This procedure is not over-difficult, and can be carried out by anyone possessed of even ordinary manual dexterity. It is easier than the podalic version advocated by some authorities. Rotation of the child in this manner on its long axis involves a decidedly smaller risk than performing an internal version or a Caesarean section—as recommended by the radical school.

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NOTES ON THE INJECTION TREATMENT OF INTERNAL HAEMORRHOIDS

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It is unnecessary at this stage to restate the advantages of this method of treatment of a very common and annoying disability. The advocates of operation for every case of piles do not seem to realize that for every patient who comes to the surgeon prepared to undergo an operation there are perhaps thirty suffering a minor degree of discomfort who are content to tinker with ointments prescribed by the nearest chemist and enthusiastically advertised in the lay press. This group of patients will never submit to operation unless their symptoms become aggravated, and it is precisely this group which responds in a gratifying manner to treatment by injection.

After five years' experience of this method I feel that there are certain refinements of technique which simplify handling of the case, and obviate most of the unpleasant sequelae which sometimes occur after injection.

Choice and Preparation of the Solution.—I think that most surgeons interested in this branch of proctology will agree that, looked at from all angles, a 5 per cent. phenol-in-oil solution is the most satisfactory one to use. Sloughing and secondary haemorrhage, which admittedly occur, only occasionally seem to be inseparable from the use of a solution which involves direct injection into the pile; since the phenol in oil is injected above the pile-bearing area this complication is avoided. It is most important that the oily solution be prepared correctly. Several writers have observed the onset of influenza-like symptoms following an injection, and have attributed them to various factors, such as the use of sweet-almond oil, mixture of water with the injecting fluid, or the use of large quantities of the solution. Following on a series of baffling cases, and with the aid of Mr. Buxton, dispenser at the New Somerset Hospital, Capetown, I have succeeded in tracing the factor responsible. The symptoms are analogous to those of protein shock, and if the vegetable oil be boiled for an hour and then filtered, the phenol being added subsequently, this complication will not occur. In other words, the process of preparation should be similar to that of the oleum phosphoratum of the B.P. The choice of oil is immaterial. After a trial of peanut oil I have gone back to using sweet-almond oil as the diluent.

Spacing of Injections.—As a general rule, and unless there is special need for hurry, it is wisest to inject at weekly intervals. It is a little difficult to observe the result of an injection if the period between is shorter, and occasionally the fluid will leak through a puncture made only a few days previously. The total number of injections varies, of course, with the case, but it is advisable at the end of treatment to ask the patient to return after a month. At this stage one further injection will often consolidate the cure. In looking over my records and contrasting them with operation cases in order to reach a decision on the vexed question of recurrence, I have been impressed with the necessity of one or two additional injections after the piles are to all intents and appearances

cured. I think there can be no question that in bad cases the percentage of recurrence is higher than it is with operation, but—in my opinion this is an important point—these recurrences are still amenable to treatment by injection, and respond very favourably in the end. It is a significant fact that medical men, when they come as patients themselves, ask to be injected in preference to submitting to operation, despite their knowledge of the perceptibly higher recurrence rate.

After-pain.—The slight discomfort following an injection may become very real pain if too large a bleb is raised subjacent to the mucous membrane. This is to be expected if we consider that an increase of tension will give rise to pain in any part of the body. The temptation to hurry on the cure must be resisted if the treatment is to be truly ambulatory. Occasionally patients are seen for the first time in an attack of acutely inflamed piles. The angry red prolapsed piles and the oedematous anal skin present a very formidable sight. Rest in bed with alternate hot and cold applications, followed by injections when conditions have returned to normal, will give good results. Injections during the acute stage may give rise to endless trouble.

Coexistence of Fissure.—No injection should be attempted in the presence of a fissure. Even where operation is indicated for the fissure it is preferable in many cases not to remove the piles at the same time, but to leave them for injection subsequently.

Badly Prolapsed Haemorrhoids.—It is in this group that the highest percentage of recurrence takes place. The first few injections should be given more deeply than usual, an endeavour being made to glue the mucous membrane to the muscular coats. Usually the injection is made with a view to raising a definite bulge, yet avoiding whitish discoloration of the overlying mucous membrane. In prolapse cases the preliminary injections are made with the needle passed just deeply enough to avoid a bulge. Occasionally in injecting through an area stiffened by previous injections some of the solution will leak through. It is better to wait a day or two and begin lower down, giving the needle an upward inclination.

Skin Tags.—Cases are frequently seen where oedematous skin tags bear witness to previous attacks of inflammation or thrombosis of external piles. Injections cannot, of course, cure these, and if they interfere with cleanliness they must be excised. In the standard operation for piles insufficient removal of redundant skin will leave the patient with an annoying reminder of his previous trouble. We are apt in our dread of post-operative stricture to err on the side of caution, and it is in such cases that it is useful to mark out, previous to operation, with methylene-blue, the area of skin to be removed.

RECONDITIONING OF TONSILS BY THE DIATHERMY CURRENT

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It is frequently noticed that infection of the tonsils—the first of a chain of lymphatic structures intimately associated with the digestive tract throughout its length—will be followed by a spread to the gall-bladder, appendix, colon, and locomotor system. In the past the only treatment has been surgical, of which the best is removal by dissection. From cases which have come under our notice we have definite clinical evidence that, as a rule, partial excision, scarification, and “firing” by the electro-cautery are more conducive to subsequent trouble than if the organ had been left intact. The ideal