

# RADICAL CURE OF FISTULA IN ANO, WITHOUT THE USE OF THE KNIFE.

[Reported by D. B. HOFFMAN, Assistant Surgeon U. S. A., San Diego, Cal.]

JOHN J. V—— A——, æt. 38, a citizen of this place, and a wagon-maker by trade, came to me, some three years ago, and complained of there being something unusual the matter with his anus. (He had been troubled slightly with hæmorrhoids for several years.) I made a casual examination of those parts at the time, and found a fistulous opening on the right side of the gut, about three fourths of an inch from the edge of the true orifice, in a highly inflammatory and painful state. I ordered the usual remedies to be used, preceding perquisition, and as soon as the inflammation and painful tenderness had subsided sufficiently, proceeded to make a thorough and careful examination. The result was, the disclosure of a complete fistula, with one opening into the rectum. I then carefully examined and questioned him, as to the present and former condition of the principal organs, with which this disease is frequently found complicated; but no organic cause of any kind could be found. I then told him the condition that he was in, and recommended the usual operation. He objected most emphatically, to this, to use his own language, "cutting business," and desired me to treat him in some other way, which I have done, with good and satisfactory results, as follows. I directed him to remain in his room, and keep as quiet, and rest as much in a recumbent position, as possible; to use a cold-water bath to the affected parts frequently, and, at the same time, throw cold water up the bowel freely, with a syringe. I also injected the fistulous opening once a day with the tincture of iodine, and gave a tablespoonful of the following prescription: *R.* Sulphur flor., rosin. pulv., aa  $\frac{3}{4}$  ss.; mel. desp.,  $\frac{3}{4}$  i. *M.* Ft. electuary. Use once a day. This course of treatment cured him in twenty-three days, and there is not a sign of the fistula, nor has there been at any time during the last three years. His diet during that time was altogether of a bland nature, no solids of any kind were allowed, and the use of tea and coffee was prohibited. Milk and strong beef soups were the principal food used.—*San Francisco Med. Press.*

## ON THE DIAGNOSIS OF HÆMOPTYSIS.

By HYDE SALTER, M.D., F.R.S., FELLOW OF THE ROYAL COLLEGE OF PHYSICIANS, &c.

I FIND it not at all an uncommon thing to meet with cases, both in hospital and private practice, in which I feel at first, and occasionally for some time, a doubt as to the source of hæmorrhage which is discharged from the mouth. This uncertainty arises in part from the inaccuracy of observation and looseness of speech of those who are describing their symptoms, in part from being deprived of any opportunity of oneself inspecting the blood discharged, and in part

from the clear and entire absence, in some cases, of all distinctive signs as to the whereabouts of the bleeding. A patient tells you he has "spit" blood, or "raised" blood, or "thrown up" blood; but the blood said to be "spat" may have come from the stomach, and the blood said to be "thrown up" may have come from the lungs; or, after having described the method of getting rid of the blood as "throwing it up," the patient on a cross-examination will confess that he coughed it up, or, after having said that he "spits" it, will admit that he never spits it without being sick. I have frequently been told by Irish patients that they "retched" the blood up, when I have found afterwards that it has really come from the lungs. Not unfrequently the closest and most searching cross-examination fails to elicit from your patients the way in which the blood was discharged, and simply because they themselves have exercised no observation at the time the hæmorrhage was occurring, and therefore find it impossible to give you any information one way or the other. If we could always see the blood, a great deal of obscurity would be cleared up, but we often find it has been thrown away, or are shown it upon handkerchiefs, or so intermixed with foreign material, and so long after its discharge, that it has lost all distinctive characters. The last source of uncertainty that I have mentioned—namely, the absence of all distinctive signs as to the whereabouts of the bleeding, is really not uncommon. In the cases of intelligent and self-observant patients, where I have had an opportunity of examining the blood, and ascertaining both by interrogatories and physical examination the condition of the lungs and stomach, I have still had some doubts as to which of these two organs the blood came from.

A case of this last character came under my observation a few days ago, in which the turning point of the diagnosis was sufficiently interesting, and which it is my purpose in the present communication to narrate. I need not enlarge upon the primary and essential importance of an early and correct diagnosis of the seat of the hæmorrhage in cases both of hæmoptysis and hæmatemesis.

I was called, on Sunday, June 22d, by my friend Mr. Guy, of Dorset-square, to see with him, as soon as possible, a patient who was suffering from profuse hæmorrhage. On arriving at the patient's house, I heard from Mr. Guy the following account of his case:—

The patient, who was sixty-eight years old, had been seized with blood-vomiting on the evening of the previous Thursday, and Mr. Guy had been hastily sent for to see him. The quantity of blood which was found to have been discharged was a washhand-basin three parts full. This Mr. Guy saw; it was free from froth. On the following day (Friday) the bleeding was much less; on Saturday it returned profusely, and on Sunday with such violence that I was hastily sent for. Mr. Guy had witnessed a good deal of the

hæmorrhage himself, and distinctly ascertained that the blood welled up into the mouth apparently spontaneously, without effort, and without either vomiting or coughing. Gallic acid and other anti-hæmorrhagics had been given, and scraps of ice swallowed at intervals; but so little was the hæmorrhage controlled by these means that the patient was of opinion that the medicine rather provoked it.

On entering the patient's room, I found an old man sitting up in bed, pallid from loss of blood, and with a feeble voice. His breathing was slightly accelerated, and his speech short; but this seemed sufficiently explained by his exhaustion and by other circumstances, not bearing on the source of the hæmorrhage, which I will presently relate. His pulse was between 70 and 80, and except being a little too compressible, was in every way natural. He told me he had no pain anywhere of any kind, and *had* had none. His history was as follows:—

He had always been a man of regular and temperate habits, and had enjoyed good health, except that for many winters past he had been liable to attacks of bronchitis; some of these had been very severe, and for the last few years he had had almost constantly a certain amount of cough and expectoration. Latterly, however, he had been better in these respects, and had been coughing and spitting less than usual; his friends, too, had been telling how much better he was looking. On catechising him, I found that he had had no recent loss of flesh, no loss of power, no streaks of blood with the expectorated mucus, no night-sweats; that he had no loss of appetite, no pain after eating, no vomiting, no epigastric tenderness; in fact, that there was a clear absence of any signs or symptoms pointing either to hæmoptysis or hæmatemesis. I was shown about half a pint of semi-coagulated blood in a basin, and certainly this was free from froth. On close inquiry, it seemed that the blood was generally, if not always, discharged in the way Mr. Guy described, and without any true vomiting.

On examining the chest I found the breathing natural, and the lungs everywhere healthy, except at the posterior part of their bases. On the left side this region was the seat of crepitation; on the right, of no sound whatever; the respiratory murmur was quite lost; that part of the right lung was dumb. Percussion was fairly resonant everywhere; hyper-resonant nowhere. I should mention that the breathing at the apices, and over the *whole* of the *front* of the chest, was compensatory in its character.

This completed the evidence submitted to me.

Now I think it will be admitted that in this case the distinctive signs of the seat of the hæmorrhage were wanting, that the evidence altogether was of a negative character, and that no one could assert on the strength of it that the hæmorrhage was either hæmatemesis or hæmoptysis. This will, I think, appear the more clear if we just consider the distinctive signs of these two hæmorrhages: thus—

In hæmoptysis we have—

The blood frothy.  
The blood mixed with sputum.  
The discharge attended with coughing.  
Evacuations not affected.  
Pulmonary symptoms and history.

In hæmatemesis we have—

The blood not frothy.  
The blood mixed with food.  
The discharge effected by, or attended with, vomiting.  
Evacuations often black.  
Gastric symptoms and history.

It might be conceived that the physical signs at the lower part of the lungs behind pointed to a pulmonary source of the hæmorrhage; but to my mind the antecedent history of chronic bronchitis deprived these signs of any significance. I felt that the crepitation at the posterior part of the base of the left lung might merely mark the present seat of the chronic bronchitis, and the dumbness of the corresponding region of the right side might depend on nothing more than the partially collapsed and partially emphysematous lung, the seat of some of the old attacks.

Thus I felt in the same doubt as my friend Mr. Guy, and was quite unable to pronounce positively as to the seat of the bleeding, when a circumstance occurred that to a certain extent supplied evidence of a positive nature. Just as I was going to leave, our patient was seized with a violent fit of coughing—the prolonged and fruitless coughing of a weak old man. After repeated efforts the material producing the cough was at length driven through the glottis, and spat from the mouth, when, behold! it was blood—a black clot, as big as a filbert, with one end distinctly frothy.

This was the most conclusive evidence we had as yet obtained, and with this modicum of positive evidence I left our patient, after having suggested the frequent administration of small doses of turpentine and opium.

I did not see him again until Tuesday morning. He had had a good day on Monday, with no profuse hæmorrhage, and only the expectoration of clots. I repeated all my old inquiries, with the view of eliciting, if I could, any further information, until, on being told that all the clots expectorated were singularly alike, the idea occurred to me that a close inspection of them might reveal the seat of their formation, and that they might perchance be found to be moulded in some one part of the air passages. I inquired of the attendant of our patient if the clots appeared to be branched, or if he had shaken them out in water, and, being answered in the negative, I procured a basin of water, and shook out in it the last clot expectorated, and which I was informed was the counterpart of the rest. To my great satisfaction I saw it, as I shook it out, unfold into a tree of blood, a perfect cast of the bronchial tubes, resembling, except in color, the plastic bronchial casts so frequently seen.

The whole thing was now cleared up, as far as the seat of the

bleeding went; there could no longer be any doubt that the hæmorrhage was poured out into a principal bronchus, of which, and of the immediate ramifications of which, it formed the mould. And I was inclined to think that this bronchus was the left, for this special reason: on listening at the base of the left lung posteriorly, I found that the crepitation which I had heard so abundantly on my previous examination was quite gone. Now if this crepitation had been due to the patient's chronic bronchitis, as I at first thought it was, it could not have so quickly and so completely cleared away. If not due to the bronchitis it must have been due to the blood—to blood that had gravitated to the most dependent part of the lung from the seat of the bleeding; being, therefore, in the left lung, the bleeding must have been on the left side, and the size of the main trunk of the cast showed that it could not have been moulded in a tube of less calibre than the principal bronchus. I was induced thus to fix upon the exact spot, and say that the left bronchus was the seat of the hæmorrhage.

Now, taking these data, what diagnosis could be built upon them? No other, I think, than that the bleeding was aneurismal; that the aneurism communicated by a small fissure—a fissure so small that the bleeding was intermittent—with the left bronchus; that it was, therefore, probably an aneurism of that part of the aorta beneath which the left bronchus passes—i. e., the convexity of the arch, or the commencement of the descending portion; lastly, that the aneurism was small, as it revealed itself by no physical signs—there was no pain, no dysphagia, no pulsation, no murmur, the pulse was alike in both wrists. There was one circumstance in the form of this clot that, as I interpret it, strongly pointed to an aneurismal origin of it. Close to the large extremity of the main trunk, two branches seemed to arise by a common stem; but on separating these branches it was found that they were adherent at their extremities; in fact, they formed a ring. Now, I cannot conceive how a coagulum of this form—an unramified ring—could be moulded in a bronchial tube. I think it must have been formed in the aneurism, and dragged thence when the clot was discharged; that it was, in fact, a portion of the coagulated blood in the aneurism; that the size of the ring probably marked the size of the aneurism, and that the pedicle by which it was attached occupied the orifice of communication between the aneurism and the bronchus. This may seem making extensive deductions from small premises, but I do not see how the annular form of this part of the clot can be otherwise explained.

Such was and is my diagnosis of this case, and its subsequent history has but confirmed my opinion. I have not seen the patient now for a fortnight (for, having expressed to the relatives my opinion as to the hopeless nature of the case, they imagined I had arrived at the end of my tether in the way of treatment, and that some one else might be richer in resource, and so sent for that some one else); but I have heard from Mr. Guy that the hæmorrhage still continues,

that the patient is getting increasingly blanched by it, that casts are frequently expectorated, though not so perfect as the one I have described, and that there is still the same absence of symptoms, either of stomach or lung disease, and of signs of aneurism.

The great point of interest about this case, and that which to me appears to make it worth recording, is the peculiar circumstance that rendered certain the previously doubtful seat of the hæmorrhage, and at once reversed the diagnosis which had in the first place been formed.

In concluding, I cannot but remark that this case seems to me to confirm an opinion I have long entertained as to the nature of those cases of supposed plastic bronchitis in which hæmoptysis precedes or accompanies the discharge of the casts. I have always suspected that in these cases the fibrinous casts are the result of the hæmoptysis, and not the hæmoptysis the result of the detachment of the casts. It seems impossible to imagine how the discharge of a peculiar inspissated mucous exudation (and the ordinary bronchial casts are nothing more) can be a cause of hæmorrhage; while, on the other hand, decolorization of coagulated blood occupying the bronchial tubes would furnish pale and ramified casts. Moreover, it seems difficult to imagine why the discharge of the casts should in some cases always be attended with profuse hæmorrhage, and in other cases with none, except on the supposition of an essential difference in the nature of the casts in the two cases. I remember some time ago being told by a physician, of a case in which the late Dr. Todd expressed an opinion that the hæmoptysis was due to the detachment of bronchial casts, which he predicted in a few days would appear. In a day or two, when the bleeding was pretty well over, they *did* appear, and Dr. Todd got no small *kudos* for his prophecy, which was thought little less than miraculous. My informant expressed the belief, and I quite concurred with him, that the casts spat up after the hæmorrhage were nothing but decolorized fibrin whose discharge had, in some way or other, been delayed.—*London Lancet*.

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OUR readers will be interested in the following communication and the accompanying Army Order, which show that the subject of a distinct ambulance organization has not been entirely neglected heretofore, at least in some departments of the army. It does not appear that the plan proposed was ordered for any other department than that exclusively under the command of General McClellan. In its details it seems to be excellent, and all that could be desired—on paper. We have heard nothing of its practical working. It will be remembered that Dr. Bowditch's lamentable experience of the entire