surviving the immediate operative risks, provided there was a chance of a radical cure of this otherwise incurable condition.

Everything, therefore, turns on the thoroughness of the diagnostic method employed, before resorting to operative exploration, to determine whether there is every probability that the disease is limited to, say, the middle two-fourths of the cervical oesophagus, the rest of the tube being apparently free from disease when carefully inspected by means of the oesophagoscope throughout its entire length. This means that the only cases in which a fairly accurate diagnosis can be immediately made are those in which the lumen of the tube, though narrowed, is still sufficiently large to allow of the safe passage of a small oesophageal tube through the cancerous area, in order that not only the upper limits of the disease shall be accurately determined, but also to determine the lower limits of the growth, and, in addition, to make certain that there is not another cancerous lesion considerably lower down the gullet—a by no means very unusual complication.

If the cervical stricture is so tight that a small endoscopic tube could not prudently be passed through it, there is a strong presumption that the case is not capable of being dealt with radically by resection; this presumption becomes a certainty if the stricture is dilated immediately by graduated bougies through the endoscopic tube, so that bougies of 7, 8, or 9 mm. diameter are passed and strike another stricture lower down. Even if they do not reveal a lower stricture sufficient to arrest their passage, a presumption of further disease can usually be inferred from the eructation of a large quantity of frothy mucus with small bubbles. The presence of such a second stricture can sometimes actually be demonstrated by observing the passage of bismuth porridge with the aid of the *x* rays.

Supposing that none of these positive signs be evident we are not entitled to exclude early disease lower down the tube, as it may not be so advanced as to cause definite stricture. Oesophagoscopy alone can help us in excluding slight lesions lower down, and an attempt should be made to increase the lumen of the stricture to such an extent as to render oesophagoscopy, by means of a small tube, possible. Sometimes this can be accomplished by immediate dilatation with bougies after applying cocaine and adrenalin; but should this method fail there are other measures by which the lumen of a cancerous gullet may sometimes be temporarily enlarged to such an extent as to render possible the passage of a small endoscopic tube. These methods are all uncertain, and include the application of radium and of the *x* rays, the internal administration of potassium iodide, and the subcutaneous injections of *neoformans* serum, of fibrolysin, of iodopin, etc. In my own practice I have relied entirely on radium for this purpose, using formerly a silver tube containing 50 mg. of pure radium bromide, but latterly a platinum tube containing 63 mg. The time dose has varied in the 10 cases that I have thus treated (in conjunction with Dr. Finzi) from three hours at a sitting, using either a silver or platinum tube-screen ½ mm. thick, to seventeen hours with a lead screen 2 mm. thick. In none of these cases was the cancer limited to the cervical oesophagus, but in 4 of them a tumid stricture impermeable to the endoscopic tube has been rendered permeable by radium treatment; and in 3 others the dysphagia was markedly relieved. In most cases more than one application is necessary, and on some lesions, more especially on some squamous epitheliomas, radium has no appreciable effect.

These methods of diagnosis for ascertaining the limits of the growth are very different from the practice of Mr. Davies, who is content with such an oesophagoscopic examination as enables him merely to see "the form and extent of the upper extremity of the growth and its nature, though not its actual length." To decide on external operation on such insufficient grounds is, it seems to me, to court frequent disaster. The only possible chance of success in this practically unconquered region of surgery depends on the most careful selection of cases based on an expert endoscopic inspection of the entire length of the gullet.

Mr. Davies's courage and admirable frankness in publishing for the assistance of others his initial mistakes and failures is worthy of more frequent imitation, and I trust that his surgical efforts in this difficult region will ultimately be rewarded by the achievement of a lasting cure.—I am, etc.,

London, W., Feb. 28th. WILLIAM HILL.

OPERATIVE TREATMENT FOR HAEMORRHOIDS.

SIR,—I do not wish to enter into controversy as to the relative merits of different operations for haemorrhoids, for I am of opinion that under certain circumstances each of the three main methods has certain advantages over the other two. But, as I have recently read in your columns considerable adverse criticism of Whitehead's method, which comes chiefly from surgeons who do not practise that method, I should like to add my testimony in support of those who, practising the operation, have written in its favour.

Since 1902—when I first learnt Mr. Wallis's method—I have performed the operation, and seen it performed by Mr. Wallis, a good many times—though using the methods of ligature and clamp and cautery as well—and I have followed up in the out-patient room at St. Mark's a large number of patients who had undergone Whitehead's operation.

The majority of the operations performed by Mr. Wallis and myself come to my out-patient room for inspection afterwards. So far as I have been able to judge, it seems to me that this method not only offers a certain cure, but that it offers a more certain cure in severe cases—especially those which are associated with prolapse, fissure, or submucous pouches — than other methods. There is no reason why it should be attended with harmful results. I have never seen recurrence of haemorrhoids after Whitehead's operation, though several after ligature, nor have I ever known any permanent ill effect to follow this method. It may sometimes appear that there is a stricture of the anus after this operation, but a careful examination will always reveal that there is no pathological stricture, but simply a small anus which performs all its functions to the satisfaction of the patient. It may doubtless be admitted that this operation requires some rather special knowledge of its principles, and some very special experience in its practice, as well as special skill in its after-treatment. It may, therefore, not be everybody's operation.

It is difficult to know on what criteria the merits of any particular method of operating are to be judged, without considering the personal factors of the patient and the operator, and also the after-treatment adopted. Failures and recurrences do not always return to the operator. Surgeons have been known to assert that they seldom see recurrences after their own particular method of operation for the radical cure of hernia, but the surgeons of the Truss Society can tell a different tale.

Any one who, like myself, has performed a large number of surgical *post-mortem* examinations at a large hospital, knows that it would be easy to make out a case against almost any operation by using the failures as a lever for wholesale condemnation of the operation "as the worst ever invented."

Mr. H. G. Anderson, a former house-surgeon at St. Mark's, has published[1] a very careful analysis, based on 500 cases of ligature, Whitehead's operation, and clamp and cautery, which came under his care. He has tabulated and criticized very carefully the immediate after-history of these operations. This table forms some basis for comparison and discussion, and should be carefully studied by those interested in the matter.—I am, etc.,

London, W., Feb. 23rd. C. GORDON WATSON.

SIR,—I have read with much interest the discussion on this subject. If my memory serves correctly, a similar discussion occurred in this JOURNAL or in the *Lancet* some ten years ago. The impression left on my memory on that occasion is that the advocates of the operation of ligature came off the best, owing to the able support of the late Mr. Allingham who was a great exponent of this method.

I must admit that the discussion to which I refer did not alter the opinion I had formed as to the merits or demerits of either Whitehead's operation or of the opera-

[1] BRITISH MEDICAL JOURNAL, October 30th, 1909, p. 1276.

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tion of ligature. In my opinion I consider we must be guided by the condition which we find when we come to perform the operation; if there are several localized piles, but the intervening mucous membrane is healthy, then I think the ligature, clamp and cautery, or some other method, such as Ball's, gives a perfectly satisfactory result. When, however, the piles are more diffuse, and there is little or no healthy mucous membrane, then I am equally convinced that the ligature is not such a satisfactory method, such a case can only be treated in a radical manner by completely removing the whole ring of affected mucous membrane; if this is done in a competent manner, then I submit with Mr. Wallis that such an operation is permanently curative. I also agree with Mr. Wallis in not regarding the ligature as a radical method, as it leaves untouched a considerable portion of the mucous membrane beneath which the veins may at a later date enlarge and develop into piles, and I have met with several instances in which it has been necessary to perform a second operation.

I cannot understand the limited view of those surgeons who condemn an operation which on their own statement they do not perform. I should have thought that every surgeon had seen failures or indifferent results from every surgical procedure, however simple, and I, for one, am not surprised to hear that this is sometimes the case with Whitehead's excellent method, as it is by no means so easy to perform as the ligature. It has not been my lot to meet with a failure in an experience of over 100 cases, and I have tried to follow up my cases for a lengthy period after the operation.

I have never met with stricture of the anus as the result of Whitehead's method, which, in the experience of those who are opposed to the method, is not infrequent; but I have no doubt that such may be the result if the operation has been improperly performed. The only case of post-operative stricture I have seen resulted from the ligature, and was no doubt due to the too free removal of the mucous membrane.

The operation I usually perform for localized piles differs to some extent from the ordinary operation of ligature in that I excise the pile vertically and suture the edges of the mucous membrane with catgut, which I think has the advantage of more securely arresting the bleeding and facilitates rapid union as the edges of the mucous membrane are approximated. In my opinion, many cases can be treated satisfactorily by the ligature, while there are many others in which ligature would be a very imperfect operation; they can only be dealt with properly by Whitehead's operation.—I am, etc.,

London, W., Feb. 27th. DOUGLAS DREW.

APPENDIX DYSPEPSIA.

SIR,—I am greatly surprised by Dr. Roberts's statement (BRITISH MEDICAL JOURNAL, February 19th, p. 473) concerning the case of Mrs. D. from Valparaiso. It is, indeed, exceedingly unfortunate that among the great number of indubitable cases of appendicitis larvata recorded by myself and many others (Sonnenburg, Lenzmann, Cotard, Dieulafoy, Korach, Walther, etc.) I should have chosen this very case "as of special interest for British readers," which has apparently ended differently than I believed. My error is due to the following circumstance. When I last saw Mrs. D. before her operation I asked her to let me know in case her complaints should return later on. A short time after the operation her husband kindly wrote to tell me that Mrs. D. was quite without pains. Since then I heard nothing, and believed myself justified to assume that her state had remained satisfactory.—I am, etc.,

Berlin, Feb. 26th. C. A. EWALD.

NURSING HOMES FOR THE MIDDLE CLASS.

SIR,—As one who has been associated with Dr. Chalmers Watson for some time in the management of the Rutland Nursing Home in Edinburgh, I have been interested in reading Dr. Ford Anderson's letter (p. 540) bearing on the proposed scheme for a pay hospital in Edinburgh for the middle class.

Dr. Anderson has doubts about the advisability of some of the details of the scheme. There may be other people who, like him, take a friendly interest in this movement, and I shall be glad if you will allow me to reply to some of his objections.

With regard to position, Dr. Anderson fears that a centrally placed pay hospital or home could not be utilized by general practitioners who live beyond the radius of one mile away from it. This fear seems to me groundless. In Edinburgh general practitioners daily cover a much larger radius than that of a mile from the centre of the town. Moreover, this scheme has been discussed by general practitioners on several occasions, and the desire to have the proposed home in as central a position as possible has been unanimous. Further, much of the work done in the home will be operative, and it is considered advisable to have the building within easy reach of those who are likely to have the responsibility of the after-treatment of such cases during their anxious stage.

Dr. Anderson thinks that the Rutland Home might be allowed to continue as it is, while others like it might be opened in the suburbs. Those responsible for its management, however, merely look upon the present establishment as a successful experiment. Many improvements, which are considered necessary, can only be carried out in a larger and better equipped home.

The proposal to have a certain number of beds at £1 1s. a week is considered by its promoters to be an important part of the scheme, but many of the details connected with the organization of the home are still under discussion.—I am, etc.,

Edinburgh, Feb. 27th. CHARLES W. CATHCART.

GENERAL PRACTITIONERS AND POOR LAW REFORM.

SIR,—Dr. P. R. Cooper, in a letter appearing in your issue for February 19th, seems to have hit on what will probably be found to be the only rational reply that the medical profession can make to the persistent demands of sets of individuals and friendly societies, and now of the State, that we should undertake the medical supervision of the working classes at nominal charity fees. What is that reply?

Dr. Chas. E. S. Flemming states in your last issue that the Central Contract Practice Committee of the Association gave Dr. Cooper's proposal much careful consideration, but apparently was unable to find any working scheme.

If our Association does not again, and very shortly, tackle this problem in a masterly way instead of endorsing with its approval clubs run at charity fees, it is most certainly true that within a few years, beyond being useful for the unpleasant duty of settling a few internal quarrels and throwing itself hopelessly against vested interests, the Association will be no catch for the general practitioners, and they will do well to leave it severely alone.

It might be desirable to quote at once this axiom, "that the true interests of the community and those of the medical profession invariably coincide" (interim report of Poor Law Reform Committee).

Take first *the interests of the community* with regard to medical services. Are they not these?

(*a*) That each person should be able to be insured, or to insure himself, against the probability of medical expenses.

(*b*) That no one should be barred from this benefit because of his age, family history, financial position, present or past health, or occupation.

Then take *the interests of the medical profession*:

(*c*) That the payment for medical services should be adequate and in accordance with the professional services rendered.

In order to decide what is "adequate" it would be necessary to take into consideration in each case all the subheads in statement (*b*). In order to elaborate "professional services rendered" it would be necessary to state as shortly as possible in list form all the more probable medical and surgical services. This has been done partly in the Public Medical Service Rules recently issued to the Divisions for consideration.

It might be said that such a table would be bulky and complex, and therefore unworkable. But this should in practice not prove so. Any actuary would be able to prepare a concise, easily workable scheme when given the necessary data. One need not, however, burden this letter with the possible solutions of this portion of the problem.

Having the interests of the community and of the medical profession defined, how is it possible to make the two coincide? Before doing this, it might be useful to

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