INTERNAL PILES: DIAGNOSIS AND TREATMENT.*

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THE days of the systematic lecture have passed away with the advent of the numerous medical journals and the excellent and cheap books of the present day; indeed, it is often a matter of surprise to me that lectures are still so popular when almost everything that can be heard in a lecture, often even the lecture itself, can be read at home in one's easy chair. Perhaps it is some relic of old custom, or possibly some compliment to the personality of the lecturer himself. I shall try in the present instance to flatter myself that it is the latter, and to reward you for listening to me this evening by attempting to give you some new point of view and to illustrate my remarks by modern instances, which are often the best means of fixing important truths in one's mind. I have always found that a fact which was illustrated by a picture, or by an interesting case, has stuck in my mind when something merely read or heard has quickly disappeared; indeed, this is probably one of the fundamental principles of teaching.

Now first of all let me get rid of one serious fallacy which is frequently a cause of trouble—that is, the meaning of the word “piles.” A medical definition would be “small tumours at the lower end of the rectum composed principally of dilated blood-vessels.” While this may be a perfectly satisfactory definition from a medical point of view, it is not what patients understand by the word “piles.” By the word “piles” they understand “any condition which produces symptoms in the neighbourhood of the rectum.” Thus piles will be used to describe such varied conditions as fissure, pruritus ani, cancer, and even fistula or abscess. It is very necessary to bear this in mind and to proceed to examine the case with an unbiased mind. If I were asked to define “piles” for a popular dictionary I should define the word as “any condition in the neighbourhood of the anus which causes unpleasant symptoms.” Patients get very confused in describing their symptoms; indeed, one man even went so far as to inform me that he was suffering from piles on his mother's side—a rather unusual distribution!

Unfortunately our own use of the word “piles” is little better than the public's, as we use the same word to describe such utterly dissimilar conditions as external thrombotic piles and internal hæmorrhoids.

I propose this evening to confine my remarks to true piles, meaning thereby the varicose tumours

found just within the anal canal. I do not propose to weary you with a discussion of the ætiology of piles; they may be due to hereditary influence, to occupation, to habits or to lack of them, but the fundamental cause is walking about on our hind legs instead of on all fours. As it is not likely that the human race will ever be willing to abandon an erect posture, the probability is that piles will remain a permanent source of inconvenience to large numbers of the population. I am constantly being asked by patients what they can do in the way of altering their habits, &c., to prevent the formation of piles. Should they drink or smoke less, or what foods should they avoid? I always reply that man was not meant to be a slave of his piles, but that they should follow the advice of the scriptures and if their piles offend them have them plucked out, but that it will be advisable to have them plucked out skilfully by a duly qualified person.

THE DIAGNOSIS OF PILES.

Now first of all a brief word about the diagnosis of piles. There is only one way by which piles can be diagnosed, and that is by seeing them; except in very exceptional circumstances they cannot be felt, and if anyone diagnoses internal piles as the result of a digital examination of the rectum, you may seriously doubt the accuracy of his conclusion. If the piles prolapse they can be easily seen, and this is the best way to see them, as one can then best estimate their severity. It often happens, however, that the piles do not prolapse or cannot be made to do so at the time, and then it is necessary to use a speculum. For that purpose, by far the best is the tubular speculum used at St. Mark's Hospital, which enables the piles to be seen *in situ* quite easily and without causing discomfort to the patient.

SYMPTOMS.

There are a number of symptoms which may be caused by piles, but by far the most common are prolapse and hæmorrhage. It is usually one of these which causes the patient to consult a doctor. As a rule the history of a case of piles follows a very definite sequence. First, there are very occasional attacks of slight bleeding at stool; later, in addition, occasional discomfort lasting a few days or weeks, but with complete freedom from any trouble in the intervals, which are often long. As time progresses the attacks of bleeding become more severe and more frequent, and there are occasional attacks of prolapse when the piles come out during defæcation and cause considerable discomfort. The next stage is marked by less bleeding but an increasing degree of prolapse, so that it always occurs after stool and difficulty is experienced in replacing the piles. In the last stage, and the one which compels the patient to seek assistance if he has not already done so, the piles come outside not only at stool, but on the slightest exertion, so that it eventually becomes impossible to keep them from prolapsing except by foregoing any active exercise. It seems almost incredible that patients

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should put up with such a distressing state of affairs, and yet they frequently do not seek advice until they are almost reduced to the condition of chronic invalids. One reason, no doubt, is that the progress of the condition is often very slow, so that they almost imperceptibly pass from one stage to the other and hardly realise what slaves they have become to an easily remediable ailment.

Occasionally bleeding is the chief symptom, and may be so serious as to threaten life. I have on at least two occasions seen a patient die from hæmorrhage caused by piles before anything could be done to save him, and have several times had to operate on patients who were in such a serious condition of anæmia that transfusion was necessary before the operation could be safely performed.

Prolapse.—The most distressing symptoms of piles are, however, caused by prolapse. When the prolapse comes down and becomes strangulated, replacement of the prolapsed mass becomes impossible in a very short time. This condition of strangulated piles is exceedingly painful and may be dangerous. I once saw a patient die from pelvic cellulitis and abscesses in the liver, caused by a mass of strangulated and gangrenous piles which could not be replaced and which were in too septic a condition to be operated upon. Quite recently I was called down to the country to see a gentleman who had a large pelvic abscess presenting in the left iliac fossa, which had resulted from an attack of strangulated piles which he had neglected. Fortunately he recovered after a distressing illness.

Pruritus ani is another symptom which may result from piles, and many cases of severe pruritus ani have arisen as the result of neglected piles. Unfortunately if the pruritus has persisted for any considerable time, mere removal of the piles will not get rid of the pruritus.

When piles have existed for a long time they may undergo degenerative changes, generally as a result of previous attacks of strangulation, or partial strangulation. The internal piles may become converted in time into large fibrous polypi which gradually develop a pedicle as the result of efforts on the part of the bowel to force them out. I have seen a fibrous polypus as large as an egg which had arisen in this manner.

It is a remarkable fact that piles produce in some persons quite a serious degree of depression—out of proportion often to the severity of the symptoms. I have seen a grave degree of melancholia thus produced which has been immediately cured by the removal of the piles. Apart from melancholia the irritability of temper which piles often cause may be the source of much domestic disquiet.

TREATMENT.

I do not propose to discuss the treatment of piles by means of drugs, ointments, suppositories, &c.; as although there is no doubt that the symptoms caused by piles can be considerably allayed and the progress of the condition much retarded by such means, that is the utmost that can be attained.

Piles once really formed cannot be got rid of permanently by such means, and the symptoms will certainly recur again, and the condition will progress even in spite of persistent treatment. Such treatment often results in the patient spending many hours a week in treating his piles and introducing medicaments, in his giving up many of his favourite habits and occupations, and often in time results in reducing him to a condition of chronic slavery to his rectal condition. In these days it is absurd for any patient to put up with such a state of things, when he can be easily cured with the maximum of safety and the minimum of inconvenience.

I have in the last 25 years performed over 5000 operations for piles and done over 4000 injections of piles, and I propose to give you briefly my conclusions from this experience.

There are in my opinion only two methods of treating piles which are worth serious consideration; these are injection and removal by operation.

Treatment by Injection.

First let me say something about treatment by injection. In the last few years the treatment of piles by injection has been boomed by various persons as if it were something quite new and wonderful and had only just been discovered. Now, as a matter of fact, the injection treatment of piles has sometime ago passed its jubilee at St. Mark's Hospital, and I belong to at least the second, if not the third, generation of rectal surgeons who have systematically practised the method. It is a good method of treating piles which has survived the test of time and of experience. It has, however, very definite limits of usefulness. It has suited the desires of many of those who have gone out of their way to boom this method of treatment to state that in it we have a complete substitute for operation, and that it affords a permanent cure of the condition. Neither of these statements is true. Not only have I treated a very large number of cases of piles by this method myself, but I have been afforded the opportunity of seeing a considerable number of cases that have previously been treated in this way by others. I would sum up my experiences of the injection treatment, as follows:—

In experienced hands, and by that I mean those who have been taught how to carry out the treatment properly, it is quite free from danger to life and there is practically no risk of serious complications. The treatment causes no pain and practically no inconvenience, and the patient is not confined in his movements or occupation while undergoing the treatment except in so far that it is necessary for him to see the surgeon at proper intervals. The results are excellent, but are not permanent. In the majority of cases—considerably over 50 per cent.—the symptoms recur after an interval which varies from 18 months to 3–4 years. In a few cases the results are permanent, but these are mostly when the piles were small and in an early stage. I don't estimate the proportion of actual cures of well-established piles by this method of

treatment as more than about 30 per cent., if as much. Further the cases must be properly chosen; the treatment is not applicable to very bad cases of prolapsing piles, or to cases where there are a lot of external swellings.

The injection treatment is by no means easy; it requires considerable practice and a good deal of technical skill to do well. Anybody can inject piles, but without the necessary skill a lot of bad results will ensue, such as pain during and after the injections, sloughing of the piles, formation of ulcers and failure to cure the condition. I have even seen bad fistulæ result from injection, but this has been when improper solutions have been used for the injection. The worst solution in my experience is urea-quinine-hydrochloride. I have never used it myself, but have seen very bad results from its use by others. The solution I always use is a 20 per cent. solution of carbolic acid in glycerine and water. Some surgeons prefer to use a 10 per cent. solution, but I have never had any bad results from the stronger solution, and have always preferred it. This solution negatives any possibility of sepsis and, owing to the very small quantity used, cannot cause poisoning, even should it get into the circulation.

It has been stated that this method of treating piles may result in infarct of the lung, but this is not the case. The injections cause an aseptic inflammation in the cellular tissues of the pile, which is followed in about a week by an aseptic thrombosis of the veins in the pile. It is improbable that any of these small clots will become loose in the circulation, but should they do so they will be arrested in the liver where they will not cause any serious harm. Only very large clots in the portal circulation can cause trouble unless they are septic. I have never seen or heard of a case of infarct of the lung following an injection of piles by carbolic acid, and do not see how it could possibly occur.

The number of injections required to get rid of all symptoms in a case of piles of moderate severity varies considerably, but I should put the average as about six.

Operative Treatment.

By far the best method of treating piles is by operation, and so safe and satisfactory has this method become of recent years that it often surprises me that patients should put up with the inconvenience of piles at all, when they can be cured so easily by a simple and safe operation. Indeed, I do not know of any other operation, or indeed treatment of any kind, which give such uniformly safe and satisfactory results as the operation for internal piles. As I have already stated I have done over 5000 operations for this condition and can therefore give you some facts as regards the results, which should be reliable.

First with regard to the risk of such an operation, for this is the question that every patient will ask when an operation is suggested. Now I suppose if one cut the nails of a sufficiently large number of

persons some of them would die during the following two or three weeks, so that you could never say that a death had never followed even such a simple operation as cutting nails. I have never had a death which was traceable directly to the operation, and out of the whole number only two patients died during the convalescent period. One of these died from acute encephalitis on the twelfth day after an operation for piles, which was proved bacteriologically to have had no connexion with the operation, and it is probable that the condition was incubating at the time of operation. The other patient died on the twelfth day from sudden heart failure following the administration of an enema. Both these patients would almost certainly have died in any case and their deaths were not in any way attributable to the operation. So that for practical purposes one may say that there is no mortality from the operation for piles if proper care is exercised.

I had better state at this stage that although I have at different times performed all the well-known operations for piles, all but a very small percentage of the operations I have performed for this malady have been my own modification of the ligature operation, which I am firmly convinced to be by far the best, and my remarks as regards the results of operation refer to this operation.

Having dealt with the question of the safety of operation, the next most important questions are: (1) The ultimate results as regards freedom from further trouble, and (2) the amount of pain and discomfort which an operation will entail.

Ultimate Results.—As regards the ultimate results, it is obvious that to give an absolutely authoritative answer it would be necessary to trace the history of a large number of patients who had been operated on for 30 or 40 years. This is hardly possible, but I have been following cases of my own now for close on 25 years and have had opportunities of seeing the end-results of other surgeons' operations during periods previous to that. Also at St. Marks Hospital we see very many patients who have been operated on for piles very many years before. The ultimate results of operation are extremely good, and while one cannot say that recurrence of the piles *never* occurs, the percentage of such recurrences is less than one-tenth of 1 per cent., or less than 1 per 1000. Also in those cases where there is recurrence I generally find that there is some definite reason, such as disease of the liver causing chronic portal congestion, chronic alcoholism which doubtless operates in the same way, or chronic morphinism, which probably acts by causing very severe constipation. I know of one patient who for over 20 years has regularly taken from 6 to 10 gr. of morphine daily. During that time he has been operated on three times for internal piles.

These remarks only apply to cases where the ligature operation has been performed by a surgeon who is thoroughly competent. In looking through my case books I find that fully three-quarters of all cases of recurrence after pile operations are cases

where the operation has been performed by a surgeon with comparatively limited experience in the performance of the operation. One has to remember that pile operations are constantly performed by all kinds of doctors, and as a matter of fact most of the bad results occur in such cases.

The proportion of recurrences after such operations as local excision of the piles and Whitehead's operation are relatively high, and it is mainly for this reason that these operations have been abandoned. The recurrences after Whitehead's operation are very frequent, and I must myself have operated on several hundred cases where a Whitehead's had previously been performed. Stone,¹ in an analysis of the after-histories of 185 cases of Whitehead's operation, found some impairment of control in 37 cases, and definite recurrence in 14, a truly deplorable tale.

After-pain.—To turn to the question of after-pain, this is almost entirely a question of operative technique. The most important point is asepsis, and the next most important point is to avoid stretching the sphincter muscle and bruising of the parts by rough handling. The operation for piles should be carried out as aseptically as any other operation. This is by no means difficult and only requires careful technique. If proper asepsis is observed there is complete absence of pain after operation, as I have proved in hundreds of cases.

Thus in a series of 200 consecutive operations performed in private, of which I kept careful record (143 being men and 57 women), 28, or 14 per cent., complained of pain sufficiently severe to require one injection of morphia, and in only 8, or 4 per cent., was the pain bad enough to require more than one injection. In all the other cases pain was either completely absent, or was so slight that it was adequately relieved by a dose of aspirin or a hot-water bottle.

As regards the *period of convalescence*. With the ligature operation this is 12 days, and a further few days at home before resuming ordinary life. The following figures are taken from St. Mark's records :—

Average Stay in Hospital after Operation in Days.

Ligature oper.		Clamp and cauter.		Whitehead's.	
M.	F.	M.	F.	M.	F.
10·8	12·2	10·7		20·7	22·1

M. = Males; F. = Females.

The same methods of technique which have been instrumental in abolishing pain after operation, careful asepsis and care to avoid bruising of the tissues, have as might have been expected, also very considerably diminished other post-operative complications. Thus retention of urine, which used to be common, is now quite a rarity, and I do not have to pass a catheter in more than about 1 per cent. of cases. Hæmorrhage has also become much less common. When hæmorrhage does occur it is usually about the seventh day, and I do not

think this complication can ever be entirely avoided, but whereas it used to occur in at least 2 per cent. of all cases, it now only occurs in about half of 1 per cent. I have never lost a patient after operation from hæmorrhage, and no hæmorrhage should ever be fatal, provided that the services of a surgeon are available. But it is never safe to leave a patient after an operation for piles in such circumstances that if hæmorrhage occurs the services of someone capable of stopping the bleeding are not available. Apart from anything else, it will be certain to be that particular patient who will bleed. The week-end habit has come to stay and affects all of us, but it should not be allowed to jeopardise the safety of our patients.

A certain proportion of cases after operation show a tendency to contraction of the scar and consequent formation of stricture, but proper after-treatment will quickly and effectively overcome this difficulty. Real stricture only results from prolonged sepsis, and this should be extremely rare in these days, though it was common enough when surgeons did not realise the importance of rigid cleanliness. Most of the cases were traceable to the use of dirty enema nozzles after operation.

Incontinence after operation can only occur from grave carelessness and consequent injury of the sphincter muscle, or from severe sepsis, neither of which should be possible with a competent operator.

THE LIGATURE OPERATION.

You will have gathered that I am in favour of the ligature operation in practically all cases. The only other operation which I regard as worth considering is the clamp and cautery. This latter gives quite good results, but in my opinion not quite so good as those with ligature. I do not propose to describe the actual details of the operation as you are probably well acquainted with them, and in any case they are better seen than listened to, but I would like to emphasise the following points :—

Absolute asepsis is essential if there is to be freedom from pain and complications. This requires considerable care both in the preparation of the patient before operation and at the operation itself. I have often heard it stated that absolute asepsis of the rectum is not possible and many surgeons firmly believing this make no attempt to secure aseptic conditions when operating on the rectum, although they will take elaborate precautions against sepsis when operating on some other part of the body. Consistently good results can never be obtained in rectal surgery without rigid asepsis. I have had a series of bacteriological examinations made to test the field of operation just before commencing an operation for piles, and the results showed no growth at all in the cultures. Special methods to secure asepsis have to be used, but they are not difficult to learn. In the first place the rectum must be absolutely empty at the time of operation, and to secure this at least 24 hours preparation is required. Antiseptics

¹ Annals of Surgery, 1913, 647.

should be freely used, but should be such as will not coagulate the mucus. The best in my opinion is lysol, about two drachms to the pint, aided with liquid soap. Thorough washing out of the rectum with this, followed by a lysol douche one drachm to the pint will get the mucous membrane of the rectum just as clean as the skin, or even more so, for there is no hard epidermal layer to hold organisms.

I have found that after the operation the best way of preventing infection of the wounds is by the free application of sterilised vaseline.

Another important point is not to stretch the sphincter muscle; this is quite an unnecessary brutality, the only advantage of which is to give the surgeon freer access to the field of operation. I never stretch a normal sphincter and never find any difficulty in obtaining access to the parts. Stretching the sphincter only causes pain and bruising. Plugs should never be inserted into the rectum, and at most only a small rubber tube which is useful in controlling oozing.

As I have already stated, I prefer the ligature operation and I believe that it is the best procedure from every point of view. At one time I, like others, thought that some kind of excision operation, where the wounds were subsequently sewn up with catgut, might give better results. Experience, however, has disproved this. No operation in which the wounds are stitched up is satisfactory when dealing with the rectum, because primary union cannot be secured in less than about eight days, and it is not possible to prevent the patient's bowels from acting for so long a period as this. An open wound which has started to granulate does not become infected if the bowels are moved gently, and is, therefore, much preferable to any wound which has been sewn up. As a matter of fact, what I found with excision and sewing up of the wounds was that while about two-thirds of the cases healed very well and without trouble, the remainder had considerable trouble. Submucous abscesses, fissures, and ulcers resulted, which in not a few cases necessitated secondary operations before the patient was cured. These operations have now been almost entirely discarded, though almost every week we see someone describing some new patent method of his own.

The operation involving sewing up of the wound which enjoyed the biggest vogue was Whitehead's operation. You will no doubt remember that it was claimed for this operation that as it removed all the "pile bearing area"—whatever that is!—a recurrence of the condition was impossible. As the result of experience we have found that by far the greatest number of recurrences have occurred after this operation, not to speak of other more serious complications which it often gave rise to. Whitehead's operation is now almost entirely obsolete and soon will be quite so.

The clamp and cautery operation gives very good results and has this advantage, that from the nature of the operation it is performed aseptically, and will,

therefore, probably give better results where the surgeon is not able to secure aseptic conditions for operating. The chief disadvantages of this method are a greater liability to secondary hæmorrhage, and the fact that it is not easily applicable where very large or numerous piles have to be dealt with. There is also a greater tendency to the formation of external tags after the clamp and cautery than after the ligature operation.

AFTER-TREATMENT.

The after-treatment for a case of piles is very important and is often neglected. The bowels should be confined for three days. It is quite unnecessary to keep the bowels locked up for longer than this, for great discomfort will be caused from wind and distension. My own practice is to give liquid petroleum by the mouth two days after operation, and on the morning of the fourth day an enema of olive oil and gruel is given with a soft catheter. The patient is then allowed to get up and use a night stool, and after the bowels have acted he has a hot bath. After this the bowels are relieved daily. The patient is allowed ordinary solid food, beginning as soon after the operation as he wants it, generally beginning with dinner on the night of the operation day.

Except for getting up to relieve his bowels and have a bath the patient is confined to bed till all the ligatures have come off. This is generally on the twelfth day after operation. He is then allowed to get up and return home in a day or two, but is warned to keep quiet for another week, after which complete liberty of action is allowed.

TREATMENT OF STRANGULATION.

It may happen that one is first called in to see a patient in whom the piles have prolapsed and become strangulated. The first thing to do is to see if the piles can be returned. This is usually impossible if the piles have been down for more than a few hours. The best way of replacing them is by means of small pieces of cotton-wool on the ends of one's fingers and steady even pressure on the piles which have come down last. If the piles can be pushed back a rubber tube should be inserted to prevent them coming down again. The chief difficulty is that it is often impossible to get the piles to remain up at all. Under such circumstances it is useless to persist as no good will come of it and much pain and distress will be caused. There is always a large mass of swollen skin at the anal margin and no attempt should be made to push this up—a mistake which I have often known made.

The best treatment at the time is hot baths and lead and opium compresses and some suitable sedative, such as morphia, to relieve the pain and help the patient to sleep. Ice should not be applied as it is liable to cause sloughing owing to the poor circulation in the strangulated tissues. If left alone the condition will gradually subside in about ten days or a fortnight.

The best subsequent treatment is to wait for a day or two till the more acute symptoms have passed off, and then to operate and remove the piles and cut away some of the swollen external parts and shell out the clots. This wants doing carefully as, owing to the swelling of all the tissues, it is difficult to gauge the amount of tissue to remove. The advantages of immediate operation are that the patient is saved a considerable amount of time, and is up and about again much sooner than would be the case if one waited to remove the piles till all the swelling had subsided.

Lastly, let me give a word of advice. *Never* treat a case of piles without first examining the patient both visually and with your finger. More medical reputations have been made and jeopardised by cases of piles than by appendicitis!

WEST LONDON HOSPITAL POST-GRADUATE COLLEGE.

THE monthly staff consultation was held at the Hospital on Monday, Oct. 12th, at 4.30 P.M. Thirty-eight post-graduates and general practitioners were present, and among the cases were the following, which showed points of considerable interest.

1. A boy of 4 years of age had been brought up to the hospital by his mother because she had noticed that he had been limping for a week or two. The boy complained of no pain and there was no history of any injury. On cross-examination it was found that he had had a bad sore-throat rather more than two months before. On examination a swelling was found on the upper third of the right femur. It was slightly tender and quite hard. The X ray examination showed an area of localised rarefaction about the size of a small walnut, surrounded by a considerable amount of sclerosed bone. The diagnosis made was chronic abscess and treatment advised was operative.

2. A boy of 12 years of age who complained of pain over the left internal femoral condyle. The duration in this case was also about three weeks and there was no definite history of injury, but tenderness was complained of. On examination the end of the femur was found to be definitely enlarged and the X ray photograph showed a certain amount of spiculation, especially concentrated in a small area which seemed to be about an inch outside the internal condyle. There was also some periosteal thickening and sclerosis round the diaphysis. The differential diagnosis in this case lay between a sarcoma and syphilis. As the child had only been in the out-patients' department a few hours before, a Wassermann reaction had not been taken. The child was admitted for further investigation.

3. A boy of 8 years of age had been brought up to the hospital by his mother with a history that he had had a fall three days before, and she had noticed a tender swelling on the outside of his left knee. On examination a hard, fixed nodule was felt about the epiphyseal line on the outer side of the left tibia. There was bruising on the skin over it and it was tender. Further examination, however, showed similar masses in the head of the opposite tibia and also in the shoulder and elbow-joints. X ray photographs were shown of these and a diagnosis of multiple familial exostosis was made. No special treatment was advised, as it was pointed out by the surgeon showing the case that these exostoses seldom require removal,

unless by their position they interfered with tendons or nerves in their neighbourhood.

4. A boy of 6 years old was shown with a fracture of the lower end of the humerus. The fracture had taken place three weeks before and the X rays showed considerable malunion with forward displacement of the upper end, which was almost ulcerating through the skin of the front of the arm. The point of interest in this case was that complete flexion was rendered almost impossible by the projection forward of the lower end of the upper fragment, and the discussion on the case centred round the problem as to whether it would be better to operate immediately in order to deal with the lower end of the upper fragment, or whether, in consequence of the nearly ulcerated condition of the skin in this situation, it would not be wiser to leave things as they were.

5. A very rare case of blastomycosis was shown. It was pointed out that this disease is practically unknown in England, but the patient had lived all his life within two miles of the hospital and followed the occupation of a wood-chopper. He lived in a very damp room near the river. The occupation and the surroundings are those which are practically always found in the history of those suffering from this disease. The patient was being treated with large doses of potassium iodide and deep X ray treatment for the ulcers.

6. A man, aged 22 years, was shown with a painless swelling about the size of half a walnut two inches behind the left ear. There was a history of having been hit with a cricket ball several years ago, and also a blow while boxing two years previously. The swelling was gradually increasing in size, and the patient had come up to the hospital complaining of the constant swishing or buzzing noise which it made in his head. On examination it was obvious that the swelling was composed of dilated blood-spaces, and the differential diagnosis lay between cirroid aneurysm and an arterio-venous aneurysm between the occipital artery and the lateral sinus.

The pros and cons were very fully discussed by the members of the staff present, but no doubt was expressed as to the treatment. The position of the swelling rendered the patient liable to severe hæmorrhage from any slight accident, and the amount of inconvenience caused by the noises in the head clearly indicated removal.

Reviews

ABDOMINAL AND PELVIC SURGERY FOR PRACTITIONERS.

By RUTHERFORD MORISON, M.A., D.C.L., LL.D., F.R.C.S. London: Oxford University Press. 1925. With 9 illustrations. Pp. 212. 8s. 6d.

NOTHING so disconcerts a doctor as a serious abdominal case, especially if it is acute, for he has to decide whether or not prompt operation is essential. Mr. Rutherford Morison truly says: "The fate of a patient, the victim of an abdominal emergency, depends chiefly upon the skill and promptitude of his doctor." Teachers have, over and over again, preached this, and the mortality among such victims cannot be lowered unless more and more doctors act as did the writer of the letter given by the author on p. 61. We agree with Mr. Morison that this letter should be pasted up in a prominent position in the consulting room of every doctor in the Empire.

This book is purely clinical; it relates almost entirely to diagnosis, no operation is described, most instructive cases are given, we are told when to operate and when not to do so, it is brief and yet not a mere catalogue of facts. All the sections show that the author has soundly and judiciously gathered together the lessons of an immense experience. This he gives to the profession in clear language; each page is interesting, and if everyone engaged in the practice of medicine would spend one evening, once a year, in reading through this small but delightful work, the gain to himself and the community would be great.