DR. R. A. HATCHER, New York: There is one point that should not be altogether overlooked. There can be little doubt that the controlling influences in the convention are not in favor of restriction. It might be claimed in the future that by silence we gave tacit assent to the program, and I do believe that our protest may have considerable value, although I doubt very much whether it will have a corresponding amount of influence.

DR. C. S. N. HALLBERG, Chicago: The subject is entirely left open to the Committee on Revision, as Dr. Loevenhart states, but those that know the Committee on Revision know that the members have already made up their minds to adhere to those principles which were under discussion, and that the Committee on Revision is certainly not in favor of any radical proposition. Still I do not object to the proposed action, and I think with Dr. Hatcher that it might do some good, if for no other reason than as a matter of record to protest against the admission of some article which might possibly be objectionable.

[The Section voted in favor of the expression of opinion as suggested by Dr. Loevenhart.]

A SIMPLE BLOODLESS OPERATION FOR HEMORRHOIDS*

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DETROIT

It is my intention to give briefly my technic for the removal of certain forms of internal hemorrhoids without the profuse hemorrhage with which this operation is usually associated in the minds of most practitioners. Having observed that most patients suffering from hemorrhoids of the internal variety are more or less anemic from the continued and constant loss of blood, as a result of their hemorrhoidal trouble, I began three years ago to use a technic which would minimize operative hemorrhage and conserve the patient's blood-supply.

With this aim in view, I have developed and have been using a very simple technic which is applicable under local as well as general anesthesia and therefore can be used in those weak, run-down patients suffering from any of the wasting diseases in whom the use of a general anesthetic would be inadvisable if not positively dangerous. The method is adapted to the removal of any variety of internal hemorrhoids and particularly to the pedunculated and prolapsing varieties.

Interno-external hemorrhoids can also be treated by this method. Very few instruments are required and in many cases dilatation of the sphincters is not necessary. The technic under general anesthesia is much the same as under local anesthesia, and inasmuch as local anesthesia is much safer and fully as satisfactory as general anesthesia for this work, I shall describe the operation as I perform it under local anesthesia.

The drugs which may be used for the production of local anesthesia in this region are various. Cocain, eucain, stovain, novocain, alypin and chloretone, as well as their various combinations with other salts, have been used in varying strengths of solution and with varying success by different workers.

During the past six months I have been employing for this operation, as well as in many other operations on the anus and rectum, a sterilized 1 per cent solution of quinin and urea hydrochlorid. I am using this solution, which is prepared from the double salt of quinin and

urea (which is made by dissolving quinin hydrochlorid in hydrochloric acid, adding pure urea, filtering the mixture through glass wool and allowing it to crystallize), because of the following advantages over any other anesthetic drug:

First: It is non-toxic and can be given in unlimited dosage. Brewster of Kansas City has used 100 grains intravenously within six hours in a patient suffering from pernicious malaria.

Second: When a solution containing 1 per cent. or over is used the hemostatic effect produced by the deposition and contraction of fibrinous exudate around the blood-vessels is of great value in preventing postoperative oozing.

Third: The anesthetic effect is prolonged; in many cases postoperative anesthesia has lasted from four to five hours to as many days and longer.

Fourth: While equal to cocain in anesthetic power, it has the advantage of being very much cheaper, and is a drug which is almost always available.

One advantage of the operation to be described is the fact that but few instruments are required. Those necessary are: a one-half ounce aseptic hypodermic syringe provided with a fine caliber sharp-pointed needle 2 inches in length, scalpel, pointed scissors curved on the flat, blunt-pointed, long-handled, curved ligature-carrier, my pile forceps, and sometimes a Sims retractor.

The patient is given $\frac{1}{4}$ grain of morphin about twenty minutes before the operation is to be performed, a soap-suds enema followed by a boracic acid enema is given, and the patient is placed on the operating table in the right or left lateral position. After the region of the anus is washed and sterilized the sphincter is anesthetized by the injection of from 10 to 30 minims of sterile 1 per cent. solution of quinin and urea hydrochlorid. The technic which I employ is as follows:

A point one-half inch below and posterior to the posterior commissure of the anus is selected and touched with a swab moistened with pure phenol. After waiting 2 or 3 minutes, or until this point is thoroughly blanched, the needle of the syringe is passed inward, upward and laterally in a V-shaped direction for about three-quarters of an inch, gradually going down into the sphincter muscle, but not entirely through it. While doing this it is well to pull down the sphincter by the index-finger of the left hand passed into the anus while the injection is being made with the right. From 10 to 20 drops of the solution are slowly injected and the needle is retracted to the point of puncture but not withdrawn. It is then pushed up on the other side in the same manner and this side is likewise injected. Three or four minutes are allowed to elapse to allow the anesthesia to become complete. Then a mechanical vibrator fitted with a cone-shaped vibrator, which has been well lubricated, is gently pressed into the anal orifice. About 3 minutes with the rotary stroke will dilate the sphincter to about the caliber of a silver dollar, which is sufficient to allow the operation to be done in a most satisfactory manner.

It is not absolutely necessary to use the vibrator. In its place one may use the index-fingers of both hands inserted opposed to each other and well lubricated, and by separating them with a gentle massage motion the sphincter may be dilated as satisfactorily in from three to four minutes.

After dilatation has been accomplished, the most dependent hemorrhoid is injected with the 1 per cent. quinin and urea hydrochlorid solution, enough being in-

* Read in the Section on Surgery of the American Medical Association, at the Sixty-first Annual Session, at St. Louis, June, 1910.

jected to blanch the hemorrhoid and give it the appearance of a Malaga grape. The lower extremity of the hemorrhoid is then grasped with the pile forceps and pulled down so that it is on the stretch. The long-handled ligature carrier threaded with No. 2 twenty-day, chromicized catgut is passed in through the mucous membrane of one side down to the base of the hemorrhoid and around to the opposite side in such a manner as to include the upper third of mucous membrane covering the pile and the blood-vessels which run longitudinally underneath, but not encircling the whole hemorrhoid as in the old ligature operation. This ligature should be placed just at the juncture of the hemorrhoid and the normal mucous membrane of the rectum. It is then firmly tied, when it will be found that the principal blood-supply of the hemorrhoid has been included in the ligature and shut off. The hemorrhoids on either side are dealt with in like manner and lastly the anterior and upper ones.

A suppository containing orthoform, 3 grains, thymol iodid 3 grains, and quinin hydrochlorid 20 grains, is inserted and the patient kept in the recumbent position for 10 minutes and then allowed to rise from the table. There will be a certain amount of edema or swelling during the first twenty-four hours, but this gradually disappears and is of no consequence. The hemorrhoids gradually shrink until, at the end of three or four weeks, there is nothing left but a small nub of connective tissue which can be painlessly snipped off at any time or left if one so desires.

This, which is the simplest form of technic, is peculiarly adapted to those desperate cases of anemia in which the daily loss of blood from the hemorrhoids is far greater than the patient's blood production. It can be performed in 10 or 15 minutes and involves the least expenditure of endurance on the part of the patient.

In the majority of my cases, when the necessity for haste and conservation of blood-supply is not quite so imperative, I modify the technic as follows:

Anesthetization, dilatation, and ligation are performed as above outlined. The hemorrhoidal tumors are then grasped in order by the pile forceps and incised in their longitudinal axes from a point about one-quarter inch below the ligature and extending down to their distal extremities. After separation of the sides of the incision, the blood-vessels and connective tissue which make up the body of each pile are dissected out *en masse* with the curved scissors and cut off one-quarter inch below the ligature. This longitudinal wound in each case is allowed to remain open and heals in from three to five days without suture. This disposes of the hemorrhoids at once, and does away with much of the swelling which necessarily follows the preceding technic.

In those cases in which there are pedunculated prolapsing hemorrhoids, it is not necessary to dilate the sphincter. After the preparation outlined above, the patient is asked to strain while in the squatting position, or while lying on his side in the Sims position, while the operator is evertng and pressing back the anus by manual pressure just outside of the margins of the external sphincters. The same technic as outlined above is carried out in regard to injection of anesthetic, ligation, and excision, and the operation is completed by the insertion of the anodyne suppository already mentioned.

The after-care is very simple. The bowels are kept confined for three or four days; on the beginning of the third day, white petroleum oil is administered in dram

doses before meals and at bedtime. This acts in a purely mechanical way, preventing the formation of hard stools and making the movements very easy. A simple soapsuds enema given through a small soft rubber rectal tube on the third or fourth day will start the evacuation of the bowels, which should be encouraged daily thereafter.

The use of quinin and urea hydrochlorid as an anesthetic possesses the great advantage over other drugs, of keeping up postoperative anesthesia of the parts, in many cases, during the entire convalescence of the patient. I consider that with the simple technic just outlined, and this newest local anesthetic, hemorrhoids can be removed without the patient suffering pain either during the operation or following it.

My experience with this technic under local anesthesia produced formerly under injections of 0.1 per cent. solutions of beta-eucain lactate and latterly under quinin and urea hydrochlorid—in all over 300 cases—leads me at this time to offer it to the members of this Section with the hope that it will prove as satisfactory in their hands as it has in mine.

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A CASE OF PERNICIOUS ANEMIA

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ARCADIA, WIS.

In the following case the patient has been under my observation during the past two years, commencing June 21, 1908. The case is a typical one of the severe type and illustrates the remissions which are so characteristic of the condition and also the manner in which the condition for the time being responds to arsenic.

Patient.—D. N., unmarried, farmer, Irish, aged 58. His father died at 86; his mother died at 73 of pneumonia. Brothers all alive and well; two sisters died in infancy.

History.—He had a broken leg five years ago, otherwise he has always been healthy. He has been an exceptionally hard drinker for a number of years, and is frequently drunk for days at a time. Six months ago he took cold after exposure during a drunken spree and has not recovered. He complains of general weakness especially of the legs, shortness of breath, loss of appetite, sore mouth, dry cough and inability to undergo any ordinary physical exertion.

Examination.—Tall, thin, large frame, skin pale yellowish color; muscles flabby, mucous membranes very pale and gray. Visible forcible pulsation of arterial trunks in neck and abdomen. Teeth poor; no sores in mouth; pulse 80, regular and soft. Soft systolic heart murmur at apex. Arteries very hard; the patient has lost considerable weight, but does not know exactly how much.

Urine Examination: Amount of sample examined, 4 oz. Very pale, clear, specific gravity 1.004, acid; no albumin, no sugar, no bile, no indican, no sediment. He had been drinking beer previous to voiding this sample.

Blood Examination: Red blood cells, 952,000; white blood cells, 2,850; hemoglobin, 30 to 40 per cent. Tallqvist; index plus; marked poikilocytosis. Many macrocytes and microcytes; many megaloblasts and a few normoblasts seen; almost no blood plates; polymorphonuclears decreased; small lymphocytes and eosinophils increased; few myelocytes.

A diagnosis of pernicious anemia was made.

Treatment.—Tincture of nux vomica and tincture of gentian compound were given before meals for stomachic and general tonic with Fowler's solution in ascending doses after meals. The patient was told to stop work and to take full nourishing diet.

Course of Disease.—July 22, 1908: The patient gained 12 pounds and felt much stronger. R. B. C. numbered