**Don'ts of Rectal Surgery.**—1. Don't tell your patient who has fistula that he can put off an operation *ad libitum*; it may at any time assume an active state and do much harm by burrowing.

2. Don't make light of your patient when he or she complains of pain after an operation for fistula, but examine painstakingly; you may find an abscess forming, or already formed, and thereby save both the patient and yourself much trouble.

3. Don't be swift to say you can cure or heal all fistulæ, for the reason that you may (*and will*) meet with tubercular fistulæ which may and do fail to heal.

4. Don't operate on a patient with a well-marked tubercular fistula, who has lost a good deal of flesh, and who is now losing flesh. Defer the operation until your patient improves in strength and flesh. Give your patient vigourous constructive treatment and operate when he begins flesh-making.

5. Don't say to your patient, because he has a number of fistulous openings that he has simple fistula. An examination may prove the existence of a stricture, the fistulous tracts being the result and not the disease *per se*.

6. Don't fail to tell your patient, who has a very bad fistula, that if he gets well of fistula, he may have a weak sphincter, or possibly incontinence.

7. Don't fail to seek out all sinuses when operating for fistula.

8. Don't fail to trim the edges of the sinus after an operation.

9. Don't tell your patient that the operation is absolutely free from all risk, and that it amounts to but little, for the reason that he may not follow out your directions, thereby making the operation which you said "amounted to but little" a *failure*.

10. Don't say to a patient, who belongs to a phthisical family or who even has incipient phthisis, that he or she should not have an operation, but on the other hand urge an operation for the reason that the patient will get rid of a dangerous local point of infection and also get well of a most troublesome and painful disease.

11. Don't delay the opening of a rectal abscess until the pus can be easily reached; but if you suspect pus, reach it with the knife, though it be ever so deeply situated.

12. Don't stuff an abscess cavity too full of cotton, but put loosely carbolized cotton at the bottom and depend on watching it to make it heal from the bottom.

13. Don't make a positive diagnosis of internal hæmorrhoids as the result of digital examination alone.

14. Don't be to ready to diagnose internal hæmorrhoids because your patient has hæmorrhage from the bowel after actions or on going to stool; not infrequently the hæmorrhage comes from a bleeding surface, there being no piles at all.

15. Don't defer an operation for hæmorrhoids because the attack is acute, for the reason that it will take as much time to subdue the acuteness as it would to get your patient well of the operation.

16. Don't leave any external tags after an operation for internal hæmorrhoids. They often, from cause or another, become irritated, giving great annoyance.

17. Don't do Vernieul's operation, viz.: divulsion for the radical cure of prolapsing hæmorrhoids. You will be disappointed, as well as your patient.

18. Don't neglect to see your patient at bed hour and make him comfortable for the night. Also see to it that there is no hæmorrhage; sometimes a ligature cuts through, opening up a blood-vessel, from which your patient might bleed to death.

19. Don't say to a patient who complains of his rectum without any local lesion, that he has nothing the matter with him. Examine his prostate, urethra and bladder. He may have one of those persistent reflexes which we occasionally meet.

20. Don't tell your patient that he has cancer of the rectum unless circumstances absolutely demand it, for the reason that it is like putting a rope around his neck.

21. Don't temporize with cases that require an operation. Such a course will not benefit the patient nor the surgeon.

22. Don't fail to do all operations on the rectum antiseptically.—*Leon Strauss, M.D., in Medical Brief.*

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**Frontal Headache and Iodide of Potash.**—A heavy, dull headache, situated over the brow, and accompanied by languor, chilliness and a feeling of general discomfort, with distaste for food, which sometimes approaches to nausea, can generally be completely removed by a two-grain dose of