able or cleanly condition; then there will be the escape of flatus, and finally of fæcal matters, this last is of itself pathognomonic of complete fistula. By an internal examination, the finger will detect, at a distance of from one to four inches from the anus, a small elevation on the mucous membrane—the intestinal opening of the fistula—and the diagnosis will be completed and assured by the passage of a probe, through the cutaneous opening, along the sinus, when it will come in direct contact with the finger.

In the incomplete form of fistula-in-ano, there will be pain, heat, and a throbbing sensation in the rectum, with some degree of hardness on the affected side of the anus; the dejections will be mixed with a variable quantity of puriform secretion. Pressure exerted externally near the anus—where the integuments according to the stage of the disease, may or may not be thinned and discoloured—will force out the pus contained in the sinus; internally, the finger meets the same appearances as in the complete form, only that finger and probe do not come together, and pain is experienced when pressure is made against the tuberosity of the ischium and verge of the anus.

d. *Polypus of the Rectum.*—Is of not very frequent occurrence; happens about the twentieth or thirtieth year, rarely after, and occasionally before these periods; defecation becomes gradually more and more impeded; there is tenesmus and weight in the anal region; the fæces are often bloody, and occasionally present a groove or furrow upon one surface, which corresponds to the point of attachment, size, and situation of the polypus. When the tumor is near the anus, or its pedicle is long, it becomes extruded through expulsive efforts, when all doubt is removed; if the polypus is retained in the bowel, the finger will generally detect, near the anus, a smooth, movable and pediculated tumor; its progress will be attended with some degree of constitutional disturbance.

e. *Fissure and irritable Ulcer of the Anus* are, from the assemblage of their symptoms, the affections most likely to be mistaken for stricture; as these two conditions are in almost every case present together, and are so nearly alike in their symptoms and consequences, I include them under one head.

Fissure and ulcer is almost invariably situated on the posterior, or sacral surface of the sphincter; the situation was only found to vary in 6 out of 100 cases; in three the fissure was on the perineal surface of the muscle, and all in women, in two on the left, and in one on the right side.*

It is more commonly seen among hysterical females and those exposed to syphilitic infection, and in enfeebled cachectic men; it may result from inattention to the regular condition of the bowels, and often accompanies a scrofulous diathesis, tubercular disease of the lungs, or as a sequence of chronic diarrhœa. There is very acute pain during and, for a considerable period, after every evacuation, and the pain is generally confined to one portion of the bowel, at its sacral aspect just above the anus; this pain will be occasionally complained of from the time of one evacuation to another; the fæces will be streaked with blood or pus, and there is a more or less constant oozing of sanious, purulent or muco-purulent matter from the anus. The finger introduced through the anus finds much difficulty to overcome the irritability and spasmodic action of the

* J. Rouse, British Medical Journal, May 12, 1860, p. 356.