentally, their spirits, air, and they become debilitated. Indeed, we are able to cheer them, and remove their pensive ideas, we must rather allow them to fall victims to the pulmonary disease - which will increase the patient's suffering or disease. If these we must be guided by the state of the lungs, and the presence of the disease at any instance, we find that the subject is young and that the lung mischief is not to be advanced, to partake our interfering.

The appearance of a phthisis in person suffering from phthisis, differ somewhat in detail. The internal, and external symptoms are larger, more irregular in duration, and the lungs more delicate than in ordinary cases. The surrounding integuments are pale, almost white, and the purulent discharge is absent, and sometimes by a coating, which like me, again the internal phthisis has lost much of its contractile power, and this is also shared by some extent by the external mucus. It shows us therefore when
Operating in these cases, I have as far as possible the internal muscle united or incurrence of feces will force to exterior.

In one or more of these appearances, we can in many instances with no pulmonary mischief in apparent, suspect the early advent of such a complication. The inverted edges of the external gaining, and the rapid appearance of the internal haemico, being very suggestive of visceral disease.

Much more, might be said upon this interesting and seminal "Complication", but I think I have entered sufficiently into the whole of the subject. Having all these myriad, suggestions more detailed, and cause, done judiciously applied, will guide us over the features, and tricks and which surround this subject, and by this account, we shall avoid failure and the knowing of being "Incumbersed Operators".

The End.

Sincerely yours.

97.
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