The diagnosis and treatment of hæmorrhoids, with general rules as to the examination of rectal diseases / Chas B. Kelsey.

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By Chas. B. Kelsey, M. D.

THE DIAGNOSIS AND TREATMENT OF HÆMORRHOIDS,

WITH GENERAL RULES AS TO THE

EXAMINATION OF RECTAL DISEASES.

—BY—

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PREFACE.

Concerning this little book it is only necessary to say that it contains the results of my own experience with the various methods of curing hemorrhoids up to the present time. It is written solely for my fellow practitioners, and with the wish that they may find it a safe guide in practice. In it many of the questions which are constantly asked as to the value of different operations will be answered as far as I am able to do so.

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CHAPTER I.

EXAMINATION AND DIAGNOSIS.

Generally, to one unaccustomed to the examination of patients suffering with disease of the lower bowel, the diagnosis is surrounded by many purely imaginary difficulties. This is shown by the fact that the first inquiry of almost all such practitioners is "What speculum do you use?" as though there must be some mechanical contrivance by which the senses of touch and vision can be so improved upon as to render the discovery of obscure troubles much simpler than it otherwise would be.

The same idea is well fixed in the minds of patients who, under the false idea that an examination and diagnosis necessarily mean a painful use of instruments, will defer treatment until disease has made irreparable progress. The surprise of such patients when a diagnosis is made by mere sight, or at most by a painless digital examination, is only equalled by that of the young practitioner when he is told that only in exceptional cases is it necessary to use any instrument whatever.

The secret of successful diagnosis of these diseases consists in taking nothing for granted. Every affection of the lower four inches of the bowel can be both seen and felt if the practitioner will only take the necessary trouble to go about it in the proper way;

and a disease which can be felt and looked at is generally easy of diagnosis. The man who fails to detect the nature of a rectal trouble is generally the one who has refused to employ the necessary and yet simple methods by which alone a diagnosis can be reached ; and the man who acquires a reputation as a diagnostician in this department is the one who simply uses his eyes and his fingers, and refuses to deceive himself by jumping at conclusions in the dark.

To one in the daily practice of any department of surgery a routine practice soon recommends itself as most likely to eliminate errors and lead to a correct conclusion ; and the following is the one which has been adopted by myself, and one to which every patient great or small, male or female, submits.

The patient's name, age, condition in life, etc., are first entered in a case book. Next he or she is urged to tell the story of the disease in all its details, and this story is never interrupted or cut short ; for in the nervousness of a first visit, often made at great expense of time and trouble, and with the fear of a painful examination before their minds, a nervous patient will often begin the history of his sufferings backward, and if allowed to recover himself by a few sympathetic words will not infrequently give the gist of the whole matter at the very end. This takes time, but time is never of any moment until the diagnosis has been made. It is often necessary to devote an hour or more to the first examination of a patient, but

no patient should be allowed to end his first visit until a diagnosis has been made or the surgeon acknowledges to himself his inability to make such diagnosis.

By the time the patient has told the story the surgeon should be in the possession of certain information, and if not he must proceed by a few direct questions to try and obtain it. What he must know is this. How long has the patient been sick? Is there any pain, if so of what character, and is it in any way dependent upon the evacuation of the bowels? Is there any protrusion of the bowels at stool, and if so what is its character, and does it return spontaneously or is it necessary to replace it? Are the bowels regular or is there diarrhœa, and of what character? Is there any bleeding? In addition it must be discovered whether there has been emaciation, febrile action, and discharge of any sort.

From such a verbal examination much may be gained. In fact the positive diagnosis can sometimes be made. But, on the other hand, it is astonishing how often the most intelligent patient will utterly mislead the examiner; and though I have great confidence in this indispensable history as a prelude to actual examination, considerable experience has taught me *never* to trust to it alone, for the simple reason that although it may convey all the information necessary, the surgeon is never sure that he is not being unwittingly led upon a false track by the most intelligent answers his patient is able to give.

For example : A gentleman whose medical fame has extended wherever medical literature is read, came to me some time since for "piles which had troubled him ever since he could remember." He was sure he had them when seven or eight years old, and an examination showed three very large fibroid polypi. Another told me he suffered only from severe pain at defecation, but asserted that "there never was any tumor to speak of." Of course I examined him for fissure, but none existed. Then after an enema, he again placed himself on the table and showed a cluster of well-developed internal hemorrhoids, tightly constricted by the sphincter.

A patient with the strongest motive for conveying all the information in her power, is often unable to do so except in language which though perfectly true, will convey an entirely different idea to the physician from the correct one. I have just returned from the bedside of a lady upon whom I operated a few days ago for a laceration of the neck of the womb and large hemorrhoids. Her nurse informed me yesterday with an air of great wisdom that the whole bowel came down for an inch or more, all around, whenever she had a passage, and the patient had already told her lady friends that she was quite sure the operation was a failure. The most careful questioning of both patient and nurse brought out the facts that every time the bowels had moved since the operation there had been a protrusion ; that this tumor was fully an

inch in length ; that it completely surrounded the anus and went back spotaneously with more or less pain. Failing to weaken this testimony by any cross-questioning, I had about made up my mind that the patient was suffering from an invagination and asked for an examination. She was placed on the commode, the protrusion was pressed down, she moved gently back into bed and I was called from the next room, but the tumor had disappeared. It had, however, been "fully an inch long," as usual. Another attempt was made and the tumor was again brought down in the same way, and this time I saw it in its enormity. It consisted of a slight eversion of the muco-cutaneous junction of the anus—the pedicles of the very large hemorrhoidal tumors I had removed. In this case the anus was very patulous, the patient of very slight muscular power and of relaxed fibre, and at the operation it had been a question as to how much of the muco-cutaneous tissue to remove. Enough was taken off to cure the patient but not enough to cause a subsequent stricture, and when the swelling subsides she will be perfectly satisfied, and there will be no eversion.

This is but an example of how little positive information many patients are able to give their physicians as to their own condition. A prolapse two or three inches long and a simple pruritus will both be described as piles.

After this line of investigation has been exhausted the inevitable examination by touch and vision follows.

General practitioners tell me they have difficulty in obtaining the consent of patients to an examination. I never have had, save once. That case was a foreigner who told me when I proposed it that he "had entirely *too great a respect for me* to allow me to do such a thing." My only answer was that I had too great a respect for myself to treat him without knowing what was the matter, and we parted amicably.

And yet an examination to a lady is not a pleasant thing. It is in fact a thing which will cause her to suffer silently for many years rather than submit to it. It is only when suffering has forced her to it that she will submit, but that point has always been reached when she consents to consult a sugeon or a specialist for treatment. Then she expects to be examined (in fact has very little respect for the surgeon if he does not examine), and it remains for him to make the unavoidable examination in the way least offensive to his patient.

For this purpose a trained female attendant should always be in waiting. After the history has been taken and the physician has in a measure gained the confidence of his patient, she is handed over to the nurse in waiting, who gives the enema, arranges the patient on the chair, covers her with a sheet, and when all is ready, signs to the doctor. His work may be done at a single glance, or may require careful investigation and examination with finger or instruments; but when it is done the patient is again given over to the nurse,

and when she is once more herself, the diagnosis is made and the question of treatment may for the first time be entered upon.

I do not know that it is necessary to dilate upon this point any further, except to say that I have found it best in my own practice to have two entirely separate waiting-rooms, one for ladies and the other for gentlemen. It is pretty well known that all patients who come to me have rectal disease, and ladies do not care to take their turn in the presence of several gentlemen. I have also a special apparatus for the administration of enemata, and in immediate connection with the examining-room there should always be a retiring-room and water-closet. This is absolutely indispensable, both for decent privacy of the patient and for thorough examination.

The enema may be given in any way most convenient, but often requires great gentleness on the part of the giver. For my own use I have rather an elaborate apparatus, consisting of a glass jar holding one gallon, which stands upon a shelf seven feet above the floor, and is filled by a rubber tube connecting with what is popularly known as a barber's faucet, by which either hot or cold water can be drawn from the same tube at pleasure. This, however, is useful for several other purposes besides the administration of an ordinary enema.

A small, smooth, glass tube may often be introduced with less pain than the usual metal tip of the

Davidson's syringe; and a small, soft rubber catheter answers an equally good purpose, but whatever instrument is used, should be either in the hands of the surgeon or of an intelligent nurse.

The examination may be made on any ordinary operating table, or on a more elaborate gynæcological chair, as the operator prefers. Since, however, there is a good deal of gynæcological work to be done in connection with this specialty, the patient should be enabled to assume Sims's position with ease. For a rectal examination alone, in male or female, the left lateral position is the best, and the correct Sims's position is not necessary. Either natural or artifical light may be used. For many cases there is little choice between the two, but for illumination within the rectal pouch artifical light has the advantage. For this reason I have long been in the habit of using a large and powerful lamp and lens, such as is used for laryngological examinations, and is figured in my work on Diseases of the Rectum.*

The small incandescent electric lights to be introduced into the bowel are of little use for ordinary examinations, because without ether and stretching of the sphincter, the lamp and speculum fill up the entire space and nothing can be seen, but under favorable conditions with a widely-dilated anus they may be of great practical advantage.

* Diseases of the Rectum, N. Y., Wm. Wood & Co., 1884, p. 63.

A better form of electric light is that manufactured by the "U. S. Electrical Co.," and shown in the cut. It can only be used with a storage battery, but it has this advantage, that it is portable, and is never obstructed by the head of the operator in his motions to obtain a good view.

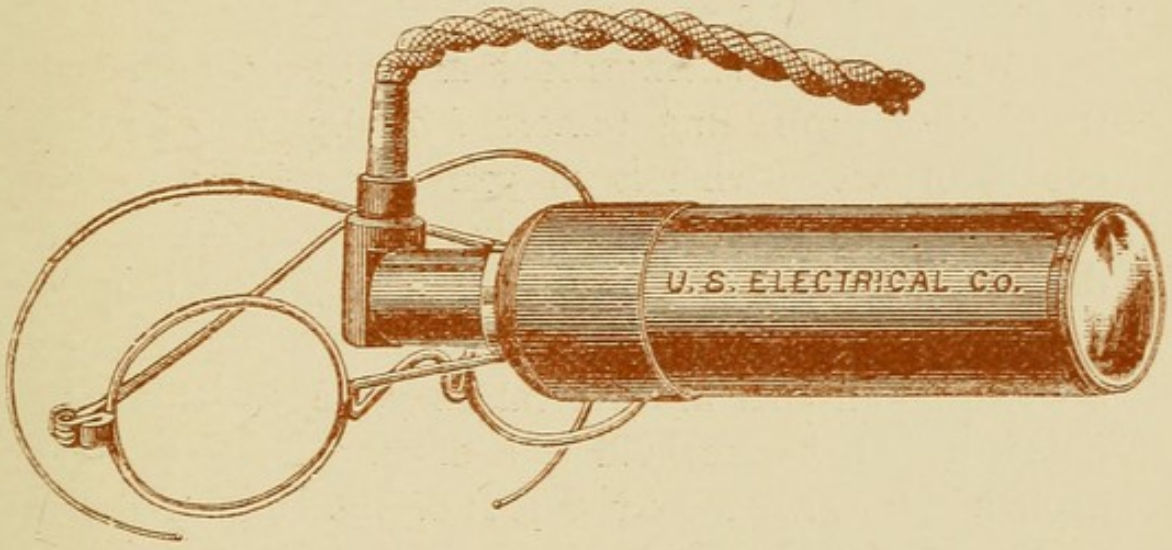

FIG. 1.

Suppose now that an enema has been given, the patient has strained down the protrusion which ordinarily takes place, and while it is down has taken the place upon the examining table in a good light.

If any protrusion at all be visible it will be one of the following things:

1. External hemorrhoids.
2. Internal hemorrhoids which have been brought to light.
3. Prolapsus.

4. Polypus.
5. Cancer.

As the patient is never able by a verbal description to enable the surgeon to decide which of these he is to treat, the necessity of this examination and the folly of dispensing with it become self-evident.

The various forms of external hemorrhoids will be described in the next chapter.

Where internal hemorrhoids are to be distinguished from other protruding tumors, I hardly know how to convey in words what is so perfectly evident to the eyes when one has seen, if only for a single time, the different varieties of tumors. The diagnosis is generally between hemorrhoids and prolapse, and where the two conditions are typical they are easily distinguished. An hemorrhoid is a distinct, varicose new growth. It springs from a part of the circumference of the rectum or anus, and when it protrudes it generally drags down the margin of the anus to which it is attached. When several hemorrhoids protrude several different points of the anal circumference are involved, and the tumors all meet in the centre, some larger and some smaller, like a bunch of large and small grapes, but all trying to get out of the anus at the same point and filling up the outlet. With prolapsus the condition is different. The bowel is telescoped into itself from above, and what protrudes is normal gut and not a new formation. The protrusion is attached evenly all around; it is composed of comparatively healthy

mucous membrane, and it does not spring from the muco-cutaneous verge of the anus, but is a part of the rectum proper, and is therefore covered by mucous

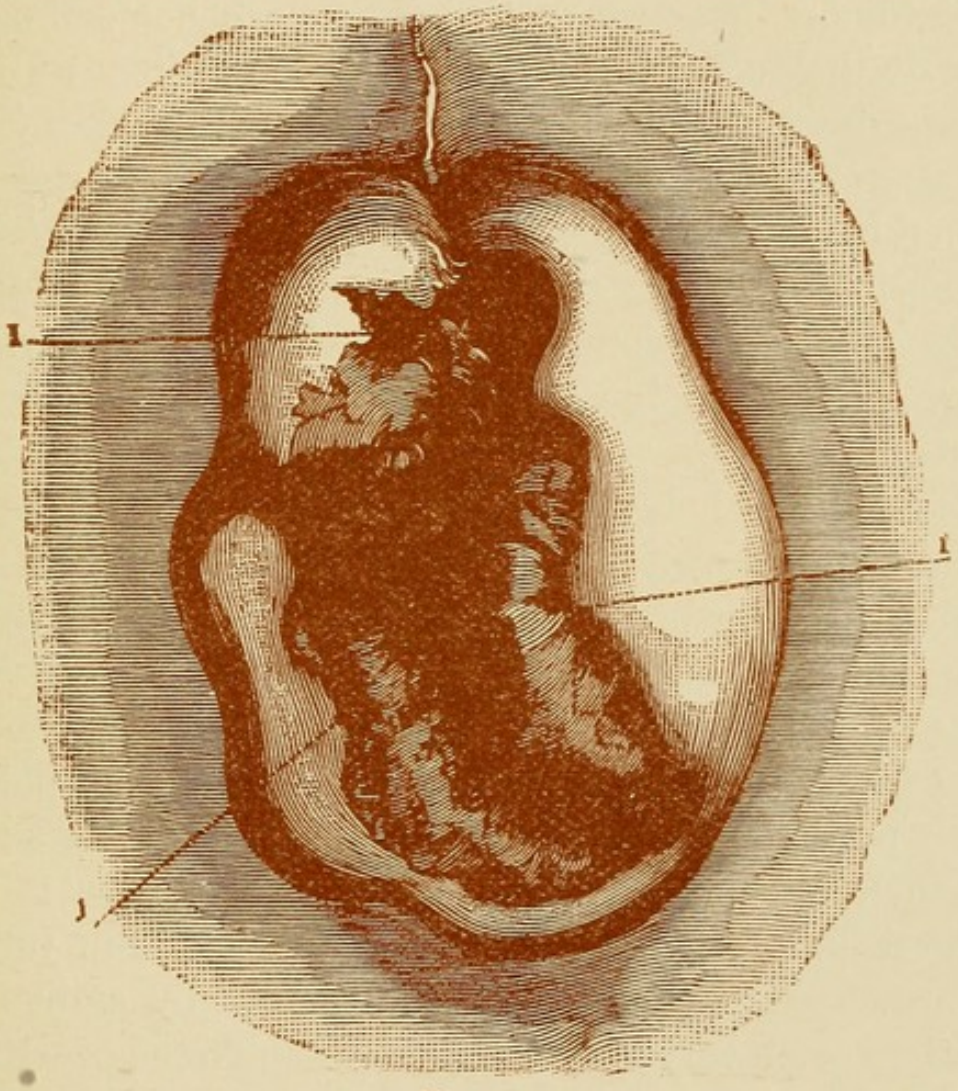

FIG. 2.

membrane, and not by skin and mucous membrane. It is one tumor and not several; and yet there is a form of disease in which the protrusion is made up entirely of the muco-cutaneous verge of the anus—swollen, enlarged, prolapsing it is true, but without

distinct hemorrhoidal tumors. The patient strains down and the margin of the anus turns out with skin on one side and mucous membrane on the other. The tumors thus formed are not properly hemorrhoids, nor do they constitute a prolapse, though they will be found described under both heads. If the sphincter be stretched the patient will be found to have large internal hemorrhoids which, by their mechanical effects, have loosened the cellular tissue at the verge of the anus. The condition to which I refer is well shown in Fig. 2, in which the part marked 1, is covered by mucous membrane, and the others by skin. And this condition may sometimes lead the operator to wonder in his own mind whether he is operating for hemorrhoids or prolapse ; but since the operation is the same in both cases, and invariably cures the patient, there is not much in the name.

Internal hemorrhoids are distinguished from polypi both by the appearance of the tumors themselves and by their attachment. In the former the base is the largest part of the tumor. In the latter the tumor is attached to the wall of the rectum by a distinct pedicle often very long and delicate. To the practised eye the appearance of the presenting tumor is sufficient for a diagnosis, but the difference between the two though easily appreciated by sight is difficult to express in words. The polypus is generally harder, firmer, and contains more connective tissue. It is also apt to be mamellated like a mulberry, while the mucous

membrane covering a hemorrhoid is tightly stretched and even. The pedicle, of larger or smaller size, is, however, the diagnostic point. A tumor the size of an egg, attached by a stalk the size of a lead pencil has little resemblance to a hemorrhoid.

Between polypus and prolapse the diagnosis is easy with care, and yet within a short time physicians of skill have sent me cases in which there had been palpable error. The first was a polypus, said to be a prolapse, in which no examination had ever been made. The second was a prolapse, said to be a polypus and which really looked very much like one, but in reality was a protrusion of a small lateral section of the bowel, involving only a small part of its circumference.

Between a cancer and hemorrhoids a mistake can hardly be made when once the tumors are seen, though the history and symptoms may be exactly identical. A lady visited me from Albany some time since giving the ordinary history of painful and bloody passages with a tumor that protruded at stool but went back spontaneously or with slight pressure. On examining this tumor, which I supposed to be hemorrhoidal, I found an epithelioma protruding from the anus, which involved the entire circumference of the bowel, but began two inches above the external sphincter and extended from this point for a couple of inches upward. It was this tumor which acted like a foreign body and was expressed in each act of defecation.

Again, I have seen old cases of protruding and irreducible hemorrhoids which have been out of the body for years, so ulcerated, eroded, and granulated that they strongly resembled epithelioma of the anus, but such cases are very rare and the distinction can certainly be made by careful observation.

Suppose now that the patient has described a distinct protrusion at stool, but when the enema has been given, and the surgeon comes to examine, no such protrusion is visible, or can not be brought into view by any effort of the patient. It has simply "gone back." Under these circumstances I cannot too highly recommend an examination with the finger while the patient is straining in the ordinary position of defecation. Under these circumstances the expulsive effort has the greatest possible effect, and a slight protrusion often becomes perceptible to the touch which cannot be seen with the patient in the lateral position on a table.

Suppose, again, that the enema has been given, the patient is in position, and there is no protrusion. A careful inspection reveals no opening of a fistula, no fissure just within the anus, and no capillary hemorrhoid (to be described in the next chapter). In fact no disease is manifest.

The next step is a digital examination of the rectum. The right index finger is oiled and gently introduced through the sphincter. No force should be used. The muscle at first is inclined to spasmodic

contraction, but this, except in abnormal states, is easily overcome by gentle pressure, and the finger may be introduced its whole length. In this way the last three inches and a half of the bowel are brought within the sense of touch, and many of the common affections may be diagnosticated—cancer, stricture, ulceration, abscess, fistula, misplaced uterus pressing upon the bowel, and internal hemorrhoids which are not sufficiently developed to protrude. For hemorrhoids of the usual form may exist with all of the accustomed symptoms except protrusion—hemorrhoids of the internal variety which are attached high up, cause pain, bleeding, and other symptoms, and yet never come down below the sphincter.

These are to be diagnosticated by digital examination. It may take a long time to educate the finger up to the point of distinguishing these soft tumors from the folds of mucous membrane in the healthy bowel, but the facility must be acquired, and it can only be done by constant practice.

Let us suppose now, once again, that all this has been done, and yet the examiner has discovered no disease. At this point he must take a decided responsibility, for if from the patient's history he believes that rectal trouble exists, he must still go on and find it, but if he have no reason to believe this, he may abandon the search at this point and commit himself to the opinion that there is no rectal trouble.

If he decide to go still further, there is but one

line of investigation to be followed, and this consists in the administration of ether, the dilatation of the sphincter, and the use of the speculum.

It will be noticed that up to this time the question, "What speculum do you use?" has not been answered, and for the reason that up to this point in the examination I use no speculum; and as the vast majority of examinations will lead to a diagnosis before this point is reached, it follows that in about ninety per cent. of all my rectal cases I use no speculum at all.

An entirely too exalted idea of the value of the speculum exists. For ordinary examinations it is unnecessary, and the diseases which cannot be detected by the routine practice already described will not very often be detected by the simple use of any variety of this instrument. So strongly has this experience been impressed upon me that I have abandoned the use of every form of speculum *for ordinary diagnostic purposes*, unless at the same time its auxiliary means can be employed—the administration of ether. With ether, a light, and a speculum, a diagnosis may often be made which would otherwise be impossible; but to use a speculum, without ether, for the purpose of exploring the rectal pouch, is merely in the vast majority of cases to inflict useless suffering.

This does not apply to the question of treatment, but simply to diagnosis. For there exists a certain class of diseases, notably circumscribed ulcers, which, when their situation is accurately known, can be

brought into the field of vision by a speculum and thus treated by direct applications, but this is a very different matter from taking a patient who complains, perhaps, of but the single symptom of rectal pain, introducing some variety of speculum by which only the most imperfect view can be obtained, and because nothing is discovered (as in the vast majority of cases nothing will be), pronouncing the patient free from disease.

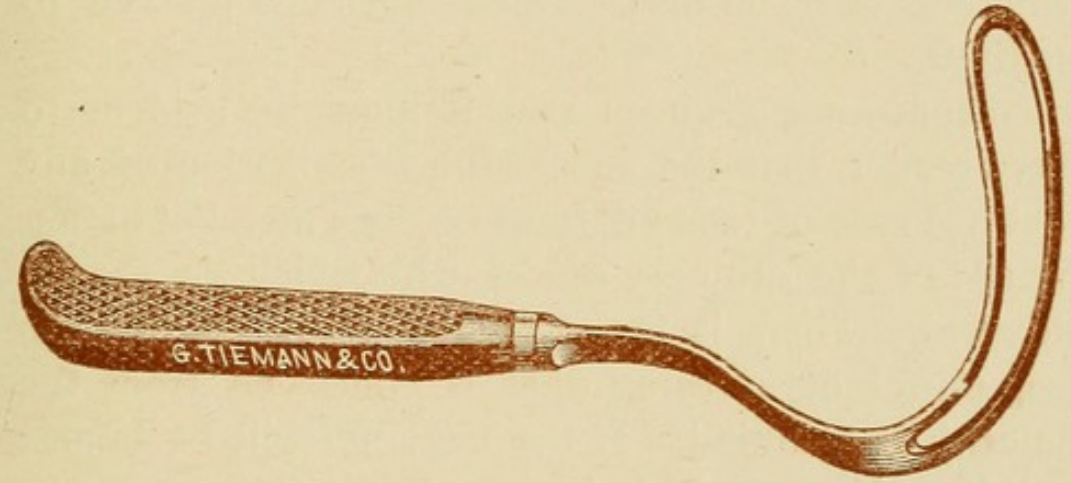

FIG 3.—AUTHOR'S RECTAL RETRACTOR.

I cannot make this point any stronger perhaps than by adding that whatever success I may have gained as a diagnostician in doubtful cases of rectal disease has come from the simple rule of etherizing my patient, dilating the sphincter, and then looking at what at once becomes plainly visible, viz. the whole lower five or six inches of the bowel. Under such circumstances, the simpler the instrument the better. A medium-sized blade of Sims's vaginal speculum answers

every purpose; or my own fenestrated rectal retractor which exposes more surface and takes up less room.

It requires some courage and self-confidence on the part of the examiner after making the usual visual and digital examination to say to his patient, "All this has led to nothing. I have no idea what is the matter with you. You must take ether, if you wish me to find out." But this is the only proper course, and should be a routine practice in every case where the symptoms of rectal disease are sufficiently marked to justify it.

From what has been said it must be evident to every reader that the successful examination of any doubtful case of rectal disease consists merely in making use of the ordinary senses, with which we are all provided. There is no occult faculty in all this, no deep power of knowing what is concealed from the majority of mankind. If the beginner will be honest with himself, and will insist upon seeing what is to be seen, and feeling what is to be felt, he will—except for the experience which only practice can give—make as good a diagnosis in his first case as the specialist who has practiced for a lifetime.

I can add nothing more to what has already been said on this point, except that the man who has foolishly allowed himself to be beguiled into prescribing some salve for a cancer, when he thinks he is treating hemorrhoids, because his patient objects to an examination, need not feel hurt when he finds himself placed

in a ridiculous light by some better man than himself, who has made his diagnosis before beginning treatment. All his tender regards for the foolish susceptibilities of his nervous lady patient will bring him no mercy in her judgment. She is willing to admit that she may have been foolish, but she will make no allowance for the foolishness of her physician, and in fact he deserves none.

There are but three ways of making a diagnosis—by question, by sight, by touch. The man who has exhausted these will seldom fail in his diagnosis, and should he do so, need not be ashamed. The man who neglects any one of them will, sooner or later, make some error which he might easily have avoided.

CHAPTER II.

THE DIFFERENT VARIETIES OF HEMORRHOIDS.

There are several perfectly distinct varieties of hemorrhoids, each requiring a different mode of treatment, and a treatment which is applicable to one may be entirely out of place in another.

Before discussing various modes of treatment, therefore, we must understand exactly with what we are dealing.

A patient presents himself complaining of hemorhoids with the usual symptoms, and an examination shows a slight swelling, perhaps the size of the end of the little finger, at the verge of the anus. This small round tumor may have any one of three distinct histories:

First.—It may have formed suddenly in the course of a few hours; may have been attended by considerable pain, and may have immediately driven the patient to seek relief. The patient has been unusually constipated in the morning, and may have strained a good deal at stool; or, he may have been up late on the previous night, have drank heavily, smoked a good deal, and lost more money at cards than he could well afford; or, without any of these palpable causes, he finds during the day that there is a sense of uneasiness at the anus, and by examining himself finds a small, round, sensitive tumor. At first he thinks nothing of

it, but as the pain increases he endeavors to push the offending swelling within the bowel, feeling sure that if it would only stay there he would find relief. The

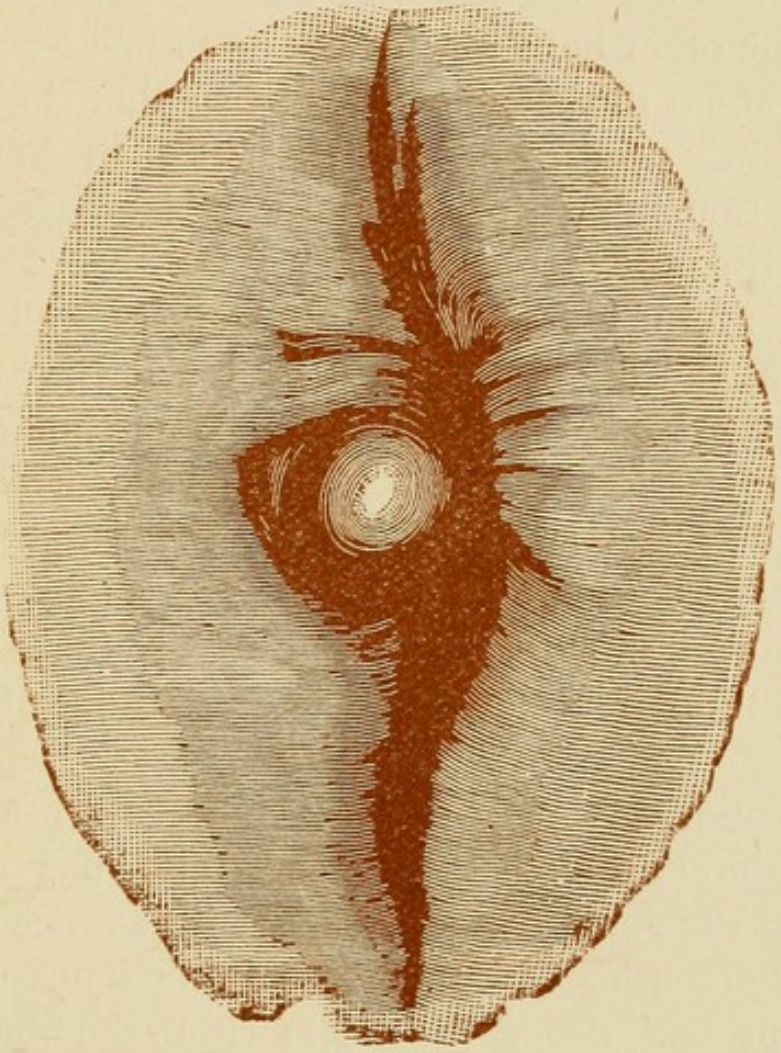

FIG. 4.

pressure gives temporary relief and as long as it is continued the tumor disappears, but the moment after it is removed the swelling is as large and painful as before. This usually goes on all day, but at night when the sufferer has gone to bed the pain is much

less, and in the morning he is quite sure that the trouble is past. After a few hours however, it is worse than ever, and then if he be at all inclined to take care of his own health he seeks medical advice. If, on the other hand, the patient be a sensitive woman, it is at about this stage of the disease that she takes a fine cambric needle and tortures herself by sticking it into the tumor. A drop of blood and increased suffering are the only results.

This form of external hemorrhoid is well shown in Fig. 4, and the pathology is well known. One of the small branches of the external hemorrhoidal veins has ruptured, and an extravasation has occurred in the surrounding cellular tissue just at the verge of the anus. The pain and swelling are due simply to the pressure of a small clot of blood, which by a simple incision through the skin may be turned out of its bed entire.

Second.—Another patient comes with a somewhat different history. He or she also has a small tumor at the verge of the anus, but it has been there for many months. It is only painful at times, but it is always present, never disappears within the bowel, and sometimes causes a great deal of suffering.

Here the tumor is evidently a tag of skin and is hard and solid, containing no clot of blood which shows by its dark color through the stretched skin. It may be red, swollen and painful, but the tumor itself is more apt to be comparatively insensitive, while

just at its base a distinct fissure of the anus is seen which is the cause of the pain. This form of external hemorrhoid can generally be traced to that which has just been described. The clot has become organized,

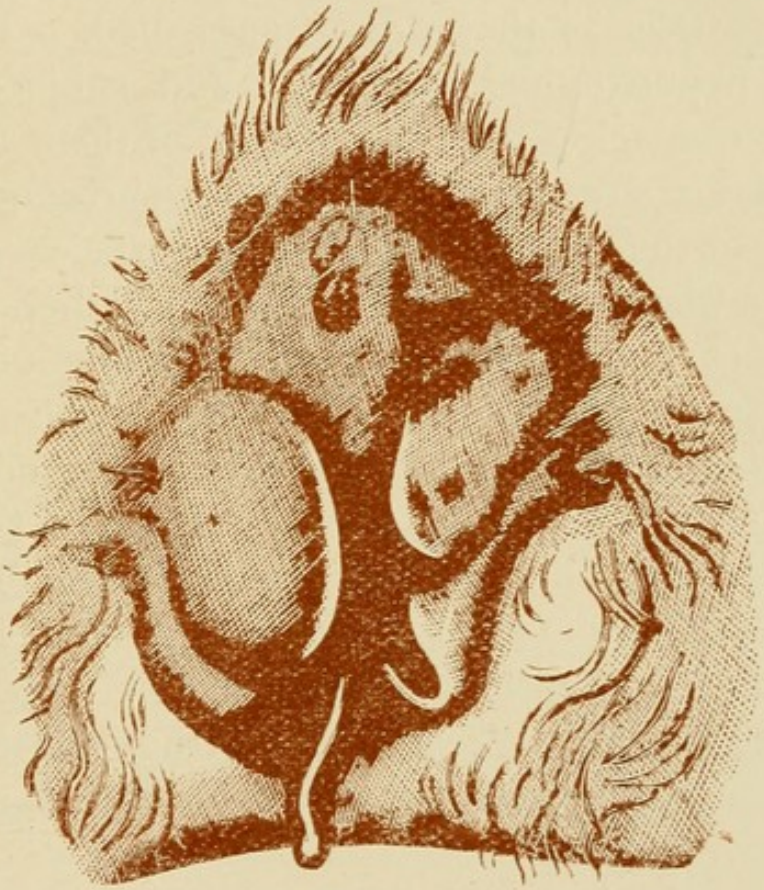

FIG 5.

the cellular tissue around it has become hypertrophied, the skin over it has been stretched till a permanent growth remains. This tumor is often passive for long periods of time, but at any moment from a slight cause which often escapes the knowledge of the patient it is liable to take on a subacute form of inflammation,

become red, swollen and painful, and cause great suffering.

Third.—The patient presents a circle of cutaneous tumors as shown in Fig. 5.

These also are cutaneous hemorrhoids or condylomatous tags as they are often called. They are merely hypertrophies of the skin and subjacent connective tissue, but there are several of them and they are of large size, almost completely surrounding the margin of the anus. The adjacent surfaces of these growths where they rub against each other, and the fissures at their bases between their points of attachment, are apt to be ulcerated. These are also external hemorrhoids, but they have been endowed with a peculiar significance by various writers, in that they are supposed to be proof of syphilitic disease of the rectum. There is I believe nothing in this idea, but there can be no mistake in the fact that they are indicative of serious disease within the bowel. This disease may be either syphilitic ulceration, stricture, or cancer.

Beyond this point I have never been able to trace the pathological significance of these tumors. They certainly, when largely developed as in the figure, indicate grave disease above the sphincters, and are due generally to the irritation of the discharge from such disease, but they are not diagnostic of the character of that disease.

Here, then, we have three distinct varieties of ex-

ternal hemorrhoids, and it must be perfectly evident that they are not all amenable to the same form of treatment, nor are any of them to be treated as would be one of the bleeding growths just within the anus, which will be referred to; or as a large, prolapsing varicose tumor arising above the sphincters, and only appearing outside the body as a result of straining at stool.

There is still another form of external hemorrhoid which differs from any yet described. In it there is little or no hypertrophy of the skin and subcutaneous connective tissue, as in the last, nor is there any blood-clot as in the first, but when the patient strains down there is a tumor formed just at the verge of the anus, and rather on the cutaneous than mucous aspect. The tumor is nothing more or less than a varicosity of an external hemorrhoidal vein, and the vessel may often be distinctly seen through the normal and delicate skin. Such a tumor is not painful, and causes no symptoms except in persons of extreme sensitiveness, who are sometimes very much worried lest it should result in something more serious.

All the forms of hemorrhoids thus far described are covered by skin rather than mucous membrane, and all of them spring from the margin of the anus. None of them arise from within the sphincter and come outside, and none of them can be forced within the bowel and made to remain there. They are all varieties of what are known as external hemorrhoids,

from their situation, to distinguish them from the internal or those which develop within the rectum proper. This distinction between external and internal is generally very well drawn, and the two forms are easily distinguishable; but in some cases the growths so involve the margin of the anus on both its mucous and cutaneous surfaces that it is impossible to say to which class they properly belong. They are partly covered by skin and partly by mucous membrane; they may in great measure be replaced within the bowel, but not entirely; and they turn out again on the least straining or exertion; and they are liable to bleed, which none of the other forms, described as purely external, ever do.

Again, there is the large internal hemorrhoid, shown in Fig. 2. This arises from the rectum proper, and may go on developing for years before it ever appears outside of the sphincter. While still comparatively small, and before the patient has ever had any protrusion at stool, it may give rise to all of the symptoms of hemorrhoids, except those due to the forcing of the tumors outside the body. In other words, the patient may have pain, bleeding, discomfort in defecation, pain in the loins, thighs and legs, slight mucous discharge with or between the passages, itching to an annoying extent, and often a train of reflex nervous symptoms, and yet never have any protrusion; and the physician must use care in his diagnosis and learn to detect these tumors by digital examination alone; for

the condition is one for which patients in the higher walks of life not infrequently seek relief, and much good may be done by treatment.

Finally, there is the nevoid condition, often spoken of as the capillary hemorrhoid. In this form the tumor is never large; never, I think, large enough to protrude from the anus even with straining. The disease is rather a group of enlarged capillary blood-vessels than a connective tissue growth. This is usually situated just within the verge of the anus, and when seen looks like the surface of a strawberry. The mucous membrane covering it is generally eroded, and the slightest touch with a probe is often sufficient to set up a free arterial hemorrhage. This is the bleeding hemorrhoid *par excellence*, but it often causes hardly any other symptoms.

Suppose, now, that an enema has been given and there is no protrusion, and yet the patient complains of bloody passages and some pain. By gently drawing apart the margins of the anus a bright red, strawberry-looking surface appears just within the margin when the patient strains down. There is little tumor; nothing comes outside when the patient has a passage, and yet he or she is nearly bloodless from the daily hemorrhage in the closet. The finger is passed up the bowel, and no changes are found. A slight touch on the strawberry-like surface occasions a free flow of blood, sometimes arterial and in jets, at others bright red, but not *per saltem*. The diagnosis

is made, and the patient is suffering from what is known as a capillary hemorrhoid.

Some time since I was asked by Dr. Watson, of Jersey City, to see with him a case with the following history.

The lady had been suffering for a considerable time from occasional severe hemorrhages from the bowel. These occurred at considerable intervals, and never while at stool, but always some time after the natural evacuation. Half an hour or so after relieving the bowels she would feel the desire for a second movement, and this would be composed in great measure of bright arterial blood, sometimes reaching half a pint in quantity. The history being given, a digital examination was made, and nothing found. By careful examination of the anus a strawberry growth was seen, which bled freely on the merest touch. I could see, when we reached the next room and I gave my diagnosis, that it was looked upon by the other medical gentlemen present with considerable doubt, and I therefore strengthened it with the offer that if, after one or two applications of strong nitric acid to this spot, the bleeding did not cease, I would come again to the city where this patient lived and make another examination under ether, without fee. The application was made and the patient was cured.

There is apparently no limit to the amount of blood a patient may lose from this form of disease. Only recently I saw in consultation a case of bleeding

to the point of absolute exsanguination from these tumors. The patient was a poor man in the tenement-house district, who had bled at each passage till his pulse was 120, his complexion waxy, and till he fainted three or four times a day. He attempted a passage at my request while making the examination, and when lifted from the commode he had evacuated fully half a pint, if not more, of bright red blood. He had no disease except these bright red arterial hemorrhoids, and they caused no protusion at stool. It hardly seemed possible that such a grave general state could result from so slight a local disease, but the cure of the local condition cured the patient.

CHAPTER III.

TREATMENT.

Before undertaking the treatment of a case of hemorrhoids both patient and surgeon should come to a distinct understanding. The latter can assure the sufferer that he may be cured at once and forever if he desires, and this applies to all forms of the disease. The only cases in which this cannot be said are those in which the patient is in such bad general condition that no interference is justifiable. If he be suffering from advanced disease of heart or kidneys, for example, and at the same time be troubled with old hemorrhoids, it may be safer to do what can be done by palliative measures and avoid anything like radical treatment. This is the only thing that should prevent the surgeon from attempting a positive cure. Ordinary disease of the lungs has never prevented me from operating and getting a good result.

Just at this point the surgeon will have many questions to answer, and one of the most common is whether nature did not intend that a great many people should have a painful affection of the rectum which should make a part of their lives miserable and cause them to lose two or three ounces of blood every time they go to the closet; and whether it is safe for the sufferer to have this beautiful condition interfered with? This question will come from very intelligent

people, who will back it up with the authority of some physician, that by suffering in this way they are escaping something worse. Should the same physician who advises that this daily bleeding be allowed to continue, make a practice of opening a vein in his patient's arm once a day for years, and withdrawing the same amount of blood, what would be thought of his practice? And yet one would be as good practice as the other.

The next question will be whether the patient can be cured without an operation, and at exactly this point many a patient will disappear. The answer will depend, as will be shown presently, upon the form of trouble present. Many cases can be cured without an operation, and many more by procedures so trivial that they carry no terror in the thought, but some can not. In the latter class of cases the young practitioner must not, for his own sake, allow himself to be placed at a disadvantage which is pretty sure to end disastrously.

Unfortunately for the public they almost all consider themselves pretty well educated on the subject of piles. Cures "without knife, ligature, or caustic" have caught their eyes in the daily press for years, and they come to their doctor not to be guided by his judgment, but to have him relieve them if he can do so, subject to the restrictions they may impose. The conditions are these. "If you can cure me without an operation I am willing to be cured, otherwise I

prefer to be let alone." There is no blame to the patient in this, for he has a perfect right to make his own bed and lie in it ; and it may be possible for the physician to do as he desires and cure him without ether, without confining him to his bed, and without any "operation," as he considers an operation. But the young surgeon must not be too anxious for the case. He may be forced to say "what you desire is impossible," and let his patient go; but he never must be led into a line of practice which is not safe, for when trouble comes no mercy will be shown him. The patient is practically doctoring himself, with a physician to assist him, and in his heart he knows it. The case goes badly and the doctor has all the blame and deserves it. The rule in my own practice is, I believe, the only one to be followed; after my examination I recommend the method of cure which seems to me the best, and from that I never allow myself to be shaken. If it seems to the physician that the clamp should be used he must in honesty use it, and not allow himself to be placed by his patient in the false and untenable position of recommending one treatment as best and then employing another. To be sure he will occasionally see his patient go elsewhere, but less often than he fears; and on the other hand he will avoid bad surgery with its unpleasant consequences. He must make up his mind at first that a great many patients had rather suffer all their lives than be cured by any operation even as safe and pain-

less as this; and he may strive to find some method of curing, or at least relieving this class which is free from the terror of a cutting operation; but he will probably discover in his search that hemorrhoids are bad things to experiment upon, and his first accident will greatly dampen his ardor, in the light of the fact that he already has at his hand a means of cure which surgically leaves little to be desired. On this point let me say that the profession in general, the great body of practitioners scattered over the country, are being unduly worried about a particular scheme of curing hemorrhoids by injections. The secret remedy is known, it has been faithfully tried in hospital and private practice by representative men both in Europe and America; it will be fully described in the course of this little book, and its advantages and disadvantages copmpared with other recognized means of treatment. I also venture to predict that as a popular quack remedy it has seen its best days; for the reaction in the public mind has already begun, and where a year or so ago every patient was determined to have nothing but carbolic acid, they now not infrequently are just as anxious to have nothing to do with it.

If the surgeon wishes to try this method of treatment, at the demand of the patient, he is justified in doing so; but it is not equally adapted to all cases, and in some respects its action is very uncertain, as will be shown later.

Some patients will deliberately choose a course of palliative treatment, even knowing that it is not curative, rather than to be cured by surgical means. For such, the practitioner must be prepared to furnish what relief he can, and this is often very great, though we cannot now enter into the details of treatment.

Though it is difficult to conceive of a case of hemorrhoids that cannot and ought not to be cured, where the patient is in any condition to bear treatment, there are some which can only be cured after prolonged preparatory treatment, and these are generally in women. The doctor who does much rectal practice becomes of necessity very familiar with many of the diseases of women. He will not be long in practice before he encounters the following combination. A lady comes to him with hemorrhoids, upon which he operates with, perhaps, the usual good result, though possibly only obtained after rather a slow and painful recovery. In the course of a few months the disease has returned, or it may be that she has never been entirely well since the operation. Another examination is made, and the patient is found to have, in addition to the hemorrhoids, an enlarged uterus with a lacerated cervix, a ruptured or greatly relaxed perineum, and a proctocele, all of which should have been cured before the operation for hemorrhoids was attempted.

Many patients dread the taking of ether more than the operation itself, and will refuse radical treatment on this account. When cocaine was first intro-

duced I had great hope that this objection might in the future be overcome, but the drug has not fully realized the expectations held concerning it. Nevertheless it answers in a great many cases, and should always be at hand. By it small tumors may be removed with absolute painlessness, and I have operated both with ligature and clamp under its influence, with great satisfaction in some cases of large tumors, but have been disappointed in others, before I found out by frequent trials the limits of its applicability.

Where the tumor or tumors to be removed are small, or where a single large one can be separated from others and cocaine be injected with the hypodermic syringe into the exact part where the ligature or clamp is to be applied, the drug will give satisfactory results. In this way several large tumors may be operated upon at one sitting, or at intervals of ten days or more, and the patient cured. But where the whole margin of the anus is involved and turns out with the hemorrhoids, and where it is necessary to bring the entire circumference of the rectum for a considerable distance upwards under its influence, the drug is apt to be unsatisfactory; for the reason that to bring all parts of the wall under its influence at one time, as is necessary in stretching the sphincter, dangerous symptoms may be produced before a sufficient quantity of cocaine has been injected to permit of painless operation.

In the New York Medical Journal, August 7, 1886,

I reported a case of this sort. It was necessary to dilate the sphincters, and with a large speculum carefully examine an exceedingly sensitive ulcer for a blind fistulous track emptying into it. One hundred and twenty minims of 4 per cent. solution of cocaine were injected into eight different points around the circumference of the anus without giving sufficient anæsthesia to operate with any comfort; and on account of symptoms of general cocaine poisoning which developed, the operation was finished with ether.

The recent suicide of Dr. Kolomnin was caused by a somewhat simjlar case of ulceration of the rectum, which he endeavored to scrape under cocaine. After three injections of six grains each the rectum was still sensitive; after another six grains, he was enabled to operate with tolerable anæsthesia, but the patient died of the drug, and Kolomnin took his own life.

The only explanation I have of the difficulty in getting anæsthesia of the whole of the lower end of the bowel without sometimes using doses of the drug which are dangerous, is the actual very large extent of surface to be affected, and the great number of sensitive nerves to be brought into local contact with the solution. On the whole, my experience has been, that in minor operations the drug, when used hypodermically, is perfectly satisfactory; but in larger ones it is not to be relied upon absolutely, and may have to be supplemented with ether.

Let us now consider in detail the treatment of

each of the varieties of tumor described in the last chapter, and I shall hope to do so in a manner which will enable the practitioner to answer his patients' oft repeated question, "how do you treat piles?" with the simple statement, "In a great many ways, depending on the case."

The treatment of the first variety, that in which a vein has ruptured and there is a small, exquisitely painful tumor at the margin of the anus, is very simple. The suffering is due entirely to the tension and pressure caused by the clot, and this should be turned out of its bed by transfixing the tumor and laying it open. The knife for this purpose should be a very sharp-pointed, curved bistoury with small and delicate blade. The point is entered on the anal aspect, carried directly through the tumor in the direction of the radiating folds, and then made to cut its way out, the whole procedure hardly occupying an instant of time. Cocaine need not be used, for to inject it into the tumor is as painful as the incision, and to rub it on the surface is almost useless. The clot may easily be expressed, if it does not follow the knife, and the incision should be filled with styptic cotton. There will generally be some oozing of blood, and this should always be stopped completely before the patient leaves the office. A good way is to cover the wound with ordinary lint, place over this a large, hard pad made of a couple of towels, and let the patient sit for a few minutes on a hard chair with the pad in place for pres-

sure. When, after a second examination, the bleeding has been found to have ceased, directions must be given to repeat the pressure in the same way at the patient's own home, should it return.

This is an operation which I occasionally take the liberty of performing without consulting the patient's wishes; but if it be explained to him and he refuses the instant relief which it is sure to give, then he should be directed to buy an ice-bag, fill it with finely broken ice, go home and go to bed, have his bowels freely moved with a saline purge, put on the ice and bear his pain till nature relieves him, which may be in one of two ways, and may take from three days to ten. The tumor may gradually subside as the clot shrinks up and thus relieves the pain, or it may go on to suppuration and end either in spontaneous cure or in a small subcutaneous fistula.

The second form of external hemorrhoid, the swollen and painful tag of skin which often has a fissure at its base, contains no clot to be released, and therefore instead of being incised should be cut off, after a few drops of cocaine have been injected into its substance. This may also be done in the office, and the same method used to stop the oozing of blood as in the other case. When the tumor has become painless to the touch with cocaine, it is seized with a small pair of hooked forceps, gently drawn upon, and cut off at its base with a single closure of a pair of stout and sharp scissors. There will be a little pain in

the cut for a day or two, and that is all. The wound generally heals very kindly, but should any application be necessary a ten-grain solution of nitrate of silver on a brush, or a dressing with a few shreds of very fine lint will cause rapid cicatrization.

There may be more than one of these tags to be removed, and they may be cut off at one time or at different visits, as the patient prefers.

In the third variety (Fig. 5) the cutaneous tumors are larger and more difficult to manage. Inasmuch as they are seldom seen to any such extent as is figured except in connection with more serious disease within the bowel, their treatment is secondary to the disease above. I seldom should operate on the tags for example unless at the same time I were operating for the stricture or the ulceration. If the patient be under ether and the stricture is divided, the external growths may be snipped off with the scissors; but otherwise there will be plenty to occupy the mind of the surgeon within the bowel without stopping for this secondary trouble, the importance of which is very slight in connection with that of the primary disease.

The fourth form—the varicose dilatation of the veins of the anus without hypertrophy of the skin—had better in most cases be left undisturbed, unless there be some special indication for interference. Except where the patient is very nervous and over-sensitive, such a condition will cause no real trouble; and in all the cases I have ever seen the suffering was

more mental than physical. However, I have been forced to relieve patients of this source of annoyance more than once, and I have done it in various ways. When he strains down it is at once apparent that we have to deal with a small tumor composed of one or more enlarged veins, often appearing through the delicate skin to be the size of a lead pencil, and perfectly distinguishable by their dark color. The question is, what to do. Ablation alone I have never tried, fearing hemorrhage. Once only have I injected such a vein with a 15-per-cent. solution of carbolic acid, seen it in a few seconds solidify and turn whitish, and subsequently slough—an experiment which for obvious reasons I do not care to repeat. I have used electrolysis with better results, but although the tumor has coagulated and decreased in size, there has been considerable pain and soreness for some days. Now, when compelled to operate, I prefer the clamp, knowing that though the operation may seem formidable for so slight an affection, it is at least safe and not at all liable to be attended by untoward accident.

There remains but one other of these minor affections—the capillary bleeding tumor within the sphincter. For this I use fuming nitric acid on the end of a stick; and it is the only form of tumor in which I believe nitric acid to be indicated. Here the slough which follows a thorough application of this kind will completely cure the disease, and by a single application a hemorrhage may be stopped that has kept the patient exsanguinated for years.

CHAPTER IV.

THE LIGATURE.

Of all the time-honored operative procedures known to the profession for the cure of hemorrhoids it is but a waste of time to discuss at the present day more than two—the ligature and the clamp. The first of these owes its present prominence to Allingham, and is often described as his operation. In the way now generally performed the name is correct, though the treatment by ligature is very old.

The principle of his method is to dissect the hemorrhoidal tumor away from its attachments for a certain extent, and then to surround the remainder of the base with a tight silk ligature. His belief is that the chief arterial supply to the tumor comes from above, and that all of the lower part may be dissected away from the muscular coat without causing any serious bleeding; while the ligature thrown around what remains is an effectual barrier against hemorrhage. The advantage of this method is that the ligature is not placed around the skin at the margin of the anus, for this is divided with the scissors before it is applied, and the ligature lies in the groove thus made, and by this means much pain is avoided, and much time is saved in the treatment.

Regarding the details of the operation but little need be said, so simple is it in its performance. The

tumor to be tied is seized with strong forceps and drawn down, the patient having been etherized and the sphincter previously dilated.

With strong scissors the lower attachments of the tumor all around, and especially the point of junction of the mucous membrane with the skin, are divided: the ligature encircles what remains, is tied as tightly as possible; both ends are cut off short, and the greater part of the tumor below the ligature is also cut off, only sufficient being left to form a good and safe stump for the ligature to hold. The patient is prepared for the operation by the previous administration of a purgative, and the bowels are confined for a week or so after its performance, and then relieved by a cathartic.

This, in brief, is the operation practiced by Allingham, and it is an exceedingly good one. I began my own practice by always performing it, and did I not believe that something else was better, should perform it still. It is as safe as any operation can well be, and when properly done, it cannot fail to cure; and perfect safety and surety are two great points to be gained in any operation.

But a considerable experience with this operation led me after a time to begin the search for something just as safe and just as sure without some of the objections which any large number of cases will be sure to show pertain to this method.

The first objection which developed itself in my

own practice was the great pain which the patient often suffered for the first week or ten days. Allingham distinctly claims that after the patient has recovered from the ether there is often no pain. I can only say that though this is sometimes the case, it is by no means the rule in my own practice, or that of other American surgeons. My explanation of the pain I have often seen is that a nerve is compressed by the ligature as well as an artery; but no matter what the explanation, the fact remains that, having followed Allingham's method in every particular, I have more than once been forced to keep the patient constantly under the influence of morphine till the ligature came away; and I know that many others have had a similar experience.

A second objection was the frequent necessity for the passage of the catheter for several days after the operation.

A third was the amount of blood lost during the operation, and the frequent necessity for leaving a considerable wad of lint in the rectum on account of the oozing, which caused great subsequent suffering and was only removable after three or four days, and then with considerable pain.

A fourth was the length of time required by my patients before they were able to resume active business.

It will be seen that none of these objections were of vital importance. The patients still recovered and

were radically cured, and in the end were satisfied in spite of these difficulties; but still there seemed to me an opportunity for a more satisfactory operation.

For these reasons I was finally, by the advice of Henry Smith, led to adopt another operative procedure, which on the whole has served me better. I still occasionally use the ligature, but I never apply it where any of the sensitive tissue at the margin of the anus is included in the loop. If a tumor be well circumscribed and pedunculated, and a ligature can be thrown around its base and still be well above the external sphincter, it may be applied without causing any great amount of reflex irritation, and hence of pain. In this way I have not infrequently seized a prolapsing tumor of considerable size, injected it with cocaine, and after a few minutes tied a string around its base and cut it off without having much subsequent pain. But when it comes to a case of large, prolapsing, internal hemorrhoids, involving the margin of the anus and attended by a good deal of the eversion of the skin, which is shown in Fig. 2, I prefer another operation, because I believe, though no safer and no more certain to cure, it will cause less subsequent pain, and less confinement to the house and bed, than the ligature.

CHAPTER V.

TREATMENT BY INJECTIONS.

As far as my own influence has gone I have done what I could to take this method of treatment from the hands of the quacks and place it upon a recognized basis. In the July number of the "American Journal of the Medical Sciences," 1885, I reported about two hundred cases treated by this plan with very satisfactory results, and in "The New York Medical Journal," Nov. 14, 1885, in answer to numerous questions, I gave full and definite directions as to its methods of application.

The fact that since then I have had a succession of bad and troublesome cases treated by this means, and that these cases have led me in a measure to be less hopeful of the results of the method, in no way invalidates the reports of my own carefully-observed cases up to that time. In writing now I shall use less glowing terms than I did then, but I have by no means abandoned the practice. It is still, to my mind, a very good way of treating a great many cases; having in certain points exceptional advantages over all others; and in the fact that it does not apply equally well to all, and that it will occasionally be followed by disagreeable consequences, it in no way differs from other operations. I say this so plainly in the beginning because I have so frequently been accused of having

first advocated the practice and subsequently abandoned it; while all that I have really done has been to state fully and freely the objections to it, as at other times I have with equal plainness stated the advantages of it. It is now at a point where every practitioner may try it for himself, and come to his own conclusions regarding its value. All that can be said of my own practice is, that while for a year or more I used it almost exclusively and was much pleased with its results, a succession of bad cases have led me to modify my views of its value and universal applicability, and that, though I now use it constantly, it is only in selected cases.

For years back a great number of irregular and often very ignorant practitioners have been travelling around the country injecting *and curing* hemorrhoids with solutions of carbolic acid. The instrument was an ordinary hypodermic syringe, the solution was for a long time a secret, but was finally discovered to be pure carbolic acid mixed with oil, or glycerin and water, in certain proportions. About the success of their treatment there could be no question in a great many well authenticated cases upon ordinarily intelligent patients, who said that they simply felt the pricks of a needle and were cured. By this simple process large hemorrhoids which had been bleeding and protruding for years disappeared after a single visit, and this often without any subsequent pain or symptoms of any sort. So often was this delightful story told

me by patients upon whom I had recommended other and to them more formidable procedures, that I was at last driven in pure self-defense to try and discover what there was in this practice, and I therefore armed myself with several preparations of carbolic acid—a 15 per-cent.—33 per-cent.—50 per-cent. and the pure acid—and proceeeded to inject them into a large proportion of my cases.

The results in many cases were surprisingly good. Some were cured without being confined to the house at all, and without any pain which interfered with their daily occupations. Others did not do quite as well. They complained of severe pain coming on an hour or so after the injection and lasting several hours, but it was rare to have them give up their work and go to bed, or to use the opium suppositories with which they were provided in case of necessity. Once in a while the injection would cause a slough and this would put an end to the treatment for a couple of weeks till it had healed, but the pain of this condition was generally bearable and the patients expressed themselves as perfectly satisfied and greatly preferring even this amount of suffering to any "operation". The cures also seemed to be permanent, none of my patients returned with a fresh protrusion of the tumors which had once been operated upon, even after an interval of four years. At this time it was rare for me to have the tumors slough after an injection. Generally there was a hardening and shrinking of the hem-

orrhoid sufficient to prevent either hemorrhage or protrusion, and this was produced by solutions of 33 per-cent. and 15 per-cent.

At this time I published my cases and also the

FIG. 7.

rules which were to be followed in this method of treatment.

The solutions of carbolic acid were made in pure water with sufficient glycerine added to make a perfectly clear and colorless mixture, and of these I kept constantly ready one of 15 per-cent. one of 33 per-cent., and another of 50 per-cent.

The glycerin and carbolic acid should both be perfectly pure, and as soon as the solution began to turn yellowish it was discarded.

The needles should be fine and sharp, and the syringe in perfect working order—one with side handles is preferable—and after each time the syringe is used it should be thoroughly washed out and left standing in fresh water.

Before making an application give an enema of hot water, and let the patient strain the tumors as much into view as possible. Then select the largest and deposit five drops of the solution as near the centre of the tumor as possible, taking care not to go too deep so as to perforate the wall of the rectum and inject the surrounding cellular tissue. The needle should be entered at the most prominent point of the tumor. If the hemorrhoid does not protrude from the anus, a tenaculum may be used to draw it into view. After the injection has been made the parts should be replaced, and the patient kept under observation for a few minutes to see that there is no unusual pain. The injection will cause some immediate smarting if it is made near the verge of the anus; if made above the external sphincter, the patient may not feel the puncture or the injection for several minutes, when a sense of pressure and smarting will be appreciated. In some cases no pain will be felt for half an hour, but then there will be considerable soreness, subsiding after a few hours. If it increases, instead of

disappearing, and on the following day there is considerable suffering, which may not perhaps be sufficient to keep the patient on his back, but is still enough to make him decidedly uncomfortable; it is a pretty good indication that a slough is about to form. For the reason that it is impossible to tell absolutely what the effect of an injection is to be until at least twenty-four hours have passed, it is better to make but one at a visit and to wait till the full effect of each one is seen before making another. If on the second day there is no pain or soreness, another tumor may be attacked; and this will often be the case.

By following these rules all went well for a time, but soon I began to be troubled with a constant succession of sloughs with their attendant pain, and the worst of the trouble was that I never knew beforehand when a slough was likely to be caused. My old solutions were all discarded and new ones made to replace them; the syringes were all sent away and renewed; and yet the sloughs continued and I began to expect to encounter this objection whenever an injection was made, for the strength of the solution or the character of the hemorrhoid seemed to make no difference. A solution of 15 per cent. would cause sloughing where one of 50 per cent. or even of the pure acid would produce only a circumscribed induration, and *vice versa;* so that after a time I was forced to confess that I had no means of determining beforehand whether the patient

was to undergo the pain of an inflamed and sloughing hemorrhoid, though the injection made should be of 10 per cent or of pure acid.

The next complication was the occasional occurrence of small marginal abscesses after injections, and as these always caused a great deal of pain this was a serious objection. They usually appeared three or four days after the injection, were situated just at the verge of the anus, causing a tumor about the size of the end of the thumb, covered partly by skin and partly by mucous membrane. They showed a decided tendency to break on both the mucous and cutaneous surfaces and leave a short, subcutaneous track connecting the two openings.

These marginal abscesses were never at the point of the injection, though always on the same side of the gut; sometimes, in fact, they were fully two inches below the injection.

Still, these complications were not of sufficient gravity to cause an abandonment of this plan of treatment. The small abscesses caused a good deal of pain but were not serious in their ultimate consequences; and the sloughs healed kindly with the aid of local applications, though they greatly prolonged the time of treatment, as I always thought it best to discontinue the injections after once a slough had formed until it was entirely healed.

There are, however, still other objections to this method of treatment. In my own practice I have had

one case of diffuse inflammation and suppuration, lymphangitis, ischio-rectal abscess, and deep fistula, following a single injection of strong acid into a small tumor; and I have heard of other cases in the practice of other surgeons. I believe that this serious accident was due to landing the strong acid entirely below the tumor and under the muscular coat, but I cannot be sure.

Again, within the past year I have twice been called upon to treat a rare form of fistula arising directly from injections. These fistulæ were of the blind, internal variety, having an opening near the anus within the sphincters, and a track running upwards from this, under the mucous membrane, for a considerable distance, and ending in a cul-de-sac. One of these cases was in my own practice, and three different tracks of this kind existed, each of which I have no doubt was caused by an injection of carbolic acid, made by myself. As I have no objection to reporting my own bad cases, that others may derive the same benefit from them that I do, I will give this in full.

The patient was a professional man of middle age, who had long been a sufferer from hemorrhoids of large size, and was in a very weak condition, having lost much blood, become dyspeptic and nervous, and having slight pulmonary trouble. The tumors were quite large, the sphincter much relaxed, and the margin of the anus very much like what is shown in Fig. 2. Injections were made several times, the so-

lutions used being the weaker ones and never exceeding 33 per cent. On the day following the first one the following entry was made in the case-book: "Considerable pain following first injection. Patient has been in bed most of the time." Two days later the following entry was made: "The single injection of five drops of a solution of carbolic acid (one to twelve) has caused great pain up to the present time. The patient has been able to be about more or less, but has suffered constantly and taken considerable quantities of opium. Examination shows the mass of tumors on one side black, inflamed, and angry-looking; and though the injection was placed in a small nodule, springing from the centre and most prominent portion of this mass, the whole group has become involved in the inflammation it has caused." Three months later the following note appears: "The patient has had considerable sloughing of the tumors, following the injections of a 33 per cent. solution, and has had one marginal abscess, leaving a subcutaneous fistula which has been cut. He is now in great measure relieved." In exactly four months from the beginning of the treatment the patient was discharged cured—that is, he considered himself cured, there being no more protrusion, except as the margin of the anus tended to roll outwards, and no bleeding. Nine months after the first injection he visited me and still reported himself as having no symptoms. Eighteen months from the time treatment began the patient

again reported with several hemorrhoids, which were attached high up the bowel, and had only recently begun to appear at the anus, and a few days later the following note was made: "Two injections (33 per cent.) without trouble. Yesterday, third injection of 33 per cent. into a distinct tumor. To-day, slough, size of a silver quarter, irregular in shape, and in addition, a marginal swelling, size of a walnut." The slough separated, cicatrization progressed slowly, and at the end of a month the patient went away, having no more hemorrhoids, but in their place an unhealed ulcer, which seemed to be doing well and bid fair to be entirely healed in a few days.

One year later he reappeared and reported that this ulcer had never entirely healed, but had gone on discharging and causing pain ever since. After several examinations, I discovered three of the blind internal fistulæ already described, and in addition, two more large internal hemorrhoids. The patient having now been under treatment two years and a half, he was etherized and operated upon. The fistulæ were laid open, and the hemorrhoids removed with the clamp, and the patient finally discharged cured.

I have noticed that each of these fistulæ were of the submucous variety, running in the connective tissue between the mucous and muscular layers, as it might be inferred that they would be; for the acid is deposited by the needle between these two layers,

and the amount of sloughing it causes is not limited to the point at which it is introduced.

It may perhaps be instructive to record one or two more cases.

In June, 1885, I was called upon to treat an old gentleman, the mayor of a small town in Ohio, living in a high, cool, country region, but much depressed with business losses and worry. He came to New York in the middle of the hot season and submitted to treatment. The hemorrhoids were the worst which, up to that time, I had ever treated by this method. The sphincter was much relaxed; the tumors had been down for twenty-five years without being replaced, and were very large and vascular. There were three distinct masses, each about the size of a hen's egg. The case was not an attractive one, considering the age and condition of the patient and the hot weather, but I undertook it. Into the largest of the three tumors I injected five drops of a fifty-per-cent. solution. It was followed by a good deal of pain and loss of sleep for two nights, with some constitutional disturbance. On the third day, the pain of the first injection having somewhat subsided, I injected five drops of pure acid into the second tumor, and had much less trouble than with the fifty-per-cent. solution in the former case. After three days more I again injected the same amount of pure acid into the third tumor. Both of these last applications caused a distinct slough with resulting ulcerated surface and free

discharge of bloody matter. After a few days more I returned to the first tumor, which had not sloughed, but simply become indurated, and injected five drops of pure acid into that. The applications were all made within the space of two weeks. During this period the patient allowed his bowels to become constipated, and I had to clean them out with repeated copious enemata. There was at one time some vesical irritation and decrease in the amount of urine, whether from direct absorption of carbolic acid or from reflex irritation I do not know, and at the end of the treatment the patient was considerably reduced in strength—so much so that I put him upon the most nourishing regimen with bark and whisky. Just as he seemed on the point of rallying I discovered a small abscess in the perinæum, which was opened, and healed kindly, having no connection with the rectum. After recovering from this and gaining a considerable degree of health he went home to Ohio, and was immediately brought to bed with a second, larger abscess on the buttock. From this he also made a good recovery, and for one year he had no rectal symptoms whatever, but at the end of that time, he informed me, bleeding had returned, and though I have not seen him, I have little doubt that he is suffering again from the same tumors.*

This patient had his own way. He was not

* Previously reported in part, N. Y. Medical Journal, Nov. 14, 1885.

"operated upon"—but he would have had less suffering and less confinement if he had been. Moreover, he would have been radically cured.

Let us now take another. *A man of about sixty has had hæmorrhoids for twenty years. He is of sedentary habits and nervous, but with no other disease than the tumors. An examination shows a very advanced case of long-standing trouble. The tumors can be divided into four chief ones—one posterior, one anterior, and one on each side; but two of these are as large as hen's eggs, and the others only a trifle smaller. They spring from above the sphincter, and are entirely covered by mucous membrane; the sphincter is so relaxed that they protrude with the slightest exertion, and the patient has worn a rectal supporter for years.

It is a beautiful case for the clamp, and fit for that only; but at the outset I am met fairly by the not infrequent obstacle—"no operation." Argument is useless; he has heard of carbolic acid; in fact, his physician has sent him to me for that treatment, and it is that or nothing. Unwillingly I consent.

An injection of thirty-three per-cent. is made posteriorly, and with the usual caution and instruction the patient goes home. Two days later he returns. He has had pain—yes considerable; but he does not mind the pain as long as he can avoid an operation.

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*Previously reported, N. Y. Med. Record, Aug. 7, 1886.

Another injection of the same strength on the left side.

It is four days before he again appears, and they have been passed mostly in bed, and he has used several suppositories, but he is now better, and "if it is no worse than this he can stand it." The tumor injected last time is much smaller, but the posterior one, which was first attacked, is not much benefited, and five drops of pure acid are placed in its centre.

Three days later he reports that he is beginning to be better, that there is less protrusion at stool, and he has left off his supporter. The last injection has not caused a slough, but a hard inflammatory induration in the centre of the tumor. Another five drops of pure acid are injected into the same mass at a little distance from the hard spot, and he then tells me that ever since his last visit he has had considerable difficulty in passing water, which is high-colored and diminished in amount.

Four days later, says he had no very severe pain after the last application, and straining at stool fails to bring down either of the tumors which have been operated upon. Another injection of pure acid into the anterior tumor, the largest of them all. Three days later he reminds me that he is in a great hurry to go away on business, and is anxious to have treatment crowded more rapidly. He had no pain at all after last injection, and fears I did not get it in. The injection has again caused a hard lump of inflamma-

tory induration, but no slough, and a decrease of about one-third in the size of the mass. There is still more work to be done on the first one, and another five drops of pure acid are injected into it, causing no pain at the time, or after, as he tells me two days later.

Thus far all had gone well, and three of the tumors had been treated without accident. An injection of pure acid was made into the last one, that on the right side. Three days later I am sent for to come to him. Before this he has come to me, but he has been in bed ever since the last injection; the urine has been very scanty and passed with difficulty; there is an enlarged and painful gland in the right groin; and a painful swelling at the verge of the anus on the right side, circumscribed, the size of an almond. Eleven days later, the patient being still confined in bed, the abscess at the margin of the anus was opened and a drachm or so of pus evacuated. A couple of days later it was found to have also opened spontaneously on the mucous side of the swelling, just within the sphincter. Ten days later this was healed. The patient had then been under treatment just forty days. He was much better; the tumors were all considerably reduced in size, they still protruded at stool, but went back spontaneously, and he promised to report again in a few days. He never did.

In this case, also, the patient would have been much better off, both during the treatment and in the

end, had he been operated upon in my way instead of his own. In fact, it is a few such cases as this that have led me to lay down the invariable rule of practice to which I have referred—to select the mode of treatment which seems to me most appropriate, and never allow myself to be led into another which I do not think as good, simply because the patient wishes it.

These cases are the bad ones, and I would not convey the idea that all are like them. They illustrate exceedingly well all of the objections to this plan of treatment which I have ever encountered, except the single one of deep inflammation and suppuration. They may be enumerated in the following order:

1. Pain.
2. Ulceration.
3. Marginal abscess.
4. Fistula.
5. The impossibility of giving any definite prognosis as to the length of time necessary to effect a cure, or the amount of suffering the treatment will entail.
6. The fact that the treatment may not result in a radical cure, but that the tumors may reappear.

There is still one other complication which may arise, and this is decided vesical symptoms, whether from carbolic acid poisoning or merely from reflex irritation, I have never been able to decide. I have seen the urine decidedly diminished, and great pain in passing it, after injections of the stronger prepara-

tions, but I have never seen the typical train of symptoms following carbolic acid poisoning.

It will be seen that none of these objections are vital. Any of the well-recognized methods of operation are attended by some pain, and occasionally by untoward accidents. I do not consider the operation by injection as dangerous to life, and I have never yet heard of a fatal case; and in all of my experience with the method I have never had but one serious complication—a single case of deep suppuration, and even this I think can be avoided by the use of weaker solutions placed more superficially.

There is still one point about which there should be no misunderstanding. From all the information attainable, I believe that my experience with this method is about that of the irregular practitioners who thrive by it, and that the proportion of cures, without any pain or bad symptoms, obtained by them is practically the same as my own. I have certainly tried all of the solutions ordinarily used by them, and some besides. The tincture of iron and the fluid extract of ergot are two from which I hoped for better results, but neither seemed to possess any advantages. From cases which have from time to time come to my knowledge, I know that abscesses, ulceration and great pain are by no means unusual sequelæ in the practice of these gentlemen. It is not long since one of this fraternity was forced by his patient to return the fee which had been paid in advance, after the pa-

tient had been confined to his house for several weeks with a deep abscess; and only a few days ago I operated with the clamp upon a gentleman who had previously had a single injection made by one of these men, had been confined to his bed with it for a month, and had then abandoned the treatment. He had been particularly unfortunate, as he had subsequently had a ligature applied by another practitioner, which, as he described it, "slipped on the fourth day," and he had then abandoned that treatment also.

I believe I have now fairly stated the advantages and disadvantages of this plan of operating upon hemorrhoids, and have put, as far as my own experience enables me, each reader in position to choose for himself whether he will use it or not.

The question in fact narrows itself down to this. On the one hand we have a method of treatment which is safe, certain and practically painless; but which involves the administration of ether, the performance of what the patient dreads, a surgical operation, and a certain confinement to the house for a few days. On the other hand we have a method which avoids the ether, the surgical operation, and perhaps the confinement to the house; but which, in fact, involves fully as much of an operation as the other, only more quickly performed, and without ether, and which is neither radical nor certain in its results. It is in fact this uncertainty as to the course of a case after an injection, and the fact that the operation may not result

in a radical cure even though it may be followed by serious complications, which keeps me from employing this method oftener than the complications themselves, or the possible dangers. I have never abandoned the idea that the patient should submit to the judgment of his physician as to his treatment, and I am not convinced that the surgeon should yield his preference for a method of treatment which long experience has proved to be as safe and certain as any operation in surgery, to the foolish prejudices of a timid patient.

As regards the comparative suffering caused by the two operations, the clamp and the injections, it may be taken for a fact that any considerable number of cases will show greater pain spread over a longer time with the latter than with the former: and all the patient actually gains in the most favorable case is the avoidance of a safe operation which he fears, while he submits to an uncertain one which he does not fear because of his ignorance; together with a few days of liberty during which he would be better off in his room.

Should the surgeon decide to employ this method the following points may not be useless:

Use the weaker solutions in preference to the stronger.

Never use it in any of the forms of external tumors already described.

In cases of large, prolapsing, and long-standing disease expect pain and perhaps marginal abscesses.

Be very cautious in prognosis as to the time the treatment will require, and the amount of pain it will cause. In fact it will generally be safer to acknowledge the uncertainty as to these two important points of the operation.

The form of disease best adapted for this treatment is the tumor of moderate size, having a well-defined pedicle, and springing from the wall of the bowel entirely above the sphincter. Such may be replaced within the bowel after the injection, and are very likely never again to be heard from; and in them, should sloughing occur it will be attended by the minimum amount of suffering.

The injection of hemorrhoids with carbolic acid, though apparently a simple and trivial affair, is to be regarded in the light of a surgical operation, and should not be undertaken by the practitioner until he has surrounded himself and the patients with all the safeguards at his command.

CHAPTER VI.

THE CLAMP AND CAUTERY.

After what has been said, the reader may be tempted to ask whether we possess any means of curing hemorrhoids which is safe, certain, and free from complications, and in this chapter I shall answer that question in the affirmative.

The operation with the clamp is generally known as that of Mr. Henry Smith of London, and to him it owes its general introduction and acceptance by the profession, as does the ligature to Mr. Allingham, though he claims no originality in the method itself but only in some of its details.

The essential idea of this operation is to seize the

FIG. 8.—PILE FORCEPS:

part to be removed, apply the clamp to its base, cut it off with scissors, and cauterize the stump. The clamp acts merely as a temporary ligature to prevent bleeding during the operation ; and the cautery is to prevent bleeding after the clamp has been removed. The instruments which are indispensable are therefore

four in number—a hook forceps to seize the pile, shown in Fig. 8; the clamp shown in Fig. 9; scissors; and the cautery.

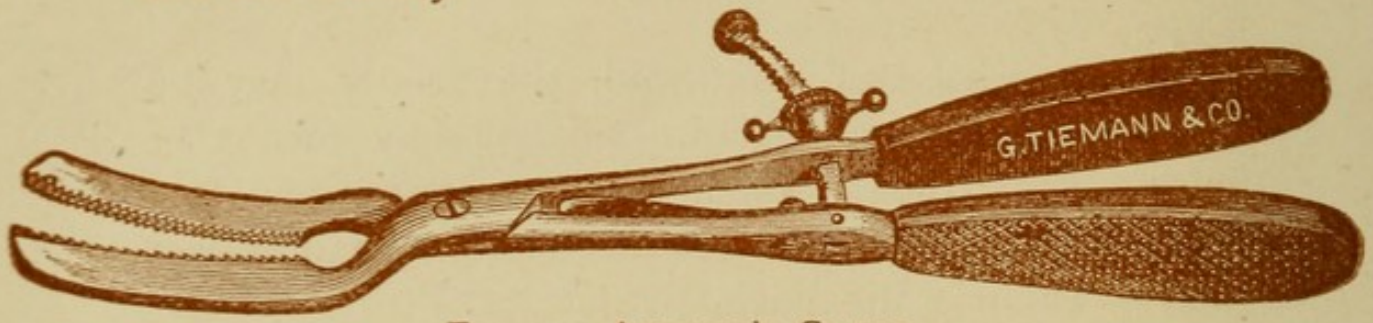

Fig. 9.—Author's Clamp.

The clamp is a modification of Mr. Smith's which I have had made for my own convenience, and the difference can be seen at a glance. Mr. Smith's instrument, Fig. 10, is armed with ivory shields to pre-

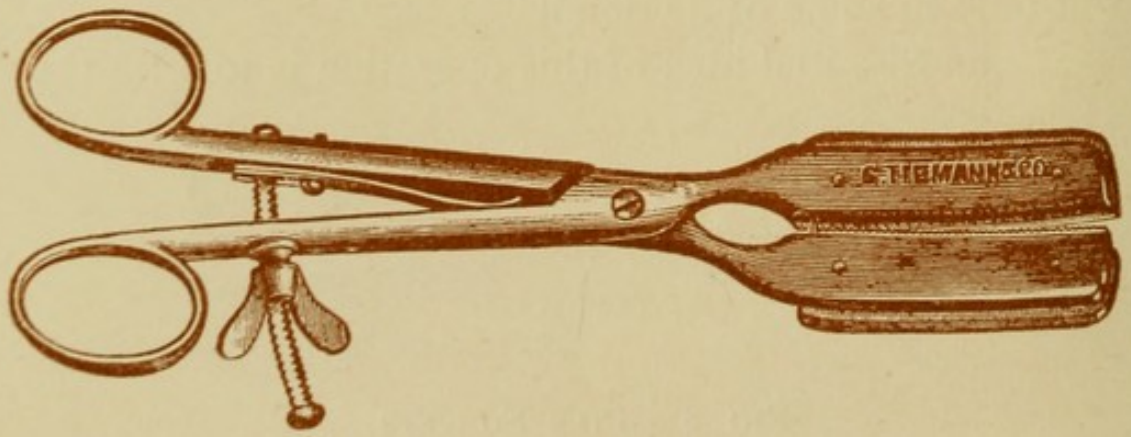

Fig. 10.—Smith's Clamp.

vent the possible effects of radiated heat; it has scissor handles; and the edges of the blades are smooth. In my own there are no shields, the handles are much larger, and the blades are serrated. I was led to abandon the ivory shields because I found them practically unnecessary and because they made

the instrument more cumbersome. The handles were modified to give increased power and to avoid the general use of the screw for closing the blades. The edges were serrated to add to the crushing force, but experience has convinced me that even with this amount of power the clamp is incapable of crushing the tissues to any extent. I have placed it on a tumor, screwed it up to its greatest possible power, and left it in this condition for fifteen minutes. While it was in position the hemorrhoid became cold and livid, but when the pressure was removed the vessels immediately filled up and the circulation was restored. It is for this reason that I say the clamp acts merely as a provisional ligature during the operation. In fact no force capable of crushing the tissues to the point of causing the occlusion of the vessels and the death of the parts can be exercised without much greater mechanical power than this clamp possesses. There can be no bleeding while the clamp is in position, if the handles are firmly closed with one hand ; but unless the cut surface has been thoroughly cauterized, there will be immediate bleeding on its removal. The advantage of the form of handle shown in my instrument over that of Mr. Smith's is that an adequate pressure can be kept up for any length of time without the intervention of the screw, and by this fact the length of time consumed in operating is much diminished.

The cautery is the most important of all the in-

struments, being the most delicate. The latest modifications of Paquelin's instrument leave little to be desired. If the operator prefer, he may use the galvano-cautery, and with a storage-battery this is a very convenient form of instrument, but I have not yet in my own practice abandoned my old favorite for the newer invention. The Paquelin cautery is shown in Fig. 11, and may be obtained from Tiemann & Co., of New York, at a cost of about thirty dollars.

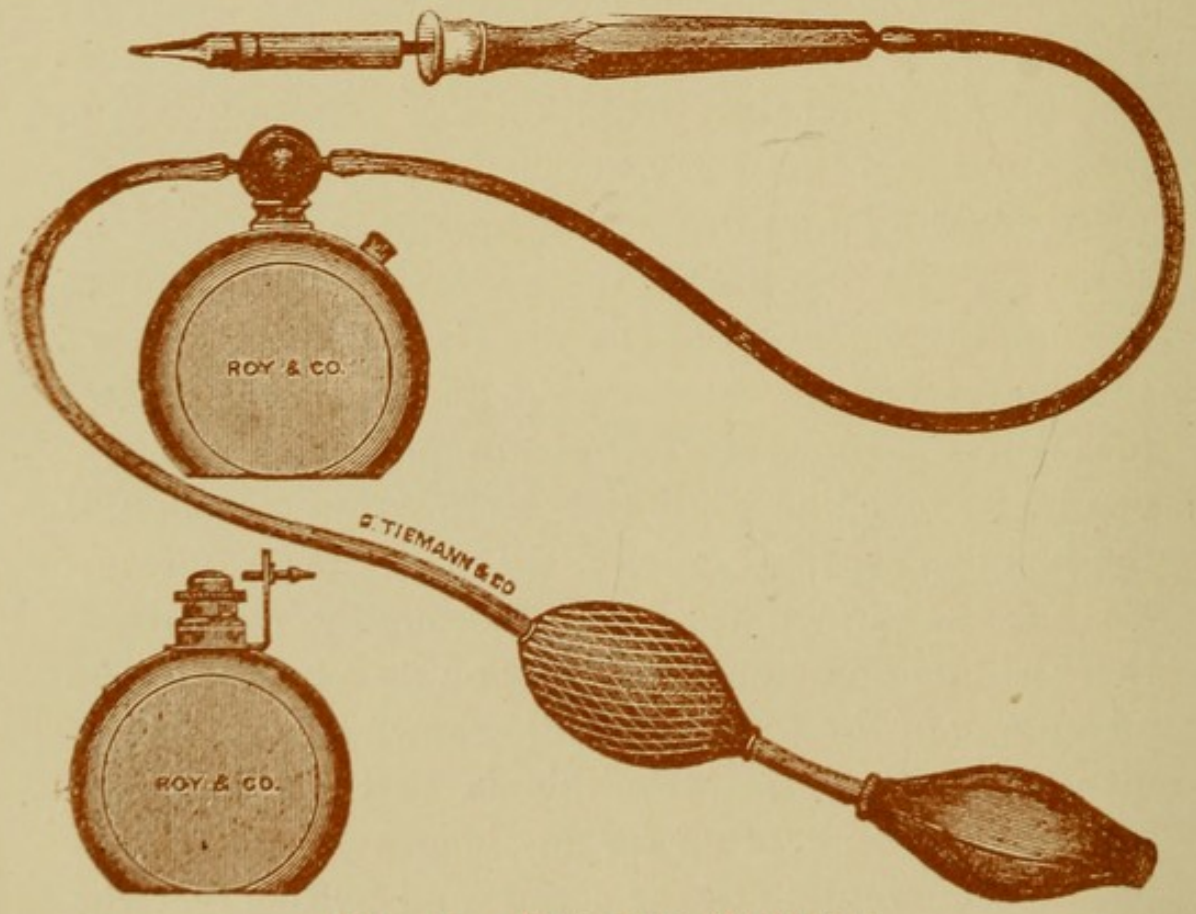

FIG. 11.—PAQUELIN CAUTERY.

Its beauty lies in its reliability and portability, and for these reasons I always carry it with me for

operating at long distances from home. Filled before starting, it can always be used on the following day, and generally after two days; and should the operation be very extensive, as in cases of cancer, it is only necessary to be provided with an additional ounce or two of benzine. The instrument merely requires to be properly understood and managed to secure perfect reliability, though I always carry an extra platinum blade, to be secure against the temporary disabling of one which generally is due to the lack of experience of an assistant.

The scissors need only to be strong and moderately long, though a slight curve in the blades will sometimes be found an advantage.

Very little preparation for this operation will be found necessary in a healthy patient. When one in good health tells me his bowels are acting regularly, I have about abandoned the time-honored custom of deranging their action with a purgative just previous to this operation, and if they have moved on the morning of the operation, all that is necessary is a simple enema of soap-suds an hour before the operation begins. If given an hour before, it will generally all be passed before the arrival of the surgeon. If given after the arrival of the operator, he stands a good chance of receiving a large portion of it in his lap and on his towels the moment he dilates the sphincter.

The operation is performed in the following manner:

As a rule the patient is etherized, though unless there is a good deal of tissue to be removed at the verge of the anus, the operation may be done with cocaine. Ether should be advised in almost every case, and cocaine only used as a substitute; for although a tumor which is visible may be removed with the latter, it is difficult to thoroughly stretch the sphincter under its influence, and by omitting this two great advantages of ether are lost—the chance to thoroughly search the rectum, and the avoidance of the pain following the operation which is secured in part by a complete paralysis of the sphincters. Many hemorrhoids which are not visible at an ordinary examination will become visible after a patient has been etherized and his sphincter dilated, and it is an awkward thing to assure a patient that he is radically cured because three or four perfectly visible tumors have been removed, and have him return in a few weeks with one or two more, which were overlooked at the operation simply because they did not crowd themselves into view.

The tumors are next seized and removed one by one. No speculum is necessary for this, but if one be used, a medium-sized blade of Sim's vaginal speculum, or the retractor shown in Fig. 3, will be found most convenient. The tumor is seized with the forceps and held by the left hand till the clamp is applied with the

right. The forceps are next detached, the tumor cut off with the scissors (but not so short but that a good firm stump remains) and the cautery is then taken from the assistant, whose sole duty should be to have it always ready, and applied thoroughly to the stump of the hemorrhoid. No haste should be used in this step of the operation. The pedicle should be thoroughly charred with the platinum at a dull red heat. When this has been done, the clamp may be loosened without being removed, to see if any vessel in its grasp is still inclined to bleed, and if a bleeding point appear it is again tightened, and the cautery is again applied. Thirty seconds is an abundance of time for each tumor, and I have often done four to the minute—the greater part of this being devoted to the thorough application of the cautery.

When all have been removed, the stumps will naturally retract within the sphincter, and no dressing will be necessary.

The thing most difficult for the unpracticed operator to understand is at just what point to apply the clamp, and this can best be learned by experience, as it really constitutes the delicate point in the operation. There is no difficulty when the tumor is an internal one arising fairly from the mucous membrane above the sphincter, and not involving the skin of the anus. In such a case the clamp does not implicate the the muco-cutaneous junction at the anus, and removing too little tissue will not leave unsightly and annoy-

ing tags of skin, nor will removing more than is necessary result in cicatricial contraction to a serious extent. But where the margin of the anus tends to roll over, as is shown in Fig. 2, considerable experience is necessary to learn just how much tissue to include in the clamp.

In such a case a groove should be made with the scissors in the cutaneous border for the application of the clamp so that no skin may be included in its grasp. If this groove is made at the line of junction of mucous membrane and skin marked in the figure, painful tags of skin will certainly be left, which will cause subsequent annoyance, and considerably detract from the success of the operation. If, on the other hand, all the protruding mass be cut off, and the clamp be applied in the groove where the protrusion joins the anus, too great contraction is apt to result except in cases where, on account of a very lax sphincter, it is deemed advisable actually to reduce the size of the orifice. The endeavor must be to so draw the lines between these two extremes in an ordinary case as to leave no tags after cicatrization, for these are always unsightly, generally annoying, and sometimes subject to a subacute inflammation which renders it desirable to remove them by a subsequent operation with cocaine.

When it is necessary to divide the skin of the anus with the scissors before applying the clamp, there will be a little bleeding, but when the clamp is used

without any preparatory cutting the operation is almost bloodless, and under any circumstances it is unnecessary to soil more than a single towel. This is a great desideratum in cases of enfeebled patients, besides enabling the operator to have his wounds perfectly dry without the use of any lint or other dressing.

The operation with the ligature, as done by Allingham, by previously cutting away a part of the attachment of the tumor, is by no means bloodless, and unless the operator takes the risk of being called back after a few hours to stop the oozing of blood, he is apt to use considerable lint, and having pressed it into the wounds to leave it. This is a constant source of pain, and often it is practically impossible to remove it before the end of the third or fourth day, when it has become thoroughly loosened by the discharges.

A rectum partly stuffed with lint, and containing three, four, or more ligatures around sensitive parts, is in a very different condition from one which contains no foreign substances, and the wounds of which have have been dressed in the most thoroughly antiseptic way possible with the cautery in the act of making them. One condition may be no safer than the other, but it is certainly much more comfortable.

No dressing of any sort is necessary after the clamp operation. If the patient seems to be doing well and complains of no untoward symptons, the

parts need not be examined for ten days, and all that is required is cleanliness to the external parts.

I usually introduce an opium and belladonna suppository at the time of the operation, and it is seldom necessary to use any further anodyne. This will confine the bowels for forty-eight hours, and about thirty-six hours after the operation—in other words, at night of the following day—the bowels should be encouraged to act by a slight laxative, either a pill or a saline. A single dose will generally be sufficient, and when the time comes for the bowels to move, an enema of oil should be thrown up the retum to facilitate the passage. In this way an almost complete clearing out of the rectum is secured on the second day. The patient dreads this first motion, but is agreeably disappointed, often being surprised that he has much less pain than his hemorrhoids caused him in each passage before they were removed.

The bowels may be treated in this way after Allingham's operation with great advantage, though his rule is to have them confined for a week or more. By the one method a comparatively, and sometimes positively, painless evacuation is gained before the rectum has become loaded with solid matter. By the other, the pain which is sometimes and generally caused needs to be seen and felt to be appreciated. I have left my bed at night, roused my assistants, driven to an adjacent city, given ether, and unloaded a rectum, on the seventh day after an operation, in a deli-

cate, nervous lady, after the rectal tenesums had reduced her to a condition of unmanageable hysteria, in spite of trained nurse, repeated saline cathartics, and enemata of all sorts; and one experience of this sort of unnecessary suffering will convert almost anybody to the other plan.

An additional advantage of thus moving the bowels on the second day is that the rectum is thus cleansed of all blood and discharges, and that no special restrictions need be placed upon the patient's diet, while much headache and general malaise which follow the constipation, produced by the daily use of opium, are avoided.

I have recently been tending a case where much trouble resulted from an unintentional departure from this rule. The usual operation was done with a simultaneous closure of a lacerated cervix uteri, and at the end of forty-eight hours the usual laxative was given.

I was told on the following day that it had acted nicely, and it was ordered to be repeated every night for the following week. Each day the patient was reported as doing well in this regard, though once or twice it was necessary to give two pills simultaneously when the bowels seemed to be acting irregularly. On the tenth day the patient was up and about, preparing to leave the city for her home. On the eleventh she had an attack of intestinal and rectal pain, and after a great deal of straining and suffering, passed a very

voluminous and hard passage, with considerable blood. It was evident that the bowels had not been effectively moved since the operation, and the result of her efforts was a tearing open of the wounds, and a further confinement to the house for nearly three weeks, each movement of the bowels being attended with some pain and bleeding.

I do not wish to convey the idea that no pain follows this operation, but I can honestly say that many patients have less pain on the day following it than they have suffered daily from their hemorrhoids for years before. I usually expect some of that annoying spasm of the levator which no stretching of the sphincter can prevent; and when this is present it will begin a few hours after the ether, and may last for the following day or two; but it is not generally sufficient to prevent a good night's sleep, and it is often so slight as to cause no comment by the patient. It is very exceptional for any anodyne to be necessary even on the first night after operating. Even this spasmodic contraction of the muscle is not always present.

The length of time the patient is confined to the house of course varies. They are generally sitting up on the second day, or at most the third day, and walking around the room tending to their own wants, the men smoking and reading, the women receiving visits or sewing: and one of the details about which the physician needs to be most strict is to keep the patient quiet in the house until the healing has so far advanced

as to make active exercise safe. Many of my own cases come from a considerable distance and are anxious to return to their own homes as soon as possible. I usually aim to secure at least ten days, but I find they are very apt to depart at the end of a week, and occasionally five days sees them on their journey. I do not mean that this should be encouraged or recommended, for it is very much better that the patient should remain quiescent until the wounds are well advanced toward cicatrization; but it shows better than anything else the general condition of the patient when there is no suffering which induces him to wish to stay in his room.

There remains very little to be said. Within the past two or three years several plastic operations have been advised and practiced—operations consisting in an elaborate dissection and removal of the hemorrhoidal tumors and subsequent careful suturing of the wounds. These have seemed to me such very long ways around to reach a given point that I have never been tempted to try them. My own practice, after much searching after improvements, has reduced itself to about this: If the patient wishes to be relieved but is unwilling to be cured, I try to relieve him by medical or perhaps the minor surgical methods described. If he desire to be cured, and I deem the case fit for cocaine, carbolic acid, etc., I employ them. If he have extensive disease, in which nothing but radical operation is indicated, and he refuses to submit to this, I have found

it better to abandon the case than to do what I do not myself believe to be to his or her best advantage. If, under the same circumstances, the patient will be wholly guided by me, I prefer the clamp to all other radical measures, as being less painful, and giving a quicker recovery.

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