time during the first week, while the sloughs are separating—bleeding, sudden, profuse, concealed, but always serious in the extreme. I have the records of upwards of two hundred cases of the clamp and cautery without a single instance of bleeding.

Right here let me again urge the thorough cauterization of the stump at the time of operation, for, as hæmorrhage is the first serious complication to be feared, every precaution should be taken to avoid it.

Unquestionably the same security can be obtained from the ligature when carefully applied, but that fact in no wise militates against the efficiency of the cautery as a hæmostatic.

The second grave complication that may occur is septic infection, showing itself primarily in phlebitis, and subsequently developing any or all of the phenomena of pyæmia. Of course an occurence such as this is always within the range of possibilities in any operation—certainly in such procedures as involve the obliteration of masses of veins, and I know of no precaution that will absolutely exclude all danger of this accident. In rectal surgery thorough and complete asepticism is not possible, on account of the normal functions of the organ. As a matter of fact, the clamp and cautery operation shows up quite brilliantly in its comparative immunity from septic complications. I myself have never seen it, and in all the cases in my immediate reach there has been no such instance.

The principal advocates of the cautery, here and abroad, all strongly insist that no other method has given such results. Theoretically this is to be expected. Certainly thorough cauterization with a red-hot iron of all cut surfaces inside of the sphincter is very unlikely to convey infection.

I have dwelt on the question of hæmorrhage sand infection because of their genuine importance, they are not likely to occur except from carelessness, but must always be borne in mind as possibilities. In my own fifteen cases and in the two hundred others upon which I am writing there as been no such trouble; so I think I am justified in speaking with confidence.

There are, however, a group of exceedingly annoying symptoms that are likely to follow all rectal operations. I speak of pain and various reflexes dependent on it. Spasm of the sphincters and levator ani are the cause of nine-tenths of the distress accompanying rectal lesions, and, curiously enough, the size of the lesion bears no relation to the degree of pain. However, the question at issue—whether the clamp and cautery operation is less liable to be followed by these disorders—is a matter of experience. In my own cases I can say, without hesitation, that there has been little or none. Not a single patient has been given more than a quarter of a grain of morphine all told, and most of them got none, for the simple reason that there has been no reason for using it. The usual history of a case after operation is about as follows:

In five or six hours the perineal pad is removed, and, if there is any soreness, hot applications are applied. The patient is allowed to get out of bed to pass water as soon as the desire shows itself. After that no dressing is required unless there is an external wound from the original scissors cut, and in that case a loose pad of absorbent gauze is sufficient. Often hot applications to the perinæum are very soothing, and in that way the patient generally obtains a good night's sleep without the use of anodynes. Suppositories of iodoform, belladonna, etc., serve very well to amuse the patient, but I doubt their usefulness, and, as a rule, dispense with them entirely. The one point of importance in the after-treatment is the early opening of the bowels. My rule is to give a laxative on the second night, so as to get a free evacuation forty-eight hours after operating. This occasionally causes more or less pain for an hour or two, but if put off four or five days is far more painful, and may even require the aid of an ether cone and the handle of a spoon. Keeping the bowels open from the beginning prevents much congestion around the wounds and renders the patient comfortable twenty-three out of the twenty-four hours. One is frequently asked, either by the patient or by the family physician, "When is the pain going to begin?" and as a rule, it does not begin.

Rarely indeed is it necessary to use a catheter except in cases of cystitis from enlarged prostate, urethral stricture, etc., and in those cases retention occurs from very slight causes.

So far as diet is concerned I make little or no change, unless for special reasons, but keep the patient in bed as long as possible, which generally means till the third or fourth day.

Sloughs separate entirely by the end of the first week, and then convalescence has begun. In an average case the ulcers are about healed in three weeks, but, unless the patient has been kept very quiet during that period, complete cicatrization may take much longer of course.

Undue contraction of the anal orifice may follow this operation as from any other, and for the same reason—the removal of too much tissue. This, however, is the fault of the operator alone. There is one simple rule by which it can always be obviated: Put on the clamp in such a way as to leave a band of mucous membrane half an inch or so in width between the several grips. In other words, use the same care in this as in any other operation.—Blair Gibbs, M. D., *in N. Y. Medical Journal.*