In cases of *fistula* after labor, Prof. Hare says a cure can sometimes be effected without an operation by touching the edges of the track of the fistula with nitric acid, thereby causing active granulation to be set up.—*Coll. and Clin. Rec.*

THE MANAGEMENT OF HÆMORRHAGE AFTER TONSIL OPERATIONS.

The frequency of alarmingly profuse hæmorrhage after tonsil operations, with an occasional fatal result, makes this a subject of exceeding interest to the surgeon. Such accidents should not, however, stand as obstacles in the way of performing these operations, for the necessity for operating is both frequent and urgent. Especially in children is the enlarged or hypertrophied tonsil very often met with, and the evil effects of the disease are so apparent to the medical and even non-medical observer, that it often calls for prompt action on the part of the physician. I do not intend here to enter into a discussion of the disease itself, but I would say that within the range of surgical diseases, I do not know of any affection that so often produces a train of more distressing symptoms than a typical case of enlarged tonsils; nor do I know of any operative procedure that gives more decided or permanent relief than their proper removal.

The ordinary hæmorrhage following the operation is of but small conseqence, as, with a little patience and care, the blood soon ceases to flow of its own accord, or, if need be, a gargle of cold salt water suffices to arrest it in the course of a few minutes. But when there flows from the cut surfaces a steady stream of blood, continuing for hours, and when the frightened patient becomes each moment weaker and more nervous and more difficult to manage, then it is that the tact and nerve and skill of the surgeon display themselves to the greatest advantage. A typical case of violent hæmorrhage from an operated tonsil, uncontrolled by the ordinary remedies and means, is an experience that no doctor will willingly confront the second time. Fortunately these very severe hæmorrhages rarely occur, but they *do* occur, and the operator should be prepared to contend with them at any time. The operation is chiefly necessary in children from three or four to ten or twelve years of age, and with an experience of over 3,000 tonsil operations, I have seen but few cases of alarming hæmorrhage in children.

The inference, therefore, is that young children are not very liable to dangerous hæmorrhage—which, for obvious reasons, is a fortunate exemption. But it is in the adult that the great danger lies, because of the hardened tissues of the gland and the increased number and size of the blood-vessels over that of the child.

Generally, the tendency to serious hæmorrhage manifests itself immediately after the operation, or at latest after a few hours. In one of my cases, however, secondary hæmorrhage occurred five days after the operation.

There can be no objection to the trial of the various styptics, for they do in some instances arrest the flow, but they too often fail, and, even when successful, they leave behind most unpleasant results.

The actual cautery applied directly to the bleeding surface has been recommended, but the objections to its use are so obvious that I could not suggest it. But I can recommend compression as a remedy. Pressure applied directly to the wound is the most satisfactory of all means. Pass the forefinger, the end of which is covered with a piece of moistened sponge, or absorbent cotton, into the mouth, and carefully cover the cut surface, and with the wound between the forefinger of the one hand and the palm of the other hand placed externally, exercise a gentle but steady pressure. The hæmorrhage ceases immediately, but recurs upon the removal of the pressure. It is now a matter of courage and confidence on the part of the patient, and physical endurance on the part of the doctor. In most cases, pressure continued for ten minutes to one or two hours suffices to permanently arrest the hæmorrhage, but in rare instances it must be continued through twelve to twenty-four hours. In these last cases assistance must be called in, so that the persons exercising the pressure can be rested at intervals of half an hour. But I have never known this mode of checking the hæmorrhage to fail and I can confidently recommend it to any one having such a case.

I read a suggestion in some medical journal not long since, which I am inclined to think has some merit in it, though I have given it no trial; that is, the hypodermic injection of small doses of apomorphia, with the view of inducing nausea, which is supposed to exercise a beneficial effect in lessening the hæmorrhage. It is worthy of a trial, for I know by experience that extreme nausea bordering on fainting, or actual syncope itself, will arrest the hæmorrhage. Before learning to rely so implicitly upon pressure, I recall several cases, in which the nausea, on account of the loss of blood, fright and nervous shock, became so intense as to be in itself alarming. In three of these cases, after unsuccessfully trying every remedy at my command and when death seemed imminent, syncope followed (in one while lying in bed), and instantly the hæmorrhage ceased and did not recur upon reviving the patients.

But since I have learned what an infallible remedy the pressure is, I have had no such bad cases as just mentioned. If the pressure is properly done and continued long enough, a fatal result