or included later in the sutures approximating the wound edges. The operation need not be hurried, as the anesthesia will last upwards of an hour, and the utmost care and gentleness should be exercised in the use of tissue forceps, retractors and sponging. It is important that skin tabs be removed at the time of the operation. Otherwise they become engorged, inflamed, and most painful.

Whether the operation is performed under local anesthesia or general anesthesia, be careful to handle the parts gently, for unnecessary dilatation of the sphincters, rapid or rough manipulations and catching with snap forceps the tissues that are not to be removed, will cause more pain and increased danger of infection.

The operation completed and the field cleansed, the rectum and anus are well covered with sterile petrolatum, carefully and freely covering each and every wound. A light gauze dressing is then applied and held in place with adhesive straps. I do not place a tube within the rectum, because I am convinced that it does not serve any good purpose, while it certainly causes the patient intense pain and is one of the active factors giving rise to retention of urine.

When the patient is put to bed, keep him in the Sim's position, or else on his face. Do not allow him to lie on his back, because, in this position, the middle and superior hemorrhoidal vessels in their upper portion are in a vertical position; at the pelvic brim, they bend at a sharp angle, so that the abdominal contents are superimposed. All of these positions cause obstruction, and as the hemorrhoidal vessels have no valves, there is a back pressure and a tendency to swelling, a giving away of the stitches and more pain, as well as delay in the process of repair. After the first day in bed our patient may turn about and assume a comfortable position.

After-Treatment—The after-treatment of hemorrhoid patients is a very exact one, but unfortunately, often is neglected, with the result that complications frequently occur. Although general standard rules for the post-operative care can be set down, there is much to be individualized in each case. In fact, it is most important that the operator himself look after his patients, so far as this is possible; for, just a little slip in the after-treatment may spoil the effect of an otherwise excellent operation.

The post-operation diet of the first day consists of liquids given every two hours; soup, broth, egg albumen, buttermilk and cream, four ounces of either, with two ounces of water. No milk is allowed. On the second day, order semi-solids: poached egg, toast, custard, rice, sago, absorbable vegetables, also cooked apple, prunes or other fruit, and for