

qualified practitioners and medical officers of health when the opinion of the former does not accord with that of a medical officer of health of any district acting under the by-laws of the district, which he has possibly and probably been instrumental in making. I enclose a copy of the proceedings as reported in a local paper and should be obliged if you would allow such portions of it to appear in THE LANCET as will set the facts fairly before my fellow-practitioners, and I should be further obliged if you and they would express such opinions on it as may seem to you and them fitting. Thanking you in anticipation,

I am, Sirs, yours truly,

April 25th, 1893.

J. G. BARFORD.

"THE TREATMENT OF HÆMORRHOIDS BY CLAMP AND CAUTERY."

To the Editors of THE LANCET.

SIRS,—Several interesting communications upon this subject have lately appeared in THE LANCET. Amongst the objections used against the removal of hæmorrhoidal tumours by the clamp and cautery reference is made to (1) pain after the operation; (2) subsequent contraction of the bowel; (3) secondary hæmorrhage; (4) pyæmia; (5) tetanus; (6) mortality &c.

In 1854 I published my mode of removing hæmorrhoidal tumours.¹ I there state that "after the excision of the tumour and the application of the actual cautery no cause of irritation remains, the operation is complete and the process of repair at once commences. The wounds when seen on the following day always appear smaller than the portions of mucous membrane which have been removed. The object of the application of the cautery is not to destroy any depth of structure, but simply to seal the divided vessels which in this operation afford the only cause of anxiety. It is not necessary in the operation now described to include all the diseased or protruded membrane. The removal of some portions exerts a beneficial influence on that which is left." Although I have seen cases in which each of the accidents above enumerated (with the exception of tetanus) has occurred, in no instance, as far as I am aware, has any one of them followed the operation which I have described. 1. In those cases in which pain has followed it has been in cases where some other operation than the one which I advocate has been performed. 2. Contraction of the bowel no doubt depends upon more of the mucous membrane than was necessary having been removed. 3. Secondary hæmorrhage occurs when a slough separates; there is no secondary hæmorrhage where there is no slough. 4. Pyæmia results from decomposing matter being left in contact with the open mouths of unsealed veins. The clamp which I have now used for many years is figured in Messrs. Maw's catalogue and is also represented in my "Hunterian Lectures." It is in the shape of a long pair of scissors, curved on the flat. The extremities of the blades are curved inwards and the smaller and shorter blade passes between the two portions of the larger. This arrangement gives great security, without any undue pressure, against anything slipping from within the grasp of the clamp. If the clamp be screwed very tightly the included portion may die, and then the patient must wait until the slough separates before the process of repair can commence. When a hæmorrhoid has been fixed a portion of it is cut off by a pair of curved scissors made on the same principle as the clamp and having the same curve. The cautery is then applied. It is dabbed on a wet sponge until very little steam is produced. It may be allowed to remain for four or five seconds in contact with the cut hæmorrhoid, which may be left exposed for a minute or two longer. The pressure of the clamp is then very gradually relaxed. Should any points of blood appear these are touched with a smaller cautery of the same temperature. The cut surface of the hæmorrhoid is then left with a very thin film of ash-coloured substance, which is aseptic and produces no irritation. When the stump of a hæmorrhoid is left it does good service by keeping the surrounding parts *in situ*. If the whole be removed the wound becomes larger by the traction from the surrounding parts. The removal of a portion, say half of a hæmorrhoid, necessarily stops the natural circulation in the remainder. The stump shrinks and ceases to be troublesome.

The same principle obtains with regard to the removal of

relaxed portions of mucous membrane. If a portion only be removed the surrounding parts are braced up during the process of cicatrisation. With respect to soft, vascular, bleeding hæmorrhoids, I adhere to the plan which I adopted many years ago and which was proposed by the late Dr. Houston of Dublin in the year 1843—viz., the application of strong nitric acid. This operation is comparatively painless if only sufficient precautions be used and a sufficient quantity of chalk paste be applied to neutralise the acid as soon as it is supposed to have produced its requisite action.

I am, Sirs, yours truly,

HENRY LEE,

Consulting Surgeon to St. George's Hospital.

Savile-row, April 29th, 1893.

EXAMINATION FEES IN LIFE ASSURANCE.

To the Editors of THE LANCET.

SIRS,—As you have given considerable prominence to the question of life assurance may I ask you to bring the following under the notice of the readers of THE LANCET?

A patient of mine decided to assure his life, and rather than do it all with one office he selected five, to each of which he made a separate proposal, asserting that I was his medical attendant and that he would not be examined by anyone else. Three of these applied to me in the usual way, the other two made a strong request to the proposer to be examined by their usual referees, which he distinctly refused. Shortly afterwards he informed me that both of these had accepted him as a first-class life. It was quite evident they must have ascertained that he had proposed to another office and secured a copy of my report from them. Under these circumstances I wrote and asked for a fee. One office immediately sent it to me, the other refused as follows:—

Atlas Assurance Company, Birmingham.

H. E. B., "local agent," Kidderminster.

DEAR SIR,—I am obliged to you for sending me Dr. J. L. Stretton's letter and copy of your reply thereto. I do not know that we have much to add to what you have already written to Dr. S—, but you may explain to him that it is the custom of Assurance Companies when an assurance is being divided between two or more offices for the medical examination to be conducted for one of the Companies, and this is usually deemed sufficient by all. It is purely an office arrangement and does not affect the medical officer in the slightest, his connexion with a case beginning and ending with his examination of the life, for which duty an adequate fee is usually paid.

Had Mr. H— been willing to go to Dr. A— we should have paid that doctor for his services, and thereafter could certainly not admit that he had any vested interest in his report.

I am, dear Sir, yours truly,

P. F. PORTWAY.

P.S.—Dr. S— must surely see that had the whole amount gone to our office he would have received no higher fee, and he therefore loses nothing by the division of the amount between various offices to suit Mr. H—'s convenience.

I have always given my report believing that it was to enable the office to decide whether they should accept the assurance for which such report was asked, and I can fully understand that if they decided to make over part of the amount to another office it might be necessary to show the report, but I cannot think it is right under any other circumstances to make use of it. No doubt offices are wise in having their own referees; but if they are so anxious to secure business that they will not insist upon such examinations, they should surely apply to the examiner indicated direct and not ascertain the fact that he has examined the proposer for another office and so take advantage of his report, which they refuse to accept in the ordinary way, without his knowledge and without giving him his fee.

If we are to be so treated, and the word "confidential" at the head of a report does not protect us, we must always ascertain whether the proposer is applying to other offices and delay our report until all have asked for our examination; indeed, this is my reason for troubling you with the matter. I may add that I have frequently examined men under similar circumstances for two or more offices and I have been in like manner examined myself; but this is the first instance in which I have known the fee refused, for I am sure life offices in general are wishful to act liberally with the profession they are so much dependent upon.

I am, Sirs, yours truly,

Kidderminster, May 1st, 1893.

J. LIONEL STRETTON.

P.S.—If, under similar circumstances, only one office is to procure the report, who is to decide which one should pay the fee? and do the others pay for the copies?

¹ Surgical Essays, p. 150.

"CASES OF CONTRACTED TENDONS."*To the Editors of THE LANCET.*

SIRS,—In THE LANCET of April 22nd Mr. W. J. Tivy has recorded some cases of contracted tendons of the toes which he had treated very successfully by tenotomy of the extensor tendons and subsequent massage. The value of this contribution has been somewhat compromised by the use of the term "hammer-toes" as applied to these cases. This latter deformity consists originally in a flexion at the first phalangeal joint, which is produced, according to the observations of Mr. Shattock and Mr. William Adams, by a deficiency in the length of the lateral ligaments. In consequence of the downward projection of the second and third phalanges the toe is pushed up during progression till at length the extensor tendon acquires an "adapted shortening." This implication of the extensor is secondary to the defect of the ligament. It would be useless to treat true hammer-toe by dividing—that is, by lengthening the extensor tendon. The flexion of the first phalangeal joint must first be corrected either by subcutaneous division of the lateral ligaments, as practised by Mr. Adams, or by resection of the articulation, as recommended in some cases by Mr. Anderson. After division of the lateral ligaments the joint can generally be completely straightened without section of the extensor tendon, which is rarely necessary. In certain cases of talipes equinus, and sometimes without any such accompanying deformity, the extensor tendons are contracted. The appearance of the toes then much resembles that of hammer-toes. In both the toe is drawn upwards, but in the one case the first phalangeal joint is easily straightened and in the other that joint is fixed in a flexed position. It is probable that Mr. Tivy's remarks refer to cases of the first description, which can be successfully treated by tenotomy of the extensors; but such an operation applied to hammer-toe would be fruitless and bring disappointment both to the surgeon and his patient.—I am, Sirs, yours faithfully,

Queen Anne-street, W., April 29th, 1893.

J. MACREADY.

"POST-PARTUM HÆMORRHAGE."*To the Editors of THE LANCET.*

SIRS,—The clinical lecture in THE LANCET of April 22nd by Mr. Stanmore Bishop emphasises, according to more modern teaching and knowledge, the principle I advocated some years ago in a paper entitled "Remarks on Post-partum Hæmorrhage."¹ After evacuation of the uterus of all its contents and the use of a hot antiseptic utero-vaginal douche, the next most valuable measure to adopt, both relatively and absolutely, in a case of post-partum hæmorrhage, I believe, with Mr. Stanmore Bishop, to be compression of the abdominal aorta. Its *modus operandi* he explains in terms almost equivalent to those employed by me in the paper referred to above. The methods described as in practice at Queen Charlotte's Lying-in Hospital in 1870 may be regarded as open to question in the present day; but I have no doubt that, though less scientific than those of modern procedure, they were of service in limiting the cases of post-partum hæmorrhage numerically as well as potentially, and I believe now, as then, would be of service in practice where it was found difficult to carry out more exact compression of the abdominal aorta by manual pressure.

I am, Sirs, yours faithfully,

H. CRIPPS LAWRENCE.

Sussex-gardens, Hyde Park, W., May 1st, 1893.

SARCOMA OF THE BREAST: ITS DIFFERENTIATION FROM ACUTE CARCINOMA.*To the Editors of THE LANCET.*

SIRS,—A clinical lecture on breast tumours published in THE LANCET of April 29th contains a proposition of so much practical as well as pathological importance that I will ask your permission at once to challenge the accuracy of the latter. The student is told that immunity of the axillary lymph glands cannot be relied upon as a test of mammary sarcoma, differentiating this from carcinoma, several cases in which those organs were found palpably enlarged being adduced in support. The error involved lies in a very common confusion

of the more acute instances of carcinoma-development in the female breast with true sarcoma. The rapidly growing encephaloid carcinomata of this organ form soft, greyish, granular masses, which, under the microscope, consist of round or ovoid cells, never of spindle-shaped forms. If the margins are examined, the acinar arrangement characteristic of breast carcinoma will be found; otherwise, the lesion will probably pass as "round-celled sarcoma." Little or no enlargement of the axillary lymph-glands can long be detected; these structures, however, are actually infected and after excision of the breast growth therein is rapidly progressive. *Per contra*, a sarcoma presents on section a yellowish quasi-gelatinous surface with distinct fibrillation, it is never granular; portions may be well organised, resembling a non-malignant fibroma. The microscope reveals spindle-shaped cells, ranged for the most part in bands, with, in the more acute examples, a variable admixture of roundish cells or free nuclei. No true sarcoma, arising from connective tissue cell-elements, ever fails to display fusiform cells in strands or bands, and *no doubtful tumour should ever be designated by that title in the absence of this pathognomonic badge*. The axillary glands are never infected—so, at least, said the late Dr. Samuel Gross ("Tumours of the Mammary Gland," p. 87), and for many years past I have vainly sought an instance to the contrary.

In surgical practice it is a matter of urgent necessity to avoid the confusion indicated, for, after the operative removal of a breast tumour (which, when incised, presents the grey granular-cut surface referred to), the surgeon who omits forthwith carefully to evacuate also the contents of the axillary cavity will fail gravely in his duty. Should he proceed to do this he will probably encounter some degree of enlargement previously undetected; in any case he will find evidence of deposits certain to have caused death, with abundant visceral deposits, within a few months. On the other hand, should the mass on section present the gelatinous fibrillated appearance indicative of true sarcoma, any interference with the axilla will only needlessly enhance the gravity of the operation.

I am, Sirs, your obedient servant,

HERBERT SNOW.

Gloucester-place, Portman-square, May 3rd, 1893.

THE ETIOLOGY OF EMPYEMA OF THE ANTRUM.*To the Editors of THE LANCET.*

SIRS,—The question as to the part which teeth may take in the causation of the condition now usually denominated "empyema of the antrum"—a question cursorily alluded to by Dr. William Robertson in his valuable paper in THE LANCET of to-day—deserves discussion. The common association of polypus and other morbid conditions of the nasal cavities with empyema of the antrum cannot be denied; but it is a disputable point whether in a majority of such cases the mischief has had its prime origin in the nose or in the teeth and antrum. It is at least certain that in a large proportion of cases of simple empyema—and probably in by far the greater number—whilst no other cause is discoverable there exists in teeth in relation with the antrum disease sufficient to account for the symptoms and for the pathological changes in the mucous membrane of the cavity. It must, however, be pointed out that it is not quite exact to speak of dental caries as the cause of these effects; they are due rather to the sequelæ of caries—exposure and inflammation of the dental pulp and alveolar abscess. Septic matter in the root canals of teeth may find its way into the antrum; or inflammation with suppuration around the apices of roots may extend to the cavity. The former accident is the more common in carious teeth which have been filled, and in which, the cavity of decay being hermetically sealed, discharges can find vent only through the apical root-foramina. In many of these cases, particularly in those in which a chronic alveolar abscess finds free vent into the antrum, toothache does not exist, and, indeed, although I and my colleague in practice in England have in late years tapped the antrum in a large number of cases, in no instance has a patient, suspecting his teeth, applied to us in the first instance. The diagnosis has always been previously made by surgical practitioners; but in a great number of instances a correct diagnosis has not been made for months and even years. These facts have been thoroughly illustrated

¹ Brit. Med. Jour., Jan. 29th, 1870, pp. 102-3.