anus to be felt by rectal touch, and the sulcus may not be apparent. This constitutes the fourth variety, and is generally known as intussusception. In the treatment of intussusception we enter at once into the domain of abdominal surgery, and into one of its most difficult departments, viz., that of intestinal anastomosis. This, I have always claimed, the specialist in the rectum should be able to do, but the limits of this article will not permit a study of these cases.

Abscess and Fistula.—Abscesses near the rectum may be divided into the superficial, those of the ischio-rectal fossa, and those of the pelvis.

An abscess of the ischio-rectal fossa is bounded by the levator ani muscle above, the skin below, the rectum on one side, and the adjacent tuberosity of the ischium on the other. An abscess of the pelvis, on the other hand, is located in the lax connective tissue around the upper portion of the rectum above the levator ani. It may assume vast proportions, blending laterally with the subperitoneal connective tissue of the iliac fossa, and burrowing in almost any direction in the true pelvis.

The causes of deep rectal abscess are various. Traumatism is perhaps the most frequent, and the injury is generally internal rather than external, being caused by the point of a syringe or foreign body rather than by kicks or falls. Such an abscess may also be due to the injury inflicted by the fœtal head in parturition, and in such a case it may be a difficult matter to distinguish the disease from puerperal inflammation. It may also be secondary to diseases of the urinary organs, and it may result from rupture, ulceration, or perforation of the rectal wall in connection with stricture. Again, it may result from an inflammation of the submucous tissue with the production of pus which first opens into the bowel and forms an internal fistula, and subsequently extends outward and forms a large abscess. Finally, such abscesses may, so far as their origin is concerned, have no connection with the rectum; they may be due to disease of some neighboring part, such as appendicitis, or to necrosis of some adjacent bone; or perhaps no adequate cause can be found, so that for lack of knowledge it may become necessary to set them down as idiopathic.

In abscess of the pelvis, when not due (as it generally will be) to septic endometritis, the symptoms are often obscure and seldom characteristic. There is more or less vague pain in the pelvis or lumbar region, which is seldom intense and is generally increased by defecation. Fever may be entirely absent, but if it is present it is more apt to be continuous than very high in degree, and chills are only occasionally met with when pus is formed. In addition there is more or less general malaise, and the vesical symptoms (retention and incontinence of urine) are apt to be marked. The diagnosis must rest chiefly upon the result of careful bimanual pelvic examination. An abscess of the ischio-rectal fossa may at its commencement be marked by the same obscure symptoms, but later the skin becomes red and œdematous, sometimes over a large part of the buttock, the pain is very severe, and rectal examination is impossible. In abscess of the pelvis immense collections of pus may form and burrow in any direction. In men the pus generally follows the course of the bowel, involves secondarily the ischio-rectal fossa, and makes its way through the skin at some distance from the anus, possibly over the trochanter or out on the buttock. In women it is more apt to pursue a contrary course, and usually bursts through the rectum or the vagina. An abscess of the ischio-rectal fossa generally breaks both upon the cutaneous surface and into the bowel at some distance from the anus, while one in the male pelvis is just as likely to open into the bladder or the peritoneal cavity as into the bowel.

The great question in treating an abscess of the ischio-rectal fossa is to prevent the formation of a fistula. This can generally be done if the proper course be followed, but the treatment must be prompt and efficient. It consists in etherizing the patient as soon as the diagnosis is made, and, without waiting for fluctuation or even for the formation of pus, in making a free incision into the centre of the diseased area, thoroughly cleaning out any cavity that may have formed, breaking down all bridles of sloughing tissue, laying open all pockets, washing out the cavity with carbolic acid, and stuffing it with lint. If this be properly done the formation of a fistula will be prevented in the majority of cases. If the abscess be left to itself, or even partially opened, a bad form of complete fistula is pretty sure to follow. The treatment of an abscess of the pelvis in men is not so simple, the disease being more serious and the prognosis more grave. If possible the abscess cavity should be opened with the knife through the rectum or by way of the abdominal cavity. In women it should be opened through the vagina. Here again we enter upon the domain of abdominal surgery, to which properly belongs the whole question of the comparative value of vaginal and abdominal cœliotomy for the relief of pelvic inflammation.

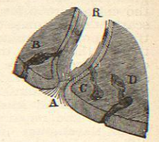


Fig. 227.—Varieties of Fistula. (Gosselin.) A, anus; R, rectum; B, complete fistula; C, blind internal fistula; D, blind external fistula.

*Fistula.*—A fistula which is not due to perforation of the rectal wall from within is the result of a previous abscess, and therefore the consideration of one leads directly to that of the other. Like the abscesses from which they arise, such fistulæ may well be divided into superficial and deep; or into those of the anus which are subcutaneous and involve at most only a few fibres of the external sphincter, and those of the rectum and pelvis, which open into the bowel at a higher point or on the surface at a considerable distance, perhaps, from the anus. Both the superficial and deep may be divided into the complete, or those which open both into the bowel and on the surface; the external, which open only on the skin; and the internal, which have an opening only within the bowel (Fig. 227). Deep or submuscular fistulæ differ greatly in their extent and gravity. In them the track is large and often double or branching, and the external opening may be far away from the anus. The whole perineum and even the gluteal region will sometimes be found pierced with openings. In these the internal orifice does not in all cases mark the superior limit of the fistulous track. This may run up a distance of several inches alongside the bowel, under the mucous membrane, while the internal orifice is only just within the sphincter (Figs. 228 and 229).


Fig. 228.

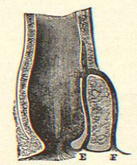


Fig. 229.

Fistulæ with Double Tracks. (Mollière.)

Fig. 228.—AB, Deep submuscular track resulting from an ischio-rectal abscess; AI, submucous track running up and down the bowel.

Fig. 229.—DE, Subtegumentary and submucous fistula with an internal and an external opening. DF, deep submuscular track having same internal, but separate external opening.

Blind internal fistulæ, or those which have an opening only into the bowel, have a somewhat special pathology. When such a fistula is caused by an abscess, it is generally one of the deep variety, which has opened into the rectum high up and continues to discharge in this way. The opening may, however, be the result of ulceration, and the track a secondary consequence. A small ulcer which shall perforate the mucous membrane and result in internal fistula may be due to several causes: to rupture of an inflamed internal hemorrhoid; to the inflammation of one of the lacunæ just above the sphincter—an inflammation caused by the lodgment within it of an irritating





particle; to the application of strong acids or any other traumatism; or to tuberculous ulceration. Such a condition is a very painful one. The opening, which may be large enough to reveal a distinct loss of substance to the touch, catches and retains particles of fæces, which cause a burning pain that may last many hours after defecation. As a result of the ulcer, an abscess forms after a time, and is accompanied by the usual symptoms. When this is small, and the induration not extensive, a speculum examination may reveal the ulcer, but the track and the abscess may escape detection—a mistake which will render all treatment directed toward the cure of the ulcer futile. There may be several ulcers, only one of which has a fistula connected with it.

A fistula may heal spontaneously or after very slight stimulation, but such cases are very rare. Setting them aside, we are brought to the question which will often be asked by the patient, and which the surgeon may not always be able to answer to his own satisfaction, viz.,—whether or not it is always best, or even safe, to attempt a cure. In certain cases of Bright's disease, cancer, cardiac and hepatic affections, etc., all surgical interference may be plainly contraindicated; but the question is most apt to arise in connection with tuberculosis. Personally I always operate on tuberculous fistulæ if I believe the disease is not too extensive to permit of healing. No cautious practitioner would think of operating on an old case of disease which was quiescent and causing little trouble, in a person suffering from very advanced or rapidly advancing lung trouble. Cough, when violent and frequent, is a decided contraindication, interfering, as it most certainly does, with the healing of the wound. The sphincters should be interfered with as little as possible, for they are apt to be weak at the best; and the general health of the patient must in no way be impaired by the confinement necessary, after an operation, to secure healing of the wound. When the fistula is of recent origin, and, as is most often the case, attended by a good deal of undermining of the skin and profuse discharge, much may be done for the patient's relief, and in the majority of cases a cure can be established without any but good results as regards the lungs.

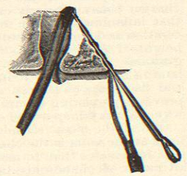

Fig. 230.—Operation for Fistula with Gorget. (Bernard and Huette.)

The prevailing idea that in order to cure a fistula it is necessary to divide the sphincter muscle, is often carried to a harmful extreme. Many of them may be cured by much simpler means, and many of them cannot be cured even by this one. There is, in fact, no rule which applies to all cases. Many sinuses in this part of the body are curable by the well-known means which are used in general surgery—free drainage and stimulation. Injections of iodine or nitrate of silver, the application of nitrate of silver fused on a probe, or of strong carbolic acid, the introduction of a fine sea-tangle tent, of a drainage tube or of a galvano-cautery wire, may any of them prove to be effectual curative agencies, but they are so more often in cases of superficial fistulæ which do not communicate with the bowel than in the deeper ones. In complete fistulæ, when not too deep, the best operation is that of incision with the knife. The mode of procedure in this operation, as well as that of employing the gorget or large wooden director to cut upon, which is often of great advantage, is shown in Fig. 230.

When no internal opening can be found, but the mucous membrane feels undermined, and the probe can be felt by the finger in the rectum, separated only by a thin layer of mucous membrane, it is a good plan to force an internal opening and treat the fistula as though it were complete. When there are two internal openings, both should be included in one incision. When, after the incision, the diseased integument is found to overlap the cut and fall into it, it should be cut away, and in old tracks the healing may be hastened many days by thoroughly scraping out the lardaceous wall with the handle of the scalpel, or by scarifying it in several places so that a healthy reparative action may be set up. Where the fistulous tracks exist in great numbers—twenty or thirty in some cases—it may be advisable to do two or three operations at intervals, rather than attempt, at a single sitting, more than the patient's strength is able to bear. In such cases there will generally be found two or three tracks which are primary, the others being merely offshoots from these, and each main track with its branches may be divided in one operation.

Fistulæ of the blind internal variety can only be dealt with rationally by incision.

Fissure and Ulceration.—The many different varieties of non-malignant ulcers which are met with at the anus and within the rectum may best be classified in the following groups: simple, dysenteric, tuberculous, venereal, and rodent.

Simple ulcers are always of traumatic origin, and the most frequent injury to which the rectum is subject is, perhaps, that arising from the passage of hardened fæces. From this cause alone, or partly also, in some cases, by reason of the fact that they protrude from the anal orifice, the hemorrhoidal tumors may become ulcerated for a considerable extent. From this cause also a fissure is often produced within the grasp of the sphincter. Another frequent cause of injury is the presence of foreign bodies, either fish bones, date stones, etc., which have been swallowed; or larger substances which have been introduced *per anum*. An ulcer of the rectum is often caused by surgical interference, such as operations upon hemorrhoids or fistulæ, or unsuitable applications to fissures or a prolapse; and, in women, extensive ulceration and subsequent stricture may be caused by bruising the rectum between the head of the fœtus and the sacrum, in parturition.

An injury due to some of the causes already mentioned may, in certain persons, and when located at the verge of the anus, assume the characters of an affection which has been elevated into a separate class, and is known as fissure, or irritable ulcer. The irritable ulcer differs in no respect from other simple ulcers in the same locality, except in the fact of its irritability. There is nothing peculiar in the ulcer itself. It may be due to a slight rent in the mucous membrane from hard fæces; to a congenital narrowness of the anal orifice and a naturally over-powerful sphincter; to the irritation of a leucorrhœal discharge in women; to an herpetic vesicle; or to the venereal sore which it so strongly resembles, the soft chancre. Any sore which is fairly in the grasp of the external sphincter is apt to become an irritable or painful one; and a fissure may be painless at one time and painful at another in the same person; or painless in one person and painful in another. An ulcer associated with contracture, spasm, irritability, pain, and sometimes even with actual hypertrophy of the sphincter, is what is known properly as an irritable one; but a fissure may be present without exciting any of these symptoms.

These ulcers are generally situated at the posterior commissure, but they may be found anywhere on the anal circumference. They are generally single, but there may be two or three, more especially when they are of venereal origin. They are more common in women than in men, because constipation is more common in the former and because the skin is more delicate. They are confined to no age and are by no means relatively rare in infants. They are generally oval in shape with the long axis vertical, and involve both skin and mucous membrane, being situated just at the junction of the two. In some cases they have the appearance of a simple erosion, in others that of an old ulcer with grayish base and indurated edges which has involved the thickness of the mucous membrane and has extended fairly down to the muscle beneath. In the majority of cases they are not attended by suppuration or the discharge of pus, but they are apt to bleed a

little on slight provocation. They are often attended by small polypi attached near their upper end, or on the opposite side of the bowel, the presence of which may counteract all curative measures directed to the fissure alone.

The ulceration which results from a surgical operation or from a foreign body is easily recognized. Those which result from acute and chronic eczema and from pruritus are generally due to the injury inflicted by the nails of the sufferer, and present no special characteristics. An eruption of herpes around the anus, similar to what is seen on the lips, may result, after rupture of the primary vesicles, in numerous small, superficial ulcers of a reddish color, secreting a little pus. These may coalesce at their edges and form a serpiginous sore. They must be carefully distinguished both from mucous patches and from soft chancres.

From what has been said of the etiology of these simple ulcers, it is plain that they must present many variations in appearance; yet the diagnosis of each from the other, and of the whole class from those which are to follow, will not generally be found difficult if proper attention be given to the history, the appearance of the lesion, and its course. The disease is generally of a healthy type, and tends to self-limitation and spontaneous cure, rather than to increase. The ulcerative action is generally superficial, and tends to spread on the surface rather than in depth. The ulcer itself is generally surrounded by the signs of reparative action, and with proper care will undergo cicatrization, the result of which, when the ulcer has a large area, will be a stricture of the rectum.

In dysenteric ulceration the diseased portion of the bowel becomes infiltrated with fibrinous exudation, and, as a result of the pressure which this exercises, it undergoes necrosis and sloughs. There results a loss of substance, and if this is superficial, the mucous membrane may regain its former state; but if it is deep, the usual cicatrix is produced, and this, when of sufficient extent, will cause stricture. The stricture arising from this form of ulceration is sometimes very extensive.

The characters by which tuberculous ulceration may be recognized are the following: a pale red surface, covered with a small quantity of serum but devoid of healthy granulations and having a varnished appearance; the absence of surrounding inflammation; a tendency to spread in depth rather than on the surface; the absence of any marked pain; the regular outline ending abruptly in healthy skin; the chronicity of the disease; and the utter failure of all treatment to arrest its course. The diagnosis may be confirmed by the microscope. A tuberculous ulcer starting in the rectum may end in perforation and fistula—a fistula with large internal opening,—and, as a matter of course, the usual operation in such a case would be followed only by disappointment. Such an ulcer has also been known to cause sudden death from hemorrhage. The treatment should either be simply palliative, or else should aim at the complete removal of the tuberculous deposit, either with the cautery or with the knife.

Under the title of *esthiomène* (lupus exedens of the anovulvar region) a number of phagedenic ulcerations, complicated with more or less hypertrophy of the nature of elephantiasis, have been described, and thus much confusion has been caused. The term should be dropped from our nomenclature as having no definite meaning. The ulceration which is subsequently attended by so much hypertrophy commonly starts from the external organs of generation in the female, and invades the anus, rectum, and vagina secondarily. It is almost never seen in men. Its favorite starting-point is the perineum, and it may be superficial or perforating, and may produce great loss of tissue, turning the rectum and vagina into one cavity. In the late stage other ulcers are apt to appear higher up, causing diarrhœa and sometimes peritonitis; but whether these are simply follicular, or are due to further deposits of lupus, has not been determined. The ulcer is irregular in outline, with a granular base of a violet-red color, and there is a slight sanious discharge. The edges are but little elevated, and are not undermined, and there is more or less hypertrophy of the surrounding tissue, and this, in some cases, is exceedingly well marked. The ulcer may cicatrize in part, the cicatrix being thin and white, and at the same time the ulcerative process will be found to extend in the opposite direction. At a little distance from the ulcer there is often a pathognomonic appearance of slightly reddish, hard nodules of tuberculous lupus, separated from the primary sore by healthy skin. With this amount of disease the constitutional disturbance is often not sufficient to confine the patient to the house.

The diagnosis is not generally difficult, although the disease may be confounded with cancer, or with phagedenic chancroid, or with elephantiasis accompanied by secondary ulceration. It is best distinguished from cancer by the cicatricial bands which it leaves behind in its ineffectual attempts at healing, and from chancroid by the surrounding tubercles, which in lupus develop in the thickness of the derma and ulcerate secondarily, while the ulcers which surround a chancroid are ulcerous from the first, being due to secondary inoculation. The duration of the disease is indefinite, and it seldom leads to fatal results. It is best treated by destructive cauterization and *raclage*.

There are several varieties of ulceration of the rectum and anus of venereal origin. Without attempting to decide upon the specific character of the inflammation which may follow the contact of the gonorrheal discharge, I may properly call attention to the severity of that inflammation and to the fact that it may cause ulceration and probably subsequent stricture. During the height of the disease the rectum is hot, red, swollen, and granular, and there is an abundant purulent discharge issuing in clots. The irritation of this may cause erosions and fissures which may reach a considerable size, or a previously existing fissure may become inoculated in this way and may increase in extent.

One of the most frequent of all the superficial ulcerations at the anus is the chancroid. It is much more common in females than in males, constituting one in nine of all cases of chancroids in the former, and one in four hundred and forty-five in the latter. To account for this greater relative frequency it is only necessary to remember the frequency of accidental contact of the male organ in coition, and the facility of auto-inoculation due to the proximity of the vulva. These ulcers are seen either on the skin around the anal orifice or just within the canal, and show a decided tendency not to pass beyond the internal sphincter. They may be single or multiple, and may be situated at any point in the anal circumference, or may completely surround it. When several such ulcers have coalesced the suffering may be severe. The sores have the same characters as those which they present in other parts of the body, and the class of women upon whom they are found is an aid to diagnosis. If any suspicion of the real character of these sores exists, the test of auto-inoculation may be tried. Ulcers of this variety tend to spontaneous cure if the parts are kept clean. In some cases, however, judicious cauterization may be found necessary. No matter how completely the ulcers may have involved the anus or the skin around it, they seldom leave any trace after healing. On the other hand, the cure may be delayed for months, and the sore may assume a chronic type due either to the coexistence of some other disease of the rectum, or to a syphilitic or scrofulous taint in the patient.

That a chancroid may extend into the rectum, cause great destruction, cicatrize, and leave a stricture, seems to be beyond doubt. That chancroid is, however, the most common cause of those grave strictures which are so often met with in women who have had syphilis, and which are generally known as "syphilitic," is by no means proved and is no longer generally accepted. That many of them are not due to this cause is rendered certain by the fact that they are often found in women beyond the suspicion of chancroid, and they are often developed late in the course of true syphilis, are not preceded by any ulceration near the anus, where chancroids are usually located, and





do have their starting point in an ulceration well above the internal sphincter.

True chancre at the anus is not very uncommon. Probably many more of them exist than are ever diagnosticated, because they cause so little local trouble. True chancre within the rectum is so rare as to be almost unknown, and the difficulties surrounding its diagnosis are very great. The appearances which it presents would scarcely be conclusive, and the absence of any other primary sore would need to be absolutely proved—something which in women would be a very difficult thing to do. Typical cases have, however, been reported (Hartley).

One of the secondary manifestations of syphilis is to be looked for at the anus and rectum, viz., the mucous patch, not an infrequent sign in the former locality, and one liable to take on ulceration from local irritation. Generally, however, these mucous patches are devoid of symptoms and disappear without treatment, or with simple attention to cleanliness and the use of an astringent wash.

Well-marked cases of tertiary syphilitic ulceration in the rectum, such as are seen in the mouth and throat, are seldom mentioned; and yet that they may exist and may cause extensive destruction is probable from analogy. Clinically there is an entire absence of authentic and well-reported cases.

Rodent ulcer is a rare disease at the anus, but it has been occasionally seen. It is found by preference just at the verge and extending into the canal from this point. It has the same characters as when seen on the face.

Not only is ulceration the most common cause of stricture, but the latter is generally a cause of the former by its obstructive action, and by reason of the changes which it causes in the nutrition of the parts. At first there are dilatation of the rectal pouch and hypertrophy of its walls above the seat of the disease, due to the effort to overcome the obstruction. In this way the coats may become of double their natural thickness. Next, an ulcerative action is set up in the mucous membrane, which begins as a simple congestion, and advances to complete destruction of the tissue over, perhaps, the whole circumference of the bowel, and for several inches above the stricture. As a result, the muscular layer may be entirely denuded, and even perforated, at a considerable distance above the seat of the disease. Finally, the gangrene which sometimes follows the continued fevers and is particularly liable to affect the female genitals, and the more severe forms of abscess may, by their extensive sloughing, end in the production of large ulcerated surfaces.

The symptoms of ulceration are quite characteristic. In simple fissure the chief one is the peculiar pain, which may be constant, but is always increased by defecation. The latter act itself may not be particularly painful, but afterward, sometimes almost immediately, sometimes after a short interval, the characteristic suffering begins, and may last in mild cases an hour or two, or in severe ones nearly all of the twenty-four hours. The pain is described as dull, gnawing, and aching, rather than lancinating, and will often extend into the loins and thighs. Bleeding at stool is also a common symptom, and the extent of the fissure is no indication of the amount of suffering it may cause. The element upon which the pain directly depends is probably the exposure of nerve filaments. Ulceration within the rectum is also attended by a train of symptoms sufficiently characteristic to render its existence extremely probable when these occur. They are morning diarrhœa of a peculiar kind, the desire for a passage coming on as soon as the patient awakes, and the stools being at first mucous, and finally containing fæces, mixed, perhaps, with blood. After a couple of hours these stools cease for the day, and nothing more is felt except occasional pain and a constant uneasiness in the part. As the disease increases, the diarrhœa will return in the evening, the discharge of blood and mucus will increase in quantity, and the pain will become constant and very exhausting. It is scarcely necessary to call attention to the extreme gravity of this condition, or to the certainty with which, if untreated, and sometimes in spite of the best of treatment, it will end either fatally or in stricture. The picture is, unfortunately, only too familiar, and a case of ulceration within the rectum is perhaps one which calls for as much skill in treatment and yields as poor results as anything in the range of surgery.

The diagnosis of the presence of ulceration is not difficult if sufficient pains are taken to ascertain the truth. No ulcer within four inches of the anus is beyond the reach of actual touch and vision, and none need therefore escape detection. The rule is simple. If the sore cannot be felt by digital examination, ether should be given, the anus dilated, and a thorough speculum examination made of every part. In every case the history must be taken into consideration as well as the appearance of the sore.

The treatment of fissure should in the first place be preventive. In those persons in whom the skin is unusually sensitive and liable to crack, there is nothing better than daily ablutions with cold water and the avoidance of anything which may tend to irritate the anus—such, for example, as the use of printed or rough paper after defecation. A fissure may often be cured by applications of weak solutions of nitrate of silver, Goulard's liniment on a pledget of lint, an ointment of oxide of mercury (ʒ ss. to ʒ i.), or the introduction of a well-oiled bougie. I seldom find a fissure which cannot be cured by this line of treatment and without the necessity of stretching the sphincter; but with these local measures must be combined the greatest possible amount of rest and the daily administration of a mild laxative to secure an easy passage. If the pain be severe, it is a good plan to have the evacuation late at night just before retiring, and then to use an ointment of belladonna freely. Instead of stretching the sphincter, which involves the previous administration of ether, many cases may be cured by drawing a sharp knife over the base of the ulcer, and cutting sufficiently deep to divide those fibres of the sphincter which are exposed. If a polypus be present it must be removed, else no line of treatment will be of any avail.

The treatment of ulceration within the rectum is a much more difficult matter, but the principles involved are the same. In both we give the ulcer rest and try to assist nature in her own methods by warding off any irritation which may interfere with the work of repair. The general treatment consists of absolute rest in bed and the taking of fluid diet. Cod-liver oil may also be given, when well borne, as a laxative and tonic. The local treatment consists in various applications. Suppositories serve a good purpose and may contain any drug desired—tannin, iodoform, bismuth, opium, belladonna, etc. The practice of introducing local remedies in this form has many advantages over that of applying them by means of a speculum, for the mere introduction of a speculum two or three times a week is apt to do more harm than the remedies will do good. Certain good results may be gained by applications made in the form of enemata, especially when the disease is high up. Three pints of water may be thrown into the sigmoid flexure through a long rectal tube, and parts may be reached in this way which cannot be so by any other method. The drug from which the best results may be expected is nitrate of silver in the strength of from twenty to forty grains to three pints of water. The application of pure nitric or carbolic acid to an ulcer within the rectum is often followed by immediate reparative action. It is especially indicated in syphilitic disease which has failed to respond to constitutional treatment.

Stricture.—Stricture of the rectum may be congenital or acquired. The congenital will be referred to under the head of Malformations. Acquired strictures may be divided into: (1) those due to pressure from outside the bowel; (2) spasmodic; (3) inflammatory; (4) cancerous.

A tumor of any kind in the pelvis will not infrequently so press upon the rectum as to obstruct its calibre. A pelvic inflammation in women may be accompanied by an amount of exudation which shall almost completely occlude the rectum. Medical literature is full of such cases, and here it is only necessary to refer to them.

Much has been written in the past upon the question of spasmodic stricture, but the condition is looked upon