MEDICINE TODAY

Current comment on medical progress, discussion of selected topics from recent books or periodic literature, by contributing members.

Gastrointestinal Disorders

"Colon Filling Stations"—In the *Journal of the American Medical Association,* page 1023, of the issue dated March 26, 1927, is found a letter to the editor, written by Anthony Bassler, M. D., of New York. It is published under the above title, and is both instructive and entertaining.

After an interesting explanation of the ebb and flow in the use of colon irrigations in Europe, Doctor Bassler calls attention to what took place in America. He quotes: "The profession and laity in our country, quite ignorant of all that Britain and Europe had gone through in this treatment, were fertile soil mentally for the recent 'great discovery' of this beneficial procedure. A nonmedical 'discoverer' of this time-worn method rose among us, and many of the profession as well as laity fell for it, dorsal, right, side, and some on their knees. . . . The number of filling stations has increased throughout New York City until today they are almost as numerous, and the signs on some of them are distinctly more conspicuous than gasoline stations."

Doctor Bassler then proceeds to set colon irrigation in its real and correct position, evaluating it in his own direct manner for exactly its real worth. He says: "Colon irrigation per se is practically a worthless procedure unless it is combined with other therapeutic measures. There are a few indications for colon irrigations for a short time, but in routine work there are far more occasions in which they are contraindicated, and still more in which they are useless. . . . On the other hand, colon irrigation is of value as a therapeutic adjunct at times, and combined with other measures it may be worth while."

In closing his remarks the doctor writes: "In 1926 forty-seven patients came to me who had been treated by colon irrigators who were not physicians, most of them proprietors of typical filling stations. . . . In the forty-seven cases referred to were two cases of carcinoma of the colon; five cases of pulmonary tuberculosis with ulceration in the ileocecal region; eight infected types of ulcerated colitis; two cases of pernicious anemia; six instances of cardiovascular renal disease; and one case of Paget's disease—in all, twenty-four instances of persons who had gone to these stations and were treated without diagnosis. Of the twenty-three remaining none had a condition which required colonic irrigation. At $5 a washing, $4165 was paid out for treatment which was not required."

Doctor Bassler's humorous sarcasm is a timely thing. We need, all of us, to understand the viciousness of the enema habit. In fact, it is second only to the cathartic habit. To continually go into the bowel and wash away normal secretions that need to be there to keep the highly specialized tissue of the colon in condition is highly inimical to good health. In fact, it produces that which the physician would cure by his treatment. It is harmful to continually use the enema for moving the bowel; but it is still more so to go into an empty bowel and irrigate it so thoroughly with all kinds of solutions.

From data secured from patients, I have recently been making up a list of fluids used for enemata and colon lavage at the suggestion of friendly neighbors, "healers," and I am sorry to say, physicians. In a short time I have listed the following: milk, honey, molasses, glycothymoline, kerosene, buttermilk, acidophilus culture, lemon juice, orange juice, flaxseed, etc. Most every "filling station" has its pet theory of some wonderful fluid with which they can wash out the colon and have the evil symptoms disappear. This process is producing endless harm and an untold amount of colitis. The medical profession should not hesitate to call attention to this evil practice.

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Radiology

Failure in Therapy of Carcinoma—It is commonly asserted that failure in cancer therapy is due to the institution of radical treatment too late in the course of the disease. Theoretically, the earlier the lesion is discovered, and the more localized it is, the more successful should be the treatment, whether radiologic or surgical. Practically, this works out in the majority of the cases, but frequently an apparently innocent and localized lesion, the excision of which is a minor procedure, is the focus of extensive secondaries. In other words, massive metastatic areas found throughout the entire organism may come from a small local, almost unrecognized lesion.

This brings us to the crux of the problem; neither our clinical experience nor our diagnostic ability is able to visualize accurately the actively growing edge of any malignant growth. Handley's masterpiece on carcinoma of the breast shows us that this edge is sometimes quite distant from the original focus.

Surgical treatment is based on the wide excision of the tumor so as to include the "growing edge;" if this is accomplished a "cure" is the reward, if not, recurrence is the penalty. Radiological treatment is based on the thorough radiation of the primary lesion as well as the gland bearing areas that drain the lymph from the infected area. In both instances, however, the treatment is essentially local. Too often, the disease is outside the influence of our treatment so that instead of obtaining beneficial