"SKIN MANIFESTATIONS OF AMEBIASIS."

BY JNO. L. JELKS, M.D., OF MEMPHIS, TENN.

The author had observed cutaneous affections among a number of persons suffering with chronic Amebic affection. In April, 1909, he reported cases before the annual meeting of the DeSoto County, Mississippi Medical Society. In May, 1909, he made similar allusions to these conditions before the annual meeting of the Arkansas State Medical Society. Again in April, of the present year, at the Tennessee State Society, in a paper, "Amebiasis, complicated in one instance by Pellagra, in another by eighteen Adenomata," he referred to these associated conditions.

In one case, observed two years ago, with very chronic amebic infection and ulceration, the patient had for more than forty years observed that the skin lesions, which were erythematous and macular, and at times edematous, depended very greatly upon the condition of the bowel at that time. This patient was returned to her family physician as incurable owing to the scarred, distorted and stenosed condition of the bowel. She has since died, apparently from exhaustion produced by a most extensive desquamative dermatitis.

Another case which was observed in the winter of 1908-1909, of chronic amebic ulceration, with liver abscess complicating, presented extensive macular, papular and pustular skin lesions which quickly cleared up under treatment, which was directed solely to the intestinal infection and ulceration.

Recently a case was presented which had been diagnosed by several able physicians and skin specialists as one of pellagra. The case presented all symptoms of amebic infection, which preceded the skin lesions, and the author found the *ent-ameba-hystolitica* in the muco-purulent material taken from the rectum, and concluded that the condition known as pellagra may have its solution as to etiology when systematic examinations are made for parasitic infections and intestinal conditions.

The author expressed the belief that those may help explain the prevalence of the condition known as pellagra in the South. A report of six cases were presented in support of his views, and he emphasized the singular coincidental, if not consequential, skin lesions in so many chronic amebic cases which have been observed by him and which responded to treatment directed solely to the intestinal infection and ulcerations. He quotes other authority both in this and other countries which are supportive of his views.

"INCONTINENCE FOLLOWING RECTAL OPERATIONS."

BY GEO. B. EVANS, M.D., OF DAYTON, OHIO.

We understand the external sphincter to be a flat plane of muscular fibers, elliptical in shape, and intimately adherent to the integument and joining with the perinei, levator ani and accelerator urinæ. It is a voluntary muscle and supplied by a branch of the fourth sacral nerve.

The internal sphincter is but a muscular ring, half an inch in breadth, in thickness two lines, and but an aggregation of the involuntary circular fibers of the intestine. Evidently the only true sphincter ani is the external—the internal sphincter ani is not subject to volition—and its sphincteric influence must be largely due to the support afforded it by the practically amalgamated muscles which form the floor of the pelvis and whose main function is the support of the hollow viscera of the pelvic cavity. Would it, therefore, be illogical to believe that the internal sphincter is not, neither can it be, made by any surgical procedure, an efficient voluntary constrictor? Certainly, it is true that efficient and satisfactory sphincteric function is dependent on normal support of the bowel by a normal muscular floor, with a normal interdependent power of sphincter muscles, hence any trauma which interferes with muscular function disables proportionately to the extent of the injury.

That incontinence does follow division of the external sphincter is not denied, and when

their division becomes a necessity the best way, if there is one, of making the incision, should be chosen. Can we hope that ere long there will be a method of cure for fistula-in-ano that will exclude even the possibility of incontinence?

Considering the anatomical conformation of the perineum, the mutual dependence of perfect function, I would admonish those engaged in rectal surgery to not forget that indifferent and multiple injuries (even surgical injuries) should not be indulged in, for fear of a result that would prove more painful and unendurable than the condition which indicated operative interference.

We believe that incontinence can be obviated by relieving the tension of the fibers of the levator ani muscle at their attachment to the external sphincter, or both the external and the internal sphincter by nicking the fibers of said muscles on either side of the fistulous tract, and thus permitting an incision of the muscle at right angles to the same

"ULCERATION OF THE RECTUM IN
PREGNANT WOMEN AND THE
PART IT PLAYS AS A FAC-
TOR IN ABORTION;
CASES."
WITH A REPORT
REPORT OF

BY LEON STRAUS, M.D., OF ST. LOUIS, MO.

Sixteen years devoted to diseases of the rectum exclusively has afforded the author the opportunity to see and classify a large number of cases of irritable ulcer of the rectum in pregnancy, to say nothing of a much larger number not associated with this condition. He has kept a careful record of these most interesting cases and has classified them with reference to certain conclusions, namely, that it is a factor not infrequently overlooked. Then, too, many general practitioners make the contention that an operation is uncalled for and unwarranted, that is to say, an operation will certainly produce the very result which it is intended to avoid.

He dissented absolutely from this contention, and for that reason reported the results of his work along this line and his final conclusions. He has operated twenty-four times for irritable ulcer of the rectum in pregnant women. Not all of these operations were made to prevent abortion. In fact only fourteen had had one or more abortions. That leaves ten for which the operation was made to relieve the distressing pain from which these patients suffer. A number of these cases are unique and teach a lesson apart from the average case. The history, symptoms and results of several such cases were reported and the following conclusions were drawn.

First—That irritable ulcer of the rectum is not an infrequent factor in abortion and miscarriage.

Second—That the local lesion is not recognized by the general practitioner as a factor in abortion and miscarriage.

Third—That you will meet strong opposition to operative interference by the general practitioner.

Fourth—That you can and should operate at any period of the pregnancy if indicated.

Fifth—That the danger and only danger is in leaving the fissure without operating.

Sixth—That you may and will often have to assume the entire responsibility for the outcome of the operative procedure.

Seventh—That we proctologists should teach on the by-ways and highways of surgery the invariable indication for surgical interference in these unfortunate cases

"A CASE OF LOCALIZED DERMATITIS
FOLLOWING THE USE OF QUI-
NINE AND UREA AS A LOCAL
ANESTHETIC IN A CASE OF
FISSURE AND HEMOR-
RHOIDS."

BY ARTHUR HEBB, M.D., OF BALTIMORE, MD.

Three days after the use of a 1 per cent aqueous solution of quinine and urea, as a local anesthetic in a case of fissure and hemor-