

Rectal and anal surgery : with a full description of the secret methods of the itinerant specialists / by Edmund Andrews and Edward Wyllis Andrews.

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RECTAL AND ANAL SURGERY

WITH

A FULL DESCRIPTION OF THE SECRET METHODS
OF THE ITINERANT SPECIALISTS.

BY

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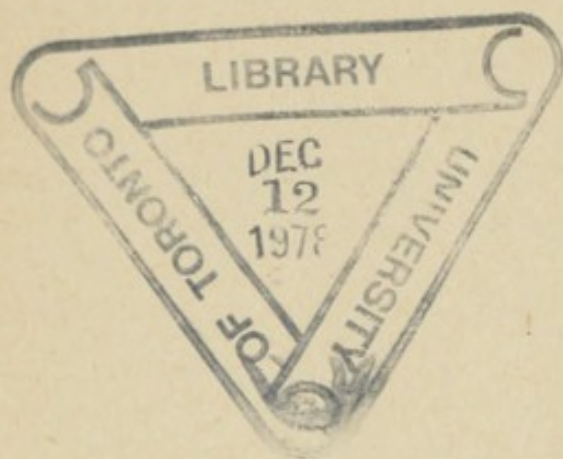
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THIRD EDITION, REVISED AND ENLARGED, WITH ILLUSTRATIONS AND FORMULARY.

CHICAGO :

W. T. KEENER, 96 WASHINGTON ST.

1892.



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THE THIRD EDITION.

The rapid sale of the first and second editions of this manual has compelled the preparation of the third much sooner than was anticipated. Advantage has been taken of the opportunity thus given to re-write and enlarge almost every part of the work, and to introduce several new chapters and an appendix. A few cuts have also been added.

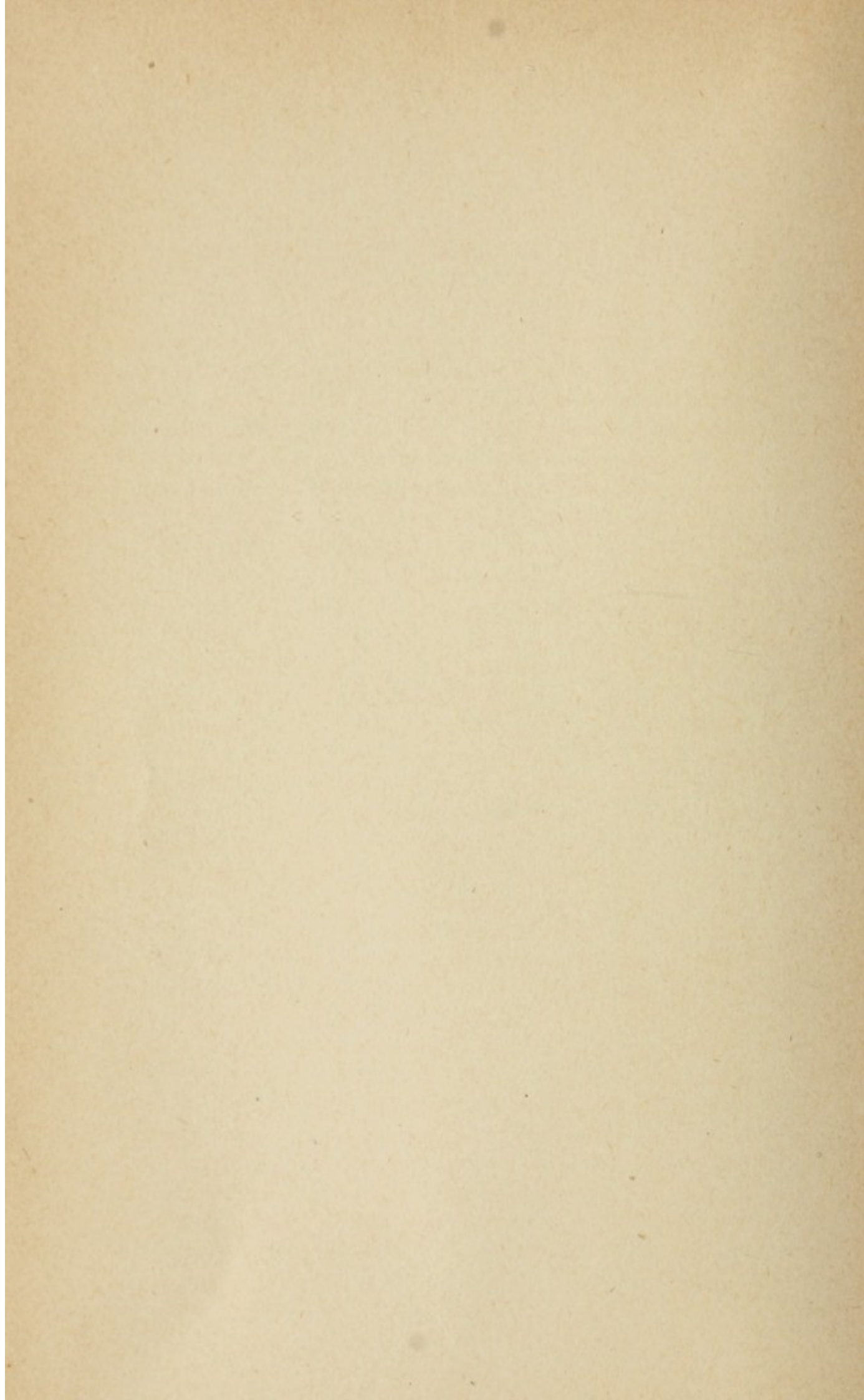
A chapter has been added upon the Neuroses of the Rectum and Anus. Rectal neuropathy now receives that separate consideration which it deserves, a new feature in this edition.

Further to make this book a *vade mecum* in the hands of those who must hurriedly turn many books in the intervals of active practice, a compact FORMULARY has been prepared, which contains in classified form every prescription in the body of the work and a considerable number of others. These are all *tried* remedies and many of them have their authors' names affixed.

With this formulary for reference, the practitioner who has once read the book can by almost instantaneous reference secure the necessary details for the treatment of any given case which is before him. These formulas have been collected from a very large number of works in various languages. Over fifty are given, and these are nearly all that can be found in a score or more of the best modern treatises, those being omitted, of course, which are practical repetitions of each other.

A chapter has also been given to the *sacculi Horneri* and columns of Morgagni in order more clearly to expose the ridiculous pathology which some have sought to connect with these innocent structures.

65 RANDOLPH STREET, CHICAGO, *January 1, 1892.*



PREFACE TO THE FIRST EDITION.

The itinerant "Rectal Specialists" of the Western States have become so numerous that very general notice has been attracted to their methods, and one good result, at least, has been brought about through their influence: Their competition has compelled physicians to give more attention to the neglected subject of rectal diseases. Hence has arisen an urgent call for information upon two points:

1. What are the best modern methods of diagnosis and treatment known to the regular profession?
2. What are the secret methods of the "specialists," and what their value?

To answer these questions we have written this book. We have endeavored to condense into it the results of our own special investigations and the established opinions, unequivocally stated, of authorities both European and American. To this we have added, in each department, the secret formulas of the irregulars which, for several years, we have been collecting.

The evolution of the itinerant pile doctor is an amusing bit of history. Some account of how the secret hypodermic method originated will be found in Chapter III.

Many of the itinerants who bought and used the secret were not medical men at all, yet even in their hands a certain amount of success was obtained, and reputation of being able to cure piles "without pain or operation" was fairly well sustained.

Regular physicians were for a number of years wholly at a loss to account for the success which these itinerants obtained. Our own discovery of the secret resulted partly from the indiscretion of a "specialist" who exemplified the saying *in vino veritas*, and partly from the information obtained by a Chicago druggist who furnished the same man and others their solutions. We published the knowledge thus obtained simultaneously in five prominent medical journals, and as a result were shortly in

receipt of hundreds of letters from persons of all classes, with reports of thousands of cases, and the results, both good and bad, of the method. The sale of "rights" ceased quickly. In several cases application was made for our testimony that the publication had been made at a certain date, in order to enable persons who had been victimized to recover money paid for what was no longer really a secret. The sums so paid for exclusive rights in a limited district were from one thousand to fifteen hundred dollars.

The modern Western "Orificial Surgeon" is lineal descendant of the original pile doctor. He uses still, in common with many reputable physicians, the hypodermic method in treating piles, but his evolution has proceeded so far that he now undertakes to treat other common rectal diseases as well, in a fashion peculiarly his own and suited rather to his own convenience as an itinerant than to his patient's real welfare. He no longer buys his secret and local right to practice, but invests from fifty to one hundred dollars in one of the "systems." He thus obtains a complete set of instruments and small secret manual of instructions which "enable persons of *no particular skill* to treat successfully all rectal diseases." As a matter of fact many of these persons are not medical graduates at all, but mere adventurers whose entire knowledge of their specialty consists in what their little book of instructions has furnished them. In some instances the itinerant is not allowed to know the composition of the various remedies directed by the secret pamphlet. He must buy them of the author of the "system," thus continually paying him tribute. Several of these "systems," by underselling each other, have greatly reduced their prices, so that from three hundred dollars they have now fallen in price to fifty, or even less, and are much improved in quality.

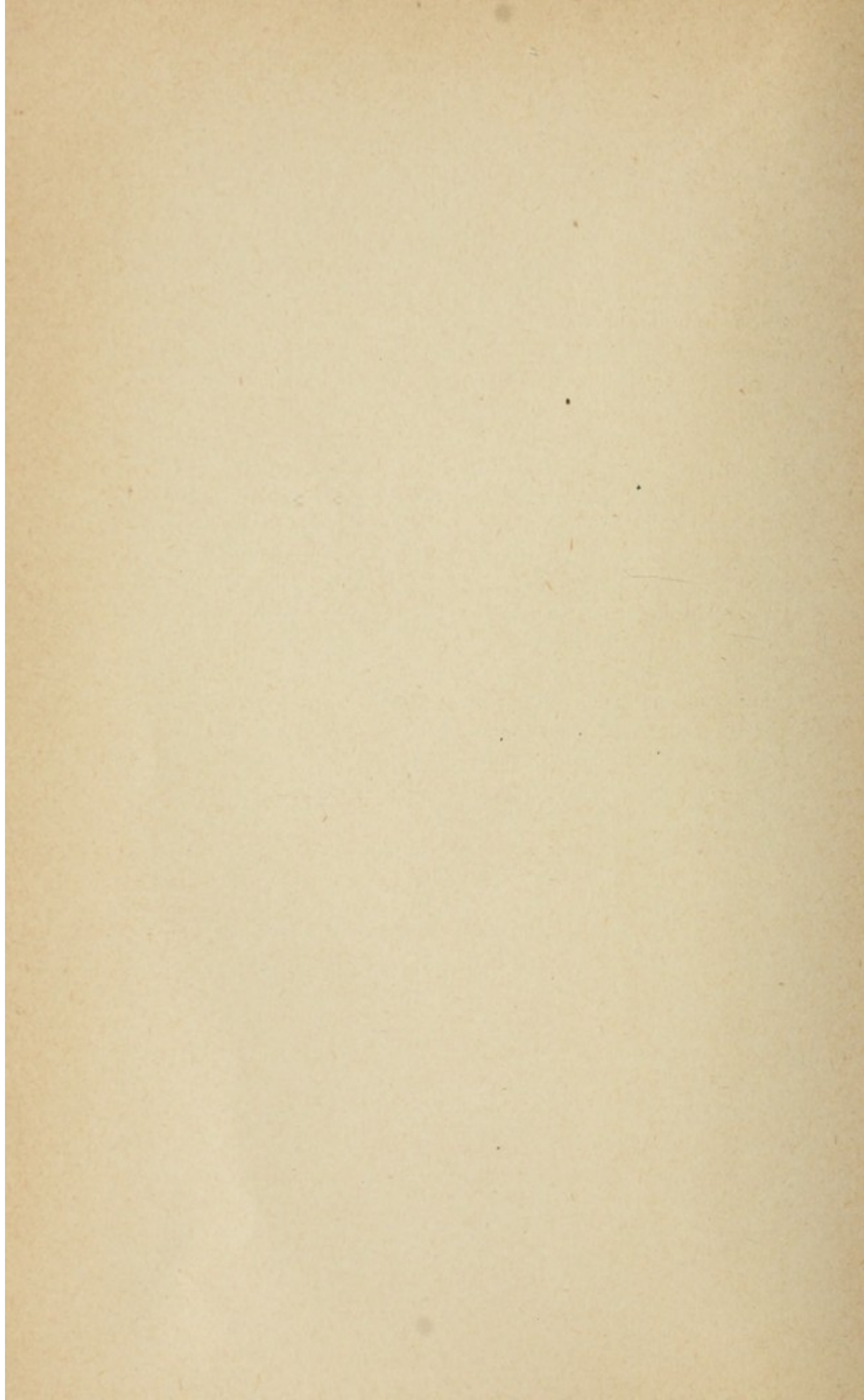
The itinerants themselves, moreover, have now enlarged their field of operation and their incomes by adopting an iniquitous mass of pathological rubbish concerning the *sacculi Horneri* and Morgagni's columns. There are few things more melancholy than the weakness of afflicted human nature for all kinds of quackery. If, however, there are differences in degree of charlatanism, that form which invents imaginary diseases for its victims is surely more vicious than that which only offers useless remedies.

From what has been said of the general attainments of the "Rectal Specialists" it will be seen that most of them are too ignorant to know better when told that the *sacculi Horneri*, the papillæ and columns of Morgagni (long ago discovered, and studied by anatomists and rectal surgeons), are signs of disease hitherto undescribed. They have a motive, too, in believing that these simple structures are lesions which demand treatment. A new source of revenue, not taxed by the author of any system, has been offered them and they have availed themselves of it with eagerness.

Thus the evolution of the pile doctor proceeds. From knowing originally but one thing he has come to a smattering of five or six, and is called an "Orificial Surgeon."

Most practitioners have greatly neglected the study and treatment of common surgical affections of the rectum and anus, and left an important field vacant for the occupation of charlatans and self-styled experts. This manual has been prepared with a view to furnishing practical rather than historical or theoretical information, for which the reader is referred to the systematic treatises such as the works of Curling, Van Buren, Esmarch, Kelsey, Cripps and Ball, or special monographs like those of Bodenhamer, Allingham, Smith, Yount, W. P. Agnew, and others.

65 RANDOLPH STREET, CHICAGO, November 1, 1887.



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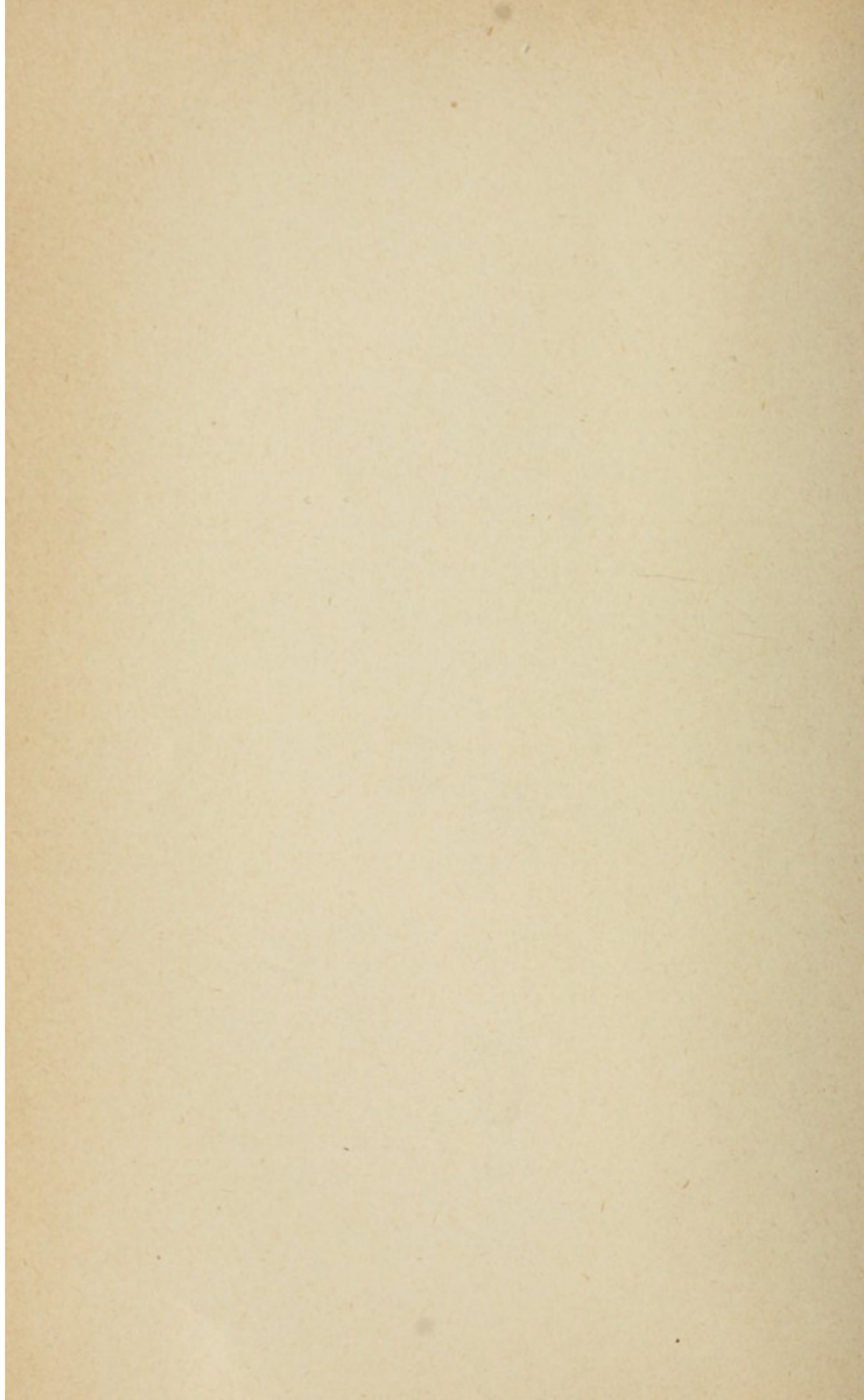
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RECTAL AND ANAL SURGERY.

CHAPTER I.

ANATOMY AND PHYSIOLOGY OF THE RECTUM.

The rectum is that portion of the great intestine extending from the left sacro-iliac synchondrosis downward to the anus. Its relations to the other organs of the pelvis are shown in Fig. 1.

The anus is the terminal orifice of the rectum, including the nerves, vessels, muscles and integuments which constitute the mechanism of the organ. The length of the rectum in the living state is from six to eight inches, but in post-mortem relaxation it becomes greater. In the main it follows the curve of the sacrum, being sharply concave in front, so that the name rectum (straight), given by the ancient anatomists from its straightness in the inferior animals, which alone they dissected, is wholly false in the human anatomy. At the lower border of the prostate the anterior concavity ceases, and the gut turns abruptly downward and backward, giving at that point a concavity behind. The upper part of the rectum lies somewhat to the left of the median plane of the pelvis.

The interior of the organ is almost smooth, showing only in two or three places any tendency to the abundant formation of large folds and pouches seen in the colon, yet the few valve-like projections which exist are sufficient very seriously to embarrass the examination of the viscus by bougies and bulb sounds.

The Peritoneal Coat.—The peritoneum nearly surrounds the rectum at its upper extremity, but as we trace it

downward it leaves, first the posterior, and then the lateral surfaces, and is absent altogether in most cases from the lower two inches. At a somewhat variable height, the peritoneum is reflected upward in front, forming a cul-de-sac, and passing over the bladder in the male, and the uterus in the female. It would be of great importance in surgical operations if there were a fixed and invariable height, below which the peritoneal pouch never extends, but examination of cadavers has so far failed to fix this danger point, that the anatomists contradict each other surprisingly, as the following list of opinions as to its height above the anus shows:

Malgaigne,	6 to 8 centimetres in males and 4 to 6 in females.							
Lisfranc,	4	inches	"	"	"	6	"	"
Ferguson,	10½	ctm.	"	"	"	15	ctm.	"
Richet,	10 ⁸ / ₁₀	"	"	"	"	16 ² / ₁₀	"	"
Blondin,	8 ¹ / ₁₀	"	"	"	"	4 ¹ / ₁₀	"	"
Velpeau,	5½	ctm. with bladder empty and 8	ctm. distended.					
Legendre,	"	"	"	"	"	"	"	"
Sappey,	"	"	"	"	"	"	"	"
Dupuytren,	7	centimetres.						
Luschka,	5½ to 8	"						
Hyrthl,	8	"						
Sanson,	11	"						
Quain,	4	inches.						
Gronj,	4	"						
Roberts,	2½	"						

These wide discrepancies may be partly due to careless observation, but they arise mainly from the great variations found in the cadavers examined. In short, the danger point has no fixed level, and varies even in the same patient with the fullness or emptiness of the bladder, being higher when this viscus is full, and lower when empty.

The most that can be averred is this: In no ordinary case will the peritoneal fold be found nearer to the anus than an inch and a half, but as hernial elongations of the pouch occasionally exist, the surgeon is compelled to hold himself in readiness to meet both the peritoneum and small intes-

tines at any level, even below the sphincter (if he happens to be dealing with a prolapse).

The Muscular Coat.—The three bands of longitudinal fibres pertaining to the colon become thickened as they descend upon the rectum and spread out so as to envelop the whole organ in a somewhat uniform coating. At the lower end, however, certain fascicles become separate as they approach the sphincter, and constitute the longitudinal ridges which are quite visible in the living state but which are scarcely discernible in the post-mortem relaxation. The circular muscular fibres lie inside the longitudinal ones, and are rather loosely connected to the latter, so that they often come down in prolapsus, leaving the longitudinal ones behind. As we descend, the lower portion of the circular fibres becomes much thicker, constituting what is called the internal sphincter. Its lower border terminates abruptly at an elastic ring of fibrous tissue which forms the verge of the anus. The fibrous ring may often be seen through the mucous membrane as a narrow and somewhat obscure whitish circle called "Hilton's white line."

Just above the verge of the anus some fascicles containing both muscular and fibrous tissue project as ridges under the mucous membrane and are called the columns of Morgagni. In post-mortem relaxation they are obscure and spread out in a reticulated form, as shown in the upper cut of Fig. 26, but in the living state the action of the sphincter

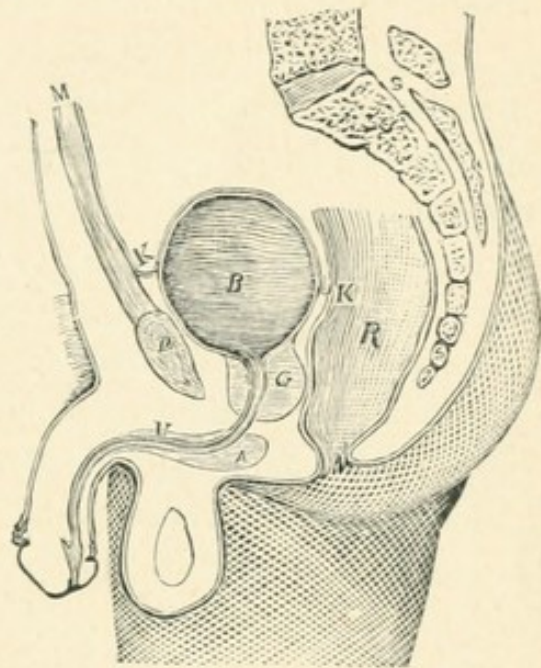


FIG. 1.

DIAGRAM OF THE MALE PELVIS CORRECTED FROM A FROZEN CADAVER.

R. The Rectum. B. The Bladder. K. K. Reflections of the peritoneum before and behind a distended bladder. G. The Prostate. U. The Urethra. A. The Bulb of the Urethra. P. The Pubis. S. The Sacrum. M. Rectus Muscle.

compresses the bands laterally, so as to make them assume a perpendicular position. They then appear as short longitudinal ridges closely crowded together, each about a centimetre long, and converging to an insertion into the fibrous ring of the anal verge. They are often described as mere folds or wrinkles of the mucous membrane, but this is an error. By close inspection the delicate and translucent mucous membrane can be seen to glide loosely over the more substantial framework of the columns beneath, but conforming to their shape. The lower ends of the ridges are connected by delicate webs covered by mucous membrane and forming little pouches at the lower ends of the grooves between the columns. The pouches are called the *sacculi Horneri*, after the celebrated anatomist Horner who described them. Their function is to retain a reserve of mucus which is pressed out by the passage of the fecal mass, and lubricates it at the moment of expulsion. The *sacculi*, like other organs, are sometimes diseased, and may require surgical treatment, but they are usually normal and healthy organs. Many of the itinerant "pile doctors" traversing the country claim that the *sacculi* are essentially and always abnormal and diseased tissues, and they make an important part of their fees by slitting them down.

The Mucous Coat.—The mucous membrane lining the rectum has certain microscopic peculiarities of interest to the histologist, which it is not necessary for our purpose to give in detail. Suffice it to say that its glandular structure secretes freely a tenacious, transparent mucus having a double function. First, it is antiseptic, and prevents the putrid fermentation of the fecal mass during its stay in the rectum; and secondly, it lubricates the organ to facilitate the act of expulsion.

The mucous membrane just above the verge of the anus is almost transparent in the healthy state, and so exceedingly extensible that it sinks into pouches before the pressure of the blunt hook like the softest and thinnest india rubber

and unskilled examiners deceive themselves with the idea that they find the *sacculi Horneri* wherever the blunt hook happens to take hold. The true *sacculi*, however, exist only at the lower ends of the grooves between the columns of Morgagni.

Between the grooves there are a few small *papillæ*, often very obscure, situated just above the verge, in a position analogous to the *carunculæ myrtiformes* of the vagina. Under each one is situated a small bulb or enlargement of a nerve twig.

The *papillæ* are probably tactile organs, which under the friction of the *faecal* mass in defecation provoke reflex contractions of the expulsory muscles above. The traveling pile doctors generally claim that they are diseased projections, and must always be snipped off with the scissors.

The External Sphincter Muscle.—This organ is a thin plane of muscular fibres, surrounding the anus as the *orbicularis oris* does the mouth. It is funnel-shaped, the inner edge being turned upward and attached to the fibrous verge of the anus, while its general surface curves downward and outward. The general form is elliptical, the posterior extremity arising from the tip of the coccyx, and the anterior being inserted into the fibrous *raphé* of the perineum. Its superficial fibres are rather closely related to the skin, and throw the latter into radiating folds. The two sphincters acting together close the anus.

The Skin.—As above stated, the skin of the anus is very closely connected with the surface of the external sphincter. It is studded with hairs, and lies in radiating folds. At the line of junction with the mucous membrane it is richly supplied with sensory nerves, so that it is subject to excessive pain in many diseased conditions.

The Connective Tissue.—This is thin and dense on the external surface of the external sphincter. Deeper and surrounding the rectum the connective tissue is very loose, to allow of the movements of the rectum, a condition which

permits an extensive burrowing of pus when abscesses form there. This accounts for the fact that anal fistulas often lead to cavities almost surrounding the rectum.

Arteries.—The arteries of the rectum and anus consist of three pairs, the superior hæmorrhoidal, which arise from the superior mesenteric, the middle hæmorrhoidal, which have a variable origin, and the inferior hæmorrhoidal, which spring from the internal pudic. They are all freely connected by anastomoses. Those ramifying above the verge of the anus form an abundant network between the mucous membrane and the muscular coat, and in cutting operations in that part are liable to bleed dangerously, unless properly secured.

Veins.—The veins constitute a complete network under the skin and mucous membrane, extending the whole length of the organ. They inosculate freely with each other. Those outside of the verge join together to make the external hæmorrhoidal veins, and terminate in the internal pudic trunks. Those in the anus proper combine into the middle hæmorrhoidal veins, which send their blood to the internal iliac trunks. The superior hæmorrhoidal veins arise from numerous minute blood sacs, quite variable in size, but averaging about three-sixteenths of an inch in diameter when injected, which lie under the mucous membrane a little above the anus. Good anatomists believe that this is the normal condition of things, and that the little blood sacs are healthy organs, and not incipient hæmorrhoids. Their proper function, if they have any, is a matter of conjecture. Proceeding upward from these sacs between the mucous membrane and the muscular coat of the rectum, the superior hæmorrhoidals at about three inches above the verge pass through certain foramina, or "button-holes," to gain the connective tissue outside the rectum, and thence proceed to join the portal circulation on its way to the liver. Verneuil, of Paris, believes, that the contraction of these "muscular button-holes" often obstructs the superior hæmorrhoidal

veins, causing distention of the little blood sacs near the anus, and thus originating piles. The older pathologists have generally believed that the true seat of obstruction is in the capillary circulation of the liver itself. Each of the blood sacs sends a small anastomotic twig through the sphincter to join the external hæmorrhoidal plexus, thus making a regular anastomotic connection between the portal and the general systems of veins.

Lymphatics.—The lymphatic trunks of the more external parts converge to the glands in the groin, while those higher up join the glands of the pelvic and abdominal groups, hence cancers and chancres of the anus infect the inguinal glands.

Nerves.

—The rectum and anus are copiously supplied with nerves, both from the sympathetic and the spinal systems. The spinal supply predominates up to a little above the verge of the anus, but as we trace the rectum upward we find the spinal

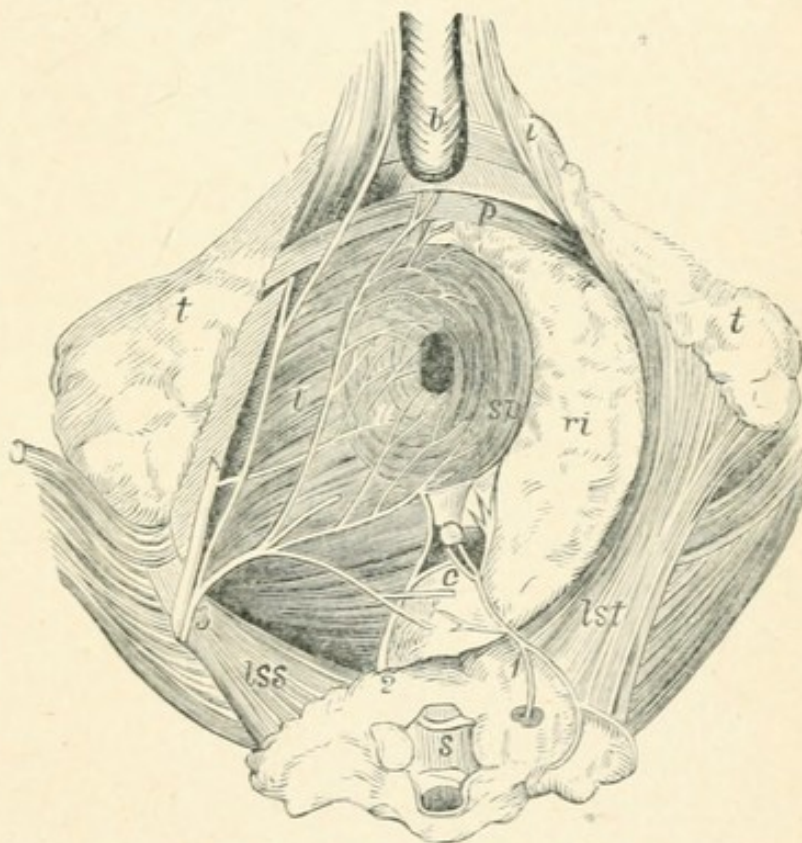


FIG. 2.—NERVES OF ANUS AND RECTUM.

1. Sacral Nerves: posterior root distributed to coccyx and ext. sphincter. 2. Anterior Root, to ext. sphincter. 3. Pudic Nerve and its branch the inferior hæmorrhoidal. *t.* Tub. ischii. *s.* Sacrum. *sp.* Ext. sphincter. *l.* Levator ani. *p.* Transversus perinei. *ri.* Isocho-rectal space.

twigs gradually giving way to those of sympathetic origin, so that at three inches above the anus the sense of touch in the healthy organ is almost absent, while at the verge

itself we have one of the most acutely sensitive surfaces of the body. The spinal trunks come mainly from the sacral plexus. Owing to the complicated supply from both systems, the reflexes of the rectum and anus are exceedingly numerous and energetic, causing frequent perplexity and some mistakes in diseased conditions as to the real seat of the patient's malady.

CHAPTER II.

METHODS OF EXAMINING THE RECTUM.

Like all other diseases depending for their diagnosis upon skill and accuracy in physical examinations, rectal troubles are the source of endless blunders and failures on the part of those who are content with half measures, or who let mere inference take the place of that persistent study which is due each individual case.

The false method is that of the bungler and amateur who is only right by hap-hazard; the true one is that of the professional expert who cannot be balked by petty obstacles, but who will reach success where others have failed, not less by his dogged persistence and thoroughness than by his superior knowledge.

Preliminary Inquiries.—The patient's own account of his ailment forms the most convenient introduction to the investigation of most cases. Despite the very erroneous notion which many patients have of the true nature of their disease, this will often throw a flood of light upon the case at once, and, to the mind of the surgeon, render further examination almost superfluous. It is best, however, to take nothing for granted, but to proceed systematically even in the simplest cases, with a definite line of inquiries, as suggested by Allingham, so that no important symptom can escape notice.

No better scheme of questions has been devised than the following:

1. Is there pain?
 Kind of pain—sharp, lancinating, burning, pulsating, gnawing, dull, paroxysmal, persistent, local, reflex.
 Is it connected with the act of expulsion (tenesmus)?
 Is it felt *after* defecation?
 Is it relieved by defecation?
 What is its duration?
 Is it relieved at times?
2. What of the functional activity of the bowels?
 Is there costiveness, or the reverse?
 Is there stomach, intestinal or liver complaint?
 Are the stools normal in color?
 In consistence? In shape? In odor?
3. Is there a discharge from the rectum?
 Is it mucous? Purulent? Bloody?
 Is the hæmorrhage abundant?
 Is the blood fresh or coagulated?
 Does it come during or after movements?
4. Is there during defecation or at any time a protrusion of the membranes?
 Does this return spontaneously?
 Can it be made to return?
 Is this painful, itching, or bleeding?
5. Is there incontinence of fæces or urine?
6. Is there a history of tuberculosis? Syphilis?
7. What has been the patient's mode of life—active—sedentary—temperate—etc?

The answers to these questions determine to some extent the direction of the *physical examination*, which is next in order, and which must modify or confirm the conclusions toward which the general symptoms point.

Position.—For operations and examinations requiring very complete access to the interior of the rectum the lithotomy position is the most satisfactory. A gynæcological chair is more convenient than a table for this purpose. The knee-chest position upon a lounge or table offers certain advantages for inspecting the deeper portions of the rectum which cannot be obtained in any other manner. The lighting is also excellent in this posture, but the use of an anæsthetic of course is not possible.

For most cases the Sim's position will be found most suitable, both in examining and operating. This is especially true in hæmorrhoids, fissure, prolapse and such troubles as do not require deep exploration.

Light.—Abundant daylight should be had from an undraped window, or a powerful artificial light such as an argand burner or oil reading-lamp placed on a stand in close proximity to the parts being examined. The tubular rectal specula require rather more light than those used in the vagina. About the same conditions are found here as in the use of the laryngoscope, and a similar condenser and hooded lamp are very useful. Darkening the room also assists very materially in their use. A perforated concave mirror held in the hand or strapped to the forehead, as in laryngoscopic work, is of great use in concentrating the light into the tube. (See Fig. 37.)

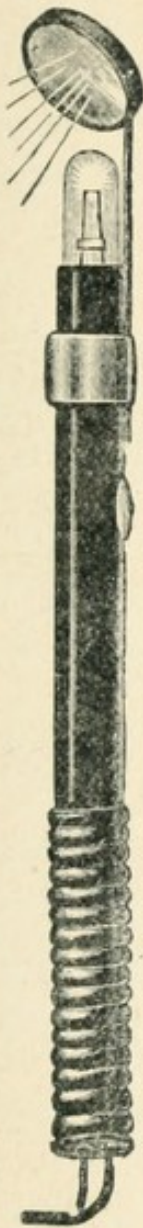


FIG. 3.
ELECTRIC LAMP.

The best portable illuminator to be carried to all sorts of localities and residences is a coil of mag-

nesian wire or of magnesian ribbon. This, when held in the flame of an oil lamp or a gas jet (a spirit lamp is better), gives a magnificent white light almost equal to direct sunshine in its blinding splendor. The beam may be reflected into the speculum by a plain or concave mirror, or thrown obliquely past

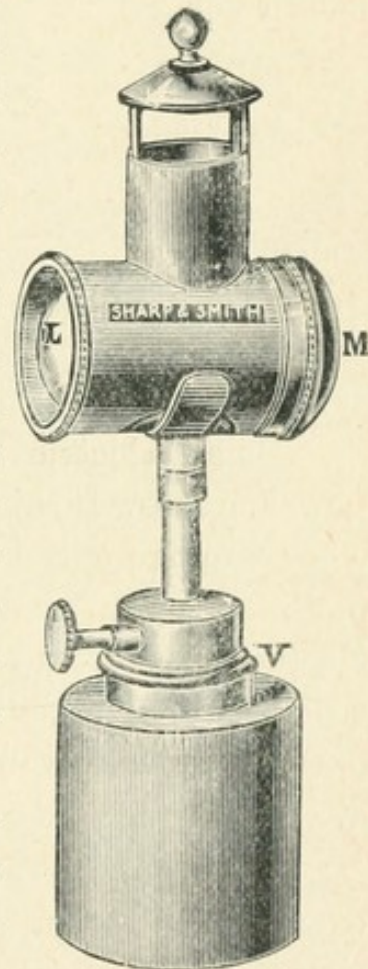


FIG. 4.—COLLINS' LAMP.

the surgeon's shoulder directly into the opening. A plate or basin should be under the light to prevent the red-hot particles of magnesia from injuring the carpet or the bedding as they fall. A calcium light, of course, would be excellent, if one should happen to be accessible at the place needed, but this could almost never be expected. In no class of work are the small incandescent electric lamps so useful as in examinations about the rectum. These can be held in the hand and thrust into the deeper parts of the cavity, furnishing a powerful illumination which no reflector can give.

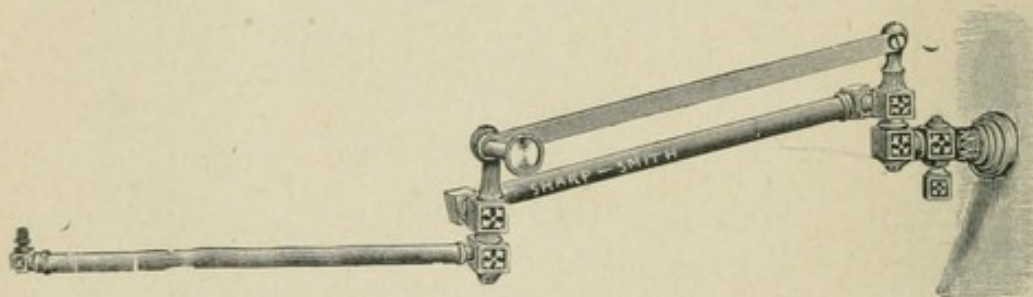


FIG. 5.—SHARP & SMITH'S GAS BRACKET.

Small electric lamps of about one-half or one candle power are now furnished for the use of surgeons and dentists. They are from the size of a pea upward and are usually mounted upon slender handles provided with a key for closing the circuit. From six to twelve Le Clanche cells costing about a dollar apiece furnish a battery which will operate such a lamp intermittently for a year without any attention.

External Inspection.—The first step in the physical examination for supposed rectal disease is a thorough inspection of the external parts. The most important signs of the presence of several common diseases are here visible.

Swelling, redness or tenderness should be carefully looked for in the tissues surrounding the anus, and the existence especially of any fistulous outlet determined at once.

The protrusion of hæmorrhoids or prolapsus will also be

noted. Hæmorrhoids, usually, are not externally visible until forcibly extruded by an act similar to that of defecation. Many patients can do this at will, while in others the tumors cannot be determined by external inspection. External inspection will also show the presence of any redness, excoriation or ulceration of the parts about the anus or of discharges from the rectum. Fissure of the anus will often show a distinct sign of its presence by a little "sentinel pile" immediately below the fissure.

Other troubles such as ulceration and stricture of the rectum, or cancerous tumors above the anus require different modes of examination. In the progress of cancer of the anus, the inguinal glands often become enlarged before the tumor has attained a large growth.

Digital examination supplements the external inspection in certain cases, and is in some respects more to be depended upon than internal inspection. For the detection of enlargement of the prostate, in strictures low down, and in testing the irritability of the sphincter, the finger is superior to all other instruments. The nail being made short and smooth, the finger is well lubricated, and gently

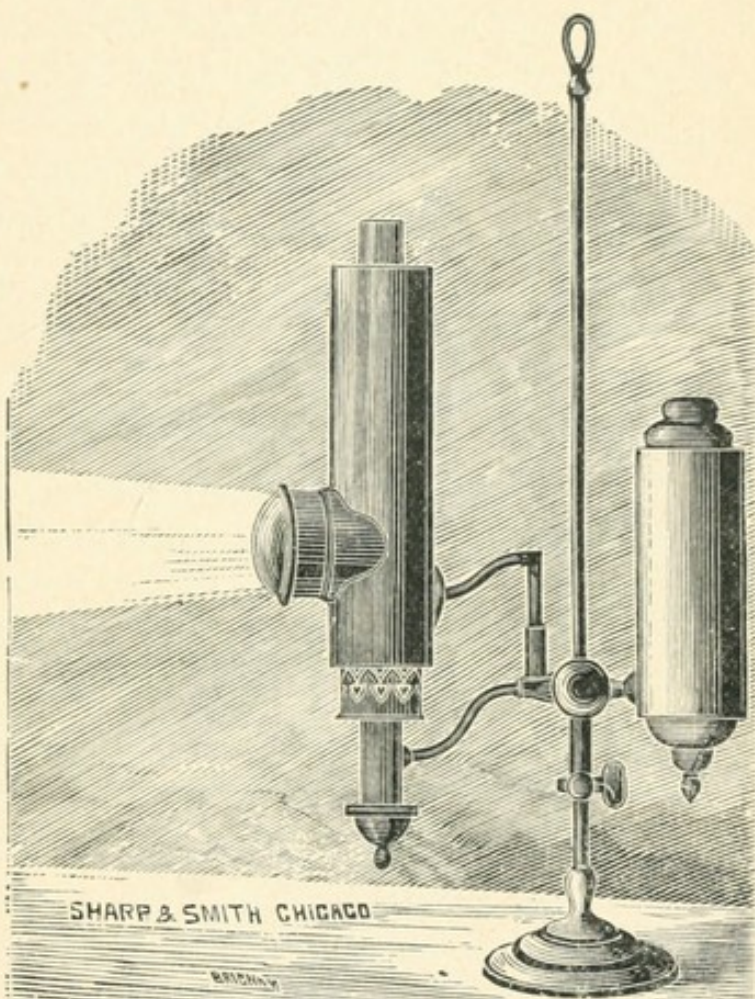


FIG. 6.

STUDENT'S LAMP WITH INGALS' CONDENSER.

insinuated through the orifice. Most surgeons prefer the index finger on account of its superior delicacy, but others like the middle digit, because of its greater length, though the superiority in length is more than lost by the interference of the adjacent knuckles. In using the index, the deepest touch is effected by putting the radial side of the hand toward the perineum, and letting the three unused fingers extend backward behind the sacrum; but in examining the prostate the middle finger is best with the palmar surface turned towards the pubis.

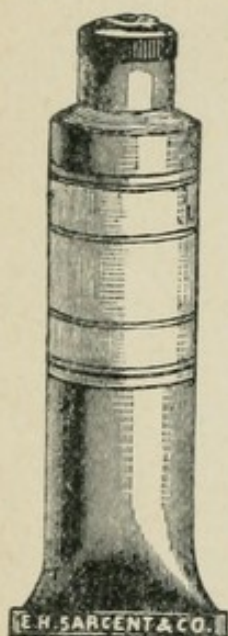


FIG. 7.—ASEPTIC
VASELINE HOLDER.

It is safer for the examiner to have the finger well anointed with some unguent which is both protective and antiseptic. Too much care cannot be exercised against poisoning the finger, as chancroidal and syphilitic ulcerations are not uncommon in and about the rectum. An incautious exposure of an abraded finger, or a "hang-nail," may give rise to very serious infection. Vaseline containing ten per cent. of boric acid, or five per cent. of carbolic acid, is useful for applying to the fingers and instruments. The latter causes a little temporary smarting when used freely upon the anal mucous membrane.

To guard against possible infection of one patient from another it is well, in addition to the ordinary disinfection of hands and instruments, to keep the lubricant in collapsible tubes, which allow the escape of such small quantities as are needed from time to time without risk of infecting the remainder.

When the lubricated finger-tip is pressed gently into the anus the resistance noticed will mark the amount of reflex irritability of the sphincters. In the normal anus this is slight, and will be felt only as a feeble contraction, which is soon overcome. In diseased conditions the spasmodic

resistance is sometimes very decided, and the introduction becomes painful and difficult. The state of the sphincter is an important part of the examination, and should always be noted.

Within the sphincter the finger finds the rectal walls in the normal state, smooth, elastic and distensible. The existence of stricture low down, of cancerous induration, or of inflammatory exudates, or œdema, can thus be determined. The finger which has become educated will readily detect any decided departure from the normal size of the prostate, and this should be noted carefully, as there occasionally seems to be an interdependence of bladder irritability and rectal disease.

As a further extension of examination by the sense of touch, recourse must be had to rectal sounds for the purpose of detecting obstructions in the deeper parts of the rectum.

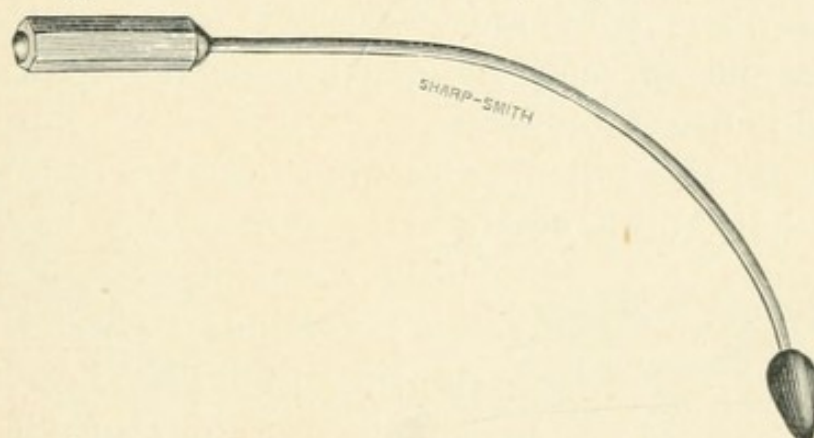


FIG. 8.—THE AUTHOR'S RECTAL SOUND.

The author's sound consists of a hollow steel staff of a curve taken from repeated examinations on the cadaver, and oval bulbs of graded sizes, from 1 cm. to 4 cm. in diameter, which can be screwed upon it. This instrument is used for diagnosis only. Its curve has proved so correct that it can readily pass into the sigmoid flexure, and be felt through the abdominal wall without serious inconvenience to the patient. The handle, staff and bulbs are perforated for convenience in injecting through them.

Sounds must be used with great gentleness, as ulcerated

spots in the intestine are sometimes exceedingly thin and may be ruptured. The easy passage of a large bulb proves the absence of stricture as far as it goes, but its arrest does not prove the existence of one. The upper rectum and lower colon have not only plications of membrane projecting into them, but the walls of the gut are liable to fold up over the end of an instrument, so that in deep sounding a mere arrest of progress does not prove the stricture.

The hand is sometimes introduced into the rectum for deep exploration. The operation, however, has sometimes caused death, and should only be resorted to when the emergency is such as justifies incurring some risk. The hand to be introduced should be small in circumference, well lubricated, and introduced very slowly and carefully, with the fingers gathered into the form of a cone. Of all exploratory instruments, the index finger is the one most frequently called for, but probes are necessary to trace fistulæ, and a grooved needle, an aspirator or a hypodermic syringe, may be wanted to detect abscesses.

Internal Inspection.—Speculums for the rectum have been multiplied until nearly every surgeon who has written upon rectal diseases, and many an ambitious “specialist” of provincial fame has invented one of his own to bear his name.



FIG. 9.—SPECULUM OF REMOVABLE SLIDE TYPE.

The sharpeners of the so-called “systems,” which have had considerable patronage among the more gullible and poorly-qualified members of the profession, have each some cheap form of ironmongery which is a more or less successful imitation of a standard form of speculum.

All of these instruments are copies of a few distinct types.

The simplest type is perhaps that of the straight tube. Tubular specula were very early employed for the rectum and were made both cylindrical, conical, and sometimes

fenestrated. For examining the deep parts of the rectum a speculum, in the form of a cylindrical tube, inserted by aid of a plug, is the best.

The author's tubular speculum is made in three forms. The tube of the first is straight and five inches in length and made of thin polished metal, and the plug is of polished hard rubber.

The light is thrown in by a concave mirror, and the membrane easily in-

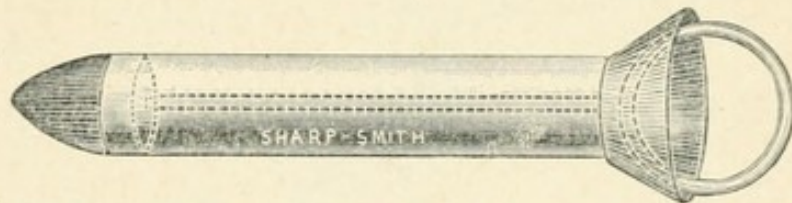


FIG. 10.—AUTHOR'S DEEP TUBULAR SPECULUM.

spected in every part as it prolapses over the end of the tube during its withdrawal. If it is desired to inspect still deeper, we use a tube curved at its inner part. This being inserted follows the curve of the rectum, and the membrane prolapsing over the end is viewed by an oval mirror inserted on a staff, giving an inverted view, like the laryngoscope.

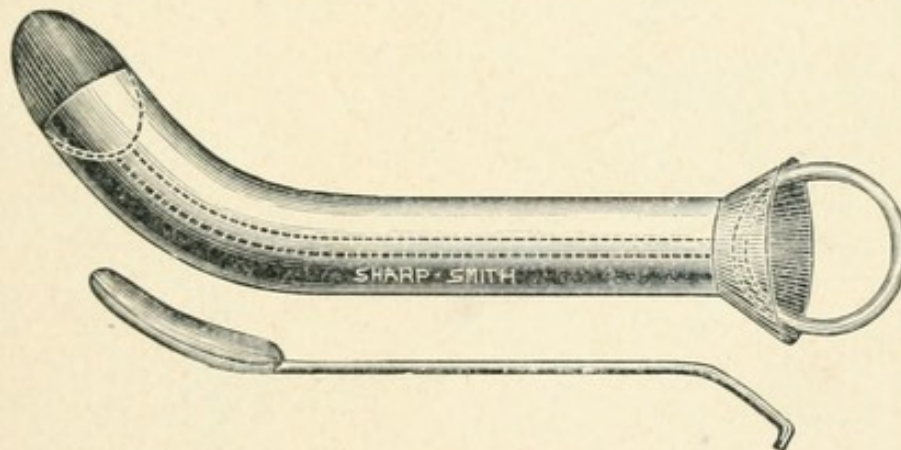


FIG. 11.—AUTHOR'S CURVED RECTAL SPECULUM.

The mirror is concave and gives a magnified view of the parts. The plan is modified from one devised many years ago by Bodenhamer. This enables one to get a very deep view of the rectal walls. Still nineteen-twentieths of practical rectal surgery lies within two inches of the verge of the anus, and the deeper instruments do not come to a very frequent use. The curved speculum is therefore of but

little use, especially as the field of view at the end of long tubes is small.

When a critical inspection of every point on the rectal walls is desired, there is nothing equal to a full-sized

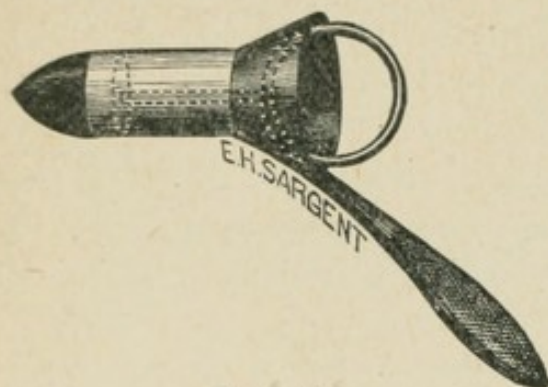


FIG. 12.

AUTHOR'S SHORT TUBULAR SPECULUM.

It must be borne in mind that nine-tenths of the lesions to be examined lie within an inch of the orifice, and hence



FIG. 13.

ALLINGHAM'S SPECULUM.

the end or through lateral openings, and the other much longer and open only at the end, for the exploration of

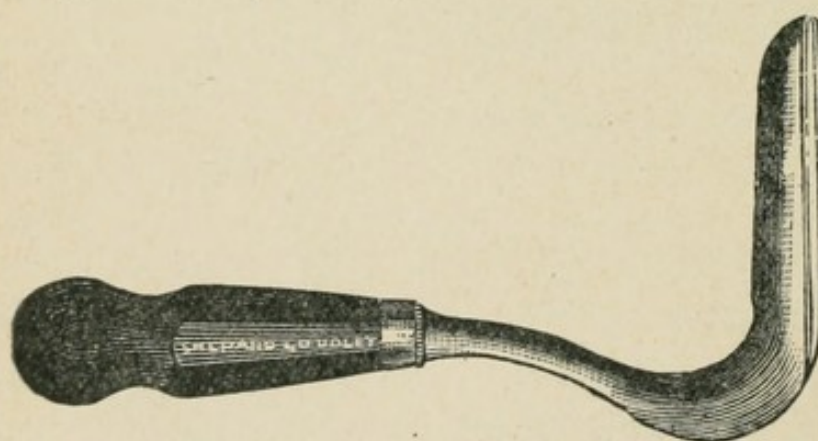


FIG. 14.—VAN BUREN'S SPECULUM.

the remoter portions of the viscus. The long instrument is inserted deeply and then slowly withdrawn, showing successively every part of the membrane as it prolapses over the open extremity. Of the short instruments, one of the best is that of Allingham. It consists of a thin,

tubular speculum, even for parts near the outlet. We use a short one for that location, on account of the illumination being better, and the fact that with a short tube the membrane closing over the end can be viewed

at widely varied angles. It must be borne in mind that nine-tenths of the lesions to be examined lie within an inch of the orifice, and hence the speculum oftenest used must show the latter, even if it fail on the deeper parts. Practically one needs at least two kinds, a short one to show the lower walls of the rectum either through

the end or through lateral openings, and the other much longer and open only at the end, for the exploration of the remoter portions of the viscus. The long instrument is inserted deeply and then slowly withdrawn, showing successively every part of the membrane as it prolapses over the open extremity.

metallic, trumpet-shaped shell, fitting closely to an ebony removable plug or core, which projects beyond the tip to facilitate insertion. A fenestrum or slot extends the whole length. The instrument is inserted with the plug in, and the fenestrum on whatever side it is desired first to examine. The plug is then withdrawn and the membrane inspected; the plug is then re-inserted and the fenestrum turned in a new direction, when the plug is again withdrawn. The plug prevents the edges of the fenestrum from scraping the membranes painfully, and by several re-insertions of it the

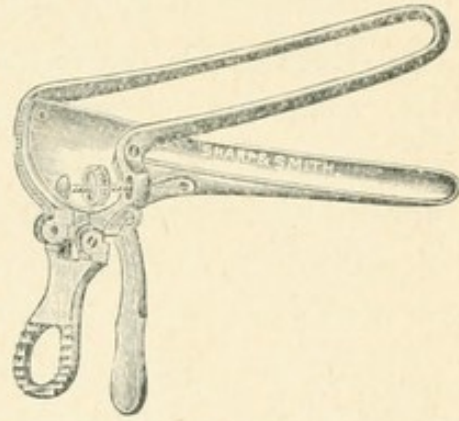


FIG. 15.—KELSEY'S SPECULUM

opening can be turned to every part of the rectal walls. The inner opening shows something of the membrane prolapsed over it, but the orifice of the tip is too small, and the instrument too short for efficiency in deep explorations. The present rectal itinerants generally use a small, tapering speculum, open at the tip, and having a plug to facilitate entrance. Like Allingham's, it is too short and too small for

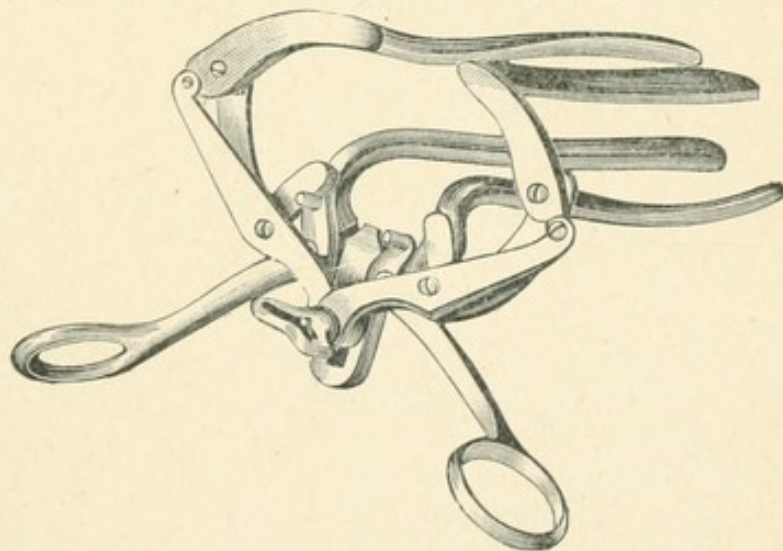


FIG. 16.—ALLINGHAM'S FOUR-BLADED SPECULUM.

deep work, but as it has a lateral fenestrum, closed by a removable slide, most of the objects sought by that ignorant class can be brought into view by means of it.

Tubular specula, however, are solely for examination. One cannot often use them in operating. A pair of Sims'

specula set in handles is very convenient in many cases both for examination and for operations.

Dr. Kelsey, of New York, has devised a good bivalve speculum, which is, however, not equal for general use to the four-bladed speculum of Allingham. (Figs. 15 and 16.)

Sets of Instruments for Rectal Surgery.—The diminutive cases of instruments sold at extravagant prices to itinerants and some unwary physicians are an illustration of the adage, "knowledge is power," since the possession of so very little knowledge on the part of an ignorant vender enables him to extract one hundred dollars from the pocket of his still more ignorant patron for ten or fifteen dollars' worth of very simple appliances. Of late competition has brought down the prices of these sets somewhat and improved their quality. Chicago parties advertise outfits at from thirty to fifty dollars, which are not different from those which at first found a market at double those figures. Nevertheless the price charged is exorbitant, and the selection is meagre and wholly insufficient for any surgeon who wishes to treat all rectal diseases.

If a physician wishes, he can provide himself with a far better outfit at a much cheaper rate by ordering from any first-class instrument store one of the following sets:

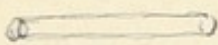
SMALL RECTAL CASE.

- 1 Hypodermic syringe with additional extra-long needle.
- 1 Allingham's rectal speculum. (Small.)
- 1 Scalpel.
- 1 Curved, sharp-pointed bistoury.
- 1 Curved, blunt-pointed bistoury.
- 1 Straight scissors.
- 1 Grooved director.
- 1 Silver probe.
- 1 Porte-caustique.
- 1 Small vulsellum pile forceps.
- 6 Curved needles (assorted sizes).
- 1 Tait's lock artery forceps.
- 1 Spool heavy ligature silk.
- 1 Bottle cocaine tablets.

LARGE RECTAL CASE.

- 1 Allingham's rectal speculum.
- 2 Andrews' tubular rectal specula (long and short.)
- 2 Van Buren's specula.
- 1 Scalpel.
- 1 Curved, sharp-pointed bistoury.
- 1 Curved, blunt-pointed bistoury.
- 1 Straight scissors.
- 1 Small vulsellum pile forceps.
- 4 Tait's lock artery forceps.
- 1 Grooved director.
- 1 Silver probe.
- 1 Porte-caustique.
- 1 Double tenaculum.
- 1 Large laryngoscopic mirror.
- $\frac{1}{2}$ Ounce magnesian wire for illumination.
- 1 Small spirit lamp.
- 6 Curved needles (assorted sizes).
- 1 Smith's clamp and cautery irons.
- 1 Hypodermic syringe, with additional extra-long needle.
- 1 Spool heavy white silk.
- 1 Hard rubber clyster syringe.
- 1 Curved rectal sound with six bulbs.
- 1 Allingham's pile crusher.
- Bottles, several, glass or rubber stoppered.

The small case will be furnished by most Chicago instrument dealers for about sixteen dollars, and the large one for about fifty dollars. If fewer or more instruments are required, the price will be lower or higher, in proportion. Even the smaller case is much better than those possessed by the itinerants.

Catman recommends a straight hard rubber tube imposing the rectum.  Through this tube rectum can be washed out regularly and there is no damming back blood from a bleeding above the tampon.

CHAPTER III.

HÆMORRHOIDS, OR PILES.

Hæmorrhoids, in the strictest sense, are varicose hæmorrhoidal veins. However, the term as used in popular language has been loosely extended to include almost every small tumor about the anus, whether of varicose origin or not. Some centuries ago they were called "Emerods," and the disease appears under that name in King James' version of the Old Testament, where the Philistines are said to have been smitten with emerods, and to have made golden models of them as expiatory offerings.

Ætiology.—This disease has its origin partly in the fact that when the patient strains in defecation, the mucous membrane is more or less everted, and in that position the hæmorrhoidal veins have no support from surrounding parts, so that the straining, by forcing the blood downward, distends them into pouches, or varices. When the rectum is continually packed with retained fæces, the veins are compressed above the anus, and the return of blood being restricted, they become additionally distended by this obstacle, so that constipation is a leading cause of the disease. The contraction, or inflammatory obstruction of the "muscular button-holes" by which the superior veins emerge from the rectum is also supposed to be a cause of their dilatation, and hence of piles.

Any obstruction of the portal vessels acts in the same way, hence diseases of the liver, large abdominal tumors and the pressure of the gravid uterus in pregnancy are common causes. When the inflammation of acute dysentery progresses downward to the vicinity of the anus, the veins are obstructed by inflammatory deposits around them, so that piles often

appear in the later stages of that disease. Finally, sundry small nævoid tumors of the anus, as well as hypertrophied folds of the skin and mucous membrane, soft polypi, and lumps formed by clots of extravasated blood under the skin, are popularly classed as piles, though not properly varices.

In cases where the obstruction is temporary, recent hæmorrhoids may recover spontaneously; but if subjected to the continued action of the cause, they tend to enlarge and become more and more inflamed. At first they are troublesome only at intervals, but these "fits of piles" grow gradually longer and ultimately merge into each other so that the tumors become permanent. As the distended condition continues, the parts become inflamed, and the integument and the connective tissues around the veins become first swollen and then permanently hypertrophied, and protuberances which originated as mere venous pouches, become solid and firm fleshy tumors. Sometimes clots of blood form in the veins, obliterating them, and leading to their cure by atrophy. At other times the veins burst, forming globular clots in the connective tissue outside the vessels, and these, like all other lumps in this region, are generally termed piles. They sometimes give origin to suppuration and are discharged, but generally the clots are absorbed in the course of a few weeks. Frequently the enlarged veins burst during defecation and copious hæmorrhage occurs. Where this recurs daily, the patient may be brought to the verge of death from anæmia.

Piles are usually divided into internal and external forms. The internal are those which originate just above the verge of the anus, and are therefore covered with mucous membrane. They are primarily varices of the superior hæmorrhoidal veins, and probably may originate in distention of the little globose blood sacs, described in the chapter on Anatomy of the Rectum as being the starting points of the radicles of these veins. Indeed, there are those who doubt whether these sacs are anything more than incipient

internal hæmorrhoids, though there is respectable authority for their normal existence. (Duret.)

At first internal piles only appear when thrust down in defecation, and recede out of sight when the effort is over. As they grow larger they are gripped by the sphincter when down, and prevented from returning, causing much pain, and sometimes bursting under the muscular grasp of the sphincter, thus causing free bleeding. The patient now learns to relieve his pain by pressing them in again with his fingers. At a still later stage they often become too large to remain in at all, and though still called internal piles they are now habitually external in position. At the verge of the

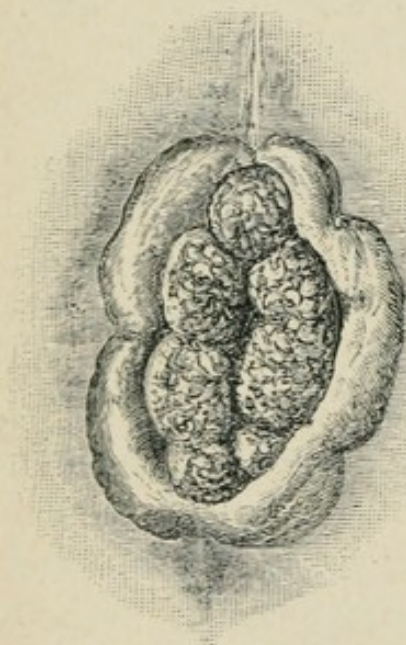


FIG. 17.
INTERNAL AND EXTERNAL PILES.

anus, where the skin joins the mucous membrane the subcutaneous connective tissue is somewhat denser than above or below, binding the integument there closer to the inner edge of the external sphincter. This circle of denser tissue resists the distention of the veins at that line, so that we usually find the internal piles above separated by a narrow groove from the external piles below. However, the dense tissue does not always maintain its grip, and we often find internal and external piles running into each other with no groove to mark the boundary between them. In short, the same pile may be both internal and external. Physicians often speak of suspected internal piles high up in the rectum. This is an error. There are no internal piles so high up that they never show during defecation. They rarely occur more than an inch above the verge.

External piles are especially liable to become obliterated by thrombus, suppuration, etc., in which case they leave

sundry projecting tabs and folds of skin which are still called external piles, though no longer containing enlarged

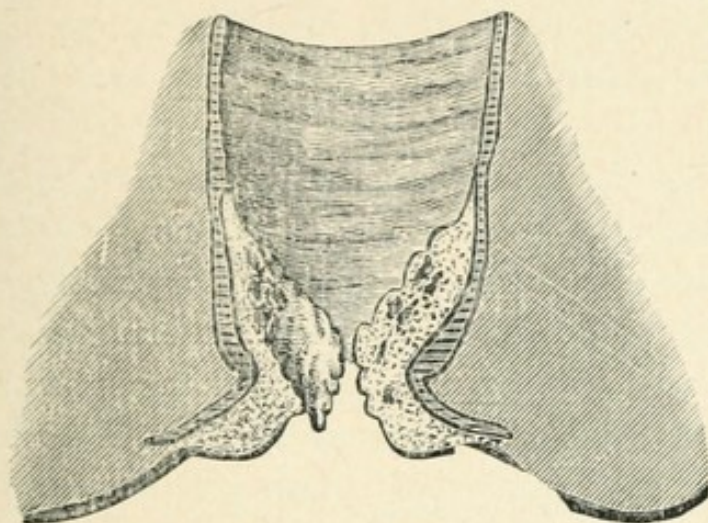


FIG. 18.—INTERNAL AND EXTERNAL PILES NOT CLEARLY SEPARABLE WITH A SMALL POLYPUS GROWING ON AN INTERNAL PILE.

veins. Most of the temporary piles formed by extravasated clots are also in the external group.

Owing to the translucency of the mucous membrane internal hæmorrhoids show the color of the distended veins beneath, and are of a bluish purple color,

while external piles approach more to a pink tint. When internal piles are found protruding, they generally present a rippled, irregular surface on account of the presence of the reticulated ridges of the columns of Morgagni, and of the sacculi Horneri among them. External piles, on the contrary, if distended are smoother in contour. The difference is well shown in Fig. 17, page 24.

The skin and mucous membrane covering piles near the verge of the anus are excessively sensitive, but the mucous membrane covering the upper portion of internal piles is nearly devoid of sensibility, a fact which should influence all our plans in operating.

Hæmorrhoidal tumors have a remarkable erectile power, not mentioned by most authors, and resembling that of the corpus spongiosum of the penis. This singular tendency enables

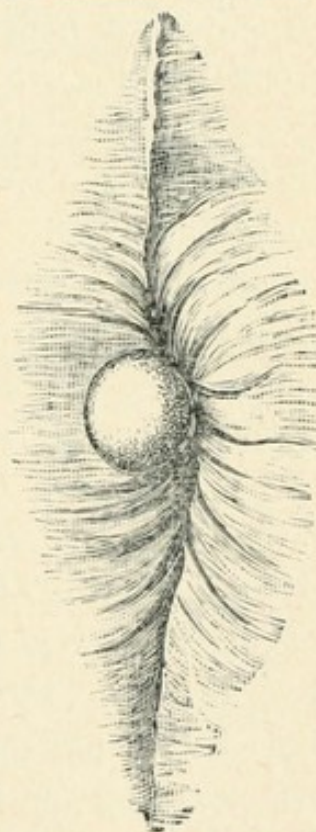


FIG. 19.—EXTERNAL PILE FORMED BY GLOBULAR CLOT UNDER THE SKIN.—(Smith.)

us to bring internal piles into view for examination or operation, by simply irritating them by a slightly rough handling with the finger. Under the touch they, in a few moments, erect themselves to their full size and are readily brought to view.

The treatment of hæmorrhoids is palliative or operative.

Palliative Treatment.—We have called the non-operative measures palliative, for in the majority of cases they fail to make a real cure, and only mitigate the suffering, yet it is true that in recent cases, where organic changes have not yet become established, many hæmorrhoids return to a state of nearly perfect health under palliative treatment, so that we may say that in such cases they actually assist nature to effect a real cure.

One of the most important measures, is to combat constipation, because the pressure of the fæcal mass compresses and obstructs the superior hæmorrhoidal veins, and thus distends them with blood and produces internal hæmorrhoids. Without occupying too much space with a topic familiar to every physician, suffice it to say that the mode of life, the diet, and the medicine are all regulated with a view to producing a gentle unirritating looseness of the bowels.

When full control of the patient can be had, it is well to place him for some days in a horizontal position, with a mild astringent wet compress bound against the anus. As defective action of the liver causes distention of the superior hæmorrhoidal veins, that organ should be regulated. Straining, or "bearing down" distends all the pelvic veins; hence the patient should be cautioned against all such efforts. Inflammation of the bladder often causes piles by inducing tenesmus and straining at the frequent micturitions; hence hæmorrhoids are common in cystitis, especially if a calculus exists in the bladder, and the cure of the urinary difficulty greatly relieves the rectal trouble.

Astringent ointments and washes with anodyne supposi-

tories are favorite palliatives. Tannin, chrysarobin, alum, zinc sulphate, plumbic acetate, and carbolic acid may be used in almost any form and combination. The opiates, cocaine, hyoscyamus, belladonna, or atropine, iodoform and bismuth are favorites for suppositories. It should be remembered that all the astringents of the tannin group are incompatible with morphine, cocaine, and vegetable alkaloids and salts generally. The aim in the use of washes and ointments should be to get an astringent effect, but never an irritation, and the strength of the preparation should be calculated accordingly. Alum and tannin may be used in almost any strength, but sulphate of zinc and all caustics must be better guarded. The tissues tolerate from two to four times more of an article in the form of an ointment, than in a wash.

Compression bulbs have been invented to slip into the rectum, and gently compress and support internal piles, but are not very effective except in a few cases.

The application of decided caustics has been resorted to, such as brushing internal piles with strong nitric acid, or nitrate of silver, or chromic acid. Good is sometimes done in this way, but mischief also may follow.

Operative Treatment by Stretching the Sphincter.—Perhaps the mildest operation upon internal or half internal piles is that employed by the French surgeons, Professor Verneuil and M. Fontan. It consists simply in making a rather slow and gentle, but complete and thorough, dilatation of both internal and external sphincters. This may be done by dilating instruments or by introducing gently through the sphincters two oiled fingers of each hand, and slowly pulling the sphincters in opposite directions until they are thoroughly stretched or dilated. An anæsthetic may be needed. Dilatation succeeds best in piles not already chronic. French authorities claim that a large proportion of hæmorrhoids are radically cured by this manipulation. It may, therefore, be a desirable method, especially when the patient is timid and cherishes a horror of ligatures and

instruments. Prof. Chiene, of Edinburgh, asserts that in rectal surgery, gradual dilatation of the sphincter and before operation gives rest after its performance as it is followed by temporary paresis. It must be remembered that severe and long continued inflammation sometimes follows these forced dilatations, and in these cases they are by no means a mild measure.

1896 **Treatment by Ligature.**—Probably the English and American surgeons have favored ligation for internal piles more than any other plan, on account of its comparative safety from hæmorrhage, embolism and abscesses. Mr. Allingham, of London, surgeon of St. Mark's Hospital for Rectal Diseases, has been the most conspicuous champion of the method, but König, of Göttingen, and many others on the continent, also favor it.

The application of the ligature renders hæmorrhage nearly impossible, and puts a very efficient barrier against the entrance of clots or septic material into the channels of the veins.

The use of the ligature for piles is very ancient. Hippocrates mentions it, and Celsus describes it. The success is excellent. When properly done, the cure is as near to absolute certainty as surgical operations ever attain, and the danger is a mere trifle. The mortality thus far ascertained is nearly as follows:

	CASES.	DEATHS.
Allingham's report of cases in St. Mark's Hospital up to 1859,	1,763	5
Allingham's report of cases in St. Mark's Hospital since 1867,	2,250	1
Allingham's report of cases in St. Mark's Hospital since previous report,	- - - - - 250	0
Allingham's private practice,	- - - - - 1,600	0
Total,	- - - - - 5,863	6

This is about one death in a thousand cases. It should be noted that five of these deaths occurred previous to 1859, when antiseptics were unknown and the hospitals of London were in a very unhealthy condition. Since that Allingham

reports 4,100 cases with only one death. The following authors have expressed their opinion in favor of ligation: Gross, Van Buren, Bodenhamer, Gowlland, Alfred Cooper, Curling, Quain, Ashton, Syme, Bushe, Copeland, Sir Benjamin Brodie, König, Frank Hamilton, Ashurst, Cripps, and many others.

Preparation of the Patient for Operation.—It is best to investigate the patient's whole condition, and rectify as perfectly as possible all diseased tendencies. Spectroscopic examination of the blood, as in all other cases, should precede the operation if any indications of anæmia or cachexia are observed. Diabetes and Bright's disease of the kidneys add greatly to the risk of all operations, and such cases are to be avoided. Hence the importance of testing the urine. Cripps refuses operations also in all cases of piles dependent on cystitis, but this is an error. When cystitis and piles coexist, each one powerfully aggravates the other, and the cure of the piles greatly assists the cure of the bladder. Many times the latter can never be cured until the piles are operated on. In malarious regions a full dose of quinine four times a day for forty-eight hours is a good preparation for the operation. The hair about the anus should be shaved off, and an antiseptic wash used there three times daily for two or three days. A good solution is carbolic acid, one part to fifty, or corrosive sublimate, one part to three thousand of water. On the day of operation the bowels should be well emptied by a cathartic, and the meal next preceding the operation should be omitted, so as to avoid vomiting during the anæsthesia.

When one or two small piles only are to be operated on, they can be anæsthetized sufficiently by clamping their bases and in that state injecting them with cocaine; but where the disease is extensive, ether is necessary. If the latter is used, the patient should strain down the piles, if possible, just before the operation, so as to bring them to view, and then go upon the table and be anæsthetized. After etheriza-

tion, he may be placed in the position of lithotomy, or upon either side, with the knees drawn up, at the pleasure of the operator.

Most surgeons now forcibly dilate the sphincter, which excites the erectile action of the piles, and also opens the anus, thus bringing the tumors well into view. It is done by inserting one or two fingers of each hand into the anus, and gently but steadily drawing in opposite directions for three or four minutes. All rapid traction is to be guarded against, because there is danger of rupturing the tissues. It is not true, however, as some writers imply, that this dilatation is necessary. We can assert from many years of experience that ligation without forced dilatation is one of the most successful operations in surgery, so much so that it rarely fails to cure; moreover it has seemed to us that when we have employed the dilatation, the patient has suffered greater pain and inflammation without any better final result. We doubt the wisdom of inflicting this added injury indiscriminately. In many cases the piles are sufficiently exposed already, and in most of the remainder a slightly rough handling of them with the fingers and forceps, or tenaculum, causes the erection before described, and enables one to bring them well into view. The irritation of a forced dilatation should be avoided whenever it is unnecessary, yet the parts just above the verge must be searched, lest hidden piles escape notice.

We next consider the number and size of the piles, for if they occupy the whole verge of the anus, an absolutely complete removal of them down to their bases will make a circular wound completely surrounding the orifice, whose contraction in healing will cause a stricture of the anus—a fact which some eminent authors neglect to mention. It is necessary in all cases to save mucous membrane enough to constitute a soft and distensible verge to the anus. Hence, when the piles occupy the whole rim, we do not tie them close to their bases, but about half way between the base

and summit, so as to leave some mucous membrane and skin between the tumors, and not included in the ligatures. There need be no fear of failure on this account. Although the ligature takes off only half the height of each pile, the stumps, after swelling temporarily, always shrink down and become atrophied, leaving a perfect cure. Having considered thus where to place the ligatures, the surgeon seizes a pile with small vulsellum forceps, or a tenaculum, and draws it out. At this stage Allingham takes a pair of scissors, and commencing at the white line where the lower end of the mucous membrane covering the pile joins the skin, dissects the tumor up from the sphincter some slight distance into the bowel, keeping close to the muscular coat. The wound does not bleed much except in rare cases, because the arteries of the pile enter it at its superior border. This incision severs the nerves of sensation, which enter from below, and makes the presence of the ligature less painful. However,

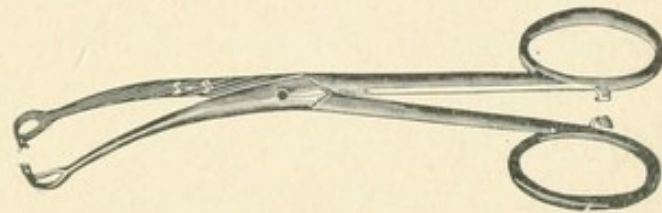


FIG. 20.
SMALL VULSELLUM FORCEPS FOR PILES.

when the piles constitute almost a continuous ridge around the anus, this plan cannot be adopted, as a ring-shaped wound and subsequent stricture will result. This deep dissection also is not free from chances of hæmorrhage. Arteries sometimes take abnormal directions, and scissors also go at times a little deeper than was intended. Hence many surgeons prefer, after seizing the pile, to cut a little groove at the proper place, around the lower half of its circumference, simply going through the integument, so as to divide the cutaneous nerves, and thus blunt the sensibility and prevent the pain which would otherwise occur after the anæsthesia passes away. The ligature, which should be aseptic and very strong, is tied in the groove made by the knife, and if the pile is large it should be tied three times around,

as otherwise the yielding of the tissue under the pressure of the ligature is liable to slack its tightness and prevent complete strangulation. After tying the knots very securely it is best to snip off a little of the summit of each tumor to permit its fluids to drain out, but not to cut so closely to the ligature as to risk the latter's slipping off. The escape of fluid allows the pile to shrink, hence a very moderate snipping will sometimes allow the ligature to slip off. We prefer silk, hemp or linen threads. Catgut can be used, but it needs special care in tying, as under the softening effect of moisture it becomes slippery and is liable to yield, and permit hæmorrhage. Chromicized catgut is partly free from this danger. Many try to press the ligature stumps back into the bowel, but we are of the opinion that there is no use in that procedure. If they remain outside they can be kept well disinfected, and all bad odor and danger of septic infection prevented. The operation being finished the stumps should be washed with an antiseptic solution, dusted with a thick layer of boric acid, and covered with a handful of antiseptic gauze held in position by a T bandage. Anodynes may be given as required, and it is well to give a hypodermic injection of morphine just before the operation. By a careful application of an eight per cent. solution of cocaine externally, or of a four per cent. solution by a hypodermic syringe under the skin and mucous membrane of the anus, many mild cases can be ligated with but little pain without any ether or chloroform, but care must be taken not to exceed a safe dose. A young surgeon in New York trying to operate under cocaine, and not getting full anæsthesia, yielded to the temptation to repeat the dose until he had injected eighteen grains into the tissue of the rectum, causing the death of the patient. Overcome with horror at the result of his error he then committed suicide.

Frequently the operation will be followed by a spasmodic contraction of the sphincter of the bladder, causing retention of urine, and compelling a resort to the catheter once or

several times. The catheter may be tied in if necessary. Some surgeons try to prevent the spasm of the neck of the bladder by dilating it with a large urethral sound at the close of the operation. The treatment of the bowels is not agreed upon among surgeons. If they are made to operate daily they cause a repetition of the painful movement. If they are restrained by opiates several days, as advised by Allingham, the fecal mass in the rectum becomes large, and hurts the more violently at last. The best way is to empty the bowels thoroughly before operating, and allow but little solid food for three days after. At the end of about three days after the operation give a mild cathartic, and at the same time soften the contents of the rectum by a warm injection. This will cause an evacuation with but little pain, and by similar means we can procure daily painless movements afterward, especially if the parts be well brushed with cocaine. The ligatures generally come away before the end of the sixth day.

Ligation is probably the safest of all operations upon piles, but causes somewhat greater pain after the operation is over than the clamp and cautery. Its almost absolute safety from hæmorrhage has made it a great favorite both in this country and in Europe. Further comparison of the two methods will be made when we come to discuss the clamp and cautery operation.

Treatment of Hæmorrhage after Operations in the Rectum.—All operations for piles are liable to a possible primary or secondary hæmorrhage, though the method by ligature is nearly safe from this accident. As the bleeding may take place inside the sphincter, a great quantity of blood may accumulate in the colon before it is observed. If hæmorrhage is discovered, or suspected, the bleeding point must be sought for, even if one has to forcibly dilate the anus and pull down the mucous membrane. The spot cannot be much above the verge. If it cannot be discovered Allingham ties a double string into the center of a large

bell-shaped sponge, and pushes it up five inches above the bleeding point, so as to prevent the blood escaping upward into the colon. He then firmly packs the parts below with cotton dusted with powdered alum or iron persulphate, and leaves the tampon there a week or more. If the bleeding point can be found approximately, but not exactly, the whole adjacent patch of mucous membrane can be pinched up and tied *en masse*, or a double ligature may be passed under the spot by a curved needle and tied each way, thus enclosing the bleeding spot.

Slighter hæmorrhage may often be arrested by ice in the rectum, or by astringent tampons, but severe cases require ligatures.

The Hypodermic Injection of Piles, or the Method of Itinerants.—In the year 1871 there lived in the village of Clinton, Illinois, a young physician named Mitchell. His practice was small, and afforded him superabundant leisure, which he employed in devising a new treatment for piles. Being a good thinker he soon conceived the idea of treating hæmorrhoids by the hypodermic injection of a mixture of olive oil and carbolic acid. Having tried his plan upon an old farmer of the neighborhood he accomplished a triumphant cure. The old farmer was delighted and garrulous, and the young doctor was needy but ambitious, and the two made a sort of copartnership, the agriculturist attending to the advertising, while the young doctor received the patients and punctured their piles and their pockets with his hypodermic syringe. Knowledge of their method spread. Certain itinerants began to sell the secret to others, pledging them to secrecy in turn, and binding each to practice only in the district for which he had “purchased the right.” Two men in Chicago are said to have paid three thousand dollars for the exclusive secret “right” to a certain portion of Illinois, including their city. Flocks of itinerants bought the secret of each other, and traversed the country in every direction until their handbills fluttered on the shores of the Pacific

Ocean. In the year 1876 one of the quacks revealed to us his method, and by taking measures adapted to the purpose we found that his information was correct. We then entered into correspondence with a considerable number of the itinerants, some of whom seemed willing to make a clean breast. We also communicated with a large number of regular physicians who had observed the practice of the itinerants, and in some cases had made use of the method themselves. In the course of this investigation we received about three hundred letters, and got rough estimates of the results of the injections in about three thousand three hundred cases.

Mitchell commenced with a mixture of one part of carbolic acid to two parts of olive oil, but he gradually varied from his first method, and at length, as I am informed, he partly abandoned the injections and adopted the plan of tearing the interior of the piles to pieces by angular needles set in handles. He probably met some of the dangerous accidents which have occurred in the injection practice, and changed to the needles on that account. His disciples, however, persisted, and in their hands the injections were varied in numerous ways. One of the itinerants wrote us that he had tested "every caustic in the vegetable and mineral kingdoms," but that he came back to carbolic acid as the best, "and the stronger the better."

The excipients generally used were oil, glycerine or alcohol, to which water was sometimes added. Carbolic acid was generally but not always the active ingredient and the strength varied from twenty to one hundred per cent. We were disappointed on the whole in the results. Although there were many beautiful cures, thirteen deaths were reported to us out of about 3,304 cases, besides a large number of dangerous abscesses, sloughings, and in some cases prolonged and terrible pain, or desperate shock, the latter being probably from embolism. In a number of cases very dangerous hæmorrhages occurred, presumed to

be from the spasmodic grip of the sphincter bursting the thin walls of a pile, squeezing out the clot, and letting loose the floodgates of the hæmorrhoidal veins, which above the verge have no valves.

It is an old experience over again. Twenty years ago the profession was charmed by the results of coagulating injections thrown into venous enlargements in other parts of the body, but we were soon stopped by the occurrence of deaths from embolism. The hypodermic injection of piles confronts us with similar dangers.

The following accidents have been reported to us out of about 3,304 cases: Deaths, 13; embolism of liver, 8; sudden and dangerous prostration, 1; abscess of liver, 1; dangerous hæmorrhage, 10; permanent impotence, 1; stricture of the rectum, 2; violent pain, 83; carbolic acid poisoning, 1; failed to cure, 19; severe inflammation, 10; sloughing and other accidents, 35.

We are the more particular to mention these disasters, because Dr. C. B. Kelsey, of New York, has recently tried the plan and states that he has never seen a death from it. Our experience in the West is very different. Twelve years ago we collected and published reports of nine of these deaths, in an article which was extensively republished in the medical journals of this country and of Europe, and about four more fatal cases have come to our knowledge since. Dr. Kelsey, like one of the present writers, was at first highly pleased with his results, but with his usual sound judgment and candor he observes that further experience developed so many instances of abscesses, sloughing, etc., etc., that he has modified his first conclusions, and now applies the plan mainly to selected cases of completely internal piles of moderate size, and having well defined pedicles. He has made the further important observation that the cures by the hypodermic injections are temporary. He says all his old patients, whom he reported cured by that method, seem to be returning to him with a relapse, and he now

reckons the duration of the cure to be only about four years on the average. (Kelsey on the Treatment of Hæmorrhoids, p. 64.)

For ourselves, we were long ago reluctantly compelled to admit that these injections are dangerous, and until some way of avoiding the perils is shown we can not recommend them except in special and selected cases.

The itinerants varied greatly the strength of the fluids used. The weak solutions acted more mildly than the others, but they often failed of cure. The strong preparations almost always cured the piles, but they produced a multitude of cases of abscesses and sloughings. The Michigan itinerant above mentioned states that he preferred positive results, and always sought to cause the piles to suppurate or mortify, and to that end he "preferred carbolic acid, and the stronger the better." Some of them use the acid at a strength of only three per cent. and others as high as 95 per cent.

The secret pile remedy of the "Brinkerhoff System" is the following:

Carbolic Acid.....	ʒj
Olive Oil.....	ʒv
Chloride of Zinc.....	grs. viij

Mix.

The little pamphlet furnished to the itinerants purchasing the "System" directs that the amount of injection inserted into the tumors shall be as follows:

Largest Piles.....	8 minims
Medium "	4 to 8 "
Small "	2 to 3 "
Club-shaped painless piles near orifice	2 "

"Brinkerhoff's System" forbids the injection of any but internal piles. It directs hot sitz-baths for cases where violent pain follows. Its prohibition against the injection of the external kind, is doubtless because of the agonizing distress apt to follow in the latter, owing to their great

supply of sensory nerves. It directs to treat only one large, or two small piles at a sitting, and to allow from two to four weeks between the operations.

Some add ergot, and others cocaine to their injections. The itinerants have used a great variety of coagulating substances besides carbolic acid, such as iron persulphate, iron perchloride, zinc sulphate, zinc chloride, mineral acids, tannic acid, etc., but on the whole carbolic acid mixtures have received the preference. The dangers have generally arisen from embolism, hæmorrhage, abscesses and septicæmia. The lower portion of the hæmorrhoidal plexus empties into the iliac veins, and the upper into portal system; hence clots or globules of the injection may be carried either to the heart or to the liver. Dr. Whitmire, a well-known physician of high standing in Metamora, Ill., tampons the rectum for twenty-four hours after the injection to prevent the clots from moving upward. In case of hæmorrhage, Allingham's method of tamponing, as described on page 34, can be employed.

Up to the present time science has not discovered any method of wholly avoiding the risks of the hypodermic injections. The method is moderately, but positively, dangerous, and we cannot recommend it as proper in ordinary cases.

If the injection plan is resorted to at all the following rules should guide us:

1. Unless cocaine is used, inject only internal piles, as those have much less susceptibility to pain than the external ones; however, if an external pile be injected a few minutes beforehand with cocaine, the pain can be in a great measure prevented.

2. Use diluted forms of the injection first, and stronger ones only when these fail.

3. Inject only one or two piles at a time, and allow from ten to thirty days between the operations.

4. Apply cosmoline to the surface to protect it from possible dripping during the operation, and keep the syringe

in a few moments to prevent the mixture from flowing out. Inject slowly.

5. Confine the patient to the bed the first day.

Treatment of Hæmorrhoids by the Clamp and Cautery.—Von Langenbeck, of Berlin, and Smith, of London, are the chief advocates of this operation, but Mr. Cusack, of Dublin, is said to be the inventor of it. Kelsey also decidedly prefers it to the ligature. The operator seizes the pile with a double tenaculum or with a small vulsellum forceps and draws it out. He then applies to its base the clamp shown in Fig. 21, so as to prevent hæmorrhage and protect the parts beneath from the cautery instruments. Smith then cuts off the piles outside the clamp with hot serrated cautery knives, while others simply use the scissors. In either case the tissue is not divided close to the clamp, but about a third of an inch external to it. The projecting stump is now thoroughly but slowly cauterized by the Paquelin cautery or by irons at a black heat, so applied as not merely to sear the cut surface, but to thoroughly “cook” the whole projecting stump well up to the clamp. The electro-cautery can be used instead of hot irons.

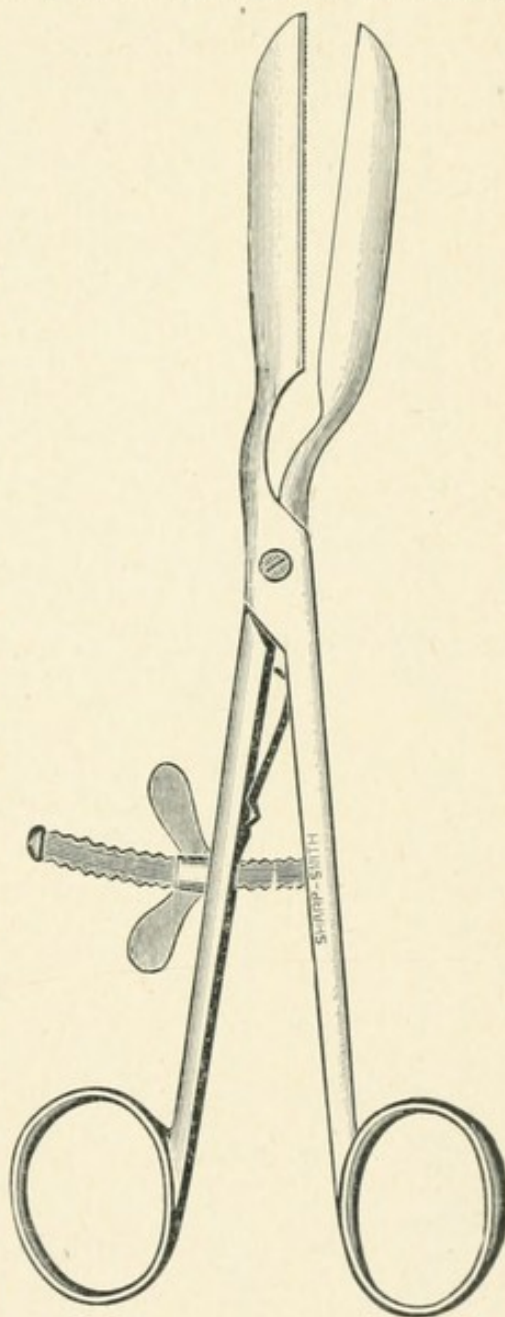


FIG. 21—SMITH'S CAUTERY CLAMP.

When every part of the stump is thoroughly and deeply

cauterized, the clamps are loosened. If any part bleeds, the clamp and cautery are re-applied until the hæmorrhage is totally suppressed. There is no safety from bleeding in this operation except in the depth and thoroughness of this burning and charring of the stumps, but with this point well attended to, the safety may be made almost, but not quite, equal to that of the ligature.

The stumps now recede within the sphincter, and the patient is placed in bed. The clamp is applied to the same spot on each pile where the ligature would be, were that used; that is to say, when the bases of the tumors occupy the whole circumference of the anus, enough mucous membrane must be saved between the prominences cauterized to constitute a good distensible verge for the opening, otherwise a stricture will result. Only half the height of each pile should be destroyed in such cases.

There is no doubt that this operation is less painful after the patient awakes, than the ligature, but with any unskillfulness, or inefficiency of the cautery, it is more liable to dangerous hæmorrhage. The idea of being cooked and burned with hot irons is horrifying to the imagination of the patient and his friends, and tends to make the cautery unpopular in private practice, but the certainty of cure by it is equal to that by any other method.

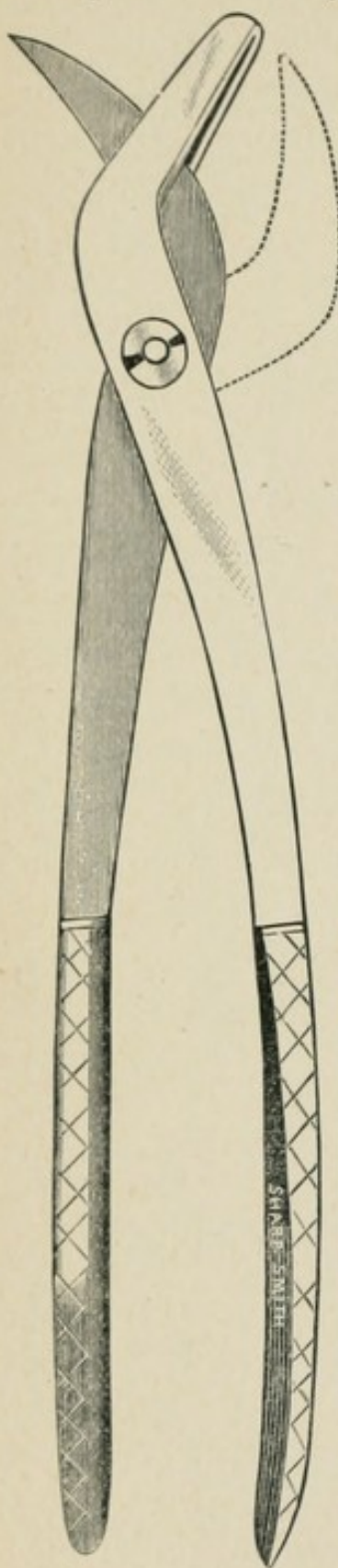


FIG. 22.—AUTHOR'S
ECRASEUR-FORCEPS,

Allingham claims that in seven hundred and twenty-five

cases treated on this plan by himself and Henry Smith there were six deaths, while in eighteen hundred cases treated by ligature there was only one death.

Smith, on the other hand, claims that the cautery plan is fully as safe as the ligature, so that these two London gentlemen are advocates each of his favorite method, and their antagonism perhaps leads each to believe the other's plan more dangerous than his own.

Treatment of Hæmorrhoids by the Ecraseur.—Many French surgeons formerly favored the removal of piles by the chain *écraseur*. We have often used for the purpose the

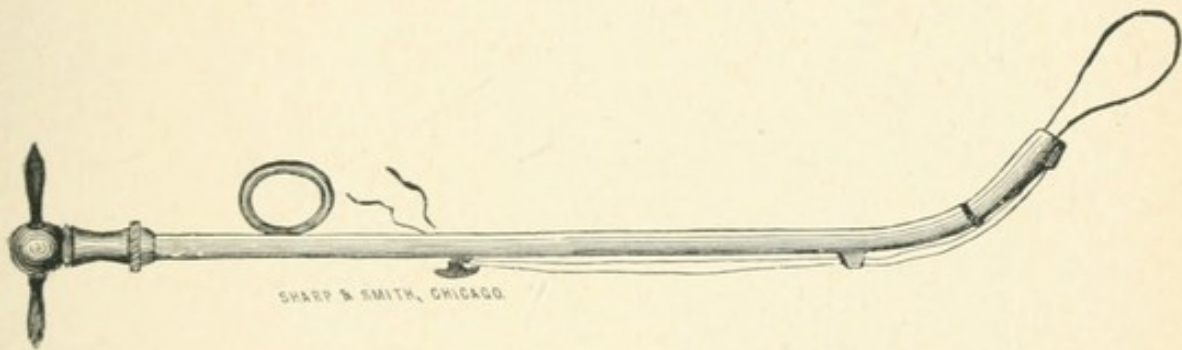


FIG. 23.—SMITH'S WIRE CABLE ECRASEUR.

écraseur forceps here shown (Fig. 22), which are of our own devising, though by an accident they are credited in the instrumental catalogues to Professor Byford. The error was not due to him, as he never laid any claim to the invention.

The instrument is easily cleaned, simple in structure, and much more easily applied than the complicated chain *écraseur*, and does not break like the wire *écraseur*. The effect on the pile is exactly the same as that of the others, neither better nor worse. Smith, of London, has devised a small pile *écraseur* (Fig. 23), using a wire cable instead of a chain.

The pile being seized with *vulsellum* forceps, the instrument is applied at the same point where a ligature would be, generally half way between the base and the summit, and slowly tightened until the tissues are severed. The patient

must be kept some days in bed, the stumps are treated antiseptically, and the general management is the same as after ligature. As in all other methods of removing piles, it is necessary to be careful and leave sufficient mucous membrane to make a distensible verge of the anus, otherwise a stricture will follow.

The *écraseur* cures piles effectually, but it is occasionally followed by dangerous hæmorrhage, so that its popularity in this country has decidedly waned. In our own practice we have discarded its use.

Crushing the Pile.—Another method consists in crushing the pile with an instrument devised for the purpose, without removing it. This merely diminishes the danger of hæmorrhage without attaining the safety of ligation. It, however, destroys the pile, and causes it to slough off, thus effecting a cure. It has been considerably but not generally employed.

Fig. 24 is one of the instruments devised for the purpose, but it is not a convenient form. Allingham devised the form shown in Fig. 25 which is much better. The pile is drawn into

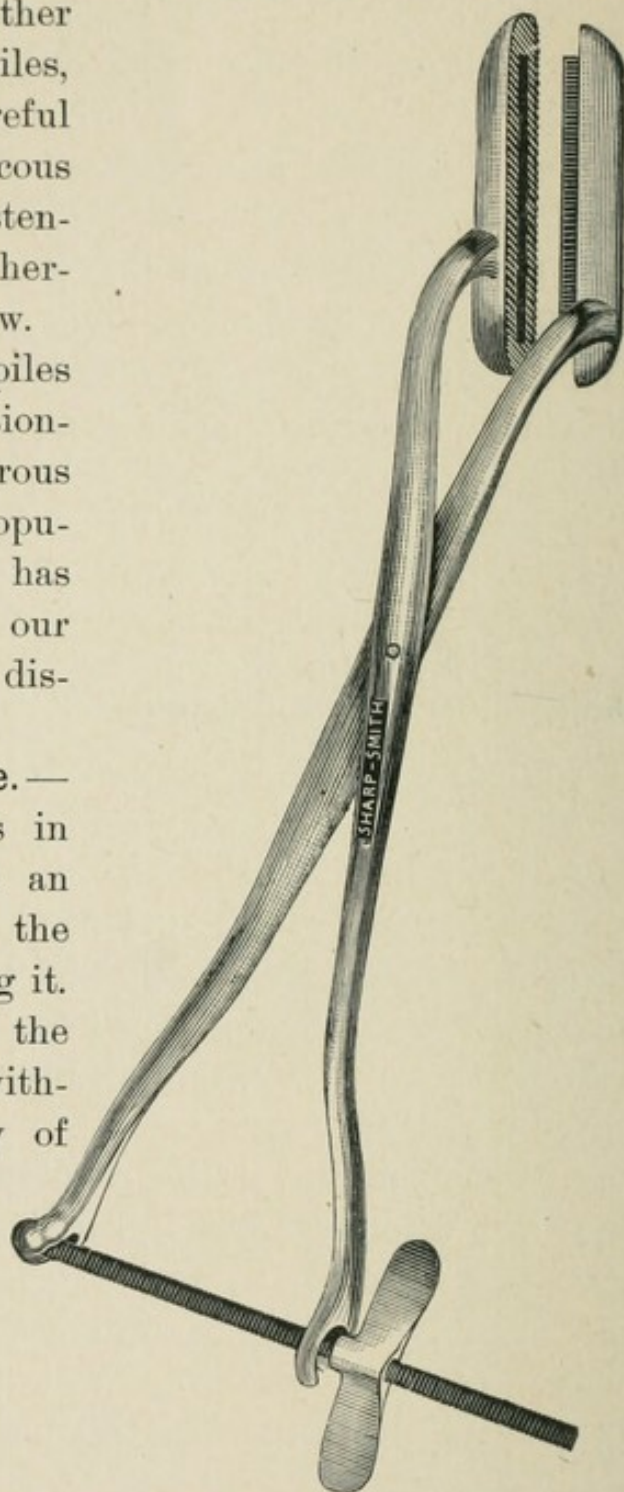


FIG. 24.—NOTT'S ECRASEUR.

the square fenestrum at the end, and a screw forces the sliding bar down upon it with great force. Allingham is so favorably impressed with this method that he uses it almost to the exclusion of the ligature, of which he used to be such a prominent advocate, but he still prefers the ligature when the piles constitute a continuous ring or ridge around the anus, because in such cases the angles of the crusher are apt to leave bleeding corners in the wounds. The action of the screw crushes and kills the pile but does not separate it from the base, so that it remains in effect much like the eschar produced by cautery.

On the whole, crushing is a good practical method, and is, perhaps, equal to any other.

Various Cauteries.—Hot irons of various forms have been applied to piles with the effect of curing the tumors. Cautery by needles, either heated by a spirit lamp or by the galvanic current, has been a favorite with some. Electricity in a weaker current is also used to coagulate the blood in the piles with considerable effect.

Potential cautery has been practiced on internal hæmorrhoids with fuming nitric acid, with sodium ethylate, and with *potassa cum calce*. Many successes and many failures have resulted from the use of these inconvenient articles.

Treatment of External Piles.—External hæmorrhoids may be excised, ligated, or destroyed by cautery. When they consist, however, of globular subcutaneous blood clots, operation is unnecessary because they will be absorbed in a few weeks or months. If painful they may be slit up and the clots turned out.

Excision of Internal Piles.—A few authors have lately

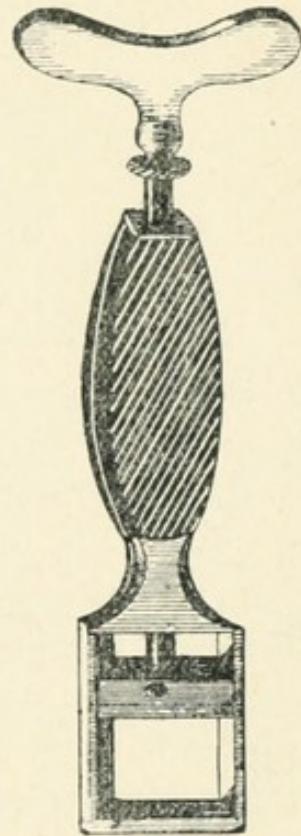


FIG. 25. — ALLINGHAM'S CRUSHER.

advocated a partial return to the discarded plan of cutting out internal as well as external piles, resorting to one or another method of preventing hæmorrhage, according to the fancy or the judgment of the writer. We are sorry to say that none of these plans are safe. One may operate a hundred times and have no trouble, but sooner or later the surgeon who cuts out large numbers of internal piles will have instances of dangerous hæmorrhage. If the incision were external, where unskilled attendants could apply compression, it would be less objectionable, but the bleeding point is above the sphincter, and the patient bleeds a colic full before he knows the cause of his faintness. He then expels a great mass of clots, and the sphincter closes, stopping the external flow and deceiving the patient with a false appearance of improvement, until another mass is expelled, and so on through a perilous series of refillings and expulsions. If the surgeon who operated happens to be inaccessible, or not to be found, the patient will be in great danger, for, even if some well-educated physician not in surgical practice is called, he will often be baffled and perplexed to control a bleeding from an internal point, whose exact location is very obscure to him.

For the method of arresting rectal hæmorrhage the reader is referred to page 33.

The Circular Excision, or Whitehead's Operation.—Mr. Whitehead, of England, published in the *British Medical Journal* nearly seven years ago a new plan of operation, which was very energetic, but involved some dangers, and was not therefore acceptable to most surgeons. Mr. Whitehead himself became dissatisfied with his method and in February, 1887, published in the *British Medical Journal* a modification of the plan, and claimed complete success in three hundred consecutive cases without a single death, secondary hæmorrhage, abscess, ulceration, stricture or incontinence of the fæces. Notwithstanding these brilliant claims the method is liable to several objections, so much so that

we have declined thus far to use it, but Prof. Weir, of New York, after trying it six times, announces his approval of it.

Mr. Whitehead's improved procedure is as follows:

The sphincters are first forcibly stretched. Next the surgeon with dissecting forceps picks up the integument near the junction of the skin and mucous membrane and with scissors cuts through the mucous membrane at or pretty near the white line indicating its junction with the skin, making a rapid incision entirely around the bowel and upward until the upper edge of the external sphincter and the lower edge of the internal one are exposed to view. The dissection is then carried upward along the inner surface of the internal sphincter separating the piles and mucous membrane from the muscle, pulling the piles downward a little firmly and snipping any resisting bands of tissue, but using the fingers and handle of the scalpel as far as possible to peel the piles away from the muscle until the healthy membrane above the piles is reached. The mucous membrane, now hanging loose in the rectum with the piles attached, is divided transversely, cutting only a moderate portion of it at a time, and securing the bleeding vessels by torsion and not by ligatures. As soon as the vessels of a section are secured, that portion of the cut edge of the mucous membrane is dusted with iodoform and pulled down and fastened by fine silk sutures to the cut edge of integument at the verge. The stitches are never removed but allowed to fall out spontaneously. Another portion of the circumference is then cut, and secured in the same manner, and so on until the whole of the circumference is divided, and the circle of mucous membrane which naturally lined the lower part of the rectum is taken away, and the membrane higher up pulled down to take its place. Prof. Weir thinks the subsequent pain is less than after Allingham's ligation, but it is difficult to see why, since the most exquisitely sensitive portion of the integument at the verge of the anus is pinched up in a circle of numerous fine

stitches, while its sensory nerve supply is not cut off as in Allingham's method. Prof. Weir's six cases are perhaps not enough to settle this question.

At this distance we are not able to ascertain whether there are any mistakes in Mr. Whitehead's enthusiastic claim to entire exemption from the accidents known to be common elsewhere after excision of internal piles, but we think caution should be for the present observed. In the United States some very disastrous results have followed the operation. Prof. Weir facilitates the separation of the piles and mucous membrane from the internal sphincter by dissecting to the upper limit at one spot first, and then with the nail or blunt point of the scissors peeling around in a circular direction. Allingham recognizes some of the objections to the method, but has tried it and even invented a complicated four-armed forceps to hold the mucous membrane during the dissection. He diminishes the risk of hæmorrhage by passing a needle and ligature through the cut edge of the skin and through the mucous membrane from the external side above each principal pile and thence around the base of the pile and down through the skin again, and tightens it, thus clamping the artery of each principal pile to the skin by the knot, and compressing its nutrient artery.

The objections which will occur to every one are these:

1. There is a great difference in patients about the liability of arteries closed by torsion to untwist their fibres under the arterial blood pressure, and resume hæmorrhage. If this occurs, the row of fine stitches set in a tender mucous membrane is not adequate resistance against the force of arterial blood. Hæmorrhage will not be common, but according to general experience in other operations at this part, it seems nearly incredible that it should not sometimes occur.

2. According to the experience both of Prof. Weir and of Mr. Whitehead, union by first intention will not always

take place, and if it does not, a circular ulcer, and, after it, a contracting circle of cicatrix will surround the orifice, and a stricture will result, precisely as it does sometimes where a surgeon incautiously removes in other operations a complete zone of mucous membrane at the same place. In one case, total and permanent incontinence of fæces resulted, leaving the patient in a most miserable condition. Kelsey mentions a case in which the mucous membrane drawn down to cover the wound proved too delicate for the comparatively rude work of the anal verge, and was kept in a distressing state of inflammation unendurable to the patient.

All things considered, it is an operation of great severity, and some danger, and ought not to be performed except in a few peculiar cases, since safer and milder methods have a perfect certainty of success.

CHAPTER IV.

PROCTITIS, OR INFLAMMATION OF THE RECTUM.

Proctitis or inflammation limited to the rectum is as distinctly a clinical entity as colitis, typhilitis, duodenitis or any localized affection of the intestinal tube. It deserves to be considered entirely apart from periproctitis or cellulitis, with which it has little in common.

Causes.—Mechanical irritation is often the direct cause of an inflamed condition of the lower bowel. After wounds and contusions there is apt to be slight muco-purulent discharge and some degree of tenesmus lasting for a few days. This is equally true of operations, particularly the removal of hæmorrhoids and forcible dilatation. When the sphincter has been forcibly dilated an increased sensitiveness of the organ almost always follows for a certain length of time, so that whatever material has descended to within a short distance of the anus is likely to be evacuated suddenly.

To this is probably due the fact that forced dilatation of the sphincter is reputed to have a powerful influence in curing chronic constipation.

Foreign bodies are not very rarely introduced into the rectum by accident or design. Children and persons of perverted instincts frequently thrust objects of considerable size into the anus. When from their shape or size these cannot be expelled in the natural motions great irritation is likely to ensue, sooner or later leading to perforation of the bowel and periproctitis. Improper or too frequent use of syringes may also cause considerable proctitis. When the fæces contain angular or sharp-pointed objects the rectum

is more likely to suffer laceration than the bowel higher up because of the indurated and inspissated character of the material which must cause such objects to be pressed more strongly in contact with the membranes. Such objects are fishbones, nut-shells, and occasionally even coins, pins and needles which have been swallowed. Certain kinds of food which undergo putrefactive changes frequently cause slight transient catarrh of the rectum. Among such articles are Brie and Limburger cheese and game too long kept.

The influence of cold is occasionally felt in producing slight irritations here as in other mucous membranes.

In parturition there is sometimes transient acute proctitis. It may also result from the presence of oxyurides.

Among prostitutes the practice of sodomy is a frequent cause of proctitis apart from the effect of contagion. The sphincter also becomes relaxed or torn. Gonorrhœal and syphilitic proctitis are, however, not generally the effects of sodomy but of infection from other parts, or of constitutional disease. Women, as is well known, are the usual victims of gonorrhœa of the rectum.

Diphtheria of the rectum as described by Trousseau is certainly a form of proctitis rarely noticed in America. It does not occur as a primary affection but in conjunction with the same disease in the throat and only in cases of severe general poisoning.

Tuberculosis of the rectum has not so much to do with proctitis as with periproctitis and fistula in ano.

Another condition favorable to the production of proctitis is a *hæmorrhoidal condition of the rectal wall*. Verneuil has called attention to the fact that the veins of the rectum in their upward course penetrate the muscular layer in such a way that they are constricted with each contraction of the bowel. Stasis of blood and engorgement of the vessels are thus brought about with each act of defecation. A condition is set up not unlike that seen in varicosities of the lower limbs, predisposing to œdema and indolent ulceration of the

membrane. This has been termed by Rokitansky "hæmorrhoidal ulceration."

Dysentery is commonly associated with some proctitis. Many cases of chronic inflammation and ulceration of the lower bowel are due to this cause, especially in hot climates.

Amyloid disease of the kidneys is sometimes responsible for inflammation and degenerative changes in the mucous membrane. Bartels assigns as the cause of this the degeneration of the blood vessels in the lining membrane.

Follicular disease of the mucous membrane is another cause of proctitis. The scattered glands of the intestine become inflamed, enlarged, and finally suppurate, discharging each a sphacelus and leaving small rounded ulcers upon the membrane. It is uncertain whether these should be considered as a cause or as an effect of catarrhal inflammation.

Symptoms.—Acute proctitis gives rise to symptoms not wholly unlike those of dysentery. It is now held that the rectum, even in health, does not act as a receptacle for any length of time, but tends normally to expel its contents very shortly after they are received. In proctitis this tendency is very markedly increased and exaggerated. While there may be no true diarrhœa, the fæces and gases are expelled spasmodically almost as soon as they reach the rectal pouch. This may occur without the patient's consciousness, but more often it is accompanied by slight tenesmus like that of dysentery.

An increased secretion of mucus is another symptom of acute proctitis. This may be clear or streaked with blood; sometimes it is expelled in small gelatinous masses apart from defecation. More or less irritation of the skin about the anus often exists as a result of the irritating discharges. This is much more likely to occur in the gonorrhœal form.

Swelling of the mucous and submucous tissue is usually present, but there is not much local pain except the tenesmus during defecation. The œdema often causes some

protrusion of the swollen membranes, a condition described by Roser as "ectropion recti."

Accompanying all forms of proctitis there may be more or less irritability of the prostate or bladder and an increased frequency of urination.

Gonorrhœal proctitis differs little in its general features from gonorrhœa elsewhere. Large quantities of muco-pus are discharged during the height of the inflammation, which usually lasts from two to four weeks. Microscopic examination will show the presence of the characteristic microbe or gonococcus (Klein).

Bumstead, Taylor and Neumann have proved that chancroids within the rectum are not by any means unusual. This must nearly always be the result of sodomy rather than of auto-infection, although the latter is possible, as by the insertion of an infected finger or syringe within the rectum. In Neumann's clinic a very clearly marked case of chancroidal ulcer well above the sphincter was observed and described in 1881. The patient admitted the practice of sodomy. In the hospital of Saint Lazare of Paris, used for the imprisonment and treatment of diseased prostitutes, we saw many cases where the anus and rectum were studded with chancroids from infection by sodomy.

True chancres of the rectum and anus would hardly be noticed by the patient. Fournier has proved their frequent occurrence, both within and outside of the rectum.

Condylomata are the most familiar of all syphilitic manifestations about the rectum. They are essentially like mucous patches or papules occurring elsewhere in secondary syphilis but owe their peculiar form to the irritation to which they are constantly subjected by the friction of the nates against each other. At times they take on almost the appearance of warts or vegetations. In the folds of the mucous membrane of the anus where there are mucous patches, there is often a tendency to the formation of small rounded ulcers with sharply elevated edges (*rhagades*).

The subsequent healing and contraction of these ulcers produce a curious folding and wrinkling of the skin, described by Sir James Paget as a true characteristic of syphilis of the rectum.

Another form of syphilitic proctitis is often met in which there is a diffused thickening of the whole rectal wall, causing it to become harder than natural and somewhat œdematous. Fournier describes this condition—under the name *ano-rectal syphiloma*—as a hyperplasia followed by sclerosis of the membranes so that they ultimately become contracted and fibrous.

Tertiary syphilis of the rectum begins by the deposit of gummata in the substance of the membrane in the form of smooth, globular, painless tumors. These run the usual course of such deposits, breaking down and producing rounded ulcers which coalesce and destroy the mucous and submucous tissue. The healing of these ulcers if extensive inevitably brings on stricture of the rectum. There is little doubt that tertiary syphilis of the rectum is very common. That it is not oftener seen in its earlier stages is due to the painless character of the affection and its remote location. Accompanying ulcerative proctitis, of a syphilitic or any form, there is of course some mucous and purulent discharge, which, however, may not attract much attention.

There is not infrequently amyloid degeneration of the rectal wall in advanced syphilis. This results from a similar condition of the intestine above. Allingham applies the term “lupoid” or “rodent” ulceration to what is probably identical with lupus in other parts of the body, though occurring often in persons not in advanced years. Some cases of extreme destruction have been observed from this disease in which the rectum was extensively undermined and the bowel left “hanging loose and ragged” “like the torn sleeve of a coat.”

Treatment of Proctitis.—Acute proctitis is commonly a transient affection when due to extension from the same condition higher up and calls for no separate treatment.

When due to mechanical irritation, local interference except to remove foreign substances is often unnecessary, the inflammation subsiding quite rapidly when rest in bed is maintained. The local use of anodynes and antiseptics in the form of suppositories is often to be recommended, however. To ensure rest the bowel should be kept evacuated. A recent British writer advises against enemata for this purpose on account of the danger of spreading infection upward. This danger can only exist in special cases. Small injections of hot water are decidedly soothing and help to control the inflammation, at the same time cleansing the rectum.

For tenesmus it is well to use

Mucilage of starch..... $\bar{5}$ ij
Tr. opii.....gtt. x to xxx

Inject slowly.

An anodyne antiseptic of great value is

Iodoform..... $\bar{3}$ i
Ext. belladon.....gr. v
Pulv. opii.....gr. x
Ol. theobrom.....q.s.
M. Ft. Suppositoria.....No. xii

Boric and carbolic acid are slightly irritating and cause some smarting of the anus if employed in too great strength, but very valuable if properly used. Corrosive sublimate is not a suitable antiseptic for use within the rectum on account of its irritating properties not less than its poisonous properties when absorbed.

Chronic proctitis is best treated by the free use of hot water to cleanse and soothe the congested membrane. The hot douche is also advised after certain injections to remove them and prevent their absorption.

Thus, for chronic proctitis

Argent. nit. gr. v.
Aq. dest. ℥ij

may be injected and removed by a subsequent enema.

While the local effect of this solution ought to be favorable, its immediate removal probably prevents any decided action. Neither are we inclined to recommend for general use within the rectum any solution which safety requires should be washed out again. It is not always possible to know how far injections are carried and whether they are subsequently removed or not by washing with additional water.

The following by Ball is of use where the discharges are fetid:

Liq. carbonis detergens. ℥ii
Tr. krameriae. ℥iv
Mucil. amyli. q. s. ad ℥iv
M. Liq. Inject ℥i morning and night.

A solution of bismuth with mucilage of starch is recommended as a safe local application, *viz*:

Liq. bismuth. ℥i
Mucil. amyli. ℥vi

It is well to remember that glycerine if used freely in the rectum will of itself be decidedly irritating. Mucilage of starch is therefore better than any preparation such as "glycerite of starch."

Prof. Matthews, of Louisville, employs mixtures containing bismuth and iodoform suspended in sweet almond oil. (See Formulary.)

CHAPTER V.

DISEASES OF THE SACCULI HORNERI.

Fortunately the sacculi are not very prone to disease, except as they participate in inflammations of adjacent parts. Still they occasionally give lodgment to small foreign bodies, which may cause ulcers of a septic character, and which by their location close to the zone of greatest nervous supply of the rectum may give origin to extensive and distressing reflex symptoms, even in distant parts of the body.

At the present time special attention has been directed to the sacculi by various persons who have gotten the idea that the sacculi, or "pockets" as they commonly call them, are never healthy, but are themselves a disease in their very nature, and that they must always be destroyed. As the patient cannot see the sacculi and is unable to deny their diseased nature, he is at the mercy of the "specialist" and pays a high fee to have such dangerous organs split open and destroyed. The sacculi are described in Chapter I., but we may be allowed to refer again briefly to them, since noisy itinerants are making use of them so extensively in their trade and doing injury to thousands of deluded patients.

The anatomy of the organs referred to is given by various authors, both old and new, and we have been at the trouble to verify their descriptions and drawings, by new dissections of our own, assisted by Professor Billings, of the Chicago Medical College. In a healthy rectum the mucous membrane just above the verge of the anus is traversed by minute branching ridges, enclosing slight concavities of varied shapes and sizes. If a healthy rectum from a cadaver be laid open and spread out after the rigor mortis is past,

the ridges will be found to curve and interlace in all directions and to be only faintly visible, but if examined during life it will be seen that the action of the *sphincter ani* presses them together laterally, so that the ridges run in a more perpendicular direction, and receive the name of *columnæ recti*. The framework of these little ridges does not consist of mere folds of mucous membrane, as some authors state. They are reticulate bands of muscular and connective tissue, and the delicate mucous membrane, when healthy, can be made to glide freely over them.

These little columns are inserted at their lower extremities into the verge of the anus, and at that point one is often connected to its nearest fellows by webs of mucous membrane, making the "pockets" above mentioned, which were long ago named the *sacculi Horneri*, by anatomists,

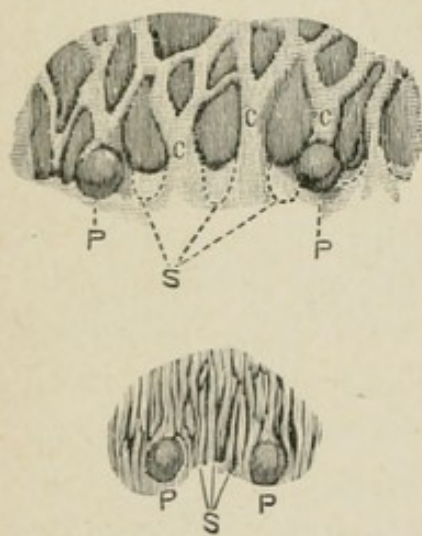


FIG. 26.

Magnified 3 diameters, from dissections by the authors. The upper cut shows the reticulated arrangement under post-mortem relaxation. The lower cut shows the same parts compressed laterally by the contraction of the sphincter. C C C. Columnæ recti. S. Dotted curves, showing the position of *sacculi Horneri* between the bases of the columns. P. P. Papillæ.

after the distinguished Dr. Horner. They are figured by various authors, and good illustrations may be seen in Smith's Anatom. Atlas, fig. 331, page 112; in Esmarch's recent work on the Rectum, and in Allen's Anatomy, plate 101. They are much less distinct in some persons than in others, but in all perfectly healthy rectums, where the mucous membrane is normally thin and elastic, the lower ends of the grooves between the columns will show hollows, which sometimes are of considerable depth, but, even if shallow, a little traction with a blunt hook readily makes them assume the

form of *sacculi* or "pockets," well adapted to deceive an examiner who is not aware of the elasticity of the membrane. In perfectly sound rectums the membrane covering the reticulated ridges and lining the hollows is exceedingly

elastic and distensible, to allow of the requisite dilatation during the expulsion of the fæcal mass. The sacculi and other hollows of the reticulated zone contain a reserve of tenacious mucus, which is pressed out as the fæces descend, and lubricates the descending mass. When carefully examined in healthy organs, the sacculi show no trace of disease, but are lined with a perfectly normal and beautifully delicate mucous membrane, which moves freely on the parts beneath, and stretches readily in any direction. The claim that they are "diseases" is simply absurd. However, these reservoirs of mucus, like the analogous pockets in the tonsils, occasionally become inflamed and even ulcerated, and then may require clipping out, as was long ago stated by Henry H. Smith, of Philadelphia, as well as the elder Gross, and by Ashhurst and others. Berry seeds and other minute objects occasionally, but not often, lodge in them.

Between the lower ends of the grooves are generally found a few papillæ, reminding one of the analogous *caruncule myrtiformes* of the vagina, though they are usually smaller. They show a healthy structure in most cases, and are supposed to be tactile organs, whose nerves communicate reflex impulses to the expulsive muscles engaged in defecation. These little papillæ with the adjacent "pockets" constitute an important part of the harvest field of the itinerants.

The following letter from the distinguished Professor Henry H. Smith, of Philadelphia, shows the error of the claim that the so-called "pockets" are a new thing in science:

PHILADELPHIA, May 4, 1887.

Prof. E. Andrews:

DEAR SIR: "The rectal pouches" ("Sacculi Horneri") are a *normal* structure, intended to hold mucus, which is forced out in defecation, to lubricate the margin of the anus, and protect it from hardened fæces. In 1792 Physick called attention to them (see American Encyclop. of Med. and Surg'y, article "Anus," by Coates; see also Smith's Operative Surg., Vol. II., p. 590, 1863), for the operation sometimes required. For their structure, see

Horner's Special Anatomy, Vol. II., p. 46, 1851; see, also, American Jour. Med. Science, Vol. XVII., N. S., p. 410, 1849; Winslow (Vol. II., p. 149) described these pouches in 1749. In "Smith's Anatomical Atlas," published in 1844, by Lea, you will find in figure 331, page 112, an accurate drawing of the "Sacculi Horneri," which I guarantee to be correct.

Truly yours,

HENRY H. SMITH.

The rise and progress of the itinerant is usually this: He buys for fifty or a hundred dollars from the owner of one of the "Systems of Rectal Surgery" a little poverty-stricken box of instruments, containing a speculum, a blunt hook, a hypodermic syringe, and a few other things. The box also contains a little pamphlet telling him how to use the instruments on piles, "pockets," fistulæ, and ulcers. With the box he receives a mixture of carbolic acid, some salves, washes, etc., with the gracious privilege of buying more of them at a tremendous price of the owner of the "System" when the stock is exhausted. He is not always allowed to know their composition.

Inserting his speculum into a patient the fully developed traveling quack always finds "pockets." If they are not there he makes them by pressing his blunt hook into the delicate membrane. A fold being thus caught he splits it down with a Sims' knife, and then finishes the operation by a forced dilatation of the sphincter, and by collecting his fee. The cutting is trivial, and including only a few of the sacculi, it does not seriously injure the patient, but the indiscriminate forced dilatations, though useful in some cases, leave prolonged bad results in others.

However, as before stated, the sacculi may be really diseased. Hence it is often necessary carefully to examine the entire circle of them, when obscure reflex distresses are found harrassing the patient. For this purpose place the patient in Sims' position in a good light and insert any good speculum. Carefully try the lower ends of all the grooves

between the columns of Morgagni with the point of a Sims' blunt hook. If any sacculus is swollen, suppurating, or

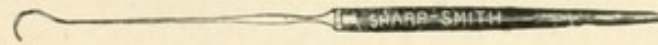


FIG. 27.—SIMS' BLUNT HOOK.

excessively sensitive, it is best to snip it out with curved scissors as recommended long ago by Prof. Henry Smith, or else to split it downward with a probe-pointed bistoury.



FIG. 28.—CURVED SCISSORS.

The incisions should not be deep, and a little boric acid or iodoform should be dusted into the wound. The number of seriously diseased sacculi found by any honest examiner will not be large, but the few discovered are, on account of their nervous relations, prolific in distressing reflexes.

CHAPTER VI.

ABSCESS AND SINUS; FISTULA IN ANO.

Suppuration in the cellular tissue, around the rectum, as well as in the walls of the intestine itself, and in the marginal region of the anus, is so frequent an occurrence that it may be said to be responsible for thirty or forty per cent. of all troubles about the anus. It may be doubted whether the experience of the profession at large would conform to that of Allingham, who found that two-thirds of all recorded rectal operations at St. Mark's Hospital, London, were for cases of fistula in ano. It is quite likely that hæmorrhoids are a more common affection in the practice of most surgeons. Next in frequency, however, without doubt, would come the various forms of abscesses and their sequelæ, sinuses and fistulæ.

Sinuses about this region are much more commonly presented to the surgeon than abscesses in the acute stage, and call for much more skill and patience in their treatment. Not every abscess in the vicinity of the anus necessarily produces a fistula. The fact must have come under the observation of all who have treated many cases of such troubles, that such collections of pus do often break or are opened externally, and heal as promptly as those in any other part of the body. On the other hand, many cases refuse to heal completely, and a sinus remains for months or years, which ultimately requires surgical interference for its removal. Early incisions into pus collections about the rectum undoubtedly tend to prevent the latter result.

Those superficial abscesses which sometimes form at the anal margin have no tendency to produce fistulæ, and require no especial description. They are due in most cases to

inflammation in some obstructed follicle or gland which has become infected with septicism, or irritated in the various movements of defecation, sitting, riding, or walking. Suppuration in an inflamed hæmorrhoid may also cause small superficial abscesses. These minor forms should be treated like ordinary boils in other parts, by fomentations, anodynes, and early incisions.

Deep abscess at or near the rectum is a more common and serious affection. The large amount of loose cellular tissue, especially behind the rectum, allows very large collections to accumulate before external pointing occurs; and as such abscesses often connect with the bowel, they may be found distended by gas and fæcal matter, and in a highly septic condition.

The causes of ischio-rectal abscesses are not always evident. The presence of foreign bodies in the rectum, the irritation produced by instruments such as syringes, or by falls, blows and other traumatic influences are often found to be exciting causes. Perhaps more often no direct history of injury is present, and the case must be classed as idiopathic. Extravasation of the intestinal contents through some ulcerated portion is supposed to be the cause in many instances. This, however, is largely a matter of conjecture, for it is not usually possible to determine whether the opening into the rectum is a cause or only an effect of the suppuration of the connective tissue outside of it. The tubercular element in causation seems to have as decided an influence in this as in other suppurative troubles. There is a marked tendency to the occurrence of abscess and fistula in phthisical patients which has long been recognized, and which has given rise to some difference of opinion as to the propriety of operative measures in such cases.

The local symptoms which mark the formation of such abscesses, are œdema, pain and often a localized red spot to one side of the anus. Sometimes the abscess takes a horse-shoe form, and presents upon the skin, both sides of the

anus, having half encircled the rectum upon its posterior side. Great tenderness and swelling accompanies deep abscess in this region, even before much redness appears externally.

Examination by the rectum reveals a thickening of the parts posteriorly, and upon one or both sides. This examination is often too painful to be borne by the patient. When fluctuation is detected by the finger in the bowel, and the abscess shows no sign of appearing externally, there is no impropriety in incising it through the rectal wall. Theoretically it would be much better to have such an opening externally only, but in practice an abscess opened by an internal incision will often heal kindly and promptly. As a rule, the swollen and œdematous condition of the parts about the anus gives an indication for early seeking the pus with an exploring needle or lancet externally. Too much importance cannot be attached to the necessity of early interference in order to anticipate extensive burrowing of the pus, perforation of the bowel, and the formation of extensive sinuses, and ultimately a fistula. It is well, therefore, to make early and deep incisions into the thickened and inflamed tissue, since when much œdema has occurred there is almost certainly pus present, and palliative measures result only in loss of time.

Abscesses properly drained and antiseptically dressed will quite frequently close in a week or two, without the formation of a fistula. The use of a drainage tube is necessary only in large abscesses, or in case the incision be small in size. The tube may be shortened from day to day, and removed finally within the first week.

Fistula in Ano.—Allingham reports 196 cases of abscess about the rectum, of which 151, or more than three-fourths, resulted finally in fistulæ. When once established, a fistula has no tendency to heal spontaneously, and may therefore be considered a suitable object in nearly all cases for surgical interference. Properly speaking, a complete

fistula is a sinus leading from within the rectum to an opening on the skin more or less remote from the anus. There are, however, cases in which the internal orifice, if any existed, has closed, or cannot be discovered by the probe. These are termed blind external fistulæ. They require much the same treatment as those which are complete. A blind internal fistula is one which has an internal, but no external, opening. Such a sinus has a tendency to become a complete fistula by ulceration through the external integument. Occasionally cases will be met with in which there is a recurrence of acute abscesses which break externally, and heal for a time.

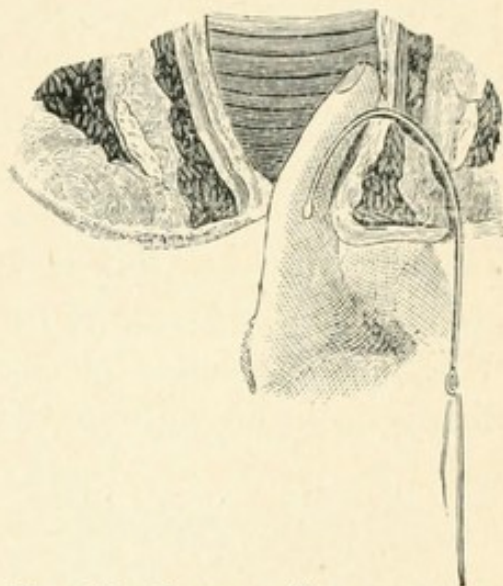


FIG. 29.—FISTULA TRAVERSED BY PROBE. (*Esmarch.*)

These are often due to the existence of a blind internal fistulous tract, which becomes the receptacle of foreign substances from the bowel.

The causes of fistula have been mentioned under the head of abscess, the disease itself being but the chronic stage of that affection. Secondary sinuses or diverticula are usually present in old fistulæ. These add much to the diffi-

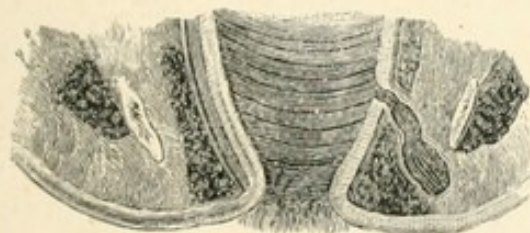


FIG. 30.—INTERNAL INCOMPLETE FISTULA. (*Esmarch.*)

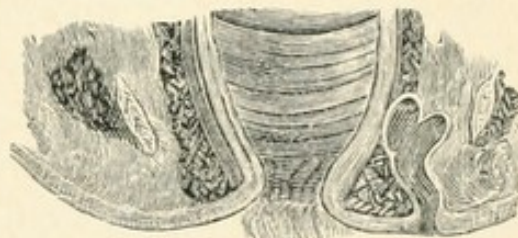


FIG. 31.—EXTERNAL INCOMPLETE FISTULA. (*Esmarch.*)

culty of diagnosis, and to the severity of operative measures. A form to be noted is the "horse-shoe fistula," so called, in which the sinus surrounds the rectum upon its posterior half, and extends equally upon the two sides, thus under-

mining the cellular tissue for about one-half the circumference of the bowel.

The symptoms of fistula are not easily overlooked. Little pain is present, as a rule, the chief discomfort to the patient being the slight discharge which is kept up from the sinus as long as it remains unhealed. This is not of itself sufficient to be exhausting, and does not prevent or interfere with ordinary occupations, so that many patients have had fistulæ for years and been conscious of no serious ailment. The annoyance of the discharge is such that most persons are earnestly desirous of getting rid of the trouble, and are willing to undergo an operation for its removal. The diagnosis is only difficult in distinguishing different vari-

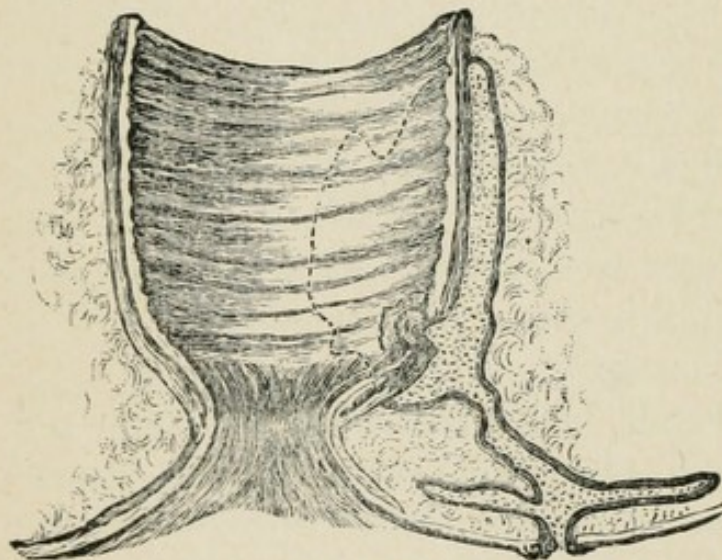


FIG. 32.—SECTION OF "HORSE-SHOE FISTULA" WITH DIVERTICULA. FROM AUTHOR'S OBSERVATIONS.

eties. There can be no mistaking the general nature of the trouble when the parts are superficially examined. A urinary fistula is not infrequently taken for fistula in ano, and operated upon with, of course, no benefit to the patient. Much care

should be taken to exclude these cases, and also those of deep pelvic or lumbar abscess, which sometimes point near the anus. The writer has frequently been called upon to examine cases of urinary fistula which had been divided, under the mistaken supposition that they were cases of fistula in ano. Urinary fistulæ may sometimes break into the bowel as well as externally. The diagnosis becomes in such cases more difficult, but the antecedent history of urethral stricture, or some urinary affection, will serve to clear up doubtful points.

The examination of a fistula is best made either with the patient upon the side affected, or in the lithotomy position. If a probe be passed into the sinus, and the left forefinger into the rectum, the latter may sometimes feel the point of the instrument projecting into the bowel at a point not far from the sphincter. More frequently, however, some difficulty is experienced in finding the internal opening, on account of the irregular character of the fistula and its numerous pouches (Fig. 32). The opening is not usually at the highest point of the fistulous tract, but is found most often not far from the junction of the two sphincters, within an inch of the orifice.

If the probe be carried to the extremity of the cavity and swept downward, pressing the wall of the gut between it and the forefinger in the rectum, it will often find the internal opening as it reaches this vicinity. In other cases, a slight protuberance, as of granulations, will indicate to the trained finger where to seek for this orifice. The expedient of injecting milk into the fistula, and watching for the point of its appearance through a speculum, is often a valuable aid in the examination.

Treatment of Fistula.—Operative measures for the radical cure of fistula are, upon the whole, the more satisfactory and free from risk. The operation of dividing the sphincters and intervening tissues yields such good results as to leave little to be desired, unless some measures can be devised of superseding the use of the knife altogether. Of such measures we shall speak further on. When the cutting operation has been decided upon, the bowels should be emptied by laxatives or enemata, and the parts thoroughly cleansed and shaved. If an internal orifice exists, it is simply necessary to pass a director through this into the bowel, and bring the end out through the anus, after which the tissue upon the instrument is divided by a curved bistoury. Lateral sinuses and diverticula should now be laid freely open, where they do not extend too far from the anus,

and the wound packed with iodoform gauze or lint, covered with antiseptic cerate. Vessels of much size should be ligatured. As a rule there is but little hæmorrhage. Those deep sinuses, which sometimes extend to far distant parts, as into the thigh or buttocks, cannot, of course, be laid open in their entire length. These will heal, however, after the division of the sphincter and the laying open of the principal sack or fistulous tract in the vicinity of the anus.

Fistulæ which have no internal opening, or in which it

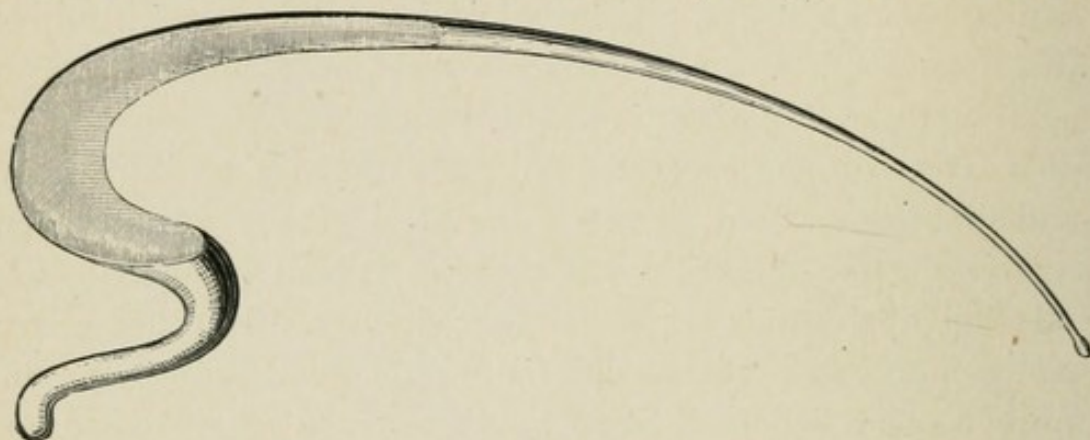


FIG. 33.—“ROYAL BISTOURY” WITH WHICH CHIEF SURGEON FELIX CURED LOUIS XIV. (*Esmarch.*)

is supposed to exist, if at all, high up in the bowel, are to be treated by division of the lower inch of the rectum only. The point of the director in these cases must be thrust through the wall of rectum at a point not much over an inch from its external orifice, and the incision made as before directed when the internal opening already existed. The surgeon may rest confident that that part of the sinus above this limit will rapidly close after the division of the parts below, and at the same time be free from anxiety about cutting the peritoneum, which, in inflamed and prolapsed conditions of the rectum, may be tightly glued to the wall of the gut and brought somewhat nearer than normal to the anal orifice. In blind internal fistulæ the reverse procedure is recommended, except that no director is usually needed, the sinus being divided downward and laid open with a curved, blunt bistoury until the bottom of the cavity is

reached and both sphincters are divided. Daily dressings are to be practiced until the granulations have lined the interior of the cut and all tendency to union of its walls has ceased. A probe should be swept through the cut so as to insure this, and the wound kept open by some form of lint or gauze, until healing from the bottom has taken place.

Hippocrates' Method.—The use of the ligature, as advised by Hippocrates, has been revived from time to time, with the hope of avoiding operative measures. Hippocrates employed a cord into which horsehair was twisted. This was drawn through the sinus into the bowel, and the two ends tightened outside the anus. The possibility of thus curing a fistula by the gradual cutting through of a ligature is evident, and there may be cases in which the method would be less severe than that by incision. It is open to the objection that only simple sinuses can be managed in this way. Those fistulæ which have numerous diverticula would not be benefited by merely closing the main channel, as new abscesses would at once form.

Elastic ligatures have been tried with success in treating fistulæ by this method. They have the advantage of cutting more steadily and continuously, and also avoid to some extent the necessity for tightening the cord, which is a painful feature of daily recurrence with the inelastic ligature. On the whole, the method has little practical value, and in its present form is not likely to become a favorite one.

Itinerant Methods.—The “traveling doctors,” and the resident irregulars found in the cities, have developed sundry methods of treating fistulæ which, though considerably varied in details, may be stated about as follows in general:

First, they explore the fistulæ with probes, some claiming advantage in a very flexible one. Then they smear the adjacent skin with an unguent, to protect it from the irritating applications employed. They then thoroughly inject every part of the fistula with a solution of hydrogen

peroxide. This is put in either through a fine flexible catheter, or with a syringe having a flexible metal pipe. After the froth caused by the peroxide has mostly escaped, some take a mixture of equal parts of 95 per cent. carbolic acid, and of 10 per cent. solution of cocaine (probably using alcohol or glycerine to complete the solution), and inject ten or fifteen minims into the remotest parts of the fistula. Instead of this last formula "Brinkerhoff System" employs the following mixture under the name of "Ulcer Specific:"

R	Dist. ext. hamamelis.....	fl.	3v.
	Liq. fer. subsulph.....	fl.	3j.
	Acid carbol. cryst.....	gr.	ij.
	Glycerinæ.....	fl.	3ij.

Misce. Signe. Inject ten or fifteen drops deeply into the fistula, and press the track of the fistula with the finger, to force the fluid more deeply in.

Many itinerants finish the operation two hours later by injecting the fistula with equal parts of oil of eucalyptus and glycerine, and putting the patient strictly to bed for two days.

It will be observed that every step in this treatment consists in the injection of some vigorous antiseptic. No disciple of Lister could fight it out on that line more persistently. A few of them prepare the fistula for injection by scratching or scarifying slightly the interior with a probe carrying a jointed scarifier, which projects laterally from the tip and scratches as it is drawn out.

An excellent regular surgeon, Prof. Matthews, of Louisville, has systematized this latter plan, and made it more energetic. He dilates the external part of the fistula with a long laminaria tent, and then inserts Otis' urethrotome and both dilates and scarifies the interior, repeating the operation as often as needful. He does not speak of any antiseptic injection, but claims success in some twenty cases.

The truth is, that anal fistulæ have a natural tendency to recovery, and are held back from it mainly by two things:

1. The unfavorable effect of the undrained septic fluids within the sac.

2. The tightness of the external opening, which prevents free drainage, and keeps the sac distended with this putrid pus.

It is demonstrated by Dr. Matthews on the one hand, and by the experiments of the quacks on the other, that by controlling these two conditions, many cases will heal spontaneously. It follows that among the thousands of patients subjected to cutting operations by surgeons for this disease, there are many who might be cured by much milder means.

CHAPTER VII.

FISSURE OF THE ANUS; OR IRRITABLE MARGINAL ULCER.

Fissure, or irritable anal ulcer, may be defined as an ulcerated crack or fold at the muco-cutaneous junction laying bare certain nerve fibres and giving rise to spasmodic contraction and paroxysmal pain of a peculiar character.

It is commonly—and correctly—asserted that this is the most painful of rectal diseases. In appearance inconspicuous, a mere innocent-looking tear across “Hilton’s white line,” it is nevertheless the source of surprising and intolerable pain, and gravely disordered reflexes.

Contrary to general belief, Bodenhamer has proved that fissure of the anus was described by ancient writers. Paulus Ægineta,* a Greek writer of the fourth century, has given a brief but adequate account of the disease. Ætius (*Medici Græci contractæ ex veteribus, etc.*—Tetr. IV, Serm. II., Cap. III) describes fissures along with condylomata.

To the French surgeons we are indebted for nearly all the modern investigations of the disease and the chief improvements in treatment. The celebrated Andrew Paré, writing about 1550, describes almost as clearly as any modern writer, the spasmodic contraction and the sharp and burning pain associated with fissures of the anus and uterus.†

*Fissures are occasioned principally by hard fæces, and, being slow of granulating owing to their callosity, must be converted into recent ulcers by paring (excoriating, scarifying or incising) them with the nails, or a scalpel; when they may be made to granulate by proper applications.—*Lib. Septem, Cap. LXXX.*

†Chapps or fissures are cleft and very long little ulcers, with paine very sharp and burning, by reason of the biting of an acride, salt and drying humour, making so great a contraction and narrowness in the fundament and neck of the wombe that scarcely the toppe of one’s finger may be put into the orifice thereof.—*Eng. Translation, 1634.*

Another early French writer—Lemonnier—has given what seems an adequate account of the affection, comparing it to the chapped condition produced in the lips and knuckles by exposure to cold.* Sabatier also mentions it in a similar connection. Molliere, Gosselin, Recamier and Boyer severally aided in the investigation of this disease. The last named, especially, brought out very clearly the importance of reflex spasm of the sphincter as a symptom. This, rather than the fissure itself, he held to be the primary and essential feature of the affection. Maisonneuve and Dupuytren advocated and practiced forcible dilatation, the former introducing the whole hand.

Among English writers Curling and Syme very early advocated the French ideas of treatment. In America stretching as a means of cure was strongly advocated in 1864 by Van Buren, who probably obtained the idea from the same sources.

Causes.—The predisposing causes of fissured anus and its peculiar train of symptoms lie in the structural arrangement near the anus and their physiology, especially of nerve control. A word is therefore necessary as to the special anatomy of the parts.

Hilton has shown that the line of junction of the skin and mucous membrane at the anus is also the exact line which separates the external from the internal sphincter. This is marked in most cases by a line of more condensed connective tissue constituting the edge of the fascia and known as "Hilton's white line." (Fig. 34). The important anatomical fact in connection with this line is that it is the point of exit of the branches of the pudic nerve which descend between the two sphincter muscles and are here distributed to the papillæ and mucous membrane of the anus.

*Les ragades ou fissures sont les petits ulcères douloureux, piquans et sans grosseur, qui suivent la longueur des rides du fondement, et qui ressemblent assez à ces engelures où crevasses, que le froid produit aux lèvres et aux mains pendant l'hiver.—Lemonnier, *Traite de la Fistule de L'Anus*—1689.

The abundant nerve supply of the mucous membrane accounts not only for the extreme sensitiveness of the part but also for its very abundant reflex communications with other organs.

Ball shows that the nervous supply of the rectum is quite analogous to that of the bladder in which the most sensitive portion of the organ is the neck and outlet.

Small ulcers about the anus are painful or not in pro-

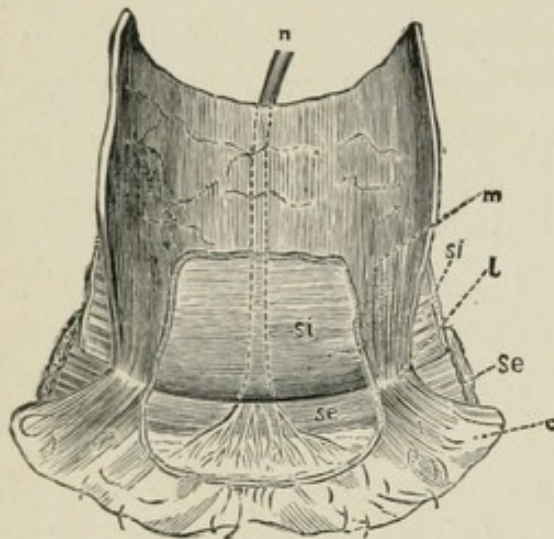


FIG. 34.—DIAGRAM OF NERVE SUPPLY OF ANUS. [After Hilton.]

m. Mucous membrane. c. Skin. se. External sphincter. l. Hilton's "white line." si. Internal sphincter. n. A nerve passing between the sphincters, and emerging at the "white line" to skin about anus.

portion as they are near or remote from this particular zone of sensory nerve supply. External and internal ulcerations which do not involve the actual meeting line of skin and mucous membrane have none of the characters of true fissure. The most plausible theory as to true fissure supposes that these nerve filaments are actually laid bare by the ulceration, something as they are in figure 34 by dissec-

tion, so as to be subject to actual contact with each motion of the bowels.

Upon this supposition it is not difficult to explain the disproportionate symptoms which so small a lesion produces.

We are thus prepared to understand why reflex spasm of the sphincter is so constant and important a sign of this disease and how other and wider reflexes are to be accounted for; such, notably, as urinary retention, radiating pains, etc.

Reference to Hilton's diagram of the nerve supply and its relation to other spinal nerves shows that impressions from the fissure are carried to that part of the cord which supplies the pudic nerves and the ilio-lumbar, lumbar and

the sciatics, which include the motor supply of the external sphincter as well as the bladder and lower extremities.

In this peculiar nervous mechanism we find an explanation of predisposing causes as well as the pathology and most important symptoms of this remarkable affection, after the ulcer has once been produced. As to the immediate causes of the fissure, they may originate in cracks of the mucous membrane, produced by forcing out indurated faecal masses. They occur in some cases from degeneration of the raw spots left by the removal of piles, and in other instances from ulceration caused by foreign bodies lodged in the sacculi Horneri. In short, any cause, constitutional or local, capable of causing ulcers in other parts, may affect the verge of the anus in the same way. The perplexing point is not the origin of the ulcers, but their astounding painfulness. Three causes combine to produce this result:

1. The verge of the anus, like the orifices of all other mucous canals, is, even in its healthy state, extremely sensitive to painful impressions.

2. The sphincter, excited by the nerves of the diseased parts to spasmodic energy, grasps the ulcer very forcibly at every contraction.

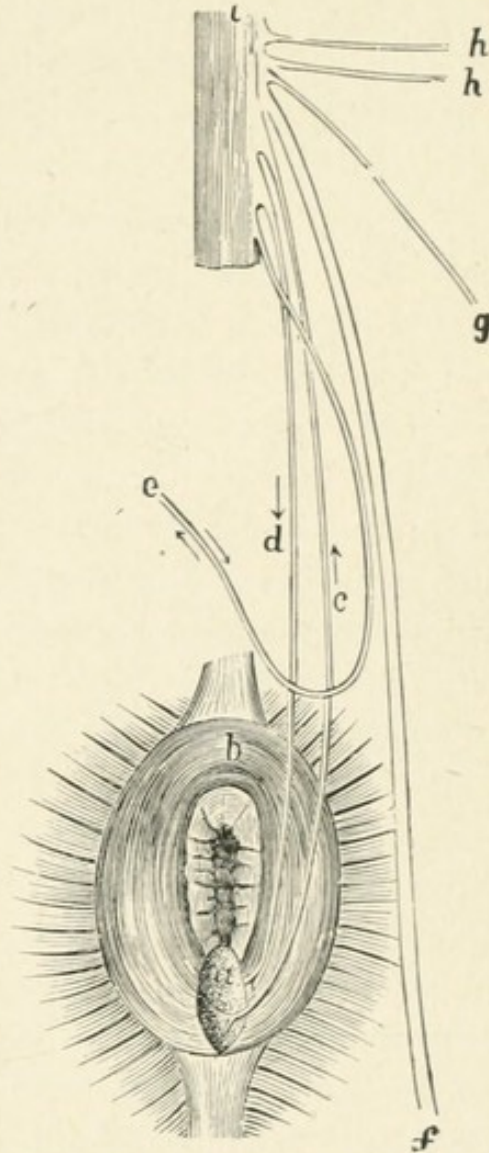


FIG. 35. — DIAGRAM OF NERVE TRUNKS WHICH ARE CONCERNED IN PRODUCING REFLEX SPASM.

a. Fissure. *c.* Sensory nerve. *d.* Motor nerve. *e.* Pudic. *f.* Ischiadic. *g.* Ilio-lumbar. *h h.* Lumbar. *i.* Spinal center.

3. The lower extremity of the fissure receives septic germs from the external air, which propagate putrescence in the secretions of the sore and give them the same virulently irritating quality, which putridity generates in the discharges of ulcers elsewhere. The facility with which antiseptics often cure the fissures gives support to this explanation.

Symptoms.—No disease presents a more distinct clinical entity than fissure of the anus. From its symptoms alone, without any physical examination, an almost certain diagnosis could be derived were such a course necessary. The pain associated with fissure is usually felt after defecation rather than during the act. It is of a dull yet peculiar sickening kind, perhaps similar to that felt after injuries to the testicles, and is described as intolerable, most patients being completely incapacitated by it for the time being. The dread of this suffering causes the patient to postpone evacuating the bowels, which in time causes hardened accumulations and aggravates the disease.

Spasmodic contraction has already been mentioned as a constant element in this disease. The iron grip of the sphincter has not a little to do with the intensity of the pain in all probability. Boyer considered this contraction the essential feature of the disease—a view which very few surgeons have accepted. It is probable that the presence of this extreme contraction first suggested the *massage cadencé* and other forms of dilatation which have been practiced in this affection. Other reflexes such as pains in the loins and lower extremities, retention or incontinence of urine or prostatic irritation are occasionally present as in most rectal disorders. Curschmann asserts that spermatorrhœa often co-exists with rectal disease.

The local lesions of fissure are wholly disproportionate to the general mischief they produce. If the patient is laid on his side in a good light, with the knees drawn up, the surgeon will usually see a red prominence close to the verge

of the anus, looking like a small pile. This has been termed very aptly the "sentinel pile." If he draw the mucous membrane away on either side, he will unfold a raw fissure or groove, running upward, which, on being spread out, presents itself as a small, oval ulcer from four to eight lines in length. A Sims' or Allingham's speculum assists the view, but in most cases the intense reflex spasm of the anus prevents this. Allingham says that it is not uncommon to find a polypus either at the upper end of the ulcer or lying against it on the opposite wall of the rectum.



FIG. 36.—FISSURE
OF THE ANUS
UNFOLDED.

The position of the fissure is very frequently dorsal, for what reason is not known. When unfolded and touched with a probe its surface is found to be excessively tender, clearly justifying the term "irritable" which is often applied to it.

Course and Prognosis.—It cannot be said that a fissure has any spontaneous tendency toward recovery if let alone. Years may elapse without any other change than the gradual wearing down of the patient's vitality from incessant pain and nervous strain. Van Buren mentions cases which had existed five years and longer, one of whom, a lady, from sheer dread of pain would postpone the natural evacuations as long as fourteen days. Complete prostration for twenty-four hours followed each movement and large quantities of opiates were given on each occasion. With proper treatment fissures of the anus can be cured with almost infallible certainty and with practically no risk, the operation most practiced being one of the simplest known in surgery.

Operative Treatment.—A fissure can be cured radically and finally by making an incision along its deepest fold through the membranes and a certain distance—say one-third or one-half the thickness of the external sphincter with a few scarifications on either side. So simple a procedure requires no further description. The line of incision should be a little longer than the fissure itself so as to

make sure of severing all the exposed nerve filaments. An anæsthetic is preferable, yet with cocaine it can be done safely and without extraordinary pain. This method is scientific, since it removes at once the principal source of trouble by severing the exposed nerve *in situ* and temporarily at least abolishing its function.

As first practiced by Boyer the division of the sphincter was made complete with a view totally to prevent its spasmodic contraction until healing had occurred. This was eminently successful and not in itself a severe operation. It was found, however, by Curling and the English surgeons that simply incising the mucous membrane and a little of the subjacent tissue practically cured as well as the complete division, and this method has never been improved by later surgeons.

Forced Dilatation of the anus for the cure of fissure has also been practiced very extensively and successfully since it was first employed by the French surgeons.

Since this is a procedure not less severe than the incision, it is not clear that it has any great advantage. It rests upon a sound pathological basis and is altogether a rational method of accomplishing the same result sought by dividing the sphincter. Recamier practiced what was in reality a dilatation of the sphincter under the name *massage cadencé* with successful results in the cure of fissure.

Maisonneuve, going much further, advocated overstretching the anus by introducing the whole hand and then forcibly withdrawing the closed fist. It is doubtful if stretching is any less severe than the small incision of the cutting operation. The after-soreness would be greater in all ordinary cases. On account of the prejudice of some patients in favor of non-cutting operations it may be found to be preferable in a certain proportion of cases.

A considerable proportion of cases can be cured by still milder measures. It is necessary first to expose the ulcer to view, and to blunt its sensibility by thoroughly wetting

its surface and edges with an eight per cent. solution of cocaine, well brushed in with a camel's hair pencil. Allowing about five minutes to elapse, the brushing should be repeated once or more times, so as to get a decided effect. The sore should now be again brushed with a solution of the kind given in this formula:

℞ Corrosive sublimate.....gr. j.
 Cryst. carbolic acid.....℥ ij.
 Hydrochlorate of morphia.....gr. v.
 Water.....fl. ℥iv.

Mix. S. Apply with a camel's hair pencil.

Next, dust or pack the fissure with dry iodoform, and place the patient, if possible, in bed. This dressing, if repeated once a day, will cure great numbers of cases. Carbolated iodoform ointment may be pressed into the fissure instead of iodoform, if preferred. Antiseptics of almost any kind, carefully placed in the cavity of the ulcer, will cure a certain proportion of cases. Kelsey favors a nightly application of Goulard's liniment, and also has cured many cases by touching the surface with a solution of nitrate of silver of the strength of five or ten grains to the ounce of water.

Allingham strongly advocates applying the following ointment several times a day:

℞ Hyd. sub. chlor.....gr. iv.
 Pulv. opii.....gr. ij.
 Ext. belladon.....gr. ij.
 Ung. sambuci.....℥j.

Misce.

An ointment of the oxide of mercury, thirty grains to the ounce, has cured many.

The following plan is more energetic, and very commonly succeeds. First, anæsthetize the ulcer as before with applications of cocaine, then thoroughly cauterize the whole floor of it with a stick of nitrate of silver, and fill the fissure with this ointment:

R	Iodoform.....	3j.
	Belladonna ointment.....	3ss.
	Carbolic acid.....	gr. x.
	Simple cosmoline.....	3ss.

Mix.

Apply this ointment thoroughly every day, after having each time cleansed the sore with antiseptics, and repeat the nitrate of silver very gently every third day.

Itinerant Methods.—The traveling doctor generally has either a long or a short circuit. The long circuit brings him back to the same place in four weeks, and the short one in two weeks; hence he regulates his times of seeing patients by the time of his return, and not according to the patient's needs, leaving some *placebo* to occupy the attention between times. In this way the case is prolonged and kept on hand as a source of revenue, according to one of the little secret books, "from six to eighteen months," when it should be finished in one-tenth of that time.

The "Brinkerhoff System," as applied to fissures of the anus, is this: Once or twice a month, as the itinerant comes around on his circuit, he inserts the little speculum, cleans out the ulcer, and applies to it a solution of nitrate of silver, forty grains to the ounce. Between the applications, the patient uses a morning and evening treatment himself. Each morning he is to evacuate the bowels, then inject the rectum with lukewarm water, and finally insert into it a little ointment, consisting of three grains of carbolic acid and eight grains of sulphur to the ounce of vaseline or lard.

For evening treatment he uses "Brinkerhoff's Ulcer Remedy," having the following composition:

R	Extract of hamamelis (distilled)...	fl. 3v.
	Solution of persulphate of iron....	" 3j.
	Cryst. carbolic acid.....	grs. ij.
	Glycerine	fl. 3ij. ℥

Add half a teaspoonful of this to the same quantity of starch, and about an ounce and a half of water. Inject into the rectum every evening.

This "system" is gotten up for itinerants who are expected to be ignorant, and who cannot be trusted with edge-tools; it therefore sternly prohibits all cutting operations, and furnishes no instrument with which an incision can be made.

Ulcers Situated Above the Anus.—When ulcers are situated high enough to be entirely above the anus, and expose no part of their length to the reception of septic germs from the atmosphere, they do not acquire the terrible irritability of true fissure. They are bathed in the bland rectal mucus, which itself is a decided antiseptic, and rarely become the seat of much pain, showing in that respect a wonderful contrast to the ulcers situated low enough to present one extremity to the external air.

Causes.—The causes of the higher ulcers are similar to those producing ulceration elsewhere, such as foreign bodies, mechanical injuries, simple inflammation, as in dysentery, tuberculosis, syphilis, chancroid, sarcoma, true cancer, etc., etc. In the prison hospital of Saint Lazarre, in Paris, devoted to the treatment of diseased prostitutes, we were shown by the surgeon in charge numerous cases of chancroids of the anus and rectum, caused by the practice of sodomy, which is prevalent to a great extent in that city. The vice is so rare in the United States, except among immigrants from Southern Europe and from China, that rectal chancroids hardly exist among native Americans. We have met them a few times, however, in cases of recto-vaginal fistula, where the virus entered the rectum through the fistula. The ulcerations of tertiary syphilis are liable to attack the rectum as well as other parts, and not being dependent on contagion for their rectal location, they are not very uncommon in this country.

Clinical History.—When simple ulcers of the rectum are of very recent origin, they are apt to be accompanied with pain, tenesmus, and symptoms of dysentery, with discharges of blood, pus, and rectal mucus, as well as fæces.

In chronic cases, these symptoms are mostly absent, though pus, yellow mucus and streaks of blood are found in small quantity. The proof of the ulceration is mainly obtained by examination with the finger and the speculum. If the ulcers are phagedenic, or large and multiple, they may occupy nearly or quite the entire circumference of the rectum, and in healing induce contraction and thus produce stricture. Most strictures originate in this way.

Diagnosis.—If pus is discharged from the anus, and the patient shows other signs of tertiary syphilis, and if on

examination one or more ulcers are found without other known cause, they may be presumed to be syphilitic. If the erosion exists on the surface of a tender and painful tumor, not seeming to be simply inflammatory, it will generally be found cancerous. The microscope will complete the diagnosis. If a tuberculous diathesis is present, or suspected, the microscopic search for the tubercle bacillus will assist the diagnosis.

When we have to deal with simple ulceration well above the verge, the finger often helps to determine their size and location, but it is not sufficient for a full investigation. In these deep cases we need the tubular form of speculum, and frequently must etherize

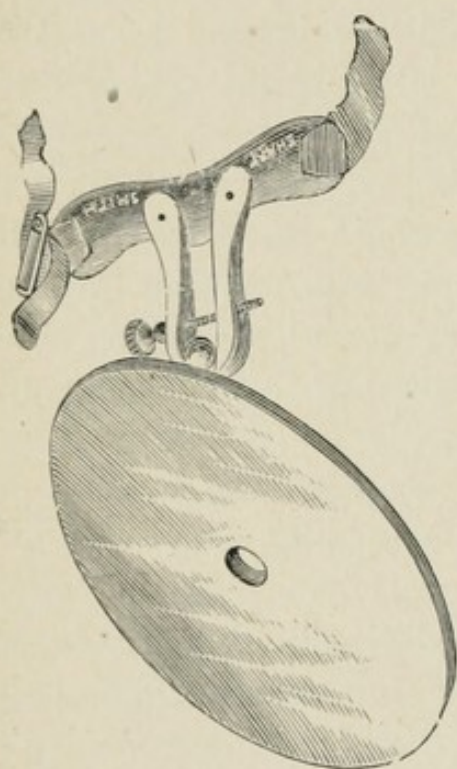


FIG. 37.—CONCAVE MIRROR TO REFLECT CONDENSED LIGHT INTO THE RECTUM. THE HEAD BAND MAY BE REMOVED AND A HANDLE ATTACHED AT PLEASURE.

the patient, if we are to make a thorough search. The straight tube will generally reach far enough, but the curved one shown on page 17, Fig. 11, will enable one to carry the search still higher. For a thorough examination it is necessary to empty the rectum by an enema.

Treatment.—When the ulcers are due to any constitutional disease, they will usually recover by simply curing the cause, without any local treatment; but if there is any local sepsis, or depraved quality of the intestinal secretions, direct applications become necessary. In either case a prolonged rest in bed is important. The great value of the horizontal position in hastening the cure is too much overlooked. “An hour’s walking and standing around the sick room will undo more than the other twenty-three can gain.” (Kelsey.)

The local medication is best made in the form of antiseptic washes and suppositories, of which nitrate of silver, two grains to the ounce, is the favorite. A large injection is thrown in and allowed to run out again, after which a suppository, containing three grains of iodoform, five grains of subnitrate of bismuth and a tenth of a grain of morphine, may be inserted. The suppository may be used twice a day, but the injection only once in two days, and if it irritates it should be made weaker. It is well, however, to rinse out the rectum daily through a tube, with warm and slightly salted water containing one grain to the ounce of carbolic acid, taking care that the fluid runs well out again, lest too much carbolic acid be absorbed. When the ulcers are seen through the speculum they may be touched with nitric acid, nitrate of silver, comp. tinct. of iodine, or carbolic acid, but the speculum should not be inserted with irritating frequency.

The substance of the whole experience of surgeons is that simple ulcers ordinarily heal through cleansing and antisepsis. It is very different, however, if the ulcers are chancroids, or the result of tertiary syphilis, or tuberculosis.

Chancroids in the rectum, as before stated, are rare in this country. If discovered they will present the yellow, diphtheritic color of the floor, common to the species everywhere, which, with the history of the case, will enable one to make out the diagnosis. It is necessary to treat such

cases by frequent applications through the speculum. To this end the rectum should first be emptied and antiseptically washed out. Then inserting the speculum, bring chancroids well into view, and first having brushed the rectum with a four per cent. solution of cocaine, cauterize them with a stick or glass brush dipped in fuming nitric acid. Rinse out the surplus of acid, remove the speculum and insert a suppository containing three grains of iodoform, five grains of boric acid and a fifth of a grain of morphine. This should be repeated every second day, until the yellow color of the floor of the ulcer disappears, and a rose tint takes its place, indicating that the virus of chancroid is no longer present, and the ulcers have become simple ones. During the treatment the rectum should be washed out three times a day with the same washes as were recommended above for simple ulcers, and when the nitric acid applications cease, the morphine may be omitted from the suppositories, unless great irritability exists. At any rate it must not be given a great length of time without an occasional week of omission, lest the opium habit be induced.

If tertiary syphilis exists, the case requires locally mere washes, like those directed for simple ulcers, but constitutionally it demands a vigorous administration of iodide of potassium or sodium by the stomach.

In tuberculous cases the local sores require ordinarily only washes like those used for simple ulcers, though, if tubercle exists in the ulcer itself, it may require to be scraped. Most tuberculous cases, however, are more medical than surgical, and require the same general treatment as is given to other tuberculous patients.

When the ulcers are dependent upon the depraved condition of the system caused by Bright's disease of the kidneys, they will usually be incurable, but still the use of mild but free washings will alleviate the local symptoms.

Whenever ulcers occupy a large portion of the circumference of the rectum, or anus, the contraction during their

healing tends always to induce strictures, which can only be prevented by mechanical dilatation, a subject which we will consider fully in the section on strictures.

CHAPTER VIII.

PROLAPSE OF THE RECTUM.

There are three forms of rectal prolapse:

1. Prolapse of the mucous membrane alone, as represented in Fig. 38.

2. Prolapse of all the rectal coats. This variety brings down the peritoneum if the extrusion proceeds to some distance, as is shown in Fig. 39.

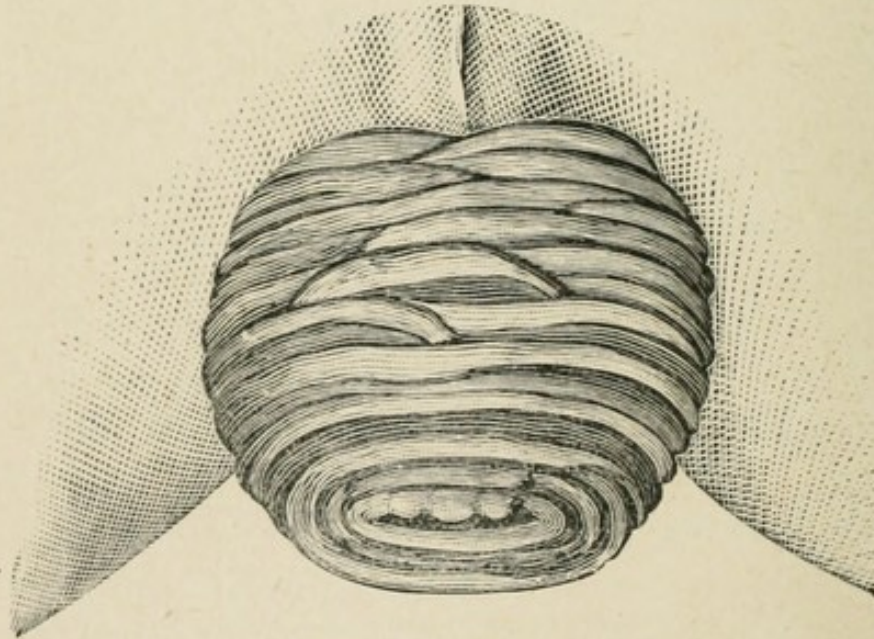


FIG. 38.—PROLAPSE OF MUCOUS MEMBRANE (*Esmarch*).

3. Prolapse of the upper part of the rectum into the lower, which is the same accident which is called invagination or intussusception in other parts of the canal.

Prolapse of the Mucous Membrane.—This is the most frequent variety, and the majority of cases are in children under five years of age. The acute cases are generally in

children, and are usually produced by simple excess of straining at stool. The mucous membrane is very loosely attached to the parts beneath, and readily protrudes. Kelsey says the first attack always comes on gradually, but this is probably an error, as it often occurs as a sudden accident in young children who have shown no sign of it before. Besides straining, we have for causes paralysis, excessive dilatation, and ulcerative destruction of the sphincters, or of any part of them.

When the attack comes on suddenly there is considerable pain, and a red and often bloody tumor is found projecting from the sphincter, which is sometimes reduced spontaneously, and at others has to be pressed back by the hand. It is naturally marked by circular folds as shown in Fig. 38, but in other cases the submucous effusion renders the tumor smooth. Prolapse of the mucous membrane alone rarely projects more than two inches. If the tumor is longer than that, especially if it assumes a cylindroid form, other coats of the intestine will be found present in the mass.

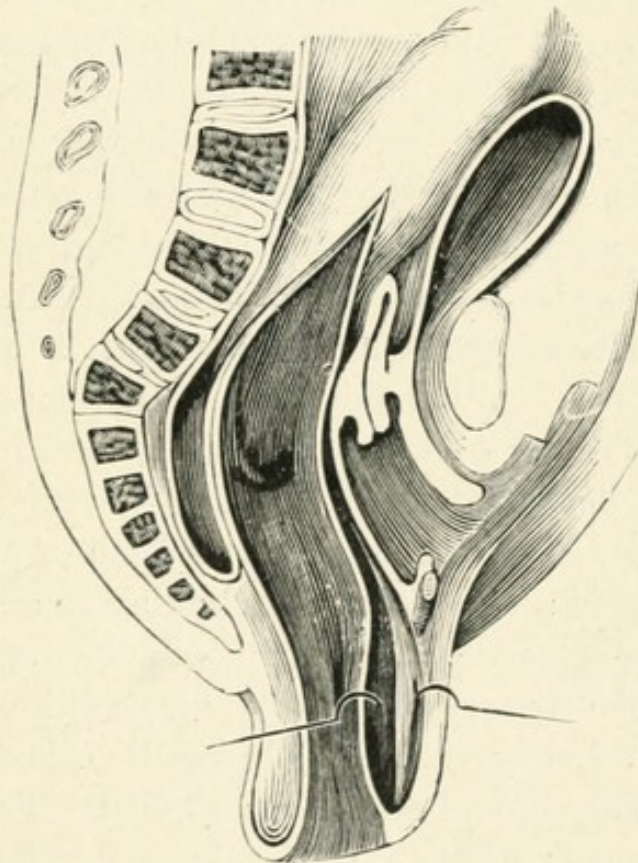


FIG. 39.

PROLAPSE OF ALL THE COATS (*Esmarch*).

In a few cases we have the third form of this accident, where the upper part of the rectum projects into the lower, and even considerable lengths of intestine from above have been known to be invaginated and protrude through the

anus. Mortification of the protruded part occasionally occurs, with the death of about half the patients.

Treatment.—Whatever the form of the accident, efforts must be made to return the mass, which can usually be done without ether by first washing the parts with solution of cocaine, and then pressing them back with oiled hands. Persistence in taxis will almost always succeed. In many cases the patient will remain cured, if he refrains from straining; but where the bowel continually comes down, artificial supports must be used. These are constructed in two ways. In one a belt is placed around the waist, and an elastic band having a solid or inflated pad attached is passed between the thighs in such a way as to press the pad against the anus. The anterior part of the band is divided so as to come up to the belt in front of each side of the genitals. Another form consists of a belt, half steel and half leather, buckled about the hips just above the trochanters, while a bent steel spring passes down behind and carries a pad to press against the anus. In temporary cases, it assists the stability of the pad to draw the nates together with a broad adhesive plaster.

The following is the plan of Dr. S. D. Powell, of New York: "It consists in rolling in and strapping the buttocks together with two strips of adhesive plaster, extending sufficiently forward to secure a good hold. The child (or adult) defecates with these in position, is thoroughly cleansed after the act, and new strips applied. This method, which, in the hands of the inventor, has never failed, is based on the fact that thereby the relaxed sphincter is elevated and supported during the strains put upon it while the child is at play, and protected from the lateral traction occurring in the squatting position assumed in defecation. It and the parts above gradually regain their contractile power, and ultimately become competent to fulfill their function normally.

The bowel being returned, and provision being made for the time being for retaining it, if needed, the surgeon

must of course seek to correct every constitutional or local disease tending to bring on the prolapse, and it is not necessary for us to enter extensively into that branch of the subject. Locally, astringent injections are of value, such as solutions of tannin and alum, sulphate or chloride of zinc, or of tincture of iron, using them at about the same strength as one would in the urethra; that is to say, we can use to each ounce of water, in most patients, fifteen grains of alum, two of tannin, of chloride of zinc, or of sulphate of zinc, varying according to the tolerance of the patients. As the rectum absorbs readily, toxic substances cannot be used except in officinal doses. Astringent suppositories containing alum, morphine, extract of belladonna and cocaine often help. Tannin is incompatible with morphine and cocaine.

Operative Treatment.—When the prolapse is due to a rent in the perineum, or across the sphincter, or to a gap made by ulceration, it can be remedied by cutting away the cicatrized edges of the gap or rent, and closing them by sutures.

Where the case is a chronic protrusion from other causes, and ordinary corrective and palliative measures have failed of adequate effect, then energetic operative measures on the prolapsed tissue itself are justifiable. The direct amputation of the protruded mass is subject to two objections. First, the cicatrix left after the amputation is a ring completely surrounding the opening, and in its subsequent contraction is liable to result in stricture. Secondly, if the prolapse contains any fold of peritoneum, the opening of that sac would involve some danger, though the precautions of modern surgery can reduce the peril to moderate dimensions. It is also to be remembered that the prolapsed peritoneal pouch may be hernial, to the extent of containing ovaries, and coils of intestines, etc. For these reasons amputations are not to be resorted to except when special circumstances compel us to confront the danger. If the gravity of the case, however, makes the amputation neces-

sary, it should be done with all the antiseptic precautions proper to intra-peritoneal surgery. The mucous membrane should first be divided, and all bleeding vessels tied. The muscular coat should next be treated in the same way. An opening should then be made in the peritoneum, the finger introduced, and the presence or absence of any hernial protrusion ascertained. If any viscera are down they are to be returned. The peritoneal coat is then to be divided, and sewed up with fine antiseptic animal ligatures, and the mucous and muscular coats closed over it in a similar manner. Mikulicz (*Deutsch. Gesellsch. für Chirurg. XVII. Kong.*) is of the same opinion, and would also apply the plan to cases of chronic prolapsed invagination of the colon. Two feet and a half of prolapsed colon were removed in one instance. Some would, however, close the whole by antiseptic stitches going through all the coats at once, as in ordinary laparotomies. This is better than Kleberg's operation of tying the gut in two halves with rubber tubes. During the recovery and for months after dilatation must be used to prevent stricture.

Sabatier, Michæliez and Potocky all favor a free use of amputation in prolapse.

Potocky has, however, in one case performed the following operation: He opened the abdomen by an incision parallel to the left Poupart's ligament, and one centimeter above it. Through this opening, seven centimeters long, he seized the rectum and drew it upward, assisting by pushing the prolapse up by a hand introduced into the rectum and pushed far upward. He then retained it by stitching the gut to the margin of the wound. The case was a success. The patient was a female, fifty-one years of age, and had suffered with prolapse for eight years.*

The operations most in favor with the best surgeons are those which remove or destroy a part of the mucous membrane and skin near the verge of the anus.

*Oest-ungar Centralbl. f. d. Med. Wissensch., No. 1, 1891.

Excision.—The skin of the vicinity having been shaved and disinfected, the patient is anæsthetized and placed on his back, in a good light, with the knees drawn up and asunder, while the surgeon sits facing the perineum, as in lithotomy. The mucous membrane is then raised from the deeper parts by suitable toothed forceps or a tenaculum on one side, and removed with the scissors, leaving a broad denuded oval patch or wound, longest in the direction of the axis of the rectum. If the skin participates in the tumor, a portion of that also is included in the lower angle of the wound. Another similar piece is taken on the opposite side. Some surgeons take several narrower longitudinal strips, but always leave enough mucous membrane to prevent serious stricture. Every bleeding vessel should be tied, and the wounds closed by sutures, otherwise dangerous hæmorrhage may occur. The patient should be then confined to bed for several days, with gentle compression upon the tumor, unless it has already retracted within the verge.

Some surgeons advise to clip out sections of the connective tissue and muscular coat with the mucous membrane, but if there is reason to think the mass contains a fold of peritoneum, this must be done with such caution as not to open the sac unnecessarily:

Cauterization.—Owing to the dread of hæmorrhage, and the fear of wounding the peritoneum, many of the best surgeons prefer the actual cautery. The patient being anæsthetized and posed on the table as before, the cautery instrument, generally a narrow one, is applied, beginning near the upper part of the protrusion, and drawing it downward, going deeper and wider at the lower part, and terminating at the junction of the skin and mucous membrane. From three to six such stripes are burned. In bad cases, Allingham burns completely through the sphincter muscle itself at two opposite points, having previously reduced the protrusion. The contraction following the burns through the sphincter, remedies the relaxed condition of that muscle,

and enables it to hold up the parts above. It is necessary, however, that the patient be kept in bed some three weeks, lest the cicatrices stretch out and leave too much laxity of the parts.

Potential Caution.—Owing to the horror felt by patients at the idea of being burned with hot irons, many surgeons have used the potential cautery, employing nitric acid, sulphuric acid, potassa, potassa cum calce, and chromic acid. These plans have not been favorites, owing to the difficulty of confining the caustics to the desired lines. This, however, is merely from want of due preparation. If the part to be destroyed is held in a trough-shaped clamp, in such a way as to conduct off the caustic fluids formed, and if the parts adjacent be adequately protected with folded napkin-cloth saturated with alkaline carbonates, in case acid caustics are used, or acid solutions if alkaline caustics are tried, the result to the patient will be practically the same as if the actual cautery had been employed, though the surgeon will have had a little more trouble with his preparations.

The Itinerant Treatment.—The itinerants use small hypodermic injections of equal parts of an eight-grain solution of muriate of cocaine and phenol sodique, or other weak preparations of carbolic acid. They insert two or three drops at each puncture, and scatter the punctures about an inch apart over the surface of the tumor. They claim to cure in from one to three visits in most cases. "Brinkerhoff," however, advises his itinerants to let prolapsus alone, and says he can give them no method of treatment worthy of their attention.

Vidal, of France, used hypodermic injections of ergotine with alleged success, but his example has had few followers in other countries.

Prolapse by Intussusception.—In a few cases the colon undergoes an intussusception into the rectum, and even protrudes from the anus a long distance. This condition, whether protruding from the anus, or stopping just above it,

can be recognized by the fact that the finger can be passed all around the invaginated portion inside the rectum. The first thing is to try and reduce it by returning the external protrusion, if any exists, into the rectum, and then endeavor to reduce the intussusception by forced injections of air or warm water. In a few cases a prolapsed ileum has come down through the ileo-cæcal valve, and followed the whole length of the colon and rectum, protruding at last from the anus. I saw one case of a little girl in which the ileum had stopped just above the anus. I first forced it up as far as possible by injecting air, and then as the walls of the abdomen were very thin I succeeded in slowly forcing the invaginated mass, by external manipulation, first up to the transverse colon, then across to the opposite side, and finally down to the caput coli. A small mass remained there which I could not cause to disappear; nevertheless the mechanical obstruction of the bowels was completely relieved and the patient made a good recovery.

Success by injection and manipulation, however, cannot always be expected, and when it fails, a laparotomy may be required. In case the intussuscepted portion requires to be amputated, the procedure is identical in principle with that already described for the amputation of an ordinary prolapse.

Hernia of the Rectum.—When the peritoneal coat comes down with the prolapse it is liable to contain links of intestine, or one of the ovaries, and sometimes the uterus or other organs. Most of the hernias come down in the front half of the prolapse, but this is not universal. The presence of the gut in the mass can often be detected by feeling it slip back under pressure, and sometimes by gaseous resonance under percussion. All operations on a prolapse must be done with due remembrance of the possible presence of a hernia. Rectal hernias may become strangulated and require a herniotomy on the same principles as in other locations, unless they yield to taxis. If the gut is found

gangrenous, it must be resected, and either joined together by anastomosis, or by any other approved plan, or stitched to the wound, so as to make an artificial anus.

Accidents have sometimes burst these hernias, causing protrusion of the gut with almost uniformly fatal results.

CHAPTER IX.

POYLPUS AND OTHER NON-MALIGNANT GROWTHS.

When a tumor is a mere hypertrophy of the normal elements of a mucous membrane and of the sub-mucous connective tissue, it is usual to call it a polypus. According to the relative amount of mucous glandular tissue, or of fibrous substance, the polypus is hard or soft. If the papillæ of the surface are multiplied and elongated they give it a hairy appearance. Others are knobby and wart-like to the look. Some are smooth, and others are granular in appearance from being covered with the follicles of Lieberkühn, or with the hypertrophied closed follicles. Some are pedunculated, and others more sessile. In the rectum they are generally small but have sometimes been found larger than an orange. Polypi are generally painless, but from special location in the grasp of the sphincter, or other causes, they may induce suffering. If they are of some size they can be generally found with the finger, but sometimes have to be sought through the speculum.

Treatment.—Polypi are to be treated by removal. The only material danger is hæmorrhage from the artery of the pedicle, though one death is on record from



FIG. 40.
CLUB-SHAPED POLYPUS,
FROM PATIENT OF
AUTHOR.

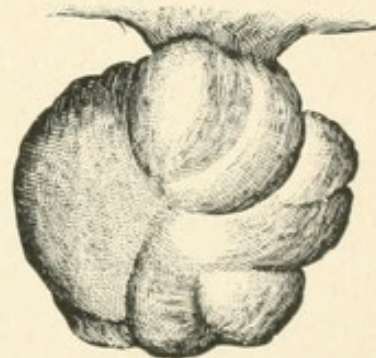


FIG. 41.—ROUNDED POLYPUS.

the wounding of the peritoneum. This was in the practice of the celebrated surgeon Brock. The patient died of peritonitis after the removal of a polypus, when it was found that it had originated in the sigmoid flexure, and had lengthened its pedicle down into the rectum, bringing with it a small tube of peritoneum in the center of the pedicle. The best way is to ligate the pedicle close to the mucous membrane, and snip it off far enough outside the ligature to prevent the knot from slipping. Many twist them off, and "trust to luck" about the hæmorrhage. Where there is nothing like a pedicle to be tied, resort may be had to the actual or

potential cautery. Whatever method is adopted, the cure is usually permanent.

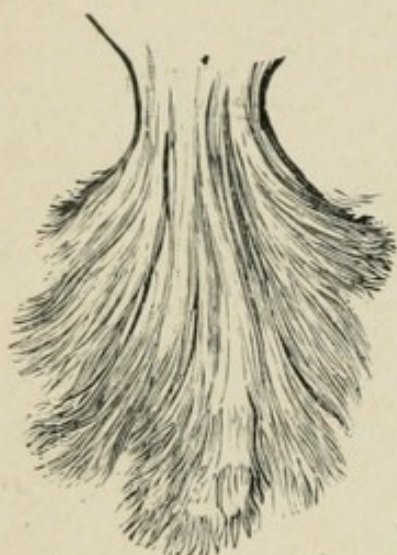


FIG. 42.—VILLOUS POLYPUS.

Itinerant Treatment.—Brinkerhoff directs his itinerants to tie the pedicle close to the wall of the gut with waxed saddler's silk. Then, if the pedicle is long, they are to snip it off outside the knot. If it is short they leave the tumor *in situ*, put the patient to bed, and constipate the bowels for about three days, when they are to give a gentle cathartic.

Vegetations, Warts or Papillomata.—These growths are hypertrophies of the papillæ of the skin, in fact a kind of external villous polypi, so to say. They were formerly considered syphilitic growths, but at present this idea is abandoned, though they generally occur on patients who have practiced venereal excesses.

In females they are to be found on both the anus and vulva at once. They consist of numerous little pedicles whose summits branch out and press against the branches of adjacent pedicles, so that the whole mass sometimes looks like a solid tumor on the surface, yet if scissors be run under so as to snip away all the pedicles, the skin is found

beneath merely dotted pretty thickly with the small stumps. It merely looks like a continuous raw tumor, just as a dense thicket of bushes, looked at from above, seems like a solid mound of foliage.

Treatment.—Vegetations may be sometimes destroyed by frequently dusting them with tannin and burnt alum, but generally the best way is to anæsthetize the patient and snip them away with scissors, using astringent lotions afterwards. A few bleed viciously and require cautery or other precautions.

Condylomata.—This term has been loosely applied both to certain elevated mucous patches of secondary syphilis, and to mere bunches of non-syphilitic skin about the anus. The syphilitic cases will disappear on using resolute antisymphilitic internal medication. The non-syphilitic varieties require the scissors if they are troublesome.

Fibrous, Fatty and Cartilaginous Tumors of the Anus and Rectum.—These are rare. If they become troublesome, they must be removed by excision.

Cystic Tumors.—These, if troublesome, must be dissected out, or else have their interiors cauterized with potassa cum calce. Iodine and nitric acid are not sufficiently energetic for the purpose.

CHAPTER X.

MECHANICAL OBSTRUCTION OF THE RECTUM.

Mechanical obstruction may arise from stricture, from foreign bodies, from congenital malformation, from the pressure of adjacent tumors or displaced organs, from spasm of the sphincter, from large polypi or other benign growths in the rectum, and from malignant tumors.

Stricture.—We mean by this term a non-congenital, or acquired narrowing of the passage. Probably a majority of the cases are due to phagedenic ulcers, some venereal, and others not, which first spread around the inner surface of the rectum and destroy the mucous membrane in an irregular band, nearly or quite around the circumference. As the ulcer grows older and heals, or attempts to do so, its cicatricial circle or cylinder contracts and narrows the passage. It is said that tertiary syphilitic deposits may cause stricture even without any ulcer, and be cured by iodide of potassium, so that the iodide thus becomes a means of diagnosis. At first little notice is taken of the obstruction by the patient, but at length he observes an increased difficulty in expelling solid fæces, and discovers that they are thin or slender, as if driven through a small orifice, unless the obstruction is so high up that the fæcal mass re-forms itself in the cavity between the stricture and the anus. In some cases the flat, tape-like form of the fæcal discharge is produced only when a violent straining forces the stricture down through the anus, while the round form follows all milder efforts, the anus then resuming its function and moulding the mass. If the destruction of mucous membrane does not extend entirely around the rectum, the symptoms of obstruction at

length cease to increase, and the case may spontaneously improve by the dilatation of the uninjured portion of mucous membrane effected by the daily passage of fæces. If, however, the ulcer is a complete cylinder, it may go on contracting until the stoppage is complete, and the patient, if not relieved promptly, may die with the usual symptoms of mechanical obstruction of the bowels. When the obstruction has become so decided that the patient habitually fails to empty the bowels, the abdomen is usually found full and tympanitic. The portion of intestine just above the stricture becomes dilated, and frequently its muscular coat is hypertrophied from its constant straining, but at other times is thin from expansion. Ultimately the mucous membrane is prone to become inflamed and ulcerated, and sometimes is perforated, producing either cellular abscess, or fatal peritonitis, according to the site of the perforation. When there is no perforation there is often a low grade of chronic peritonitis with adhesions, pain on exertion, vomiting, etc. Even if no perforation or peritonitis ensues, death will follow a complete mechanical obstruction in a short time.

Examination.—Preliminary to treatment, the surgeon must make a careful physical examination. Generally the finger will suffice, but not always. The rectum having been emptied by enema, and the patient lying either on the side or back, the index finger is lubricated and inserted, and will generally reach the stricture. If the point can be carried through, one can determine whether the strictured portion is short, or whether it continues on for some distance. If the obstruction is beyond the reach of the finger, a rectal sound with a curved staff, with about six interchangeable bulbs of different sizes, will enable the surgeon to ascertain the size and location of the stricture. (See Fig. 8 on page 15.) If it be very small, a britannia metal urethral sound may be required. The ordinary straight, stiff rectal bougies are useless here, and the flexible ones of Wales' pattern are little better, as the position of the tips cannot be known on

account of their flexibility, unless a steel staff be inserted through them. There are often difficulties in distinguishing a stricture from an obstructing rectal fold, but in such case great advantage is obtained by distending the gut with air, or with warm water, which smooths the folds away, and diminishes the perplexity. Metallic sounds must be used with the greatest gentleness, lest they perforate some spot thinned by ulceration, or fragile from other diseases. They give imperfect information because they may be stopped by rectal folds where no stricture exists, yet if they pass, the fact is important because it proves that there is at least no stricture smaller than the size of the bulb passed. If the stricture is only a little beyond the finger, it is well to anesthetize the patient and insert the whole hand of either the surgeon or a selected assistant. The hand should be narrow, well lubricated, and the fingers and thumb gathered into a cone, and slowly pushed through the sphincter. After passing the sphincter, the force used must be very moderate, as the destruction of the elasticity and strength of the walls of the gut by the disease, give a possibility of tearing through into the peritoneal cavity, an accident which has occurred more than once.

Treatment.—Constitutional treatment may be required to remove whatever unfavorable diathesis be present, especially the syphilitic, and in partial stricture, on which no operation is at present intended, it is often necessary to use laxatives, to keep the fæces in a semi-fluid condition, as well as tonics and proper regimen to sustain the patient. Medical treatment alone will rarely cure the stricture itself, however, except in a few of the syphilitic cases, and those pseudo-strictures which consist merely in spasmodic action of the sphincters.

The operative treatment consists in dilatation, divulsion, and incision both internal and external, to which may be added colotomy.

Dilatation.—This is generally commenced by gently

inserting one or more fingers, if the stricture is within reach, and repeating the process at intervals of two to six days. The parts should be benumbed with cocaine a few minutes

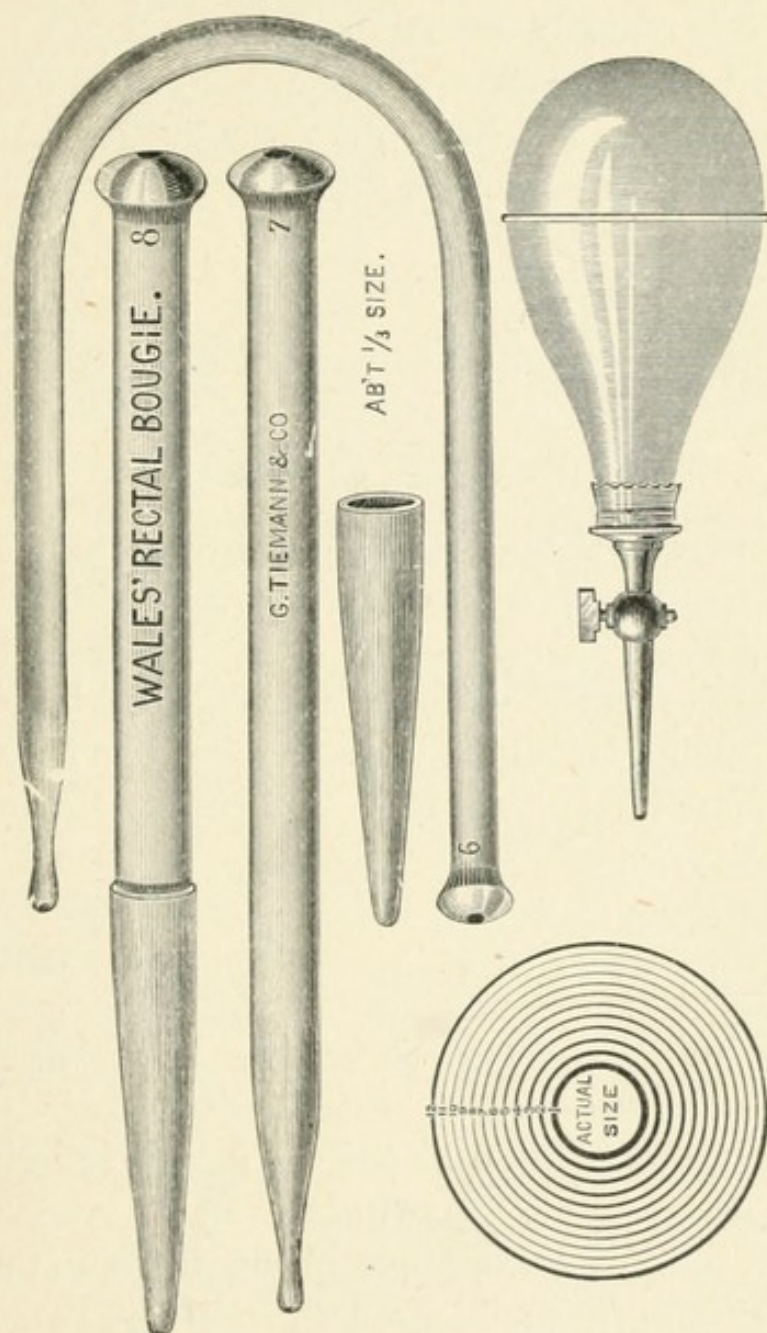


FIG 43.—WALES' BOUGIES AND SYRINGE FOR DISTENDING DILATING SACS.

beforehand, the finger well lubricated, and slowly inserted. When the orifice becomes too large to be further distended by the finger, some conical rectal bougie is to be employed, of which Wales' rubber instruments are the best now in

market. These are to be inserted very slowly, increasing the size gradually, so as neither to overcome the patient's fortitude, nor to risk bursting through into the peritoneal cavity. Mechanically speaking, any stricture within safe reach can be gradually dilated to any desired size, exactly as is done with the strictures of the urethra, but the greater size of the rectum, and its more overpowering nervous sympathies, render it much more difficult to maintain the

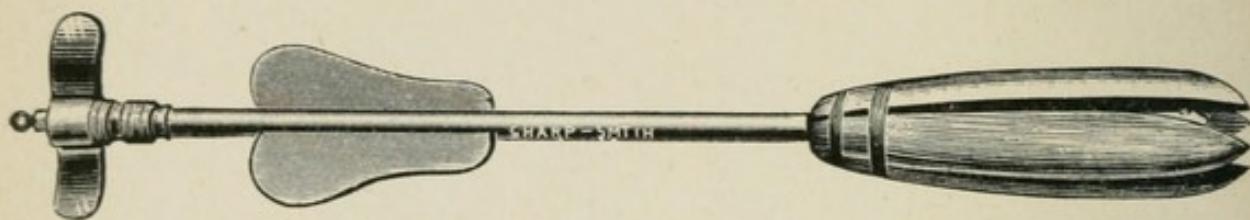


FIG. 44.—SARGENT'S RECTAL DILATOR.

fortitude and tolerance of the patient at a working standard. Still, by gentleness, encouragement and patience, great results can often be obtained by the gradual method. It is claimed that a rapid dilatation can be obtained by electricity passed through a metallic bougie pressing into the stricture, just as is done in the urethra, but practically the results are not satisfactory.

Wales and Davison have each devised dilators, consisting of elongated rubber sacs, which are inserted into the stricture in the empty condition, and then made to expand by forcing in air or warm water. Very good results can be obtained by the use of them.

Divulsion.—When the stricture is well below the peritoneal folds,—that is to say, within an inch of the verge,—it can be rent open by force, provided the vagina in the female, or the urethra in the male, are not involved in the substance of the induration.

In performing this operation the patient is anæsthetized, and the usual method is either to nick the inner edge of the stricture in several places with the bistoury, or as is the better way, nick in one place only and that directly backwards toward the sacrum, so as to guide the rupture in a

direction where there are few vessels, and no peritoneum. The divulsion may be made by the fingers, by conical rectal bougies, or by any of the mechanical divulsors invented for that purpose, of which there are several. We generally restrict ourselves to the fingers, and to Wales' rubber bougies, preferring them to the weapons of steel. The proper cases for divulsion are those where the patient's fortitude is not persistent enough for gradual dilatation, or when other circumstances compel haste, and at the same time the stricture is quite near the anus. The sole advantage of the method is that there is less danger of hæmorrhage than in cutting. When the stricture is situated much more than an inch above the verge, the danger of tearing into the peritoneum begins, and divulsion is then correspondingly dangerous. In such cases it is to be avoided unless some urgent reason exists for braving the peril. In old and debilitated patients there is some danger of shock after divulsion, and deaths sometimes occur.

It has been proposed in operations about the rectum which involve the peritoneum to seek the disinfection of the whole alimentary canal by giving salol or naphthol freely internally. Like similar attempts to render the urine aseptic through the exhibition of drugs, it has little practical importance to the operator, who should only rely on skill and good technique in managing the peritoneum rather than blindly trust any theory of "intestinal antisepsis."

External Incision, or External Proctotomy.—In some cases where both dilatation and divulsion are unadvisable, we must either put the patient to a little risk of a smart hæmorrhage, or else relieve him by the rather undesirable operation of colotomy, or operate by cautery. When proctotomy is done with the cold knife, the method is as follows: The rectum being emptied and the anus shaved, the patient is anæsthetized and placed either in the lithotomy position, or on his right side with the knees drawn up. The left index finger is oiled and inserted up to the stricture with

the palmar surface toward the sacrum. A straight probe-pointed bistoury is then made to glide along the finger and through the stricture, if the latter is low down, or only to it, if higher up. The knife is then swept backward along the mesial line until the heel comes close to the point of the coccyx, while the point rests on the finger in the rectum. A free gush of blood follows, but the wound can be easily spread wide open and the bleeding vessels secured. Then, if the stricture is not already cut, the knife is passed into it and cut backward into the wound already made. The wound is then tightly packed with lint and the patient sent to bed, using opiates if needed.

The dread of hæmorrhage has caused improvements to be devised. The incision may be made from without inwards, by the galvano-cautery knife, and most of the danger

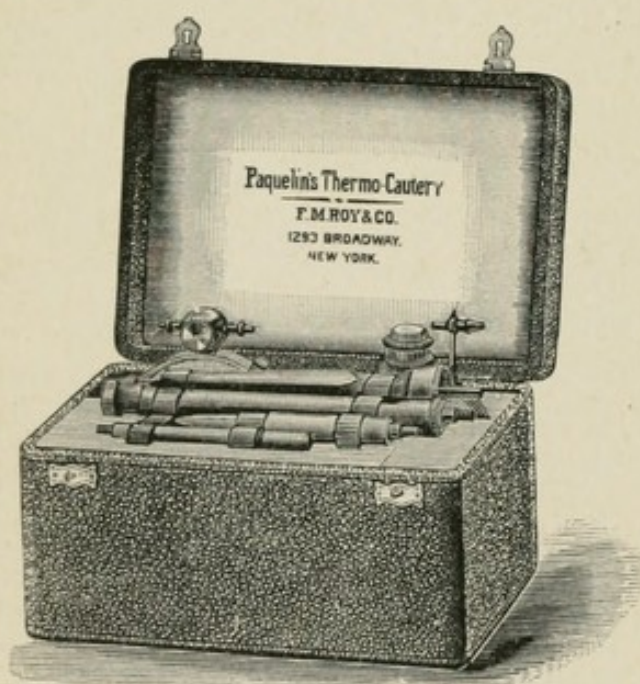


FIG. 45.—PAQUELIN'S THERMO-CAUTERY CASE.

of hæmorrhage avoided. A third method is to insert a trocar into the skin below the tip of the coccyx, and push it straight to the end of the finger inserted as before said into the rectum. Withdrawing the steel, and leaving the canula in place, a platinum wire is carried into the rectum, and brought out of the anus. The canula is

drawn out, the ends of the wire connected with the battery, and the loop is made slowly to burn its way outward by gentle traction upon it. A fourth plan is to insert the trochar as before, carry the chain of an *écraseur* through

the canula and out the anus, and attaching the chain to the instrument, crush the tissues through in the usual manner. A fifth plan is to grasp the tissues in the curved jaws of the *écraseur*-forceps of our invention, and divide them in that way. The *écraseur* methods, however, are not as safe from risk of hæmorrhage as the galvano-cautery.

The wound is dressed antiseptically and left open during healing. The retention of fæces is not always perfect afterwards, but the condition even then is preferable to that following colotomy, for which it is a substitute.

It is a curious fact that even when a stricture is too high up to be actually divided, the division of the sphincters in proctotomy still, in some way not well understood, often greatly relieves the obstruction.

Internal Incision, or Internal Proctotomy.—This is performed by dividing the stricture internally, directly backward toward the sacrum, and sometimes, also, but with care, directly forward a moderate distance. By thus keeping in the mesial plane the vessels divided are small and the risk of hæmorrhage is not great, yet surgeons dislike to perform the operation because the sphincters are intact, and hæmorrhage, if it occur, will be concealed from view until it has attained dangerous proportions, and at the same time is in situation where measures for the suppression of it are very difficult of application. Still, peculiar circumstances may sometimes compel one to take the risk. The operation is performed as follows:

The patient being placed in the lithotomy position, or else made to recline on the right side, the finger is passed in and the point of it cautiously insinuated through the stricture, with the palmar surface toward the sacrum. A straight probe-pointed bistoury or a lithotomy knife is then made to glide along the finger through the constriction, and then to cut boldly backward toward the sacrum. If a narrow ledge or shelf exists in front, an incision may also be made in the mesial plane forward, but not so far as to

endanger the peritoneum, the vagina, nor other important organs.

The chief objection to internal proctotomy is the fact that the wound is so situated that the discharges become septic, and cannot be completely corrected by irrigation; hence in many cases the wounded meshes of the connective tissue become infected, and dangerous septicæmia follows. Kelsey combats this by inserting a large trochar at the apex of the coccyx and carrying it into the seat of the incision, and then putting a drainage tube in. To prevent the tube slipping out it is well to use a long one with fenestra in the center, and bring one end out of the anus, thus preserving a secure track of antiseptic irrigation. The tube can be removed after three days.

Plastic Operations for Stricture.—When the stricture is quite low down, either close to the anus, or confined to it, Esmarch's plastic operation is best. The stricture is divided forward and backward in a straight line. The mucous membrane is then dissected up and drawn down and stitched to the margin of the incision as is shown in Figs. 46, 47, and 48.

When the contraction has resulted from a burn, or other injury, which has acted upon the skin somewhat widely, the best way is not to drag out the mucous membrane, but to bring in flaps of external integument cut in various patterns to suit the peculiar forms of the injury and stitch them into the linear incision.

Excision of the Stricture.—When the constriction extends somewhat higher up, but not too far, the cicatricial mass may be cut bodily out, much as if it were a cancer, and the mucous membrane drawn down, and stitched to the margin of healthy tissue below.

If the stricture be still higher up, and the urgency of the condition justifies some risk, an excision can often be performed at a much higher level, by cutting back alongside the sacrum, drawing the gut down, and excising a portion in

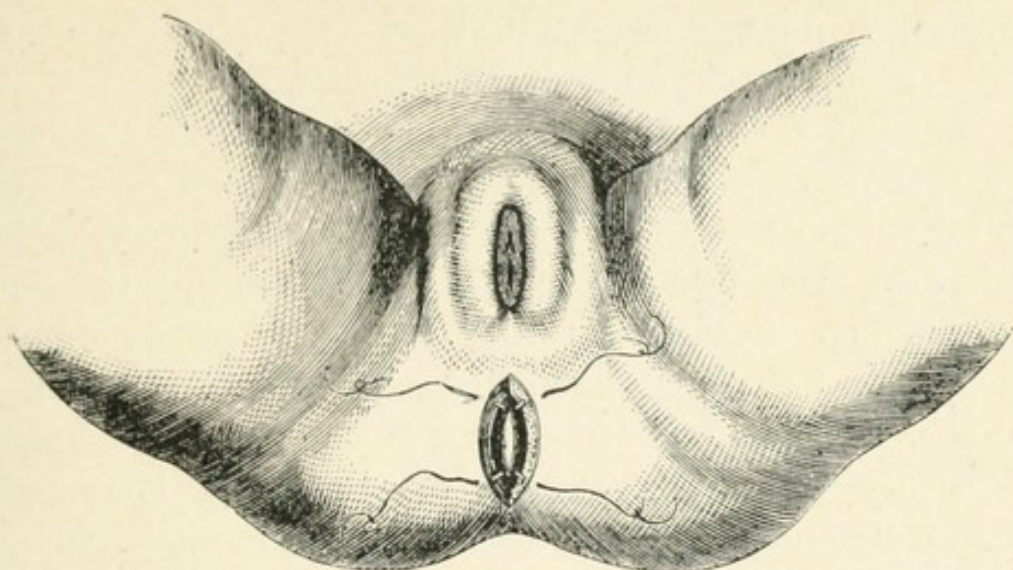


FIG. 46.—FIRST STEP IN PLASTIC OPERATION FOR STRICTURE (*Esmarch*).

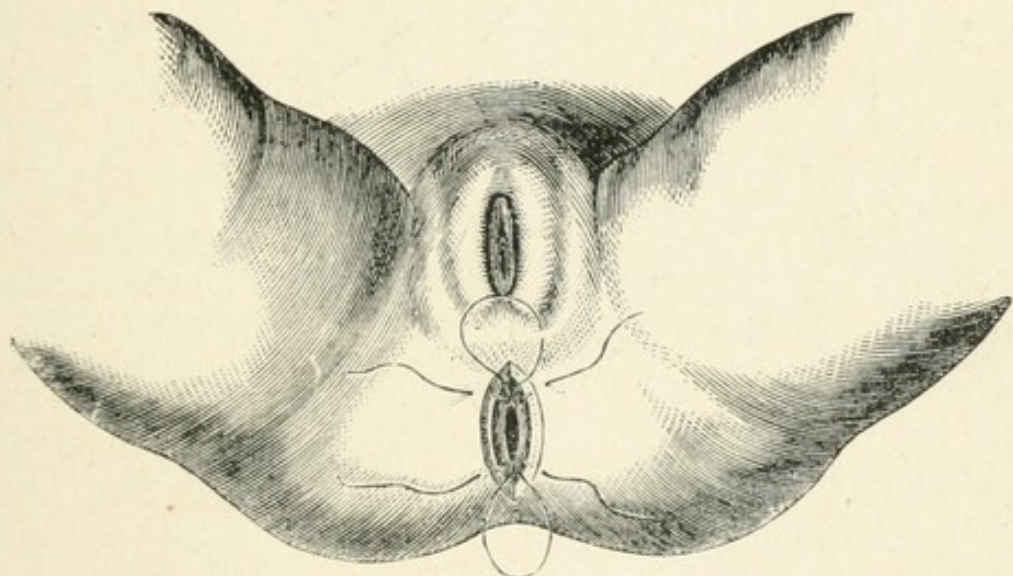


FIG. 47.—SECOND STEP IN PLASTIC OPERATION FOR STRICTURE (*Esmarch*).

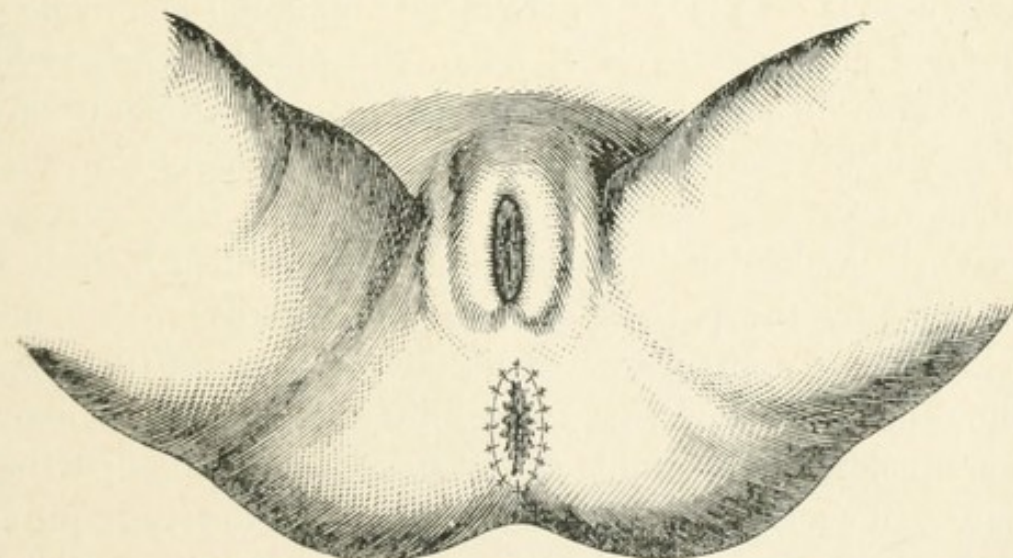


FIG 48.—OPERATION FINISHED (*Esmarch*).

the same manner as is described for the high operation on cancer in the chapter on Malignant Tumors.

Lumbar Colotomy.—If the condition of the rectum is such that no operation of reasonable safety can restore the natural route of the fæces, it is necessary to perform left lumbar colotomy, which is done in accordance with the usual directions on that subject in all surgical text-books. A description of the operation will be given in the chapter on Malignant Tumors.

Obstruction from Foreign Bodies.—Foreign bodies occasionally obstruct the rectum. Thus, a farmer in Michigan fell upon a blunt stake of half-decayed wood, which entered the anus some distance and broke off, leaving the fragment in the interior. It was extracted, and the patient recovered.

A laboring man, accustomed to bolt his meals with great rapidity, presented himself, with obstruction and sharp cutting pains of the rectum. Nothing was visible to external inspection, but the finger being introduced, discovered a large, jagged piece of mutton bone lying crosswise just above the verge.

In another case, a crushing fracture of the pelvis dislodged a large flake of bone, and drove it into the rectum two inches above the anus.

A case is on record where a man suffered such violent pain from the presence of stone in the bladder, that, in his desperation, he seized a large, jagged stone, five inches long, and forcibly thrust it into his rectum completely above the sphincter.

Various slender but elongated objects which have been swallowed by the patient, such as nails, needles, fish bones, chicken bones, splinters of wood, etc., may make their way without difficulty downward until they land crosswise above the sphincter, when trouble and obstruction for the first time ensue. In such cases there may be some dexterity required to extract the foreign bodies with the least irritation, but no

formidable difficulty occurs. The foreign object can usually be turned so as to bring it down easily; but if not it may be necessary to cut it in pieces with bone pliers, or even to incise the border of the anus to remove it.

Benign Tumors in the Rectum.—Polypi and other benign growths sometimes become so large as to obstruct the canal. In these cases they must be removed by the measures already described under the head of "Polypus," or if the situation renders that impossible, then a lumbar colotomy may be required.

The malignant tumors will be discussed under a separate head.

Obstruction by Displaced Organs.—Frequently a retroflexed or retroverted fundus of the uterus presses upon the rectum sufficiently to make a partial obstruction. Similarly the descent of enlarged ovaries, coils of intestines, etc., into the sac of a hernia alongside the rectum may cause material embarrassment in its functions. The only cure is to replace the wandering organs where they belong.

Pressure of Tumors and Swellings Outside the Rectum.—Fibrous, cartilaginous, and bony tumors of the pelvis sometimes obstruct the rectum. Cartilaginous growths especially may fill the entire cavity, and make a very great obstruction. In some cases these obstacles can be removed by carefully planned operations, which will have a better hope of success if done early. Sometimes the form and location of the growth admits of a complete operative success in relieving the rectum, even when the whole tumor cannot be removed. The excision of some projecting edge or angle may be all that is needed. If, however, the obstruction goes on increasing, and becomes so nearly total as to threaten the destruction of the patient's health, or life, lumbar colotomy must be performed. There is a prevalent opinion among physicians that an artificial anus is a terrible thing, and not much preferable to death. This is an exaggerated view. True, an artificial anus is a source of

some inconvenience, yet by the exercise of a little care and ingenuity, these inconveniences are greatly relieved, and the patient may make his life very comfortable to himself and not disagreeable to his friends.

Inflammatory swellings may so press upon the rectum as to impede the evacuations. They rarely effect a complete obstruction. If they should do so, it will usually be found that an abscess is present which must be evacuated, when the obstruction will disappear. A solid inflammatory swelling must be managed by antiphlogistic and antipurplicative treatment just as in other parts of the body. We never knew one to produce complete stoppage, but if it should occur, a temporary artificial anus might become necessary.

Spasmodic Contraction of the Sphincter.—This is usually caused by fissures of the anus, or other irritation in the vicinity. It does not amount to complete obstruction, yet it may induce constipation. Usually the treatment consists merely in the cure of the fissure, or other local cause, but sometimes a forced dilatation is also useful.

Impaction of Fæces.—The cause of this condition is a long continued omission to perform the act of defecation, whether from paralysis of the expulsive muscles, spasm or involuntary contraction of the sphincter as in fissure of the anus, or in any other condition of the organ rendering defecation painful. The impaction may also be due to simple neglect of the patient or of his nurses to secure evacuations when there is long constipation, or to a torpid dementia of the patient causing the matter to be overlooked and forgotten.

In rare instances a large intestinal concretion has been known to come down and lodge at the sphincter, blocking up everything above it.

Whatever the cause may be, the hardened fæces gradually fill and distend the rectum with a somewhat firm and consistent mass which at last the patient is unable to expel.

Similar impactions sometimes occur higher up in the colon and even as high as the cæcum itself.

The diagnosis is not difficult if the finger is introduced into the rectum, but if that test be omitted all sorts of errors may be possible. A travelling foreigner once called on the writer to see his wife, who was, he said, in labor. The absence of any sign of a gravid uterus led to an examination of the rectum, which was enormously distended with hardened fæces. The griping pains provoked by the expulsory efforts led the woman to suppose she was about to have a miscarriage. Sometimes the irritation of the mass provokes a frequent catarrhal discharge with pain, etc, but no full evacuation. Such cases have even been called diarrhœa, and the condition aggravated by the use of remedies which stop evacuations.

The reflex irritation sometimes provokes a dry cough, in accordance with the general law that irritations of the anus have a reflex irritating influence on the larynx, a fact known to some professional singers who carefully observe their own condition. The fæcal mass, examined from the vaginal side, has often been supposed to be a tumor.

If the obstruction goes to an extreme degree it may bring on vomiting as in mechanical obstructions of the bowels generally.

The treatment is not usually difficult. In mild cases a cathartic, or even a large injection will often suffice. In others the fingers, either alone, or aided by such a scoop as is found in lithotomy cases, or a large curette will accomplish such a reduction of the mass as will allow the work to be finished by cathartics and enemas. In married women two fingers in the vagina assist very much in forcing down the masses. In bad cases it is necessary to anæsthetize the patient, dilate the anus, and then with the fingers and a scoop, or a strong dessert-spoon patiently dislodge the material. As there is often a large reserve of material in the colon above, cathartics are needed until the whole is emptied.

CHAPTER XI.

MALIGNANT TUMORS OF THE ANUS AND RECTUM.

These, as in other parts of the body, may be carcinomas or sarcomas. The carcinomas are the most numerous of the two in this locality, but whatever their relative frequency, many authors, including Cripps and Kelsey, include both under the general term cancer, while others apply that name only to the carcinomas. The sarcomas are rare in this location, but deport themselves when found much as they do elsewhere.

Causes.—The etiology of both forms of malignant disease is unknown. Much has been said about a hereditary tendency to cancer. Professor Frank Andrews published some years ago statistics of inquiries into the ancestry of two hundred cancer patients, showing that they had almost exactly the same amount of that disease among their parents and grandparents as prevails on the average among the adults of the whole community. About the same time, Mr. Harrison Cripps, of London, showed that the parents of cancer patients in St. Bartholomew's Hospital had the same average amount of cancer among them as is found among the adults of the whole English people, according to the statistics of the Registrar General. These careful analyses of masses of facts, joined to others of the same character, tend to weaken the whole theory of hereditary transmission of cancer, whether in the rectum, or elsewhere. Turning to other causes, we find that the statistics of the United States Census Bureau show a clear relation between cancer and climate, as we have elsewhere proven by collating the figures

of three successive decennial censuses of the United States. It is clear, that in this country cancer prevails most near the sea, and least at a distance from it; also, that at equal distances from the sea, it abounds decidedly more at the north than at the south. What this peculiar influence is, which is found prevailing at the north, and near the sea, is utterly unknown. The clinical phenomena constantly suggest that it is a microbe introduced into the body from without, but the efforts of microscopists to identify it, though claiming success, still require fuller confirmation. At present we must be content with a degree of uncertainty. The advocates of the microbe theory point out, in support of that opinion, the undeniable fact that cancer of the rectum is most frequent near the outlet, and diminishes as we go upward, as if it had its origin in some germ entering the parts from external sources—a fact of considerable weight, though not decisive of the question. Mr. Cripps has given in his valuable work a very careful discussion of the etiology of rectal cancer, and supports the same view. (“Cripps on the Rectum,” p. 315.)

Carcinoma of the rectum often spreads in a flat stratum between the mucous membrane and the sphincter, where it feels somewhat as if a foreign body had gotten itself bedded in the tissues, but in other cases it is a more rounded or irregular mass. In either case, it gradually extends, infects the inguinal and mesenteric glands and the liver, and, in short, destroys the life, like any other carcinoma. Occasionally we see the colloid forms, as in the upper viscera.

In the majority of cases ulceration of the surface takes place, but not rapidly enough to prevent the increase of the size of the mass, so that in many instances complete obstruction of the rectum occurs. The pathology of the disease is very interesting, but our limits do not permit entering upon it. We can only refer the reader to an admirable discussion of the subject in “Cripps on the Diseases of the Rectum,” pp. 288 to 370.

Diagnosis.—Except in very early stages it is not usually difficult to distinguish rectal cancer from other growths.

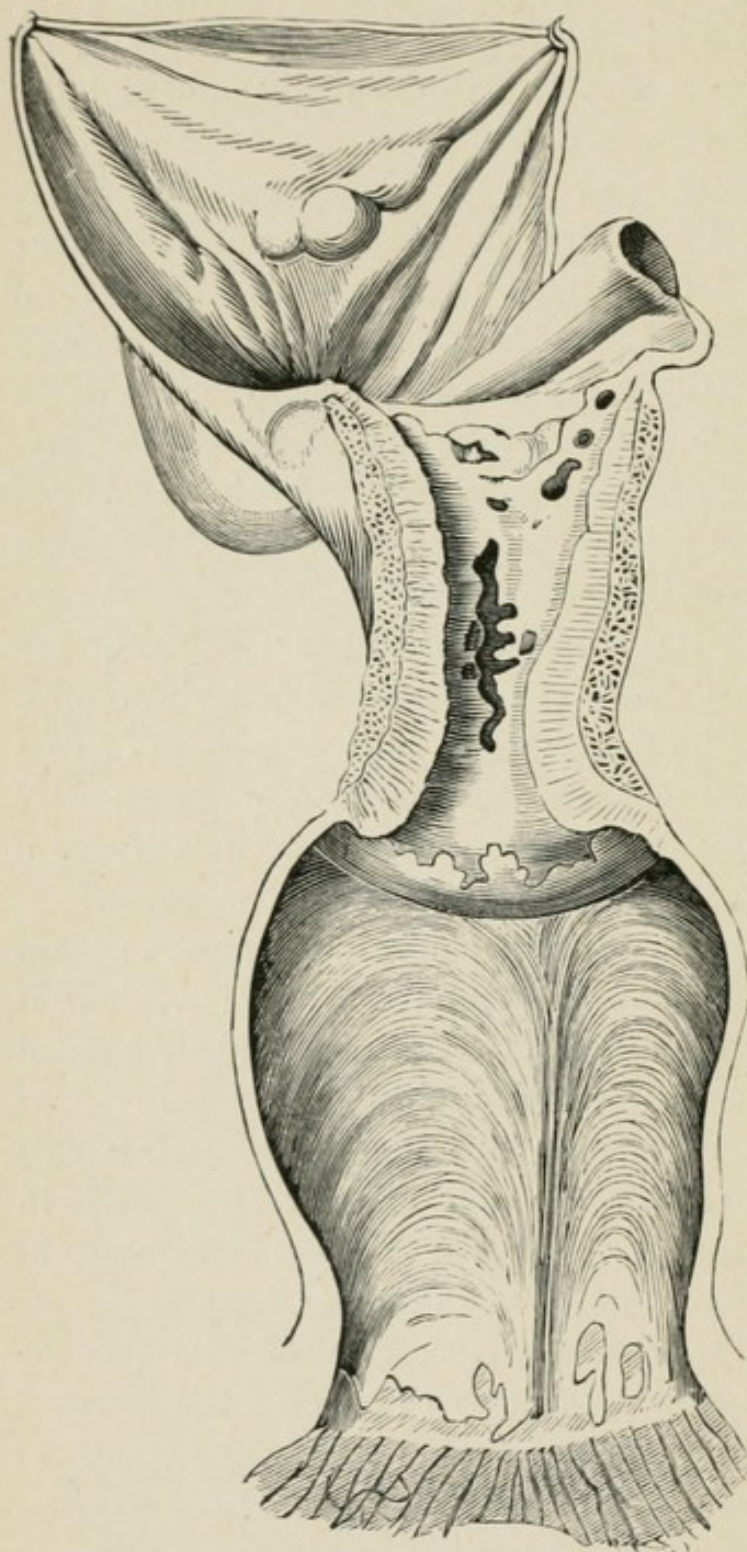


FIG 49.

CANCEROUS STRICTURE OF THE RECTUM (*Esmarch*).

If, however, there is ground of doubt, the location is such that it is easy to excise a sample, and subject it to microscopic examination. The fungous form of cancer might be taken for an innocent villous growth by one unaccustomed to distinguish them. However, the following characters will guide one generally to a correct conclusion: Villous innocent growths are generally pedunculated; cancers rarely so. Villous tumors, unless ulcerated, are bathed in healthy, transparent mucus; cancers discharge offensive, dirty-looking matter, which is neither

mucus nor simple pus. Villous tumors are soft, but yet somewhat tough; while the fungous cancer, though somewhat soft, is less so,

and yet breaks readily under the finger nail, and easily bleeds. The villous tumor springs from a soft, healthy mucous membrane, which glides freely on the deeper coats; while the cancerous fungous grows from an indurated lump or patch in the bowel, which seems fixed or rigid.

In suspected rectal tumors, where the diagnosis is doubtful, a small specimen should be taken for microscopic examination, and, if the case is truly malignant, the typical structure of carcinoma, or of sarcoma, will usually be found by a competent microscopist. The situation renders it easy to excise a sample. If the village practitioner be not skilled in microscopic pathology, he can place the sample in a vial of alcohol, and send it to a competent pathologist in some larger town.

Treatment.—This may aim at a radical cure, or at simple palliation. The radical cure consists in the complete extirpation of the tumor, and of a stratum of apparently sound tissue around it. Numerous variations have been devised in the details, but the following description will give the plans mainly adopted by the best surgeons, among whom Volkmann has perhaps given the most systematic account:

1. When the tumor occupies a circumscribed spot only on the circumference of the lower rectum, or of the anus, we first make a thorough dilatation of the anus, and then boldly excise the tumor, cutting far enough from it to take away all the diseased tissue. If the tumor is somewhat high up, we pull it down with vulsellum forceps, and, if the dilatation of the anus does not sufficiently expose it, we take a bistoury or scalpel and divide the posterior margin straight back to the coccyx. After the removal of the growth we study the form and dimensions of the wound, and so far as its extent will permit, close it with sutures, and guard it from serous infiltration by drainage tubes.

2. In some cases the tumor involves the entire circumference of the rectum, but has not infected the anus. We

then divide the sphincter backward to the coccyx, and also forward into the perineal region. The posterior incision goes deepest. Drawing the two halves of the anus asunder, the growth is taken out, and the gap is filled by drawing down the mucous membrane and stitching it to the cut margin below. The two halves of the sphincter are next closed with deep sutures, and a drainage tube inserted into the posterior seam.

3. In other cases the growth not only occupies most or all of the circumference of the rectum, but the anus also. We then proceed as follows: Dividing the anus behind and before, as already mentioned, we commence outside the line of disease, and dissect upward outside the gut until we get above the cancer. If a hole should be cut into the peritoneum, it is either immediately closed with a continuous suture of antiseptic catgut or plugged with a well carbolized sponge. The rectum is next cut off, the tumor removed, and all bleeding vessels secured. Next, the opening in the peritoneum is sewed up, and if the bowel will yield to tension, it is drawn down and stitched to parts below. However, this cannot always be done.

The operation is a bloody one in spite of all care, and every preparation must be made for promptly arresting hæmorrhage.

4. If the tumor extends high up, English surgeons generally advise to let it alone, but Kraske of Freiburg in Germany, as well as Bardenheuer and others advocate extreme measures, and not only remove the whole rectum, but have even pulled down the colon from above and removed ten inches of it, as well as the base of the bladder, the prostate, etc. Numerous forms of the high operation have been tried, generally on the following essential plan:

An incision is made from the anus back to the tip of the sacrum, and thence along its left border and along the left side of the sacrum up to the second sacral vertebra. The left border of the sacrum is cut away, or the whole bone is

sawn across at the level of its third vertebra. The coccyx is removed or turned over with the soft parts to the right. The sacrosciatic ligaments are cut off, and the soft parts retracted, torn, and otherwise parted, thus thoroughly laying bare the rectum behind. It is now possible to separate with the finger, etc., the whole circumference of the rectum from its connections both at and below the tumor and to pull down some of the colon above. Openings in the peritoneum are closed with catgut, and the portion of the rectum containing the tumor is drawn out and resected, or if necessary the rectum, anus, and all are removed.

The high operations reported in Germany are some sixty or more, with a heavy mortality apparently, though reports of operators differ widely. Those who did not die of the operation, nearly all had a recurrence of the cancer. On the whole the operation would seem to be proper in a few cases where the tumor is recent, movable and small and free from any evidence of infection of adjacent parts, or of the mesenteric glands and liver, but should be rejected when far advanced.

The sum of the whole matter is this: Cancer of the rectum can be excised from any part of its length, and the operation has a fair prospect of saving life, if done early, but in cases much advanced, especially if high up, the prospect of shortening life by operation is far greater than of lengthening it.

The French surgeons have used the *écraseur* instead of the knife to divide the tissues, thus diminishing the risk of hæmorrhage, but probably increasing the shock. Cripps devised an ingenious method of making a strong whip-cord do service in dividing the tissues, instead of the chain of the *écraseur*. The platinum wire of the galvano-cautery and the galvano-cautery knife are used with excellent effect to avoid hæmorrhage. Verneuil, of Paris, uses both the *écraseur* and the galvano-cautery knife in the same operation. The *écraseur*-forceps of our own devising is more convenient of

application than the chain écraseur. It is sometimes necessary to excise the coccyx and a little of the sacrum to enable one to reach the rectum at a sufficiently high point.

The mortality of the high operations is pretty heavy, but that of the low ones less so. The peritoneum, though variable, comes down on the average pretty near to the highest point which can be reached by the index finger; and this point is called by Kelsey the "danger line."

Taking all cases together, we have the following table:

AUTHORITY.	TOTAL CASES.	DIED OF OPERATION.	DISEASES KNOWN TO HAVE RETURNED.	Disease not returned at times from a few months to four years.
Cripps' Collection.	64	11	20	34
Allingham.....	13	0	13	0
Billroth	Not stated.	13	Not stated.	0
K. Frank's Collect'n	51	1

These statistics are imperfect, and therefore unsatisfactory, but they show at any rate that some cases are permanently cured.

Dieffenbach claimed thirty cases permanently cured, but in his day the means of accurate diagnosis of carcinoma did not exist, and the correctness of his statistics is more than doubted.

Sarcoma of the Anus and Rectum.—The diagnosis from carcinoma must be made, if at all, by the microscope. Its early removal is as urgent as that of carcinoma, and its prospect of success is much better.

Palliative Operations.—Malignant tumors are prone to block up the anus and produce first a stricture, and gradually a total obstruction; hence, in cases too far gone to admit of excision, we must combat the occlusion. As the stricture comes on gradually, it can usually be overcome by inserting from time to time a conical rectal bougie, giving an anæ-

thetic if necessary. This ruptures the obstructing belt, and gives renewed ease each time. In some cases it is justifiable to scoop away some of the mass with the curette. If the obstruction has become nearly complete and extends so high that it cannot be locally mastered, we must resort to left lumbar colotomy, which relieves the distress and obviates the immediate danger. In short, it enables the patient to evacuate the bowels in comfort as long as the disease in other parts permits him to live. As the disease progresses, anodynes may be used according to the necessity.

Colotomy for Cancerous Occlusion of the Rectum.—Formerly the opening in the left-lumbar region behind the peritoneum was preferred. This is sometimes called left lumbar colotomy, or Callisen's operation. One merit is that it does not open the peritoneal cavity, and this is worthy of consideration, for in spite of occasional assertions to the contrary, careful surgeons know very well that antiseptic precautions have only lessened, but not abolished, the dangers of laparotomy. Another advantage is that the gut shows less disposition to prolapse through the artificial anus after the posterior operation than after the anterior.

Bryant, of London, has done the operation 170 times, and strongly prefers it, while other men actively contend for the anterior operation. It must be confessed with regret that many of the writers talk like prejudiced partisans on the two sides and not like men of science intent solely on benefiting the patient. As above stated, after the lumbar operation the gut shows less disposition to prolapse through the artificial anus.

On the other hand the inguinal position enables the patient to manage the discharges and attend to his own cleansing much better than when the opening is behind. Moreover, the opening into the peritoneum is not large, and very little exposure of the viscera to the air occurs, so that under strict antisepsis the risk, though real, is slight; hence a large number of surgeons give it the preference.

The method of procedure in lumbar colotomy is as follows: The skin of the left lumbar region should be scrubbed with soap and an antiseptic solution several times during the thirty-six hours preceding the operation, and during the last six hours should be kept moistened with the same. The patient is anæsthetized and laid on a table in a good light. At this point some writers have recommended to distend the bowel by injecting air into the anus, so as to make the colon larger and easier to find. The grimness of this joke will be obvious if we consider that the anus in these cases may be closed by the cancer so effectually that neither air, nor anything else, can be gotten through. However, there is little need of clysters. The bowels are usually well distended already with their retained contents.

The patient being laid with the right side down and a cushion under the loin, the surgeon proceeds to ascertain the position of the descending colon. The area, or field of operation, is bounded above by the last rib, below by the crest of the ilium, behind by the longissimus dorsi, and the common mass of the *erectores spinæ* muscles, and in front by a perpendicular line carried upward from the center of the crest of the ilium. In this quadrangle lies the descending colon with its axis about half an inch posterior to the vertical line drawn upward from the center of the crest of the ilium. The center of the crest is best found by running a line from the anterior to the posterior spinous process, and erecting a vertical one from its center. Mark the position of the axis of the intestine, as above ascertained. Now make an incision through the skin about four and a half inches long, whose center shall cross the line marking the axis of the gut. The incision should be oblique, passing downward and forward in the same direction that a rib might be supposed to assume if one existed at that level, and should be about half way between the last rib and the crest of the ilium. This direction, however, is not imperative. If special circumstances require, it can be perpendicular or

transverse. Dissecting carefully down, the *latissimus dorsi*, the thick border of common mass of spinal muscles and the anterior edge of the *quadratus lumborum* will come to view, and external to them the external oblique muscle and its fascial origin. Divide the fasciæ and the external oblique muscle on a grooved director, and also the anterior or external border of the *quadratus lumborum*. That portion of the gut not covered by peritoneum, lies under the border of the *quadratus*. The loose fat connected with the colon and kidney is now exposed, unless it has been removed by emaciation. Displace the fat by the finger and the gut will come to view, and may be recognized by its large size, its greenish color, the presence of one of the longitudinal muscular bands and its tendency to sacculation of the walls. Now at a point three-quarters of an inch in front of the perpendicular axial line of the gut, pass a semi-circular needle through the skin of one edge of the wound down into the gut and thence out again about half an inch from the point of entrance, and out through the skin of the other edge of the wound, and draw after it a stout ligature. Repeat this process behind the axial line, and by these loops raise the gut up into the wound. Next, incise the gut parallel to the incision in the skin nearly from one loop to the other. A blunt hook will now easily draw out the loops from the inside of the gut, and by dividing them, four ligatures are at once produced, wherewith to tie the cut edges of the intestine to the skin. A few more stitches are required to support adjacent parts.

After the surplus contents of the intestine have escaped, the wound can be dressed with oakum, or any other porous antiseptic absorbent. The stitches should remain until, by their looseness, they show that they are no longer useful.

A water-proof pad is used after recovery to restrain the discharges, aided if need be by a truss spring.

Inguinal colotomy is best performed as follows, though there are other good methods.

The parts being shaved and disinfected, draw a line from the navel to the anterior superior spine of the left ilium. An incision nearly parallel to Poupart's ligament, but a little nearer to perpendicular, is drawn so that its center crosses the line about an inch and a quarter from the iliac spine. Cripps and Kelsey think that if the skin is drawn tense toward the umbilicus during all the incisions until getting down to the fascia transversalis the resiliency of the tissues will subsequently cause them to slide valve-like over the opening in the gut, and act somewhat like a sphincter. After all bleeding is suppressed, the peritoneum is opened and the oiled and disinfected finger is inserted along the curve of the brim of the pelvis until it meets and follows the mesentery of the colon to the sigmoid flexure, which is then brought out. If the colon is found it will easily be recognized by the longitudinal muscular bands. If only a small intestine is brought out, another search must be made. Now stitch the parietal peritoneum to the edge of the skin to prevent intra-peritoneal hæmorrhage, and bring out the gut. Pass a long needle through the abdominal wall opposite the junction of the middle and lower thirds of the wound, peritoneum and all, then push the needle behind the gut, and through its mesentery and thence out through the opposite side of the wound. The gut is now held firmly up. Now stitch the gut to the edge of the wound all around its circumference, in such a way as to leave two-thirds of its calibre in front of the stitches, and draw out the needle. If the urgency of the obstruction requires, an opening is made at once in the gut, but if not two or three days should elapse to allow of adhesions forming. Then an oval piece is snipped out of the front of the gut with the scissors.

It goes without saying, of course, that this being a laparotomy, and a laparotomy made on a patient in a very unfavorable condition, the utmost care must be observed in the antisepsis.

In case the obstruction has existed so long, and is so

tight, that the patient is in a decidedly bad condition, he will be especially prone to peritonitis, and it is best in such cases that the lumbar colotomy should be employed, to avoid opening the peritoneum.

CHAPTER XII.

MALFORMATIONS OF THE RECTUM— PRURITUS ANI.

Children are occasionally born with no outlet to the bowel. In some instances the obstruction is merely a thin

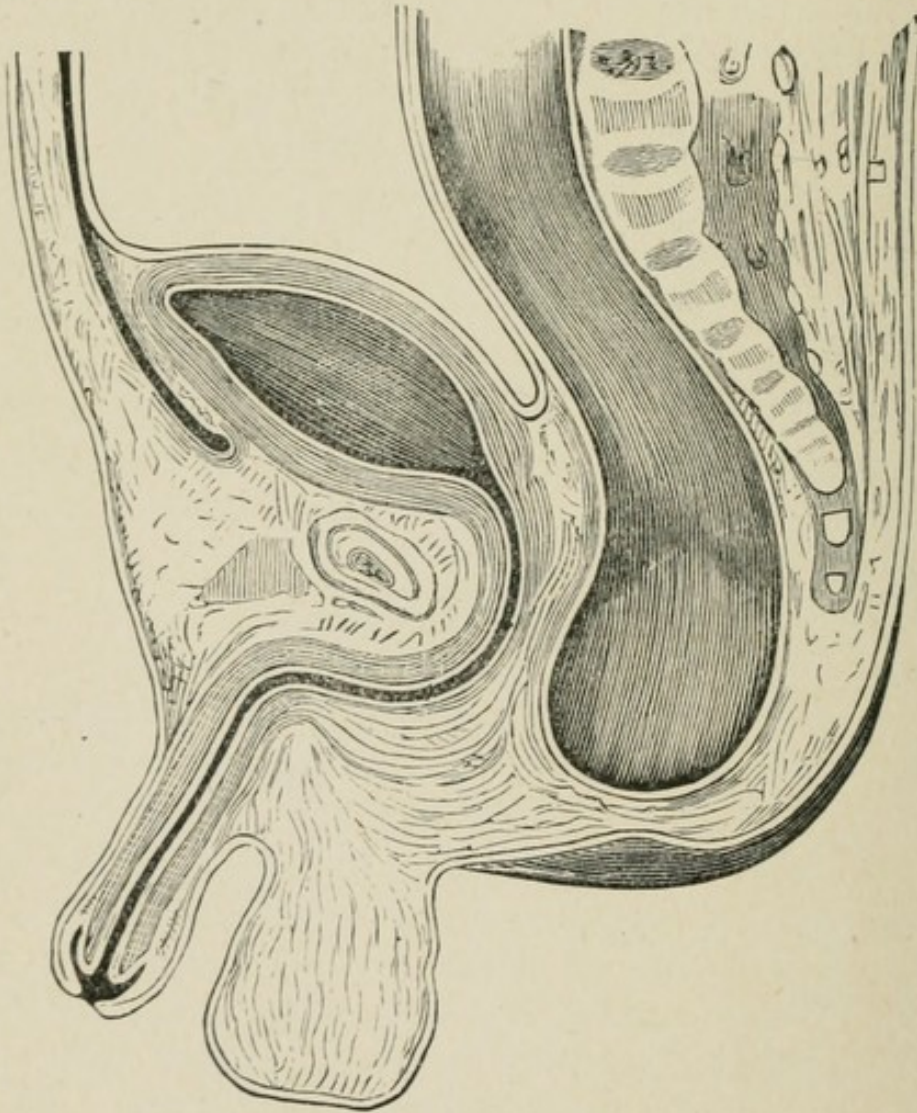


FIG. 50.—IMPERFORATE ANUS (*Esmarch*).

membrane across the anus, through which the dark shade of the meconium shows. In other instances the anus and lower

rectum is perfect, but there is a septum higher up. In other cases the whole rectum is wanting, and even some portion of the colon. There are also instances where the rectum ends in the vagina or in the bladder.

Treatment.—Where there is only a thin membrane

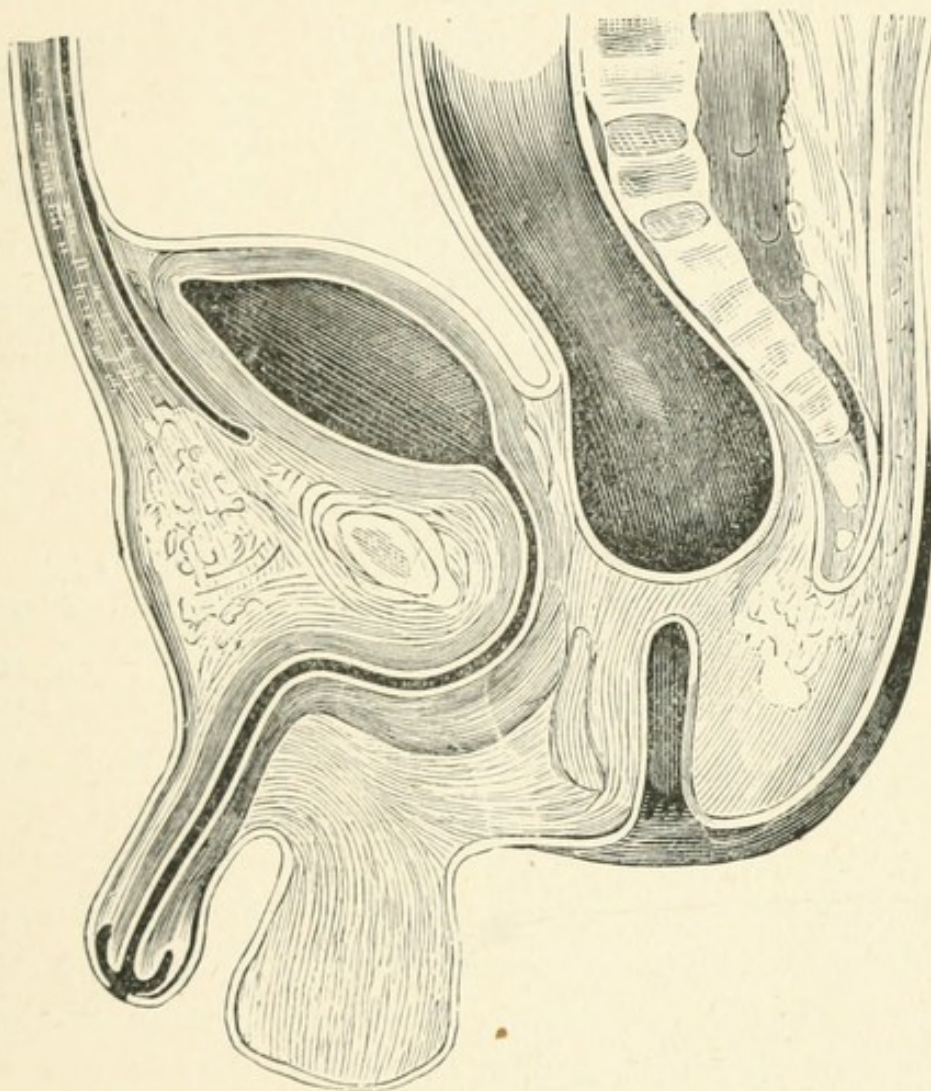


FIG. 51.—IMPERFORATE RECTUM (*Esmarch*).

closing the anus, it is easy to divide it by a crucial incision, and cure the patient.

If the rectum stops higher up, then we are in doubt as to where the *cul de sac* is to be found. It is proper, however, to seek for it. The patient being anæsthetized, an incision is made from the center of the spot where the anus should be, directly back to the tip of the coccyx. If the

cul de sac of the gut is there at all it will be in or below the hollow of the sacrum. The incision is therefore cautiously made on the middle line, close to the sacrum, and, if needful, the coccyx may be excised to enable the operator to get higher up. The gut is felt for with the finger, and if found is opened, and if possible drawn down and stitched to the incision as near to the normal location of the anus as its extensibility will permit without much tension. In this blind search the operator feels very uneasy as he goes deeper. If child has been born long enough to generate gas in the intestines, the resonant *cul de sac* of the rectum, if it exists there, may be detected by percussion on the sacrum. We have found, also, that by taking a small stick, five inches long, with the ends squarely cut off, and inserting one end into the wound, and against any tissue suspected to be the end of the gut, we can elicit the tympanitic sound by tapping with the finger against the outer end of the stick if the gut is really there. If the gut is not found, then a lumbar or an anterior colotomy must be made above, in accordance with the usual rules for that operation.

Mechanical Injuries are somewhat rare about the rectum.

Incised Wounds.—These may be caused by accident, or be the necessary result of operations. Owing to the location, purely accidental incisions are rare. A part of them are made by surgeons acting carelessly in the operation of lithotomy. They occur also from stabs and falls on sharp objects. The incision bleeds freely, and may do so dangerously. The gas, mucus and fæces also escape through the wound, and when the accident occurs in lithotomy urine also flows out at every micturition. The lithotomy cases are not very uncommon, and have occurred in the practice of nearly all the world's great lithotomists. Most of them heal spontaneously, but a few of them result in obstinate rectourethral fistulas. There is also danger from peritonitis if the peritoneum is wounded, and of septic cellulitis and

abscesses if faecal effusion takes place into the connective tissue.

Treatment.—Incised wounds of the rectum which simply cut across the sphincter into deeper parts, but do not injure important organs, if seen early, may be closed with sutures as in other incised wounds. If the weapon has entered like a stab, tunneling into the rectum, and therefore leaving the sphincter undivided, and is seen early, it may be sewn up on the rectal side in hope to get a union by first intention. If some days have elapsed since the wound, it is now a fistula and must be treated as directed in the chapter on that subject.

The rectal wounds made in lithotomy are sometimes among the most annoying of cases. True, they often heal spontaneously, but if they fail of that, they become rectourethral fistulas which often resist repeated operations. When the accident first occurs, there is no doubt that the incision would have the best chance if closed at once by sutures on the rectal side, but the lithotomist rarely has the requisite instruments with him at the time, and the opportunity passes by. Most authors write on this subject like perplexed men, but generally agree reasonably well on the following course:

If the primary operation for closing the incision has failed, or not been attempted, take plenty of time for expectant treatment, which results in the spontaneous cure of the majority of cases. The wound should be kept clean; the rectum kept empty, and a sheaf, consisting of three large soft rubber catheters, kept in the anus for drainage, that there may be no pressure of gas or mucus in it to force open the contracting fistula.

If this fails, and the remaining opening is very small and high up, success will sometimes be obtained by electro-cautery of the internal orifice, and the re-introduction of the sheaf of catheters. If this fails, or if the opening is both large and high up, then anaesthetize the patient, make a wide

dilation of the rectum, and operate on the part as in vesicovaginal fistula. The operation is somewhat difficult, and not certain of success. It is well, in some cases, to vary it by raising a flap of mucous membrane, and sliding it across the refreshed opening, stitching it to its new place. If this also fails, our best authors are silent as to what should be done next. Apparently, they are in despair, so far as these upper fistulas are concerned. In the lower ones, however, where the orifice is down near the sphincter, if plastic operations fail, success is pretty sure by simply cutting the fistula through into the gut, as in ordinary fistula in ano, and treating the wound as usual after that operation. Our opinion is that a bold extension of this plan to the higher fistulas would succeed, with some modifications to adapt it to the locality. We have, however, not yet had occasion to test this opinion in actual practice.

When an incised wound has opened the peritoneal fold, it should be freely opened and explored, and the peritoneal rent sewed up. If blood and fæces have escaped into the cavity, they should be immediately washed out, even if a regular laparotomy has to be performed for the purpose.

Punctured and Lacerated Wounds of the Rectum.—

These are the result of various accidents, as when farmers slide from haymows upon pitchforks or sharp stakes, or in falls among crushed and broken timbers, and goring by the horns of cattle.

They are considerably dangerous when they lead to the effusion of the rectal contents into the loose connective tissue. In such cases they require free openings below for washing and drainage, and especially a thorough division of the sphincter, and, if the peritoneal cavity is opened, cleansing, sewing up, and possibly laparotomy may be required, just as in incised wounds.

Gunshot Wounds.—These are decidedly dangerous, not so much from the injury to the rectum itself, as from the wounding of the other organs by the same bullet. The

Surgeon General's "History of the War of the Rebellion" gives 305 cases, with 44 deaths.

In many of these cases there is great effusion of rectal contents into the connective tissue, and sometimes into the peritoneal cavity. The urinary passages, also, may be wounded, and contribute a deadly addition to the putrefying mass.

These cases require prompt action. It is well to extract the bullet, if possible, but that is not the chief indication. Hæmorrhage must be stopped, if troublesome, by any and all of the usual methods. (See Chap. III.) Bushe long ago devised a cold compressor. A bladder was attached to a double tube in such a way that it could be inserted into the rectum, and strongly distended with ice water.

Dupuytren also called attention to the importance of preventing septic infiltration by such a thorough division of the sphincters as would insure a free downward drainage. At a later period, Simon, of Heidelberg, in a paper of great merit, strongly enforces the same measure, and the whole experience of the world to this hour emphasizes these three precepts:

1. Divide the sphincter, in most cases, up to the track of the bullet, and keep the wound wide open.
2. Make other free incisions wherever needed.
3. Irrigate thoroughly with antiseptics.

In these ways the mortality of these serious wounds may be reduced to the lowest rate permitted by the concomitant injuries.

CHAPTER XIII.

THE NEUROSES OF THE RECTUM AND ANUS.

The rectal and anal neuroses are so numerous and widespread, so simple and obvious at times, yet at times so complex and remote, that we should not be surprised to find in them a subject of misconception and of downright charlatantry. An extraordinary amount of "queer" pathology and many strange, grotesque theories in neurology have been evolved of late by the brotherhood of "Orificial Surgeons"; theories and conclusions which would astonish the medical world had the medical world time and inclination to give heed to them.

We have an observant eye on these gentlemen and their systems, and we propose from time to time to publish their brilliant discoveries, as we did in the first instance the hypodermic method of treating piles. Unfortunately, so far, we have only found them exploiting as original discoveries the well-known work of others, a kind of fraud easily practiced upon the public and half-educated "medical men," but not calculated to impose upon the whole profession. Certain it is, however, that many followers have been found for these curious "systems" in the western states. Of course the number of reputable and skillful surgeons who have found rectal surgery a profitable specialty, is also now considerable, and these, not less than the whole profession, have probably given too little study to rectal neuropathy in its local and general bearings.

The subject is an obscure and elusive one, and has never been exhaustively studied. No such classic monograph can be cited on the rectal neuroses as Ultzmann's "*Ueber die Neuropathien (Neurosen) des männlichen Harn und Gesch-*

lectsapparates," on the urinary neuroses, a work admirable in its special field. Nevertheless the nerve pathology of the rectum offers an even more interesting field of study and a far more difficult one.

Etiology.—It may be set down at the outset that the rectum, like other parts of the intestinal canal, and the stomach, bladder, urethra, etc., has complex motor and secretory functions which are capable of derangement through the nervous system, and of reacting upon the nervous system when deranged. It is unnecessary to cite in analogy the profound impression which even slight gastric trouble may make upon the brain and its functions, causing vertigo, neurasthenia, spasms and even confirmed epilepsy, or the violent "urethral chill" and accompanying pyrexia which the most careful introduction of a catheter causes in some men. Or, speaking again by analogy, if the existence of phimosis in childhood can cause serious reflex disturbance, it requires no argument to show that an irritation of the anus or rectum may also cause disturbance. Nervous reaction to all bowel troubles is profound in degree. In the rectum, however, or in its terminal portion, we find what does not exist in any other part of the intestines, a full supply of sensory nerves. Hence we have here added to those of the sympathetic system the possibility of sensory neuroses, of which the peculiar disease, known as fissure of the anus, is a marked example.

Before considering the different varieties of rectal neuroses it may be well to inquire in general what degree of severity and importance these have as compared with the neuroses of other parts of the body. Are they, like those of the stomach, capable of inducing disease in the brain and nerve centres by long-continued irritation? Can mere rough handling cause dangerous or fatal collapse as in the case of the bladder? Can radiating pains or general malaise and debility, such as follow disease of the ovaries, be traced to local disease in the rectum?

The answer to these questions must be a reserved one. We do not know that rectal neuroses follow closely the line of symptoms of other neuroses. In many directions they are similar, in others less severe, and in still others obscure and baffling, yet not the less real and troublesome. Not only may local disturbance in the rectum give rise to general neuroses, but, *per contra*, the state of the general nervous system may be the cause of varied local symptoms. Acute or chronic disease of the brain or cord, with or without structural changes, and all neurotic troubles classed as neurasthenias and marked by abnormal exalted reflex excitability are prone to affect the rectum. The causes to which we allude are mainly those which produce other neuroses, flushing, vertigo, incontinence or retention of urine, vesical tenesmus, etc. They are most common in anæmic persons in early life. Overstudy or business anxiety, great fear, loss of property and the like may often be found to have brought such individuals to a state of extreme prostration. It cannot be disputed that there is a class of such cases, analogous to that in which impotence, spermatorrhœa, etc., are the chief troubles, in which the rectum and anus are the seat of severe neuroses.

Fear or sudden shocks to the nervous system often produce involuntary evacuations of the bowels, or, on the other hand, obstinate constipation may follow great mental strain of any kind. Some obscurity must be admitted to exist as to the exact nervous mechanism involved in these symptoms. Through the hypogastric plexus of the sympathetic, which is in intimate relation with the sacral, the uterine, or vesical and the lumbar spinal nerves, the anus and rectum, and the genito-urinary organs are inter-related (Eckhard). Not only do they react upon each other, as when operations on the rectum cause retention of urine, but they are both subject to the same impressions from the central nervous system.

We propose to describe in detail the rectal and anal neuroses in the following groups:

1. Vaso-motor (sympathetic).
2. Sensory.
3. Motor.
4. Secretory.

1. **Vaso-motor** neuroses of the lower bowel have for the first time been studied in the last three years. It seems certain that in some individuals the mere distention of the organ with any material may profoundly affect the whole ganglionic or sympathetic nervous system.

Dr. Belfield, of Chicago, has observed that the use of the rectal inflated bag in operations upon the bladder is accompanied by a decided arterial depression amounting to fifty per cent., and that this disappears upon its removal. Continuing experiments upon dogs, he found that a similar effect could be produced by irritation of the rectal mucous membrane.

These observations have not yet been confirmed in the practice of many other surgeons. If confirmed they are of course to be explained by the fact that above the sphincters the nerves are chiefly from the sympathetic system. Instead of pain, alteration of blood pressure, etc., is the natural result of their disturbance.

Dr. Pratt, of Chicago, in a novel and interesting work, mentions a similar effect upon the heart as attending rectal dilatation, "Provided the subject experimented on be a sufficiently sensitive one to make careful observation possible." He describes his observations as follows:

"After the patient is completely anæsthetized, let the thumbs be inserted into the rectum only far enough to impinge against the external sphincter. If dilatation be practiced, no more effect upon the respiration will be produced than by pinching the integument in any other part of the body supplied by the cerebro-spinal system. If, however, they be inserted far enough to impinge upon the internal sphincter, the effect upon

the respiration is very remarkable. The patient seems at once to be seized with an inability to inspire. The heart's action becomes slow and feeble, and, in sensitive subjects, the condition passes on to complete syncope. The phenomenon can be demonstrated upon one-half or two-thirds of all the cases put under an anæsthetic."

We are compelled to differ from this writer as to the frequency of this phenomenon, while not denying its occasional occurrence. In no considerable number of cases met with have we been able to demonstrate it.

It is not true, moreover, that rough handling in rectal examinations, the use of large enemata of fluid or air, or even wounds and injuries of the organ usually cause much surgical shock, vaso-motor spasm or fall of arterial pressure. As a class rectal operations are as free from these complications as those in any part of the body.

2. Sensory Neuroses.—The region of the anus is peculiarly rich in sensory nerves, while the upper portions of the rectum are nearly devoid of sensibility. Hence diseases such as ulceration in the upper portion are nearly painless, while even small lesions about the anal verge are acutely painful. The nerve distribution about "Hilton's white line" has been described in the chapter upon "Anal Fissure," a disease which could almost be classed as a neurosis. Without the actual occurrence of a lesion it is also possible that sensory disturbance may take place whenever there is slight hyperæmia of the membranes.

Hyperæsthesia of the anus will invariably be found to be present when there is local irritation from hæmorrhoids, proctitis, prolapsus, etc. While a normal rectum will bear the insertion of a small speculum or the oiled finger without pain, one only slightly diseased will often be so sensitive as to make internal examination nearly impossible, or, if persisted in, the cause of severe after-pain for a week or more. In this state of hyperæsthesia, which is common in the rectum, the part is perhaps the most sensitive in the whole

body, not excepting the eye, the urethra or the bladder. It is, therefore, not unaccountable, that the element of pain is so prominent in all rectal troubles.

Closely associated with hyperæsthesia is *neuralgia* of the rectum and anus. Undoubted cases are found in which severe pain in the lower bowel is unaccompanied by any local lesion. This may or may not be associated with motor neuroses, such as tenesmus of the bladder and rectum. It is sometimes a concomitant of brain or spinal disorder, and sometimes a purely local neurosis.

Purely nervous forms of *pruritus ani* are not very uncommon, and such are the most intractable and hopeless. A case has been reported in the practice of a surgeon of Puyallup, Washington, in which intense and intolerable pruritus of central nervous origin was present with temporary insanity in a girl of eighteen years. The case is without parallel in the violence and suddenness of its invasion. It was found necessary to keep the patient under the influence of chloroform, or partially so, for hours and days at a time. Violent scratching, to the point of lacerating the tissue, was indulged in by the patient during every waking moment. She was kept partially narcotized with chloroform several weeks, when more or less improvement took place. Several hundred ounces of chloroform were used by inhalation. This is a very marked, though unusual, case of sensory rectal neurosis of central origin. Another form of sensory neurosis of the rectum is seen in the train of symptoms following fissure of the anus, a slight lesion *per se*, but which is sometimes known to cause violent paroxysmal pain, vertigo and syncope.

Reflex pain is a very common form of rectal neurosis. In bad cases of hæmorrhoids, wounds, or injuries of the anus, or severe proctitis, local pain is often less severe than the radiating pains in parts more or less remote. Severe lumbar pain is a very constant symptom of rectal disease, particularly of hæmorrhoidal troubles. When there is great irrita-

tion of the anal membrane, a pain like that of cystitis, with or without vesical tenesmus and retention, is usually felt. Like that of true cystitis, this pain is often referred to the glans penis, and is accompanied by frequent micturition. Its cause is explained by the arrangement of the nerve supply above mentioned.

Many patients with rectal disease complain of pains more or less severe radiating into one or both thighs. This is very common after operations upon hæmorrhoids and in cases of inflamed and strangulated piles without operation, also in acute proctitis and prolapsus.

3. Motor Neuroses of the anus and rectum are intimately connected with sensory disturbances.

Painful tenesmus of the bowels in dysentery may exist without local disease of any kind. One of the most obvious facts in the physiology of the rectum is that it tends to expel every substance which is forced into it either from the colon or from without. It is probable that the rectum is normally empty at all times except just before defecation, and is not physiologically in any sense a receptacle for retaining faecal matter. On the contrary, it attempts to expel promptly whatever comes below the sigmoid flexure, and if unable to do so causes discomfort. The motor impressions from forced injections of the rectum or from irritating substances such as glycerine, in fluid form or suppository, is not confined to the organ itself, but is transmitted to the whole lower bowel.

Rectal spasm is a constant symptoms of proctitis, but it like neuralgic pain, may exist without local disease. *Spasm of the sphincter alone* is also found as local expression of a general neurotic condition, and as a result of fissure, piles, etc. On account of the large sensory nerve supply at the anus there is much more reflex disturbance in spasm of the sphincter than in rectal spasm, *i.e.*, prostration, faintness, etc.

Motor urinary reflexes are among the most obvious and easily explained effects of irritation, disease or surgical

interference about the rectum. The pudic branch of the sacro-coxygeal plexus is the common source of the inferior and medium hæmorrhoidal nerves which innervate both the sphincters ani (external and internal) and the lower third of the bladder and sphincter vesicæ. Spasm of both sphincters is a natural and usual result of irritation of either alone. In the female the vagina receives its nerve supply from the same branches. In a large majority of rectal and vaginal operations temporary retention of urine occurs.

There is a constant tendency to vesical spasm in rectal trouble, and *vice versa*. The normal evacuations also tend to occur simultaneously, entirely apart from the will.

Enuresis in childhood is to be explained partly by reference to the same nervous mechanism. Before the age of one year there is no voluntary resistance of the sphincters, and discharges of urine and fæces take place whenever there is the slightest expulsive force. Control of the sphincter ani begins at one year, but control of the urinary sphincter not until the age of two years (Ultzmann), or after dentition. After this age bed-wetting in children may be considered abnormal. Our reason for describing it here is that it has been found amenable to local rectal treatment, while itself a local bladder neurosis, pure and simple. It furnishes an excellent illustration of what favorable as well as unfavorable impressions may be made upon other nerves through the nerves of the rectum and anus.

Guersant stands almost alone in assuming that incontinence or bed-wetting is due to congenital defect in development. Desault, Trousseau and Bretonneau, on the other hand, refer this trouble to functional disturbance of nerve supply of the vesical sphincter. No one supposes this affection to be in any way connected with disease of the rectum. Nevertheless, it is now known that it can be cured by rectal faradization in a very prompt and complete manner. The success of this form of indirect treatment through the rectal

nerves seems to open the door to other possibilities. It is fair to ask, if rectal reflexes are so profound and remote when disturbed, why advantage may not be taken of them to impress the nerve centres favorably in a great variety of nervous troubles.



FIG 52.—ULTZMANN'S RECTAL ELECTRODE.

4. Secretory Neuroses of the rectum undoubtedly exist independently of local disease. Most changes in the rectal secretions are probably caused by local inflammation, catarrhal proctitis, ulceration, or else by disease of the bowel above. Purely nervous derangements of secretion do doubtless exist, however, and what is equally important, general neuroses may exist as sequels of the local disease.

Ultzmann has shown the close analogy of uterine cervical catarrh in nervous and hysterical women to chronic prostatic congestion with like neuroses in men. Beyond any question both sexes may suffer similar nervous phenomena associated with catarrhal proctitis, pruritus ani, the presence of worms or ulcers near the anus, hæmorrhoids or fissure.

In acute intestinal catarrh a large quantity of mucous is found in the stools, some of which is rectal mucous, nearly normal in quality but increased in quantity. The reaction is alkaline except in acute diarrhœa of children. In all cases of frequent evacuation, even without irritation of the rectum itself, the rectal mucous is supplied in large quantities, and may be seen with the naked eye in hyaline masses. Its function is protective and lubricant. In nervous persons small masses having the consistency of jelly may be expelled from the anus. These may be perfectly odorless, transparent, or stained with urobilin from the fæces. A curious fact, and one of practical importance, is the close connection which often exists between the condition of the rectum and

larynx, a fact which has been brought to our notice by professional singers. Slight rectal catarrh with either diarrhœa or constipation is apt to be associated with mild acute or chronic laryngitis. This must point to a neurotic connection of the two organs. Persons who use the voice are obliged to guard against any overloading or irritation of the lower bowel with extreme care. Many persons are troubled by slight moisture caused by catarrhal discharge from the anus, without visible redness or irritation of the mucous membrane, or any sign of ulceration. Such excess of secretion occurring at irregular times may be of nervous origin in strict analogy with what we know of phosphaturia, glycosuria, and the appearance of indican (glaucuria) and even transient albumenuria as nervous phenomena. Phenol is normally present in the stools. Mucin, urobilin are also present in all cases. An examination of the fæces will reveal the presence of several common diseases by simple chemical tests. It is not our purpose to enter upon the subject here, but we recommend that all who make rectal troubles a study become familiar with the great authority, Nothnagel. (*Beitrag zur Physiol. und Pathol. des Darmes*, 1888.)

Pruritus Ani.—The causes of this troublesome and obstinate complaint are diverse. In the first place we meet here nearly all the itching skin diseases which may occur elsewhere, such as eczema simplex, eczema marginatum, erythema and herpes, and without going into tedious details, we may refer the reader to any modern treatise on skin diseases for their description and diagnosis. Owing to the great sensitiveness of the anal verge, itching of the part is apt to have a greater intensity than elsewhere. Those skin diseases which are due to a fungoid parasite, such as the trichophyton, etc., need careful diagnosis by the microscope in order to determine their character.

A frequent cause of pruritus is the presence of pin worms, or *oxyuris vermicularis*, in the rectum. These produce most trouble in the evening. They may often be found

with the speculum, but the surest way is to watch the successive evacuations for some time. In some cases they seem to be easily cured by various remedies, but in others they are never all exterminated, and though made seemingly to disappear for a few weeks or months, yet they multiply again, and require occasional treatment throughout life. Pediculi are sometimes the cause of the itching.

Pruritus ani is frequently a neuralgic trouble, caused by irritation in other parts. For instance, little ulcers or inflamed spots among the sacculi Horneri, just above the verge, frequently cause great itching of the verge itself. Internal piles at the same level may have a similar effect.

It is curious, also, that stricture, and inflammation of the upper portion of the urethra, sometimes cause rectal itching. In other cases it appears to be due to some lesion of the sensory nerve fibres surrounding the verge, for it yields to the nerve stretching produced by a forced dilatation of the anus.

In other instances it is directly or indirectly due to disease of the spinal cord and brain.

Finally, it may be caused by depraved and irritating secretions sent down by the rectum, colon, or higher bowels.

Treatment.—The first step is a complete examination of the parts externally and internally. We thus ascertain if there is any eruption of the skin, any ulcers, inflammations or hæmorrhoids present. Ascarides and pediculi are to be searched and watched for. In males the question of stricture or other causes of irritation in the upper half of the urethra is to be decided. If eczema is present, it may require arsenic internally and local treatment externally, as in eczema of other localities. If trichophyton or other parasitic fungi are found, they must be destroyed. If ulcers, inflamed spots, fistulas or internal piles exist, they must be radically cured. If stricture of the male urethra is found, or cystitis in either sex, these diseases must be removed. Constitutional disorders must also be treated, constipation corrected, and

good digestion secured. If no constitutional or local diseases are found, the itching is probably a neurosis. If due to disease of the brain or spinal cord these organs are to be treated; if to the nerves themselves surrounding the anus, the forced dilatation of the anus should be tried, in order to stretch the anal nerves.

Local applications are often successful, and yet in many cases they totally fail. It is well to have a good list of them for trial.

In case of pediculi, mercurial ointment is sufficient. If ascarides are present, a weak solution of carbolic acid injected into the rectum at evening is at least a temporary help. After trying varied vermifuges, we find that sulphur given internally seems to be one of the best destroyers of the worms, but it does not make absolutely complete work. It should be followed by some purgative containing rhubarb and aloes, or other stimulants to the mucous follicles of the lower bowel. Whenever the patient has a pretty complete emptying of the bowels with free discharge of rectal mucus, he invariably remains free from trouble for a considerable period, as the habitat of the worms is in the mucus, and mucus evacuations sweep them out more effectually than any others.

When the microscopic fungi are the cause, sulphur, sulphurous acid, bichloride of mercury, and iodine can all be used in quantities and strength adapted to the case. Dr. Carson "cuts" a drachm of camphor, in a trifle of alcohol, and then rubs it up in an ounce of lard, and looks upon it as almost a specific, if well rubbed upon the anus, and also put into the rectum. In all cases the parts should be well washed with soap and hot water before applying the local remedies—and in many, a washing out of the rectum with the same, through a double canula, is also necessary. When simple chafing is the cause of pruritus, a powder of sub-nitrate of bismuth, precipitated chalk and starch, is curative. Professor Matthews, of Louisville, highly praises "campho-

phenique," or camphorated phenol. This is made by rubbing together one part of crystalized carbolic acid and two parts of camphor. The product is a liquid, which is allowed to stand some hours, and is then washed with water before using.

Compresses of hot water, as hot as they can be borne, relieve many cases of a certain type. Compound tincture of green soap, and according to the following formula, is added by Kelsey to the hot water compresses.

R	Saponis viridis,	}aa ʒj
	Ol. cadini,		
	Alcohol,		

Misce.

The following are useful:

R	Chloroformi.....	fl. ʒj
	Ung. oxid. zinc.....	ʒj

Misce.

R	Mur. cocaine.....	gr. xv
	“ morph.....	gr. x
	Acid carbol. cryst.....	ʒj
	Tinct. aconiti rad.....	fl. ʒiij
	Unguent. petrolii.....	ʒj

Misce.

This must not be inserted inside the verge in large doses.

Allingham highly praises the following:

R	Liquor carbon. detergentis (Wright's) ..	fl. ʒj	
	Glycerinæ	fl. ʒj	
	Zinci oxid pulv.,	}aa ʒss
	Calamin. prep.,		
	Sulphuris precip. pulv.....	ʒss	
	Aquæ pur.....	ʒvj	

Misce.

Also this by the same author:

R	Sodæ borat.....	3ij
	Morph. hydrochlor.....	gr. xvi
	Acid. hydrocyan. dilut.....	fl. ʒss
	Glycerinæ.....	fl. ʒij
	Aquæ.....	fl ʒviij

Misce.

Kelsey advises this:

R	Acid. carbol.....	ʒss
	Glycerinæ.....	fl. ʒj
	Aquæ.....	fl. ʒiij

Misce.

It is pretty strong, and often requires to be diluted.

Kelsey also advises the following:

R	Chloral.....	ʒj
	Camphoræ.....	ʒj
	Ung. petrol.....	ʒj

Misce.

R	Menthol.....	ʒj
	Ol. amygd. dule.....	fl. ʒj
	Acid carbol.....	ʒj
	Zinc. oxid.....	ʒij
	Cerat simp.....	ʒij

Misce.

R	Ung. picis.....	ʒiij
	“ belladon.....	ʒij
	Tr. aconiti rad.....	fl. ʒss
	Zinci oxid.....	ʒj
	Ung. rosarum.....	ʒiij

Misce.

Carson's formula is:

R	Camphor.....	ʒj
	Alcohol.....	q. s
	Dissolve and add to lard.....	ʒj

Misce.

We recommend as satisfactory in some obstinate cases Johnston's formula:

R	Sod. hyposulphitis.....	3viiss
	Acid carbol.....	gr. lxxv
	Glycerinæ.....	3iv
	Aquæ.....	3viiss

Misce.

When any of these are found too strong they require to be diluted or weakened. Those containing powerful narcotics must not be inserted in too large doses into the rectum.

Allingham finds that the mechanical pressure of a hard pad bound against the anus, or the insertion of a smooth hard rubber plug into the rectum is a substantial relief to some patients.

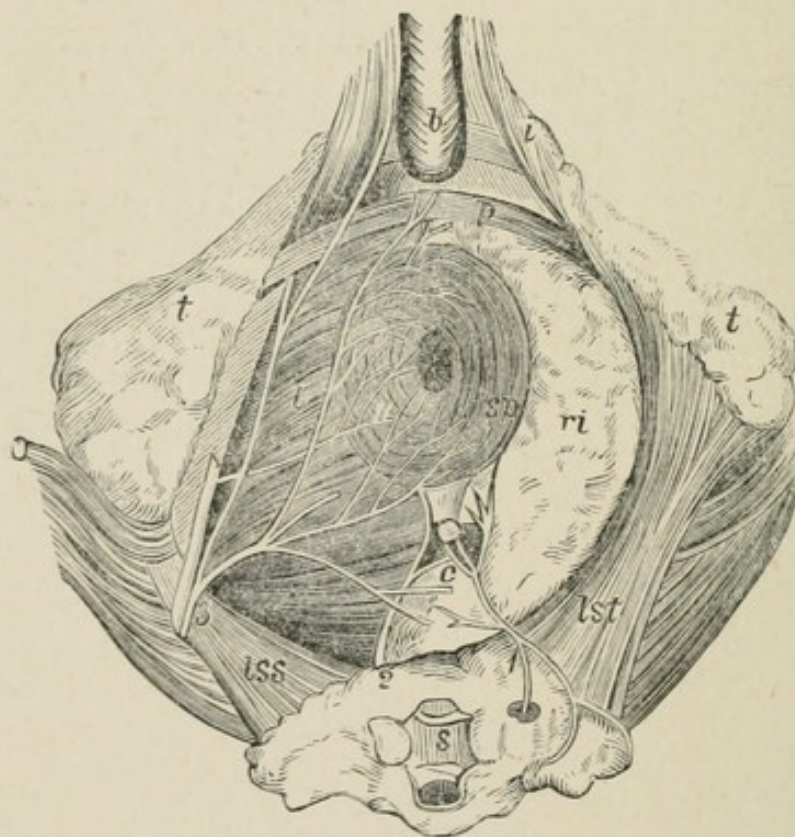


FIG 53.—NERVE DISTRIBUTION ABOUT THE ANUS.

1. Sacral Nerves; posterior root distributed to surface of coccyx and external sphincter. 2. Anterior root, to external sphincter. 3. Pudic nerve and its branch, the inferior hæmorrhoidal. *t.* Tub. ischii. *s.* Sacrum. *c.* Coccyx. *sp.* Ext. sphincter. *l.* Levator ani. *p.* Transversus perinei. *ri.* Ischio-rectal space.

Nerve Stretching.—A sort of nerve stretching accomplished by forcibly dilating the sphincters has a curative effect on some obstinate cases of pruritus, which are probably to be classed as neuroses.

The cut on preceding page (after Hilton) gives a clear representation of the local nerve distribution.

APPENDIX AND FORMULARY.

SECTION I.

1. *Contract of "Rectal Specialist."*

The following is an exact copy (personal items being omitted) of a contract to cure piles shown us by a patient who was still suffering from that affection. The method used by the guarantor of the cure had been the hypodermic injection and the relief obtained had continued a number of years.

I hereby agree to pay to Dr. ——— & Co. the sum of[25 dollars].....to cure me of.....[piles]..... with which disease I am afflicted. The above amount to be paid to Dr. ——— & Co. as soon as cure is effected. Cure agreed to be complete when the.....[tumors are removed]....

I further agree to go to the office of Dr. ——— & Co.and submit to treatment. Should I neglect or refuse to go and submit to treatment as above agreed, without some providential hindrance, then the above shall become due and payable the same as if I had been cured.

[Signed] ———.

Rec'd payment ———

The use of such contracts is not only unprofessional, but does nothing toward raising an operator in the estimation of intelligent patients.

2. For use upon instruments and fingers.

R Acid. boric..... $\overline{3}$ ss—j

Ung. petrol..... $\overline{3}$ j

M. Keep in collapsible tubes.

3. For instruments and fingers.

- ℞ Ung. petrol..... $\bar{3}$ j
 Acid. carbol.....gr. xxv
 M. Keep in collapsible tubes.

SECTION II.—PROCTITIS.

4. For acute proctitis.

- ℞ Tr. opii.....x-xxx
 Mucilage of starch..... $\bar{3}$ ij

5. For acute proctitis.

- ℞ Iodoform..... $\bar{3}$ i
 Ext. belladon.....gr. v
 Pulv. opii.....gr. x
 Ol. theobrom.....q. s
 M. Ft. Suppositories No. XII.

6. For acute proctitis.

- ℞ Liq. carbonis detergent..... $\bar{3}$ ii
 Tr. krameriaë..... $\bar{3}$ iv
 Mucil. amyli.....q. s. ad. $\bar{3}$ iv
 M. S. Inject $\bar{3}$ i morning and night.

7. For acute proctitis.

- ℞ Liq. bismuth..... $\bar{3}$ i
 Mucil. amyli... .. $\bar{3}$ vi

8. For acute proctitis (Dr. J. M. Mathews, Louisville).

- ℞ Sub-nit. bismuth..... $\bar{3}$ j
 Iodoform.....gr. x
 Sweet almond oil..... $\bar{3}$ j
 M. S.—Inject.
- ℞ Fluid hydrastis..... $\bar{3}$ j
 Aquæ..... $\bar{3}$ j
 M. S.—Inject.
- ℞ Listerine,
 Aquæ.....āā $\bar{3}$ j
 M. S.—Inject.

9. For chronic proctitis.

℞ Argent. nit. gr. v.
 Aq. dest. ℥ij

To be injected and removed by a subsequent enema.

SECTION III.—HÆMORRHOIDS.

10. For hæmorrhoids (where it is desired to confine the bowels after operation.—Allingham).

℞ Pulv. cretæ aromat. ℥j
 Tr. opii or liq. opii. sedativ. ʒ xv
 Spts. æth. nit. ℥j
 Mist. camphoræ. ℥iss

M. S.—To be taken night and morning for two or four days.

11. For hæmorrhoids (laxative).

℞ Magnes. sulph.
 Magnes. carb.
 Sulphur precipitat.
 Sacch. lactis. āā ℥ss
 Pulv. anisi. ℥ij

M. S. One or two teaspoonfuls in water at night (Prof. G. T. Elliot).

12. For hæmorrhoids (laxative, "*Pil quattuor*." Van Buren).

℞ Ferri. sulph. exsicc.
 Quiniæ sulph. āā ℥ij
 Ext. nuc. vomicæ.
 Ext. aloes. āā gr. xij

M. Ft. pil. No. XL. S. One three times a day.

13. For hæmorrhoids (laxative, "*Pil salutis*").

℞ Ext. aloes.
 Ext. hyoseyami. āā ℥j
 Ext. nuc. vomicæ. gr. iv
 Ol. anisi. gtt. iv

M. Ft. pil. No. LX.

14. For hæmorrhoids, with ulceration (Allingham).

℞ Bismuth. sub-nit. ʒij
 Hydrarg. chlor. mit. ʒij
 Morph. sulph. gr. iij
 Glycerinæ. ʒij
 Ung. petrol. ʒj
 M. S. Use in pile syringe.

15. For hæmorrhoids.

℞ Acid. tannic. ʒij
 Ext. belladon.
 Pulv. opii. āā ʒss
 Ung. petrol. (or lanolin). . . . ʒj
 M. S. Apply inside and outside.

16. For hæmorrhoids.

℞ Cocaine hydrochlor. gr. x
 Ol. theobrom. q. s
 M. Ft. Suppositories No. XV.

17. For hæmorrhoids (Ball).

℞ Morph. hydrochlor. gr. x
 Ext. belladon.
 Acid. tannic. āā ʒj
 Vaseline.
 Lanolin. āā ʒj
 M.

18. For hæmorrhoids.

℞ Chrysarobin. gr. xx
 Iodoform. gr. vi
 Ext. belladonnæ. gr. v
 Cacao butter. ʒvi

M. Sig.—For ten suppositories. One each day.

By substituting vaseline for cacao butter the same formula makes an ointment for external piles.

19. For eczematous external hæmorrhoids (Ball).

℞ Liq. carbonis detergentis. . . . ʒj
 Liniment. calcis. ʒv

20. For inflamed external hæmorrhoids (Yount).

- ℞ Cocaine hydrochlor. gr. v
 Ext. belladon.
 Ext. opii.
 Ext. aconite.
 Ext. stramonii. āā 3ij
 Glycerinæ. 3ss
 M. S. Apply on cotton or lint continuously.

21. For hæmorrhoids.

- ℞ Plumbi subacet.
 Bals. Peru.
 Ext. belladon.
 Zinci. benzoat. āā 3j
 Adipis 3j
 M.

22. For hæmorrhoids (with tenesmus).

- ℞ Pulv. opii.
 Ext. belladon. āā gr. x
 Ol. theobrom. q. s
 M. Ft. Suppositories No XV.

SECTION IV.—HÆMORRHOIDS (2).

23. For hypodermic treatment of hæmorrhoids (Powell).

- ℞ Acid. carbol. (crystals) gr. xx—3ij
 Tr. thujæ 3j
 Aq. dest. q. s. ad 3j
 M.

24. For hypodermic treatment of hæmorrhoids (early formula).

- ℞ Acid. carbol. (crystals). 3ij—3iv
 Glycerinæ. q. s. ad 3j
 M.

25. For hypodermic injection of hæmorrhoids (not much used).

R Acid. carbol. (crystals)...95 per cent
 Aq.....5 per cent
 M. S. 95 per cent. sol. carbolic acid.

26. For hypodermic treatment of hæmorrhoids (Overall).

R Acid. carbol. (crystals melted).
 Fl. ext. ergot.
 Ol. olivæequal parts.
 M.

27. For hypodermic treatment of hæmorrhoids ("Brinkerhoff System").

R Carbolic acid..... $\bar{5}j$
 Olive oil..... $\bar{5}v$
 Chloride of zinc.....grs. viij
 Mix.

The little pamphlet furnished to the itinerants purchasing the "System" directs that the amount of injection inserted into the tumors shall be as follows:

Largest Piles.....	8 minims
Medium ".....	4 to 8 "
Small ".....	2 to 3 "
Club-shaped painless piles near orifice	2 "

"Brinkerhoff's System" forbids the injection of any but internal piles.

28. For hypodermic treatment of hæmorrhoids ("Rorick System").

R Carbolic acid.
 Glycerinæ..... $\bar{a}\bar{a}$ $\bar{3}ij$
 Fl. ext. ergot..... $\bar{3}j$
 Water..... $\bar{7}ss$
 Mix.

29. For hypodermic treatment of hæmorrhoids ("Painless injection" of Dr. Green, a traveling pile doctor).

℞ Carbolic acid..... $\bar{5}$ j
 Creosote.....gtt. x
 Acid. hydrocyanic.....gtt. j
 Olive oil..... $\bar{5}$ i

Mix and unite under water. Sig. Inject enough to turn the tumor an ashen grey color.

30. For hypodermic treatment of hæmorrhoids. (Dr. Silas T. Yount of Lafayette, Ind., advocates very weak injections, *viz*):

℞ (5 per cent. sol).
 Acid. carbol.....gr. xxiv
 Aq. dest..... $\bar{5}$ j

M.

℞ (3 per cent. sol).
 Acid. carbol.....gr. xviss
 Aq. dest..... $\bar{5}$ j

M.

31. We have given weak solutions a thorough trial and abandoned them, for the reason that they give a maximum of swelling and pain with a minimum of curative effect. Strong solutions in our hands give little or no pain, very limited swelling and more certainty of action. We can speak highly of Dr. Agnew's formula (San Francisco).

℞ Acid tannic. Squibbs..... $\bar{5}$ ij
 Glycerinæ $\bar{5}$ ss

Mix and add:

Acid salicylic.
 Sod. boratis.....āā $\bar{5}$ ij
 Acid carbol. 95 per cent.... $\bar{5}$ ss

M. S.—Inject 3 to 30 minims.

No 31 is modified by Agnew from

32. Shuford's formula.

R Sod. borat.
Acid salicylic.
Glycerinæaa 3j
Acid. carbolic.....3iij

SECTION V.—FISTULA.

33. For fistula (Itinerant method).

R (First step).
Hydrogen peroxide.....3j—3iv
Aq.....q. s. ad 3j
M. S. Inject the fistula deeply.

34. R (Second step).

Acid. carbol.....gr. xl—3j
Glycerine or alcohol.....q. s
Aq.....q. s. ad 3j

M. S. Inject 15 drops after the hydrogen bubbles have ceased.

Or (Brinkerhoff)

35. R Dist. ext. hamamelis.....fl. 3v
Liq. fer. subsulph.....fl. 3j
Acid. carbol. cryst.....gr. ij
Glycerinæ.....fl. 3ij

M. S. Inject ten or fifteen drops deeply into the fistula, and press the track of the fistula with the finger, to force the fluid more deeply in.

Many itinerants finish the operation two hours later by injecting the fistula with equal parts of oil of euclayptus and glycerine. In attempting this treatment always keep the outlet of the fistula dilated with a bone collar button.

SECTION VI.—FISSURE.

36. For fissure of the anus.

R Corrosive sublimate.....gr. j
Cryst. carbolic acid.....℥ ij
Hydrochlorate of morphia. gr. v
Water.....fl. 3iv
M. S. Apply with a camel's hair pencil.

37. For fissure (Allingham).

℞ Hyd. sub. chlor. gr. iv
 Pulv. opii. gr. ij
 Ext. belladon. gr. ij
 Ung. sambuci. ℥j

M. Sig. Apply several times a day.

38. For fissure.

℞ Hydrarg. oxid. flav. gr. xxx
 Ung. petrol. ℥i

39. For fissure.

℞ Iodoform. ℥j
 Belladonna ointment. ℥ss
 Carbolic acid. gr. x
 Simple cosmoline. ℥ss

M.

Apply this ointment thoroughly every day, after having each time cleansed the sore with antiseptics, and touch with nitrate of silver very gently every third day.

SECTION VII.—ULCERS.

40. For rectal ulcers (see also Nos. 4, 5, 6, 7, 8, 9).

℞ Argent. nit. gr. ij
 Aq. dest. ℥j

M. S. Inject and wash out with warm water.

41. For rectal ulcers.

℞ Iodoform. ℥ss
 Bismuth. subnit. ℥j
 Morph. sulph. gr. j
 Ol. theobrom. q. s

M. Ft. Suppositories No. X. S. Insert one, morning and night.

SECTION VIII.—PROLAPSUS.

42. For prolapsus (Itinerant method).

℞ Cocaine hydrochlor.
Phenol sodique.....āā gr. viij
Aqʒj

M. S. Inject in spots one inch apart over the tumor.
("Brinkerhoff's system" advises its followers to avoid treating prolapsus.)

43. For prolapsus (Vidal de Cassis).

℞ Ext. ergot. fl.....ṁx—Lx
S. Inject with hypodermic syringe.

SECTION IX.—PRURITUS.

44. For pruritus ani (parasitic form).

℞ Camphor.
Spts. rectific.....āā ʒj
Adipisʒj
M. S. Inside and outside the rectum.

45. For pruritus ani (Kelsey).

℞ Saponis viridis.
Ol. cadini.
Alcohol.....āā ʒj
M.

46. For pruritus ani.

℞ Chloroformi.....fl. ʒj
Ung. oxid. zinc.....ʒj
M.

47. For pruritus ani.

℞ Mur. cocaine.....gr. xv
Mur. morph.....gr. x
Acid. carbol. cryst.....ʒj
Tinct. aconiti rad.....fl. ʒiij
Unguent petrolii.....ʒj
M.

This must not be inserted inside the verge in large doses.

48. For pruritus ani (Allingham).

R	Liq. carbon. deter. (Wright's) . . . fl.	℥j
	Glycerinæ	fl. ℥j
	Zinci. oxid. pulvi, }	
	Calamin. prep., }	āā ℥ss
	Sulphuris precip. pulv.	℥ss
	Aquæ pur.	℥vj

M.

49. For pruritus ani (Allingham).

R	Sodæ biborat.	℥ij
	Morph. hydrochlor.	gr. xvi
	Acid. hydrocyan. dilut. . . . fl.	℥ss
	Glycerinæ	fl. ℥ij
	Aquæ.	fl. ℥viij

M.

50. For pruritus ani (Kelsey).

R	Acid carbol.	℥ss
	Glycerinæ	fl. ℥j
	Aquæ	fl. ℥iij

M.

It is pretty strong, and often requires to be diluted.

51. For pruritus ani (Kelsey).

R	Chloral.	℥j
	Camphoræ	℥j
	Ung. petrol.	℥j

M.

52. For pruritus ani.

R	Menthol.	℥j
	Ol. amygd. dulc.	fl. ℥j
	Acid. carbol.	℥j
	Zinc. oxid.	℥ij
	Cerat. simp.	℥ij

M.

53. For pruritus ani.

℞ Ung. picis.....3iij
Ung. belladon.....3ij
Tr. aconiti rad.....fl. 3ss
Zinci oxid.....3j
Ung. rosarum.....5iij

M.

54. For pruritus ani.

℞ Ext. conii (freshly made).....3j
Lanolin.....3ij

M.

55. For pruritus ani (with external eruptions).

℞ Acid. salicyl.....gr. x
Spts. rectific.....3j

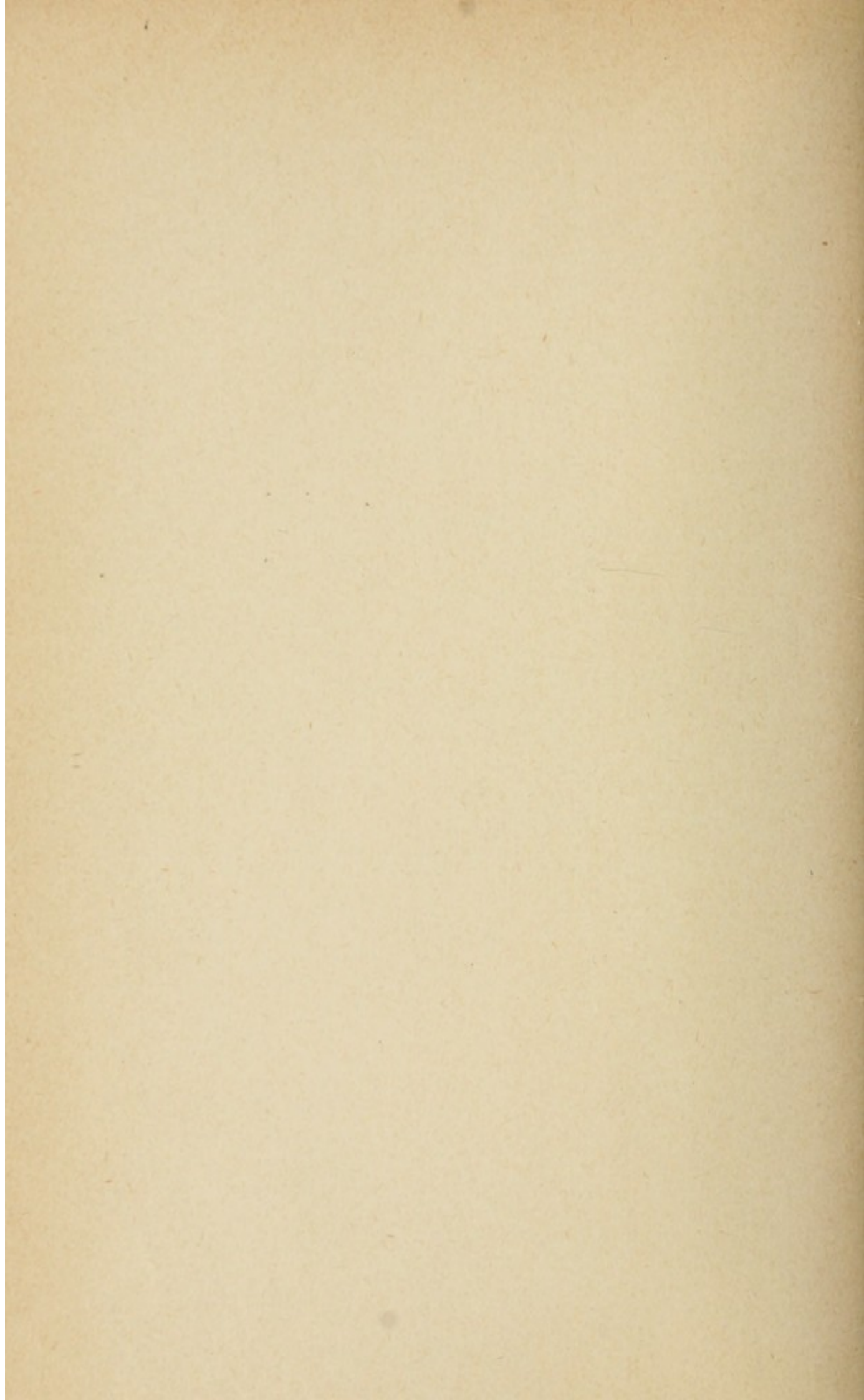
M.

56. For pruritus ani.

℞ Hypophosphite of sodium.....3j
Carbolic acid.....3ss
Glycerine.....fl. 3j
Listerine.....fl. 5iij

Mix. S. Use as lotion.

No. 56 is similar to Johnston's formula given on p. 142.



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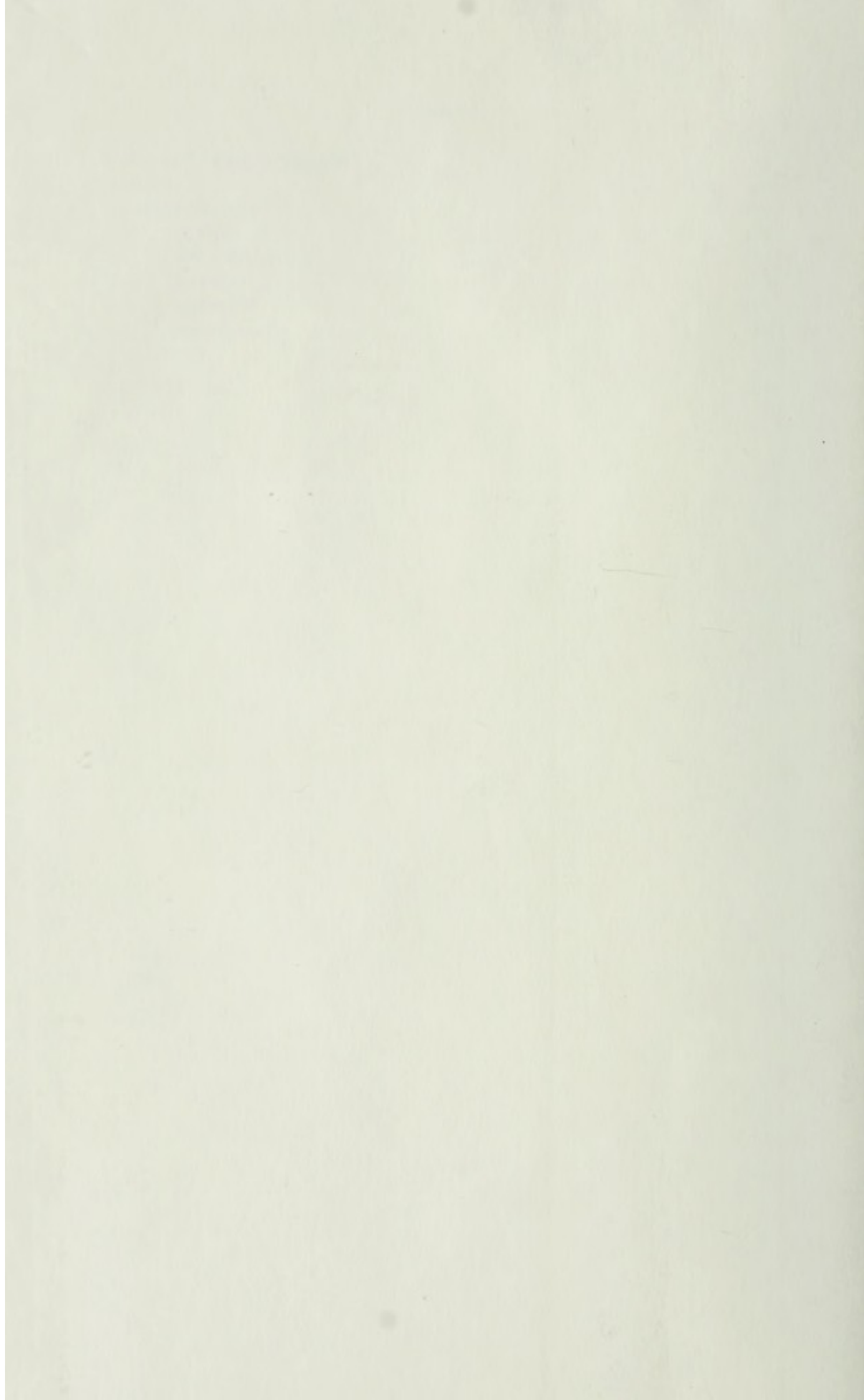
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