CLINICAL LECTURE ON RECTAL FISTULA AND HÆMORRHOIDS.

Delivered at the Westminster Hospital.

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GENTLEMEN,—We have had, lately, numerous cases of rectal disease in our male and female wards; but, as the subjects of rectal fistula and hæmorrhoids are sufficient for one lecture, permit me to introduce typical specimens of each disease:—1, rectal fistulæ; 2, external hæmorrhoids; 3, internal hæmorrhoids.

1. *Rectal Fistula*.—The young delicate man in Mark Ward, H. H., aged 26, single, is suffering from three fistulæ, namely, one buccal fistula, one incomplete, and a third complete rectal fistula. His buccal fistula was set up by the extraction of three molar teeth at one sitting (one in the right upper, two in the right lower jaw); abscess followed, and a sinus two months afterwards, through which a piece of the inferior maxilla passed. Then his rectum gave inconvenience; he noticed a moisture at the anus, pain in defæcation, and general lassitude, compelling him to leave off his office work. He has been operated on, and is now quite well; strangely enough, his mother has also been operated on by myself at Westminster for rectal fistulæ a few weeks after her son's admission. She is also quite sound now.

There is necessity for surgeons to be more accurate in their naming these common affections. For example, the name "fistula in ano" is wrong. The anus is but a line; and fistulæ are either on the rectal or the perineal side of this line, so I shall teach you that abscesses in this quarter may be perineal, ischio-rectal, sacral or rectal, and are rightly so named according to their respective situations and aperture; that "fistula in recto" is a term only applicable when one of these abscesses opens into the rectum, in addition to a second opening on the perineal side; and that "fistula in ano" is but rarely, if ever, really seen.

Fig. 1.

It is quite the exception for me, in hospital practice, to examine a patient (supposed to have rectal disease) unless he be under the influence of an anæsthetic. Any such examination, without sleep, is ineffectual, and the necessary examination and operation are conveniently linked, to the great relief of the patient, and to the satisfaction of the surgeon. Therefore, preparatory to a careful examination, order the rectum to be thoroughly cleaned with warm soap and water, and then place him at once on the operating table; these remarks apply equally to abscess, fistula, or hæmorrhoids. In trivial cases, cocaine may act well as a local anæsthetic, but, in most cases, a general anæsthetic is better, as giving more scope for an extended operation in time and space, and mitigating very much the unpleasant-

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ness to the patient, whose feelings must be hurt at the necessary exposure.

The posture of your patient must next engage your attention. Let him lie on the back, with his nates all but overhanging the edge of the table, and his wrists and ankles linked by leathern straps and buckles. It is extremely easy to elevate any perinæum by two assistants using the legs as levers, working towards the armpits. This plan is especially useful in private, where your client's perinæum is not unfrequently eclipsed by a feather-bed; and, as the surgeon economises time, secures a full view, and has full scope for instrumental manipulation by his attention to these details, do not omit to lay stress on such suitable posture. In external hæmorrhoids, decubitus on the left side, at the edge of the bed, may suffice for examination after the operation has been performed.

The next point to be attended to is the speculum. I have used my own wire speculum (Fig. 1) for ten years, and, practically, I cannot wish for a better one; it is clean and roomy, giving the maximum of view of the vault of the rectum with the minimum of space occupied, and allowing a probe, or forceps, or knife, or scissors to pass easily between its bars.

Before use, you can warm and oil it; after use, place it into a can of boiling water, and it is ready, then, to be at once wiped clean and dry. Its cost is only five shillings; this, and the other instruments mentioned in this lecture, have been made for me by Messrs. Wright and Co., 108, New Bond Street.

You will pass the speculum carefully and gently, and, in a case of fistula in recto, you are now to clear up the doubt (if any exist) as to the fistulous track being complete or incomplete (that is, whether the perineal sinus communicates or not with the rectum).

My old and illustrious teacher, the late Professor Syme, used, to emphasise the fact that many of the so-called fistulæ in recto did not communicate with the rectum, but were only true fistulæ after the surgeon's probe had pushed through and ruptured the mucous membrane of the rectum. Feeling sure that Mr. Syme would not have made such a statement without good reason, I have repeatedly made use of the following practical operative procedure; and am prepared to corroborate his testimony by a proof of fact. If you take one of my hydrocele syringes with a pointed glass-nozzle (Fig. 2), and fill it with milk, and

Fig. 2.

Fig. 3.

insert the same nozzle into the perineal wound (your eyes being fixed on the mucous membrane of the rectum, seen through the speculum), and inject slowly the milk, you will find one of the two following circumstances happen: (1) the milk will run through the rectum out at the anus as a white stream; or (2) you can see the white injection through the transparent membrane bulging into the rectum, or insinuating itself on its submucous track along the rectal wall. This demonstration

has been frequently given by me on rectal patients in this theatre, and appears conclusive and indisputable.

The complete division of the sinus or fistula and the sphincter recti muscles is the only operative treatment required; and the necessary instruments are a grooved probe and sharp-pointed bistoury. You need not use the speculum in all cases; but, should you do so, the steps of the operation can be traced with exactitude by the senses of sight and touch; the speculum permitting much scope for both. After the operation, be scrupulously clean in your treatment; and, if the patient suffer pain, splint his bowel with opium; and use an enema of warm water prior to a natural motion. Cod-liver oil and steel are good drugs in these cases; but I attach more importance to a good nutritious bland diet, and rest in bed until cicatrization is completed. In cases where the healing process is slow, one touch of the platinum-cautery (flash of fire) stimulates the parts, and promotes contraction.

External Hemorrhoids.—Often the redundancies of skin around the anus are due to syphilitic hypertrophy, or to simple inflammatory thickening, or really have, for their nucleus, a distended and misshapen hemorrhoidal vein; such exaggerations become more exaggerated after injury or excess, and then give acute pain to the patient. Rest in bed, cleanliness, temperance, and enemata will often suffice; but, should operative measures be decided upon, you may with safety cut off all such superfluities outside the circle of the anus, and treat the wounds as ordinary superficial sores. In any suspiciously vascular tumour, make use of the ligature (as any nevus would be treated in any other position of the body), and so effect insurance against hæmorrhage. Cleanliness really more suggests this method than any real danger to the patient; for, so far as my experience goes, hæmorrhage is alone to be feared when occurring within the intestine. Here let me insist on the peculiarity of the circle of veins around the rectum (these hemorrhoidal veins), from an anatomical, pathological, and therapeutic point of view. Anatomy teaches us that these venous junctions, situated at a dependant and unsupported portion of our bodies, and readily affected by heat, cold, or exposure, eventually fall into the general venous and portal venous circulating main streams. Hence, any sluggishness in flow may be accentuated by the general or portal conditions; and the duplicate conditions of a sedentary life with portal obstruction, double the chances of an intemperate slugard being a victim to piles, by reason of this venous trysting place being markedly influenced by both causes. Moreover, in treatment, temperance, regulated exercise, and the recumbent posture (according to discretion), illustrate really mechanical aids, and permit easy explanation of success through the study of anatomy. Should any external hemorrhoid be very vascular, or suggestive of giving trouble by primary or secondary bleeding, you may prefer adopting the usual treatment for internal hemorrhoids to the ligature; and this leads me on to describe the method usually adopted by operating surgeons at the Westminster Hospital.

Treatment of Internal Hemorrhoids.—In Cooper's *Surgical Dictionary*, you can read how, in 1828, the use of the cautery was deemed old-fashioned and obsolete; now, in 1885, the cautery is, beyond others, our therapeutic agent. The present introduction of clamping the piles, and burning them off, is due to the late Mr. Cusack, of Dublin; his instrument has been improved by Mr. Henry Smith, of King's College Hospital; and the clamp which you know I am fond of using (Fig. 3) is a modification of my own. What you require in any clamp are, 1, firmness of grip; 2, quick action; 3, a non-conducting medium placed between hot platinum knife and your patient's skin. You will find that these conditions are complied with in my instrument.

M. Paquelin's benzoline cautery has superseded the clumsy, dirty, and primitive hot irons. This cautery is before you, and needs no special description now.

In using the clamp, first clean the surface of the piles, which descend on slight provocation, and, so far as practicable, hold your instrument in a line radiating from the anus, and grip a convenient mass, and not too much at once; by so doing, you will be less liable to injure long tracks of the sphincter recti muscles, and you emphasise the benefit of the cautery. Some surgeons consider that the blades of the clamp must be parallel, and that bleeding is apt to result at the end of the mass caught by blades which are not parallel. I cannot remember one single instance where this accident has happened to myself, for I have never yet been introduced to an internal hemorrhoid so indurated as to resist the great power and purchase of my clamp-handles. Fixity of tenure is absolutely secured by the clamp, therefore the fault of not securing the pile rests rather with the surgeon than with the instrument. Occasionally, in cases complicated with ulceration of mucous membrane, a distinct artery can be noticed bleed-

ing *per saltum*. The first case that I saw of this nature occurred in the practice of that good British surgeon, John Hilton, at Guy's Hospital; he tied the vessel, and the hæmorrhage naturally stopped. You must do the same, and you must not be too proud to examine the vessel on which your patient (so suffering) has been sitting; for the arterial splash and colour on the white china are easily recognisable; and thus the real nature of the disease is painted in its true colour, and prints its own mark. After all the hemorrhoids have been carefully removed, inject about one ounce of sweet oil into the rectum; and, should oozing be free, plug the rectum. Practically, a sponge covered with oiled silk, and compressed by a strong pair of bone-forceps, is the best means for gaining security from hæmorrhage; and a piece of string attached to both prevents any inconvenience from retention of the sponge in the rectum.

I have been in the habit of condemning the digital application of sponges as almost useless, for not sufficient expansile force is exercised on the capacious rectal wall; whereas the use of the compression and leverage by the bone-forceps allows the sponge to be readily introduced into the rectum, and its expansion follows upon the gentle removal of the blades, one finger preventing any protrusion of the sponge during the withdrawal of the bone-forceps. This most useful pair of pincers is now before you on the table.

Fig. 4.

Lastly, your patient requires a bandage to support his perineum, and to allay straining. (Fig. 4.) I will now show you how to put on a capital bandage for this and other operations, requiring a T-bandage; it is simple and efficient, applicable for hernia, varicocele, prolapsed rectum, ruptured perineum, etc. The surgeon only requires an ordinary broad bandage; and by arranging it in the manner shown in the woodcuts (anterior and posterior view), an efficient and comfortable support is given. The shoulder strain is in the right place, and no pressure is caused over the abdomen; its security also renders the bandage available for varying surgical dressings. I have never liked the ordinary T-bandage, for it causes most uncomfortable pressure on the abdominal wall; and, if really efficient, tends to compress the very system of veins which, I have told you, require favour and relief from congestion.

The after-treatment consists in good nutritious non-stimulating diet, rest in bed, the moderate use of opium, and retention of feces, so as to avoid the action of that complicated group of muscles necessary for the act. I have often had my patients pass two or even three weeks without any action of the bowels; and, although to the general patient this confinement seems very dreadful, any ill effect can be readily overcome eventually by a warm soap and water wash. The sponge is usually expelled or withdrawn on the succeeding or second day, and recovery is complete in about one month from the day of operation.

In concluding this lecture, let me give you my own opinion on the very great value of male attendants as nurses in these cases of hemorrhoids in men, or in any case of operation on or near the generative or perineal portion of a man's body. Surgeons are not sufficiently explicit on this point; for such cases need constant cleansing

and occasional lifting; and, excellent as women nurses may be as subalterns in easy forms of general surgery, or in cases of their own sex or children, yet commend me to the trained and disciplined service of a male attendant, as my non-commissioned officer in operations, such as I have now brought before you.

CLINICAL LECTURE ON THE TREATMENT OF DETACHMENT OF THE RETINA.

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THE lecturer commenced with a brief reference to the causes and nature of detached retina, and to its diagnosis, and proceeded:

Detachment of the retina has always been held to belong to the class of cases for which remedial measures can do but little, and this, despite much vaunted new drugs and surgical procedures. The cases, however, which you have seen in our clinique, and some of which I bring before you in more detail to-day will, I doubt not, have convinced you that, at all events in some cases, our art is able to accomplish a good deal. ~~There are~~ the methods that may be pursued for the treatment of this affection, that I ask your attention; and let me bring now before you some of them, and others save at length.

Rest in bed, in the recumbent position, and in a darkened room, is a desirable proceeding; and, at the same time, a compressive bandage may be applied over the affected eye. To this may be added the application of the artificial tooth to the temple, and the internal use of iodide of potassium. The object of all treatment is the restoration of the detached retina to its proper position, and a great means towards this end would be accomplished if the subretinal fluid could be absorbed. In this way much was hoped from jaborandi, and, shortly after it came into vogue, its alkaloid pilocarpine was extensively used, and was favourably spoken of by some writers. It was used in our wards some time since, in a good number of cases, with, however, a doubtful beneficial result. We looked in vain for the excellent successes of which others had spoken, but, in most instances, it certainly did no good; and it is questionable whether, in other hands, it occupies now a prominent place as a curative agent. Its use, moreover, is not pleasant to the patient. No one can, perhaps, deny that, in some cases, benefit has resulted from one or other of the methods of treatment just referred to; but, generally speaking, if any, it has been slight and transient, and the disease has soon become again, if temporarily checked, progressive.

Let us pass now to the surgical or operative side of the question. Many years since, Gräfe passed a needle through the sclerotic, and punctured the retina. In this way, he hoped the underlying fluid would escape into the vitreous chamber. Sir William Bowman improved on this method by employing two needles.

These methods, however, looking at the subject from the manner in which other collections of fluid are treated, were hardly what were required. If there be fluid in the pleura, the chest-wall is tapped, and the liquid evacuated; and the same in other parts. Why could not such a procedure be adopted in the case of subretinal fluid? Sichel is said to have punctured the sclerotic as long ago as 1859 to let the serous fluid out, and Gräfe, of Halle, has recently adopted such a procedure extensively. The credit of introducing these measures undoubtedly belongs to those just mentioned; but Dr. Wolfe, of Glasgow, has also practised a scleral incision, and has recorded some very successful cases. Gräfe performs his operation by telling the patient to look well upwards, and then, seizing with forceps a fold of conjunctiva in front of the equator, he punctures the sclerotic between the inferior and external recti muscles, and the fluid escapes. De Wecker has sought, it may be mentioned, to accomplish the evacuation of the subretinal fluid, and the re-application of the membrane to its proper place, by the insertion of a fine gold thread seton in the sclerotic. I have never felt disposed to make use of this method.

In a large number of cases I have, however, punctured the sclerotic, and have adopted the plan already referred to, as well as one in which the knife was entered under the conjunctiva, some little distance in

front of the selected point for puncture of the sclerotic. In this way, the latter was made subconjunctivally.

Dr. Wolfe proposed that the conjunctiva should be separated in front of the region of sclerotic where it was intended to incise it, and it was thus laid bare. He claims considerable success for his operations. It has been contended that there is little difference between the procedure he advocates and that adopted by Gräfe. In practice there is, I believe, a considerable difference in favour of proceeding in the way Dr. Wolfe suggests. This, at all events, is my opinion, after experience with both methods.

In Gräfe's, the fluid escapes underneath the conjunctiva, and, besides remaining there for absorption, there would very possibly in some cases be a limit to which drainage would take place, with semi-resistant structures over and around the scleral puncture. In Wolfe's the sclerotic is bared, and the fluid readily drains away. I may mention also that, ever since using the electro-magnet for searching the vitreous body, I have been familiar with the advantage of dissecting up a flap of conjunctiva, to bare the sclerotic at the selected point for incision. Sclerotic wounds heal well. The conjunctiva may be united by a suture, but this is sometimes unnecessary.

Let me now draw your attention to cases which have been under treatment, and which you have had the opportunity of observing from time to time.

CASE I.—You will remember William C. A., policeman, aged 43. He first came under notice on December 1st last. Ten weeks before, on closing the left eye, he discovered that the sight of the right eye was very defective. On examination, we found a distinct detachment of the retina on the outer and lower side; it did not reach to within a little distance of the optic papilla, but it extended from the more baggy portion in a less defined manner. $V = \frac{1}{6}$, and there was no improvement with + or - glasses. Tension was normal, and the vitreous humour was clear. The only assignable cause was that in the discharge of his duty he had been in sundry disturbances, and received blows on the head from stones. He was ordered iodide of potassium, and a few days later he was made an in-patient. Rest in bed, with compressive bandage in addition, was prescribed.

On December 21st, no appreciable improvement had, up to this date, taken place, and it was determined to puncture the sclerotic. For this purpose, cocaine was instilled, and the conjunctiva was separated up to a point between the external and inferior recti, nearer the latter than the former, and towards the equator. This place was selected because it was there that there was the greatest collection of fluid. After bleeding had ceased, the sclerotic was incised with a Gräfe's cataract-knife, at the equator, and the direction was meridional. Not merely a puncture was made, but the knife was allowed to cut its way for a little distance, making, perhaps, a wound as long as two widths of the knife; the wound was kept open by turning the knife on its axis; some amount of fluid, but less than had been anticipated, escaped. He was placed in bed, and the eyes covered with a bandage, and the after-treatment pursued which will be referred to in detail further on. Slight improvement followed the operation. There was still some detachment at the outer side; it had nearly gone below where the puncture had been, and the greatest bulging was on the upper and outer part. On February 8th, 1886, the sclerotic was again punctured, and, this time, the site selected was between the superior and external recti—nearer the latter. A large quantity of fluid escaped. He was kept in bed a week. The detachment became very much less. On February 22nd, there was still a little detachment, but it was very decidedly less since the operation. The field of vision had improved, and, as he said, he had recovered the power of seeing towards his nose. $V = \frac{2}{3}$. March 2nd, $V = \frac{2}{3}$; he read Jager 16.

He is here to-day. He speaks of a great improvement in his condition by the operations. I am indebted to Mr. Bishop for recording the notes of this case.

CASE II.—The other patient you have also seen many times, both in the wards and in the out-patient room. He tells us that, on February 5th, he found, on accidentally covering the right eye, that the left was very dim. He came under our observation on the 12th, and the manner in which he described his visual defect at once attracted attention. He could not see, he said, anything towards his nose. Examination disclosed a large detachment involving all the outer half of the retina, reaching close to the optic disc. Its inner edge was somewhat oblique from above downwards, and the detachment formed a bag which moved freely, and evidently contained a large quantity of fluid. He could see objects, fingers faintly, by turning the eye outwards. The field of vision, roughly taken, showed it to be wanting entirely on the nasal side, and contracted above and below.

He was urged to enter the infirmary with a view to operation. This he declined to do at once, but was made an in-patient on the 15th.