which was connected with the heating apparatus beneath the floor. Every person who entered the operating theatre had to take off his coat and wear a sterilized one, and also had to wear big rubber boots in order to complete the precaution against the introduction of stray pathogenic organisms into the operating room. Lastly, we were incarcerated for a few minutes between two doors in the wall of the operation theatre whilst a current of sterilized air was passed over us. By taking all the above precautions Professor Iversen was able to prove that the gospel of surgical cleanliness could be observed without the use of antiseptics in clean operations. Modern operating theatres in our public hospitals are built in such an expensive fashion that it is not possible for the middle and upper classes to get their operations done under such palatial surroundings. A hundred and fifty years ago it was only the well-to-do who could command the services of a medical man; to-day it is only the poor and the working man who gets the best places in which modern operations can be performed according to present-day ideals. The fallacy of these high ideals is shown by the result of operations in private houses.

Some years ago, whilst gleaned information and hints from hospitals at home and abroad before the erection of our new aseptic operation room in Cardiff, I was much impressed with the extraordinary varieties of basins and taps that were in use for surgeons to wash their hands in. It would be waste of time to describe the devices which I saw in use for preventing the surgeon soiling his hands after washing them in water. In one place a nurse was told off to turn on and off the hot and cold water taps, in other places three levers were worked by foot in order to avoid being shadowed by a nurse, but yet one could not get tepid running or falling water to wash in, and had to be content with stagnant water in a basin. Some taps had handles which were "manipulated" by the leg, or the knee, or the elbow, and one had two separate crutch-shaped levers for the hot and the cold supply, and were controlled by the front of the biceps region being placed in the crutch! In the bewilderment and complicity of the above appliances for washing we fell back upon the shampooing taps of our ancient associates—the barbers—and had them fitted over a basin at such a distance that one can wash his hands and forearms in running or falling water at any temperature desired. The single handle of the shampooing tap is turned off by the surgeon himself by using the sterilized ebonite shield which is kept in $\frac{1}{2}$ carbolic lotion. Washing in falling water is so important and still so rarely seen in practice that I think our simple mechanical device is worthy of record. (Fig. 3).

Fig. 3.

There are other fashions in the manufacture of surgical appliances which are of little importance were it not for the inconvenience and the unnecessary expense that we are subjected to by their adoption. When I started practice every instrument was made with a "take off" joint, a fixed joint being considered unorthodox and "old-fashioned" like the old unwashed operating coat, but it was not long before one experienced that one half of the instrument got astray during critical moments, and the blessings of the surgeon took the practical form of going back to the ancient screw joints that he could depend upon.

Lastly, I will just refer to the superstition that grew up a few years ago against wood being used as material for operating tables. Every operation theatre that had a wooden table in it was at once a fitting theme for the jeers, jibes, and sneers of the up-to-date surgeon whose new instincts demanded glass, iron, steel or some new alloy that theoretically lent itself to the chase and death of the ubiquitous germ! Still plain wooden tables answer the purpose as well, if not better, than those of the more expensive fashionable forms, because in this country, and any other country that I know of,

the patient's naked back and the table's top are never in immediate contact and are not sterilized for a condition which patients would not tolerate for a single moment. Wood is a non-conductor and is relatively comfortable for contact with the naked skin, whilst metal is a good conductor, is difficult to keep clean and warm, and soon chills those who are unfortunate enough to have to lie on it; the myth of their "superior asepticity" over wood is upset by the very practical fact that during operations some warm non-conducting porous material is placed under patients. Surgeons who disbelieve in the efficacy of thread gloves often depend upon the efficiency of sterilized towels being placed under or over garments worn by patients; seemingly they are not frightened by the possible stealthy creeping of a wandering microbe through towels from tables or parts of the body other than the hands.

I believe that the present desire of surgeons is towards the simplification of the ritual of the gospel of cleanliness and to the adoption of sensible methods which can be observed in places other than the modern palatial halls of our public hospitals.

REMARKS ON THE VALUE OF THE SIGMOIDOSCOPE IN THE DIAGNOSIS BETWEEN PRIMARY AND SECONDARY COLITIS.

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At the present time, when the subject of colitis is receiving considerable attention from both surgeons and physicians, it is not, I think, out of place to draw attention to some of the more important points in the diagnosis of this condition. It has often seemed to me that colitis is not infrequently labelled as a disease in cases where it is merely a symptom. Thus, cases where there is chronic diarrhoea or frequent discharge of mucus with the faeces, and even cases where there is little more than some undue looseness of the stools, are often called colitis, and treated for that condition without any further evidence than that afforded by the symptoms, and perhaps a digital examination of the rectum.

In these days when we are beginning to recognize the paramount importance of diagnosing and treating disease in its earliest stages, it is most necessary that in all cases where such symptoms are present a most careful examination should be made before treating the case as one of colitis.

In addition to the information obtained from an examination of the stools, which should, whenever possible, be supplemented by a report on the chemical and microscopical characters, the diagnosis rests upon (1) an examination of the abdomen, (2) an examination of the bowel.

EXAMINATION OF THE ABDOMEN.

This may result in the detection of some abdominal condition to which the colitis is secondary, or at least accessory. Such conditions, for instance, as a chronically inflamed or thickened appendix, which though it may not have given rise to a definite attack of appendicitis, may yet be the cause of the colitis. Or a freely movable kidney may be discovered which, by pressing or dragging upon the colon, may be the chief factor in the production of the colitis. The hard rope-like feeling of the colon, as felt through the abdominal wall in some cases of colitis, is also an important diagnostic point in some cases, as it indicates an unduly irritable condition of that portion of the bowel.

THE LOCAL EXAMINATION OF THE BOWEL.

A careful digital or bimanual examination of the rectum should always be made in order to exclude any rectal cause for the symptoms, as there are several conditions of the rectum which may somewhat closely simulate colitis in symptomatology.

CASE I.

A gentleman, aged about 50, had for some time suffered from some looseness of the bowels and a feeling of discomfort in the anus. He said that he had a feeling as if the bowel had not been emptied, and a constant feeling of weight in the part. He was thought to be suffering from cancer of the bowel. A careful examination, however, excluded the presence of any growth in the rectum or pelvic colon, and led to the discovery of a much-hypertrophied anal papilla, which was undoubtedly the cause of his symptoms.

It is now possible by means of the electric sigmoidoscope to examine the whole of the rectum and the greater part of

the pelvic colon directly; most valuable information can thus often be obtained. I believe that a careful examination of the pelvic colon with the sigmoidoscope ought always to be made in cases in which symptoms of colitis exist. Serious errors in diagnosis can thus often be avoided and definite information can be obtained on which a rational line of treatment may be based. Those cases in which the symptoms of colitis are due to a tumour (simple or malignant) situated high up in the bowel can by such an examination be separated from those in which the cause of the colitis is different, and a growth perhaps detected at a date when its removal is still possible. The two following cases are good examples of this:

CASE II.

A woman, age 42, under my care at St. Mark's Hospital, had suffered from diarrhoea for about three months before I saw her. The bowels acted several times a day and the stools consisted largely of slimy mucus. She passed considerable quantities of mucus at times. During the last month the bowels acted six or seven times in the twenty-four hours. At no time had she ever seen any blood in the stools. When I first saw her she had been under treatment at another hospital for colitis for six weeks. A careful digital examination of the rectum revealed nothing abnormal. I was inclined to believe that the case was one of true mucous colitis, especially as she had never passed any blood, and had a history of attacks of pain in the abdomen, followed by diarrhoea and the passage of much slimy mucus. I have recently made it a rule, however, always to examine such cases with the sigmoidoscope as a routine. And in this case the examination revealed the presence of a malignant stricture situated about 7 in. or 8 in. from the anus.

A careful examination seemed to indicate that the growth could be successfully excised from the abdomen. At the operation, however, I found on opening the abdomen that there were several secondary malignant glands up the side of the aorta, and I was therefore obliged to abandon the excision and perform colotomy.

CASE III.

The patient was a man, aged 63, who was under my care at St. Mark's Hospital in November, 1904. Eighteen months before I saw him he had an attack of diarrhoea, accompanied with considerable pain and tenesmus. This lasted for about six weeks, and then stopped. There was no blood in the stools. Two other similar attacks of pain and diarrhoea had occurred between this and the time when I first saw him. During the last attack he noticed a little blood with the stools on one or two occasions. On examining him with the sigmoidoscope, I found a papilloma about the size of a five-shilling piece situated on the posterior wall of the rectum between the middle and upper Houston's valves. I subsequently removed the growth, after excising the coccyx, and restored the rectal wall. The patient made a good recovery, and has remained well since.

A case is recorded by Dr. Pye-Smith in the *Transactions of the Pathological Society* (vol. xlvii) which is very similar to my first case:

The patient was a woman, aged 50, in Guy's Hospital. She had been suffering for over a year from constipation with distension of the abdomen and occasional attacks of diarrhoea. During the whole time she had been passing, at frequent intervals, large soft gelatinous shreds, and more or less complete mucous casts, per anum. She had frequent gripping pains, and there was visible peristalsis of the intestines. A microscopical examination of the casts showed that they consisted of mucus. The patient died, and at the *post-mortem* examination it was discovered that she had a carcinomatous stricture at the commencement of the sigmoid flexure. The colon both above and below the stricture was greatly thickened and distended. After removing the adherent mucus, the mucous membrane of the colon was found to be normal except at the site of stricture.

Dr. Pye-Smith mentioned two other similar cases, one of Dr. Goodhart's and one of Mr. Hutchinson's.

These cases show, I think, that typical symptoms of mucous colitis may exist with a malignant growth of the bowel and that without a careful local examination it is often impossible to distinguish between a case of simple mucous colitis and one of malignant disease of the bowel.

In other cases, again, an examination with the sigmoidoscope reveals the presence of ulceration and further often enables us to ascertain the position and limitations of the ulcerated area and thus to form a definite opinion with regard to the best method of treating it. In fact the examination with the sigmoidoscope replaces a more or less guess-work method of making a diagnosis in such cases by an exact observation.

CASE IV.

The patient was a young man, a patient of Dr. Bruce Porter, aged 27. Three years ago, while in South Africa, he had a bad attack of diarrhoea (said not to be dysentery), for which he was treated in hospital. His stools at that time consisted of blood and slime. He got slightly better, but more or less ever since he has suffered from diarrhoea and has passed blood and slime. On returning to England he got much worse, and when I saw him with Dr. Bruce Porter he was much emaciated, was suffering from more or less continuous diarrhoea, and was

passing much blood and mucus. An examination with the sigmoidoscope revealed the presence of numerous shallow ulcers with a granular base extending throughout the whole of the sigmoid flexure. The appearance of the ulcers was not tuberculous. A careful examination of the discharges showed the presence of pus, but there were no tubercle bacilli or bilharzia parasites. Considerable improvement followed a carefully-regulated diet and irrigation of the colon.

In cases of real mucous colitis an examination with the sigmoidoscope is sometimes the only method by which we can be certain that we are dealing with that condition and not with a new growth in the pelvic colon. This is well shown in Case v. The similarity between the symptoms in this case and in Case i, where the symptoms were due to cancer, show how impossible it is to make a correct diagnosis without a direct examination of the parts such as can be obtained with the sigmoidoscope.

CASE V.

The patient, a man aged 35, was employed as a chef. For about three months he had suffered from diarrhoea and constipation. The bowels often acted six or more times in the day, and the stools consisted largely of slimy mucus. He had never passed any blood. The attacks of diarrhoea were generally initiated by colicky pains in the abdomen. There were often periods of constipation between the attacks. A careful examination was made of the abdomen, and the pelvic colon and rectum were also examined with the sigmoidoscope. Beyond some slight congestion of the mucous membrane, however, nothing abnormal was found. I came to the conclusion that the case was one of mucous colitis, and he was placed upon von Noorden's diet. The symptoms disappeared almost at once, and he remained free from his trouble until some months later, when he got a recurrence, as the result of dietary indiscretions. A return to the diet, however, was again effectual in getting rid of his symptoms.

In the present position of our knowledge of the numerous conditions of the large bowel which are often grouped under the name of colitis, it does not seem possible, or even desirable, to attempt to classify these various conditions too exactly. But I think it is most important that the greatest care should be taken to exclude carefully the presence of any definite lesion of the bowel before attempting to treat a patient with symptoms of colitis. The cases I have quoted seem to me to prove how utterly fallacious a diagnosis of colitis based entirely upon symptoms may be. And I believe that a careful examination of the pelvic colon with the sigmoidoscope should be made a routine practice as a preliminary to treatment in all cases of colitis.

WANDERING SPLEEN: HAEMORRHAGE WITHIN THE CAPSULE: SPLENECTOMY: RECOVERY.

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Cases of wandering spleen are, generally speaking, of sufficient rarity and sufficient interest to place on record. The following instance presents some unusual features even in this uncommon condition, which invest it with additional clinical and surgical value.

REPORT OF CASE.

History.

P. L., aged 54, sent to me by Dr. Knott, of Southsea, was a spare woman of healthy rosy complexion; she was married, and had had nine children, five of whom were living; four had died of children's complaints. She had always had good health and normal confinements; had never suffered from any abdominal or other injury, and till the present illness had never felt any pain or inconvenience in the abdomen or pelvis.

She stated that about two months previous to her admission to the Royal Portsmouth Hospital on November 5th, 1904, she had influenza, though in the light of future developments it is more probable that her illness was associated with some pathological changes in the tumour. While recovering from this attack, which, whatever its nature, was accompanied by the usual symptoms of feverishness, she was seized with sudden pain in the lower abdomen, retching, and faintness. She stayed in bed for a week, during which time she had fever and profuse perspirations, but no return of the pain after the first day. Dr. Knott attended her during this illness, and discovered a tumour in the lower abdomen. The acute symptoms subsided quickly, and did not return up to the time of my seeing her two months afterwards.

When I first examined her, at the end of October, a largish tumour occupied the false pelvis and lower abdomen, extending