THE ABDOMINO-PERINEAL OPERATION FOR RECTAL CANCER.

To the Editor of THE LANCET.

SIR,—In answer to your correspondent Dr. R. Leonard Ley, writing in *THE LANCET* of Feb. 22nd under the above heading, I should like to point out that he has fallen into one or two errors owing to the fact that he is not acquainted with the more recent developments of this operation. In the first place, he considerably over-estimates the mortality of the operation in the hands of those who have had some experience in its performance. He puts the mortality at 40 per cent. This is certainly much too high at the present time, even in non-selected cases. My own mortality for this operation during the last three years comes out well under 20 per cent., and I have never attempted to select my cases in the sense of choosing those most suitable from a statistical point of view; they have only been selected from the point of view of giving the patient a reasonable chance of cure; and quite half the cases have been men, and a number of them over 60 years of age. 45 per cent. of my own patients in the last three years have been over 60 years of age and 60 per cent. over 55 years of age. In an operation of this magnitude, performed as it must necessarily be upon elderly patients usually in a poor state of health, there will always be a serious risk, but with improved technique and experience the mortality has been very much lowered, and my own record would show a still lower mortality had I not had the misfortune to lose two cases from embolism within the last year.

Dr. Ley states that the chief cause of death from this operation is sepsis. I quite agree with him that this was so in the early cases, but it is not now. I have only lost one case from sepsis in the last three years, and with careful technique this danger should be avoided. The success of this operation, as in so many surgical procedures, depends upon the technique, not only of the operation, but also of the preliminary preparation of the patient and the after-treatment of the case, and it is here quite as much as in the actual performance of the operation itself that care and experience tell.

I see no advantage in the performance of a preliminary colotomy, and one very serious disadvantage—namely, that there will be grave risk of infection from the colotomy opening at the second operation for the removal of the growth. I agree with Dr. Ley that the operation should certainly never be performed when the bowel is full of “evil-smelling fæces.” It is essential that the bowel should be thoroughly cleared out before the operation, but this can be satisfactorily done without having recourse to a preliminary colotomy. Of course if the stricture is so tight that there is practically obstruction a colotomy must be performed, but this is seldom the case when it is feasible to remove the growth at all. In many cases, especially in women, there is no necessity for a colotomy, it being possible to bring the bowel down, even after extensive resection and thorough clearing out of the glands. I do not think that a preliminary colotomy saves much time in the performance of the operation. The entire operation in a favourable case—that is to say, in a thin woman, where there is a fairly small growth—can be performed in less than an hour, and this is not an unduly long period. I believe the mortality from this operation will be still further reduced as the result of experience and improved technique.

I am, Sir, yours faithfully,

P. LOCKHART MUMMERY, F.R.C.S. Eng.

Cavendish-place, W., March 4th, 1913.

SUPRARENAL EXTRACT IN GRAVES'S DISEASE.

To the Editor of THE LANCET.

SIR,—Mr. James Berry in his lecture on “The Surgery of the Thyroid Gland” asks for evidence in favour of the use of suprarenal extract in Graves's disease as recommended by the late Dr. George Gibson. May I contribute a fragment? Mrs. A. has been under treatment at intervals since March, 1910, for Graves's disease with the usual symptoms of moderate severity. Improvement was always obtained by a mixture of iron, belladonna, and strophanthus. In October and November, 1912, however,

these remedies entirely failed, and the patient seemed in a serious condition from anæmia and heart weakness. I happened to have a bottle of Allen and Hanburys' elixir of suprarenal gland and gave her this with advice to rest. I called at her house last week and on inquiry she said: “That was wonderful medicine you gave me. I cannot live without it.” The evidence which further questions elicited seems as conclusive of cause and effect as such testimony can be.—I am, Sir, yours faithfully,

C. E. H. WARREN.

Dagnall Park, Selhurst, S.E., March 3rd, 1913.

A POINT IN EXAMINING URINE.

To the Editor of THE LANCET.

SIR,—When testing urine for sugar we usually add a few drops of urine to the freshly boiled Fehling's solution, and then boil them together. But I find that if the urine be poured from a pipette on to the surface of the just boiled Fehling's solution, and the tube be set up for a minute in the test tube rack, we may get a sugar reaction to manifest itself from glucose solutions too dilute to precipitate copper oxide when the test is done in the usual way. The oxide forms at the interface and in the urine, where there is little caustic alkali or tartrate to dissolve it. This is of interest in examinations for life insurance, and I do not see it chronicled in the usual text-books.

I am, Sir, yours faithfully,

W. E. HOME,

Pathologist to the Hospital.

Royal Victoria Jubilee Hospital, Victoria, Vancouver Island,
Feb. 3rd, 1913.

* * This quite useful observation has been made before by the late Dr. W. Howship Dickinson.—ED. L.

A DISCLAIMER.

To the Editor of THE LANCET.

SIR,—We regret that our names have appeared in an article on the treatment of consumption which was published in the *Daily Telegraph* on the 1st inst., and wish to state that the article in question was written and published without our knowledge and consent.

We are, Sir, yours faithfully,

J. CAMPBELL MCCLURE.

F. MEHNARTO.

J. HORNE WILSON.

KENNETH E. ECKENSTEIN.

R. TANNER HEWLETT.

Welbeck-street, Cavendish-square, W., March 4th, 1913.

THE RELATIONS OF OPERATOR AND ANÆSTHETIST.

To the Editor of THE LANCET.

SIR,—In a recent leading article¹ in *THE LANCET* it was pointed out that if any issue ever came to be tried in the law courts involving any question as to the mutual relations of surgeon, anæsthetist, and patient the result must depend upon the ordinary common law applied to the merits and circumstances of the individual case. Hitherto, as far as I am aware, the contingencies that might have led to litigation have not done so, and if the administration of anæsthetics in dental operations be taken into account it will be appreciated that an enormous number of occasions on which differences of opinion could arise between anæsthetist and operator are characterised by harmonious coöperation in the patient's interest.

The most easily to be imagined case in which the relations of an operator, surgical or dental, and an anæsthetist might come to be discussed in a court of law would be an action for negligence brought by a patient. Actions for alleged negligence by patients against surgeons or dentists are, of course, not uncommon, and a surgeon or dentist, if he found himself blamed by a patient, might allege that failure on his own part to achieve a successful result was due to something done or omitted by the

¹ *THE LANCET*, Dec. 7th, 1912, p. 1599.