(a) A pile is then clamped in a long narrow-bladed forceps (Fig. 1) (Kocher's artery forceps answer admirably).

Fig. 1.

(b) The redundant mucous membrane and pile is cut away by scissors (Fig. 2).

Fig. 2

Fig. 4.

(c) A curved needle threaded with catgut hardened in formalin is then inserted immediately above the clamp and the end of the catgut secured by a knot (Fig. 2).

(d) A continuous suture is next rapidly applied round the clamp (Fig. 3).

Fig. 3.

(e) The clamp is withdrawn (this can be done without the slightest difficulty) and the suture tightened, leaving a vertical line of continuous sutures within the rectum (Fig. 4). The upper end of the ligature, which is left long for the purpose, should be held firmly in the left hand whilst the lower end is being tightened, so as to prevent puckering.

(f) Each pile is treated similarly in turn.

The advantages of this method are that it can be very rapidly carried out; there is no loss of blood; the suture, being continuous, is an efficient haemostatic after the forceps have been removed; it cannot possibly slip, so there is no danger of subsequent haemorrhage. No raw surface being left, the bowels are encouraged to act regularly from the first. As a rule patients are up and about at the end of a week. The catgut is absorbed in eight to ten days and does not require removal.

NOTE ON INTESTINAL ANASTOMOSIS: SPECIAL FORCEPS.

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THE accompanying illustrations represent some anastomosis forceps which were made for me by Messrs. Down Brothers, and which other surgeons may find useful. They consist of two forceps each $6\frac{1}{2}$ in. long, with very slender well-tempered spring-arched blades three-sixteenths of an inch wide. These may be covered with indiarubber tubing, and the compressing force is so slight and yielding that the gut is not injured by their application. To one forceps a thumbscrew is attached, concave on the surface, and $\frac{1}{2}$ in. in diameter. It is so made as not to become completely detached and therefore cannot be mislaid. The other forceps has a slot and depression corresponding to and receiving the thumbscrew when the two forceps are combined (Fig. 1).

For use, the gut beyond the part for removal is clamped by the separate forceps and the diseased bowel excised, leaving

Fig. 1.

sufficient gut beyond the forceps to admit convenient suturing (Fig. 2). Then the two forceps are clamped together in

Fig. 2.

parallelism, as in Fig. 3, the combination being conveniently held in one hand. For suturing, a posterior peritoneal stitch

Fig. 3.

may be first inserted (1), and then the mucous and muscular coats united (2). This stage is seen half completed in the figure. Finally, the posterior peritoneal stitch is again picked up and used to unite the anterior peritoneal surfaces. The union is shown completed in Fig. 4, the bowel contains water without leakage, and the union is secure.

The chief advantages of this instrument are the possibility of union in layers, the steady approximation of the ends of bowel for anastomosis, the use of only one hand for holding the approximated ends, the absence of any marked internal

Fig. 4.

diaphragm when the union is complete, and the availability of the independent forceps for use as intestinal clamps.

THE PRESENCE OF DIPHTHERIA BACILLI IN ATROPHIC RHINITIS.

[A PRELIMINARY COMMUNICATION.]

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THE presence of Klebs-Loeffler bacilli in the nasal cavities of persons suffering from atrophic rhinitis was first noticed by Bellfante and Vedova¹ in 1895, and these observers expressed the opinion that the disease was caused by an attenuated form of the diphtheria organism. Their observations were subsequently confirmed by Attilio.²

Fraenkel and Loewenberg³ have ascribed the causation of the disease to a diplobacillus (closely resembling Friedlaender's pneumo-bacillus) which they have named the bacillus mucosus. The constant presence of this bacillus has been confirmed by Abel and others, and I mention it here as it was frequently present in the cases dealt with in the present paper. The bacillus mucosus is, however, generally believed to be the cause of the fetor and not the direct exciting cause of the disease "atrophic rhinitis."

Atrophic rhinitis has to be distinguished clinically from disease of the nasal fossae resulting from congenital or acquired syphilis, from rhinitis sicca, and from a form of atrophy which follows hypertrophic rhinitis such as is common amongst the tobacco workers of this city. Ozaena is a symptom common to all these conditions but it is only a symptom, and the correct diagnosis of the disease must be made from a consideration of the history and the rhinoscopic appearances. True atrophic rhinitis is distinguished by the pallor of mucous membrane, the shrinking of the bony structures, the formation of crusts, the penetrating character of the ozaena, the cachexia induced in the sufferer, and the presence of a leucocytosis.

Excluding as far as possible other diseased conditions of the nose such as I have already named, I have made bacteriological examinations of the nose in 23 cases of atrophic rhinitis. Twenty of these cases were females and one a male; in two I have no note of the sex. The ages varied from 9 years to 57 years, the average age being 22 years, only three of the patients being more than 25 years of age. The average duration of symptoms was seven years, but in one case the condition had been present forty-five years. In 75 per cent. the sense of smell was absent or defective, and with one exception ozaena was noticeable in all the cases either by the patient or other persons.

The material for bacteriological examination was taken from the nose by means of sterile cotton-wool swabs, and from these films were prepared and cultures made. The films were stained by methylene blue, Gram's or Meissner's stains. The culture media employed were glycerine agar, serum agar, and occasionally broth. Many of the cases were examined on several occasions.

In twenty of the twenty-three cases (87 per cent.) a bacillus was found resembling in morphological and cultural