artificially displaced, which rarely, if ever, happens with a mucous surface, for instance, the mucous membrane of the intestinal canal below an artificial anus remains normal and continues to secrete mucus, and the canal remains pervious. It is not a pseudo-membrane, for these exude a fluid of a fibrinous character, as in croup or diphtheria. It seems to be a great difficulty to know what the functions of this tissue are outside of a walling of the contents from penetrating surrounding tissues. Now, owing to the role this membrane plays in those cases, it appears to me that early treatment might in many cases avoid much of the after complications.

It is not only important to prevent an anal abscess from becoming fistulous, but it is equally important after the fistulous passages have formed to treat them radically before their parieties and internal linings become perfectly organized. In early childhood it is remarkable how fistulous tracts get well by the mildest measures, as rest, simple dressings, diet and laxatives. But in those cases of rectal fistula, when the soft parts become involved, attended with deep burrows and sinuses, and more than one external opening, the only treatment is the ligature or knife. The following method was employed in my own cases, and seemed at the time to be a perfect one and theoretically correct, but my results have not borne this out and I would be pleased to know when and why it fails.

*Operation.*—Empty bowels on eve of operation by an efficient cathartic, say castor oil, in the morning, a dose of Rochelle salts, followed by an enema until all the contents of the rectum are removed, and at the same time administer an astringent to insure safety at the operation. The region for operation should be rendered absolutely sterile. Give anæsthetic in all cases to relax sphincters. Patient in dorsal lithotomy position, stretch sphincters with thumb, touch lower bowel with antiseptic, and plug above extent of sinus with sponge on a string. Insert a grooved director in the sinus emerging at the inner opening; if there is none, make one; insert finger and draw end outside anus, thus having whole sinus outside, then lay open the whole course. If there be branches lay open, similarly curette and make antiseptic. Now dissect out the whole indurated tissue surrounding the sinus, or that being a cavity, if any contraction dilate, curette these, and a clean, healthy wound should result. Two methods are now adopted; one is, pack the canals and wound with sterilized gauze (iodoform I prefer), and after the first three or four days do not pack tightly but lay the dressing in loosely and let the wounds heal by granulations from bottom. The second is, close the wound with a needle threaded with catgut, begin from above the inner end and proceed outward until the excision is completely closed. Put in submucous sutures by inserting needle just below the mucous membrane on outside of cut surface, carrying round the wound opposite excluding mucous membrane, then close the rest of the wound with a continuous suture. Irrigate and powder or seal with collodion, and dress with an iodoform bandage, and keep in bed. Confine bowels for five days, give a limited fluid diet. If the sphincter requires division cut it at right angles and not obliquely; by doing this a union of the deeper sinus may be got sooner, as more complete rest can be secured; but warn the patient of the result or else you may be sent for in a hurry to tell you the effect. Often the fistula may be cured spontaneously, because the lining membrane not being mucus it may contract, the parieties come together, discharge cease, and the walls adhere, leaving nothing but a cellular cord, sooner or later disappearing. I have little confidence in escharotics as I have tried them time and again with negative results. Electricity is recommended. I have not tried it except by inserting a silver and copper probe dipped in $HNO_3$, and introduced together into