remained tender and swollen for weeks, but gradually became less so; yet even so late as February 8th, a flat area of induration, with slight tenderness, was very evident at the injection site in both of us. At the same time as the injection a drop of the solution was instilled into my own conjunctival sac, and into that of Mr. Riddell and Mr. Williamson, students of medicine. No anæsthesia of the cornea or conjunctiva was observable in any of us. It had no perceptible action on the pupil or accommodation.

On purpose to institute a comparison between the effects of this drug and of cocaine, Mr. Middleton and I subjected our forearms to the action of cocaine. On January 29th, at 12.25 p.m., 5 minims of a 10 per cent. solution of cocaine were hypodermically injected into the back of each of our left forearms. The act of injection was much less painful at the moment than that of either of the solutions of drimine. After five minutes (at 12.30), a patch of skin over the spot elevated by the injection, the patch being $\frac{3}{4}$ of an inch in greatest diameter, oval in shape, with its long axis corresponding to that of the forearm, was anæsthetic to the prick of a needle, while the sensibility around was perfect. At 12.43 the anæsthesia was so complete on the patch that incisions, made slowly and deliberately down to the aponeurosis of the forearm, caused no pain in my case, and only slight discomfort in that of Mr. Middleton. At 12.45 the wounds were sutured, painlessly to me, and nearly so to Mr. Middleton, in whom the anæsthesia was throughout less perfect than in myself. At 12.50 the above patches became surrounded by an area of rosy redness, over which sensation was decidedly diminished. These areas increased in size, were oval in shape, and extended down the forearm from the point of injection, but scarcely ascended above it at all, and were on Mr. Middleton's arm of a rounded oval shape, on mine more of a ribbon form. At 12.50 their measurements were 2 by $3\frac{1}{2}$ inches in Mr. Middleton, and 4 by $1\frac{1}{2}$ inches in me. Surgical needles could be passed through the skin with little pain, and an incision was made in my forearm down to the aponeurosis, without intolerable discomfort. The suturing of this incision was disagreeable, but not actually painful. At 1 p.m. (25 minutes after the injection), these areas of deadened sensation occupied one half the circumference of the forearm, and everywhere within them the sharp points of a pair of dressing scissors could be scored over the skin, so as to scarify it, without causing actual pain. Sensation of contact however remained, and was never entirely abolished. This was possibly due to the movements communicated to the deeper parts. The anæsthesia corresponded pretty closely to the area of redness of the skin. In Mr. Middleton a secondary patch of complete anæsthesia appeared for a short time, 2 inches below the injection site, and was, like the patch there, of oval shape, and about $\frac{3}{4}$ of an inch in greatest diameter. The anæsthesia faded more rapidly on my arm than on Mr. Middleton's. The wound made began to smart badly at 2 p.m. with me, in Mr. Middleton's arm not until 3.30 p.m., or three hours after the injection.

It seemed as if the insensibility were due to a gradual diffusion of the cocaine through the subcutaneous tissues from the point where it was introduced. The wounds made under cocaine healed badly in both our arms, showing more inflammation, induration, and pain than should have been expected on my arm, while, on Mr. Middleton's, the wounds suppurated superficially. In neither of us was the induration gone on February 8th, that is, ten days later.

These experiences indicate pretty clearly that, as a local anæsthetic, drimine has little, if any, effect, and certainly cannot be compared with cocaine. It is possible that the drimine supplied to me may have been altered in composition or have otherwise lost its effect during its prolonged transit from the Antipodes. This suspicion is, I think, strengthened by a letter I received (after the above notes were written) from Dr. Reid's brother, who writes: "The sample sent was stale through exposure; another sample sent at the same time was quite decomposed." Fresh supplies are, however, expected, and, if they reach my hands, shall be duly submitted to trial, and the results made public.

MR. J. S. MORGAN has offered £10,000 towards the fund being raised for Guy's Hospital, provided the required £100,000 be raised on or before May 1st next.

ROYAL ASYLUM OF ST. ANNE.—The annual festival of the Royal Asylum of St. Anne's Society was held on February 22nd; and, as the report shows that a large proportion of the boys and girls clothed and educated by the Society are the children of members of the medical profession, it seems but justice to call attention in these columns to the admirable work accomplished by this noble charity. In lending their hall for the purposes of the festival, the Salters' Company set an example which might well be followed by other companies.

A NEW AND IMPROVED CLAMP FOR HÆMORRHOIDS, WITH NOTES ON THE OPERATION OF CRUSHING.¹

By CHARLES JOHN SMITH, M.R.C.S.,
Formerly Surgeon to the Farringdon Dispensary.

TO-DAY I have the pleasure of submitting, for the first time to a meeting of my professional brethren, a new, and—as I hope I may be justified in claiming for it—an improved clamp, for the now almost universally accepted operation of crushing piles. Of the various crushers introduced for this operation, two only (Benham's and Allingham's) have come into general use. The unwieldy crusher, known as Benham's, has fairly yielded to, if it has not been quite superseded by, Allingham's fenestrated instrument; but even his excellent clamp appears, in my humble opinion, to possess certain disadvantages, which it has been my endeavour if possible to

overcome. What measure of success has been obtained in the clamp now submitted to this meeting, time and experience will show. In my own hands it has—somewhat naturally, cynical critics may feel inclined to say—fully answered expectations; and I am able to affirm that its efficiency, as a crusher, has been fully equal to the economy of time gained in its use.

The principle upon which it was formed will at once strike all who, being of mechanical turn of mind, have had occasion to handle the "spanner" or "screw-hammer" of the workshop. The action is direct. The upper bar, it will be seen, is, by a slow acting screw, drawn down upon the lower bar; the slow screw giving an amount of power that is very striking compared with the quicker acting screw which I used in my first instrument.

The lower bar, it will be noticed, has a return at its extremity; for this important modification of my original design, I am indebted to my friend, Mr. Blaker, of the Sussex County Hospital, who pointed out the advantage to be gained by preventing the possibility of the escape of any portion of a pile under treatment. That this was, indeed, a most important point, I demonstrated in a case I was operating upon a few days back—when, for the sake of experiment, I put my first designed instrument on a largeish pile—and found that, as soon as pressure was brought to bear upon it, there was an escape of tissue which might have been fatal to the success of the operation. It is but right that this valuable suggestion

of Mr. Blaker's should thus early be acknowledged by me.

The experience already gained has suggested no other modification, although perhaps a broader grip for the left hand might with some advantage be given; this is a matter easily arranged with the makers of the instrument, Messrs. Maw, Son and Thompson, whom I would here thank for the kindly interest they gave and the trouble they took, in producing the clamp strictly in accordance with my directions.

The mere description of the instrument now given is a poor apology perhaps, for the time and attention which have been so kindly accorded by this meeting. I will, then, with some diffidence, venture to supplement this, by mentioning a few points in connection with the operation itself, which have occurred to me in my experience.

First, then, as to preparing the patient. It always has been insisted, and always should be insisted upon, that the bowels are well

¹ Read in the Section of Surgery at the Annual Meeting of the British Medical Association at Brighton.

cleared out prior to the operation; in ordinary cases, a good dose of castor-oil, given the day before, will suffice, but if the large intestine appears to be unusually loaded, a brisk purge once or twice before this will be distinctly advantageous. A recent case, in which I was called upon to operate rather hurriedly, brought this very uncomfortably home to me, for the patient, soon after the operation, began to pass bulky motions, and developed a decided tendency to diarrhoea. This condition of things kept me very anxious lest hæmorrhage should result; but I took at least this comfort from the case—which, up to the present, has done well—that my crusher had satisfactorily performed its task, while it also set me to consider how far it is really necessary to keep the bowels quiet for many days, as is the custom, with opium. To return: on the morning of the operation, a warm enema should be used, to ensure the perfect emptying of the lower bowel. No food should be allowed for some two hours before the operation; this minimises the chance of sickness after the anæsthetic. The anæsthetic I usually employ is the A.C.E. or 1.2.3. mixture, which, as you know, consists of 1 part of alcohol, 2 of chloroform, and 3 of ether, but in the case of women, I always use chloroform alone; for this reason: I have found ether produces in women a considerable congestion of the vessels of the rectum—indeed, in one or two cases, the whole area has appeared a darkly congested mass. The why and wherefore of this I have not yet discovered. I can only state what I have found to be the case. Next, I should lay stress upon the importance of fully dilating the sphincter, and drawing down the gut as much as possible, so that a perfect view of the field of operation may be gained. Operators will bear me out in my statement that this is of the utmost importance for the easy and efficient dealing with the piles. In the JOURNAL for July 31st, there is an account of a little instrument designed by a namesake of mine, Dr. F. A. A. Smith, of Portsea, for the purpose of securing the perfect protrusion of the piles. I hope to have an early opportunity of using that instrument.

The next point I endeavour to gain is to crush the piles, so that the wound is made in the axis of the transverse diameter of the bowel. I do not know that there is very much in this, but it is a “fad” of my own, based upon the supposition that as dilatation of the gut is in that direction, less strain is likely to be put upon the wound by adopting this course. At the same time that I endeavour to compass this object, I am careful to include as little tissue as possible within the bars of the crusher; and this is one advantage that I claim for my clamp,—it can be more easily adjusted under the tenaculum with which the pile is seized.

Having crushed the pile, I allow the clamp to remain closed for two minutes; there is no doubt that a less time would suffice, but I prefer being on the safe side.

Another point I would mention is the method of dealing with a pile which comes down to the verge of the anus. In such a case, having seized the pile, I detach it by a cut, which I make where the mucous surface joins the skin. I found, if this were not done, I got considerable swelling of the wounded skin, which not only gave rise to much unnecessary pain, but produced the appearance of inflamed external piles. On one occasion, when I had operated upon a patient of Dr. Mackey and Dr. Withers Moore, of Brighton, I had subsequently to snip off these inflamed tags; this is altogether an undesirable business, and, as such, to be avoided.

Concerning the after-treatment, I have little or nothing to say which is novel. I have always followed the excellent teaching of my master, Mr. Allingham. Just lately I have modified the T-shaped bandage which supports the pad of cotton-wool upon the anus. This I do in accordance with a plan illustrated recently in one of the medical journals, by carrying a bandage over the shoulders, thus relieving the patient from the discomfort of pressure round the waist. Up to the present time, I have been lucky enough to escape all trouble from hæmorrhage, save in one case, that of the patient mentioned just now. In that case there was bleeding very soon after the operation, lasting for some days, but, happily, never severe. It was due to the patient, a self-willed lady, insisting upon enthroning herself upon the night-stool within a short time of the operation (which event, by-the-by, she celebrated by taking a pint of champagne), and having from the outset discarded pad and bandage.

In two cases I have had some little trouble with the wound, but I found that suppositories of hamamelis and iodoform stimulated them to healthy action. Here let me parenthetically mention that the objectionable odour of the iodoform may be well disguised by the addition of one-eighth of a grain of coumarine to each suppository. This not only removes the odour, but replaces it by a perfume which is, I believe, that of the active principle of the Tonquin bean.

One word, in conclusion, as to an objection which has been raised to

this operation in persons of comparatively advanced age. I have heard it gravely asserted that no one after fifty years of age should be submitted to the operation of crushing. I have operated upon persons nearer seventy without having any anxiety or trouble, and cannot understand the objection. I certainly would infinitely prefer the clamp to the ligature, even in the oldest patient.

I am conscious that I have trespassed upon your time and patience; but I trust that if, beyond my instrument, I have not been able to bring forward much that is particularly new, I may at least have succeeded in interesting some among my audience in the operation of crushing hæmorrhoids.

SURGICAL MEMORANDA.

INCISION IN TONSILLITIS.

IN the BRITISH MEDICAL JOURNAL, February 5th, page 228, Dr. Charles Maclean makes some remarks on the above subject, and as I am sure that, should his practice be followed in every case of quinsy without discrimination, more harm than benefit would result, I beg leave to make a few remarks.

Those who have had extensive dealings with such cases know that the treatment varies greatly in the different stages which mark the progress of this affection, and that, with or without special treatment, it may terminate in resolution or go on to suppuration. Now it is only in the latter form that incision is called for, and I hold that it is not good practice to make that incision unless the presence of an abscess can actually be diagnosed. Certainly, as soon as this diagnosis is arrived at, the correct treatment is the immediate evacuation of the pus by incision.

Dr. Maclean says: “A large incision seldom fails, in my experience, to modify the course of the disease almost at once.” It is this sentence I mainly object to, as it leads one to suppose that, in whatever stage he finds an acutely enlarged tonsil, he incises it, and recommends others to follow his example. Blood-letting, general or local, was in olden times the routine treatment for quinsy in its early stage; the former is, I think, almost wholly abandoned, but the latter—by means of scarifying the surface of the inflamed tonsil—is frequently resorted to, and with considerable benefit. It is in the earlier part of this stage that guaiacum and aconite are so useful; but in addition to these, free scarification, followed by the use of soothing moist inhalations, will often bring about the desired resolution. Incision at this stage should not be practised.

Then, as regards the presence of the internal carotid artery, if the incision to evacuate an abscess be made as usually recommended, it need never be feared. The bistoury, when making the incision, should be directed upwards and inwards, thus cutting away from this important vessel. In a paper published by me in the *Edinburgh Medical Journal* for August, 1886, on “Hæmorrhage following Tonsillotomy,” it was shown that the cases, elsewhere fully reported, of serious hæmorrhage from the tonsil, almost invariably followed incision, and that the bleeding was mainly from the tonsillar branch of the internal carotid or from the ascending pharyngeal artery, never from injury of the internal carotid, which vessel, in cases of tonsillitis, as remarked by Dr. Maclean, is rather displaced outwards by pressure of the swollen gland.

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DEATH FROM WHITLOW.

W. P., aged 7, was brought to my consulting-room on the evening of October 6th, 1886, suffering from a small whitlow on the ring-finger of his left hand. On examination, I found the whole left hand and forearm cedematous, and inflamed in patches. The temperature was 101°, the pulse 120, and the tongue was thickly coated. Having made an incision on either side of the distal phalanx down to the bone, and ordered linseed-poultices, with frequent warm water bathing, I prescribed a calomel and compound jalap powder, with a saline mixture containing small doses of aconite. On the 9th, the temperature and pulse became normal. The patient was then put upon quinine, steel, and port wine. On the 10th, the cedema of the hand and arm had disappeared, and the finger looked comparatively healthy. On the 11th, retching and vomiting set in, without any increase of either pulse or temperature, and continued unabated in spite of the use of such remedies as bismuth, cerium, hydrocyanic acid, opium, etc., until the morning of the 12th, when death took place from exhaustion, although beef-tea and port wine were frequently administered by enema. From first to