

as their opportunity to play upon the credulity and gullibility of human nature.

“REVIEW OF PROCTOLOGIC LITERATURE FROM MARCH, 1909, TO MARCH, 1910.”

BY SAMUEL T. EARLE, M.D., OF BALTIMORE, MD.

The Committee on Proctologic Literature reviewed the following papers as worthy of the attention of the members of the Proctologic Society:

“The Treatment of Hemorrhoids by Zinc-Mercury Ionization,” by T. J. Bokeham, which appeared in the Proceedings of the Royal Society of Medicine, May, 1909, p. 135.

A paper by Dr. Herman A. Bray in the Monthly Cyclopedic and Bulletin, May, 1909, p. 268, “The Importance of Careful Post-operative Treatment in Rectal Operations.”

A paper from the Albany Medical Annals, May, 1909, vol. XXX, by Dr. George Blumer, New Haven, Conn. “A Neglected Rectal Sign of Value in the Diagnosis and Prognosis of Obscure Malignant and Inflammatory Diseases Within the Abdomen.” The sign is spoken of as the rectal shelf, which is observed on making a digital examination of the rectum on the anterior rectal wall, from two to four centimeters above the prostate gland in males. This shelf is of almost cartilaginous feel which projects into the rectal cavity. In some cases the circumference of the rectum is involved in an annular zone of infiltration, more marked anteriorly and tapering off toward the posterior wall, a signet ring stricture, as Schnitzler calls it. The summary of his paper is contained in the following:

1. In certain forms of carcinoma of the abdominal organs, notably gastric carcinoma, and in some cases of tubercular peritonitis, implantation metastases in Douglas' pouch are common.

2. These metastases impinge upon the rectum and may infiltrate its submucosa, causing a peculiar shelf-like tumor on the anterior rectal wall, readily felt by the examining finger.

3. In cases of gastric carcinoma this may

be an early metastasis, and occurs especially in males.

4. In such cases the primary tumor may be latent and the metastasis may be large enough to cause symptoms of obstruction. It has been mistaken at times for rectal carcinoma and has been removed as such.

5. The not infrequent occurrence of this rectal shelf makes it a diagnostic and prognostic sign of a good deal of importance, and warrants the statement that in no case of obscure abdominal disease should a rectal examination be omitted.

Dr. W. I. Dec Wheeler, in the London Lancet, March 6, 1909, gives excellent reasons for always using the abdominal route, or a combined method for excision of carcinoma of the rectum, whenever the malignant growth is three inches or more above the sphincter.

The technic for Excision of the Rectum in Prolapsed, as given by Dr. John H. Cunningham, Jr., Boston, Mass., Annals of Surgery, May, 1909, is referred to and favorably commented upon.

Dr. A. L. Wolbarst's improved rectal irrigating tube is referred to. A description of the instrument may be found in the Journal of the American Medical Association, July 31, 1909.

“MALFORMATIONS OF THE ANUS AND RECTUM: REPORT OF FOUR CASES.”

BY ALOIS B. GRAHAM, A.M., M.D., OF INDIANAPOLIS, IND.

Congenital malformations demand prompt surgical treatment. Many cases are never reported, and the percentage is evidently much larger than statistics indicate. These malformations are sufficiently uncommon and interesting to warrant placing every case on record. Report of four cases.

- Case 1. White male child, born with no trace of an anus, and in whom careful dissection and exploration failed to find any trace of a rectum. Colostomy was suggested but the

parents refused their consent. Child died four days later. Autopsy refused.

Case 2. Colored male child, age five years, born with a complete obstruction of the anus by a membranous diaphragm, which was perforated by the attending physician. Examination revealed a dense stricture, almost impermeable, involving the entire anal canal. The interesting point was the presence of a hypospadias through which feces had escaped for two years. The communication between the rectum and urethra was the result of ulcerations above the stricture rather than defective embryological development. Surgical treatment was refused.

Case 3. Colored female child, age fifty-six days, in whom examination revealed a well-formed anus and a protruding or bulging imperforate rectum. A photograph shows a pronounced distention of the abdomen the result of a fifty-six days' intestinal obstruction. Posteriorly, the rectum had no attachments, and the finger could be introduced easily behind the bulging imperforate gut, through the anal canal, into a blind pouch. A fistulous opening was found in the vagina just behind the hymen. The meconium and a small quantity of feces had escaped through this opening. The protruding rectal mucosa was dissected from its attachments and excised. The rectal mucosa was then sutured to the free skin at the anal margin, except for one-eighth of an inch posteriorly. This was used for drainage in case the blind pouch became infected. This patient made a good recovery. At the last examination, which was three months following operation, the finger could be introduced easily into the rectum, the stools were normal, and sphincteric control was good. The fistulous opening into the vagina was closed, and the posterior rectal mucosa was firmly united to the skin at the anal margin. With the exception of an abdomen, which seemed to be a trifle prominent for one of its age, the child appeared normal.

Case 4. White child, one of twins, age forty-two hours, in whom examination re-

vealed an imperforate urethra and no trace of a anus. Penis and scrotum were well developed, but neither testicle could be palpated. Careful dissection and exploration failed to find any trace of a rectum. A two inch incision was made in the median line just above the pubis, but no bladder could be found. Decided to perform a colostomy or sigmoidostomy. A portion of what was supposed to be the sigmoid was opened and a large quantity of meconium escaped. Exploration revealed a pouch which appeared of much larger dimensions than a normal colon or sigmoid should be. Operation was completed, and yet our inability to find the bladder made the case a hopeless one. Child died twenty-four hours later. At autopsy no bladder was found. The entire large intestine was removed. This case is of interest from the point of view of defective development. The pouch-like termination of the intestine might well be termed a monstrosity. The writer is inclined to believe that it is one of those rare cases in which the colon or sigmoid opens into the uterus. While the local examination revealed a male child, with the exception of being able to palpate the testicles, the examination of the specimen removed at autopsy reveals marked evidence of the female generative organs. This child was a traverse hermaprodite—namely, one in whom the external genitals seem to be of one sex and the internal of the other. Report of examination of specimen states that the pouch-like termination of the intestine is formed of three organs: namely, the bladder, uterus and rectum.

"THE USE OF QUININE AND UREA HYDROCHLORIDE AS A LOCAL ANESTHETIC IN ANO-RECTAL SURGERY."

BY LOUIS J. HIRSCHMAN, M.D., OF DETROIT, MICH.

Dr. Hirschman presented to the Society a report of his work with quinine and urea hydrochloride as a local anesthetic in ano-