A few suggestive points regarding technic may be helpful. The standard color tube is inserted into one of the two openings, for instance, *D*, and the sliding door raised until the window is exposed. The calibrated tube with its contents ready to be estimated is inserted into the other opening, *E*, and the diluting fluid added drop by drop and mixed until the color exactly matches that of the standard, that is, when the color as seen at one half of the window is of exactly the same shade as the other half. When this is accomplished, the sliding door is raised high enough to enable one to observe the height which the fluid has attained. The calibrated tube is graduated up to 140, and in making readings, in order to obtain close results, it is best to make a reading at that point at which the color just matches the standard and then slowly continuing the dilution and taking other readings, accept as the final figure the one just previous to the point at which the color became fainter. The instrument should be held at a distance convenient to the eyes of the observer.

AN IMPROVED INFLATABLE FACE CUSHION

RAYMOND C. COBURN, M.D., NEW YORK

An essential requisite in the administration of nitrous oxid is that the face cushion form an air-tight fitting with the patient's face. There is a decided tendency, when an inflatable rubber cushion is used, for the patient's expira-

An improved inflatable face cushion.

tions and saliva to moisten the rubber, so that the cushion slips off the solid face piece, especially when a metal face piece is used, so that the solid face piece rests on the patient's cheek, instead of on the rubber cushion. This malposition permits the nitrous oxid to escape and air to be inspired, thus interfering with a proper and successful administration of nitrous oxid.

To obviate this difficulty, I have had a wire inserted within the inflatable rubber cushion, as shown in the illustration. This wire insert prevents the cushion from becoming displaced and from slipping out of its proper position. The wire is sufficiently pliable so that it may be changed in form and size, as may be needful.

AN IMPROVED HEMORRHOID OPERATION

WILLIAM LEE SECOR, A.M., M.D., KERRVILLE, TEXAS

The three common methods of operating on hemorrhoids—clamp and cautery, ligature, and suture—each leaves much to be desired before the ideal is reached.

Of the three methods, the one which is freest from post-operative pain and secondary hemorrhage, which closes the mucosa and leaves the rectum most nearly normal, is the suture method.

The best technic for this procedure is to sterilize the field with 3 per cent. iodine solution, grasp a pile at its tip with

a hemostat, and draw it down so that another hemostat may be placed at the top of the pile. With the pile on the stretch by the two hemostats, a narrow-bladed clamp (Ferguson's) is placed on the base of the tumor, and the tissue outside of the clamp cut away. Then with a curved round-pointed needle and No. 2 iodized catgut, an over-and-over stitch is made around the blades of the clamp, to cover in the entire raw surface. The clamp is loosened and slipped out of the loops of the stitch, the stitch is drawn up tight, and the two ends are tied together.

During the past ten years I have done this operation many times with perfect satisfaction, except for one point of danger which from my own experience seems more theoretical than practical, but nevertheless exists. In placing the stitch around the clamp, the needle may carry infection into some of the large veins of this area, giving rise to local or remote abscess formation. The iodine method of sterilization reduces the chance of this accident to a minimum.

In order to avoid even this small element of danger in a hemorrhoid operation, I have devised the following technic:

The field is painted thoroughly with 3 per cent. iodine solution. A hemorrhoidal tumor is picked up and put on tension

Procedure of the operation: *A*, grasping of pile with two hemostats; *B*, clamping; *C*, suturing.

by two hemostats as in the operation described above. Then its base is clamped with a special clamp having a slit in each blade similar to the Mayo-Moynihan stomach clamps. The tissue outside of the clamp in the grasp of the hemostats is cut away, then a No. 2 catgut suture with a needle at each end is used in making a back-and-forth shoemaker's stitch through the slit in the blades, the clamp is removed, and the stitch is tied.

In this operation, half of the split blade of the clamp crushes the tissue and vessels back of the suture line, and no infective material will travel from the stitch holes through the veins.

The mucosa is nicely approximated, and the firm stitching insures against any hemorrhage. A small strip of gauze covered with sterile petrolatum is left in the rectum for twenty-four hours. There is little pain. The bowels are moved on the fourth day, and the patient leaves the hospital in a week.

This operation done under novocain—sacral anesthesia—leaves little to be desired as to safety, simplicity and end-results.