freely incised. Freezing with ice or ether-spray might replace general anæsthesia. Afterwards a piece of fine sponge, cut to fit the part and moistened with laudanum or comp. tinct. benzoin, may be kept in contact with it. These little anal abscesses, which, like those of the eyelids (hordeoli), often originate in glandular follicles, cause an amount of pain out of all proportion to their size. They occur more frequently before middle life, and in some individuals show a tendency to habitual recurrence. The regular use of an astringent or alcoholic lotion to harden the skin is often of service in such cases. One form of this marginal abscess undoubtedly takes its source in a little varicose venous pouch—one of the varieties of origin of the external hæmorrhoid; this, when left to itself, is likely to leave behind it a minute "blind external fistula," often associated with a little flap of shrivelled integument.

A *painless* variety of marginal abscess sometimes forms insidiously, generally in a delicate, perhaps phthisical subject, it may discharge itself and leave a little fistula without its existence having been suspected. This is more of the nature of what is known as the "dermoid" abscess, and it requires decided local stimulants to make it heal after incision.

Where the focus of pus formation is situated further from the verge of the anus and beyond the grip of the sphincter, the pain, even of the acutest grade of abscess, although from its greater size very considerable, is not so constant and intolerable as in the first variety. There is more or less extensive redness of the skin, followed by central softening, and accompanied by febrile reaction. Entire rest, narcotic and sedative poultices, with early and free opening, are the remedies. Such a case, if not promptly met, might linger a fortnight or longer. One of its prominent difficulties is to provide for defecation without great temporary increase of pain. It is better that this should be done daily, or every other day, than to run the risk of fæcal accumulation and its consequences, which might interfere with subsequent prompt repair. The best means to use for this purpose are a moderate dose of some mild, reliable laxative, such as castor oil, sulphur and cream of tartar, or fluid extract buckthorn, assisted at the right moment by an enema of warm water and sweet oil.

The introduction of the nozzle of the injecting tube is not painful under these circumstances, if rightly managed, and it is usually wise to overrule the objections of a patient who has no experience of this remedy. The obstruction to the local circulation from a loaded rectum constitutes a positive aggravation of the malady.

This is the more common form of acute abscess near the anus. When left to itself the complete relief from pain which follows spontaneous discharge leads the patient to dismiss the trouble from his mind and consider himself cured. It is only some weeks later that the fact forces itself upon his attention, in consequence of finding his clothing more or less constantly soiled by a watery and perhaps offensive discharge, that a fistula has formed.

It happens, occasionally, that a collection of pus forms outside of the rectum, in most cases just on a level with the upper limit of the sphincter, and, failing to reach the surface externally, and in most cases causing no very urgent pain, finally discharges itself into the bowel, so that the patient after voiding some matter at stool, finds himself relieved. It is in this matter that which is called the "blind internal fistula" forms—a variety of fistula which is not very common. The relief, however, in a case like this, is not usually permanent; a hard lump remains somewhere on the buttock, near the anus, and continues somewhat tender on external pressure; sooner or later it becomes the seat of another abscess, which may break externally, and thus the complete process of repair failing, the "blind internal fistula" is converted into a "complete fistula."

In both this and the last variety of abscess the exciting cause is undoubtedly, in most instances, a perforating ulcer at the bottom of one of the lacunæ of the rectum, which are situated just above the external sphincter, the ulceration having been provoked by the lodgment in the little pocket of some source of irritation derived from the passing fæces. Hence an explanation of the fact that when a complete fistula follows one of these abscesses its communication with the bowel is found most frequently just above the upper limit of the external sphincter. Not rarely the starting-point of the abscess is in the substance of this muscle, so that the resulting fistula actually traverses the muscular mass. When the abscess extends entirely outside of the sphincter muscle, it then occupies the ischio-rectal fossa, and, in the loose connective tissue and fat of this region provided to accommodate the varying bulk of the rectal pouch, finds room for rapid development

It is a much more grave form of rectal abscess, that which takes its origin, at first, deep in the ischio-rectal fossa. It is caused in some cases, doubtless, by ulcerative perforation of the rectal pouch; in others as a direct result of constitutional dyscrasia. The progress of these cases is often slow, insidious, and depressing, because the pus tends to travel inwards—in the direction of least resistance rather than towards the surface. The dense integument and subcutaneous cushion of the buttock become thickened and brawny, often over a considerable extent of surface. There is not, necessarily, any very urgent pain or throbbing; but fever is present, and frequently there are evidences of septicæmic depression. When the surgeon is not familiar with these cases, and waits for evidences of fluctuation before interfering, extensive destruction of pelvic connective tissue may occur, involving danger to life. A finger in the rectum will recognize increased heat and an œdematous, doughy feel. The indications are those of phlegmonous erysipelas; the surgeon should make an early and free opening with the knife through the integument, and follow it with his finger, so as to secure a direct and sufficient outlet—not only for pus, but for sloughy débris. This affords the only assurance of safety. When it is neglected there is liable to be extensive surface ulcera-