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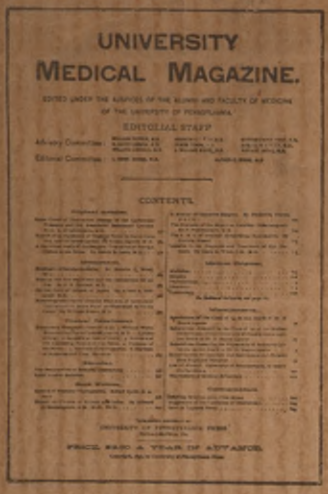

UNIVERSITY
MEDICAL MAGAZINE.

EDITED UNDER THE AUSPICES OF THE ALUMNI AND FACULTY OF MEDICINE OF THE UNIVERSITY OF PENNSYLVANIA.

EDITORIAL STAFF

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PRICE $2.00 A YEAR IN ADVANCE.

JULY, 1896

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BY JOHN H. MUSSER, M.D.,
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AND
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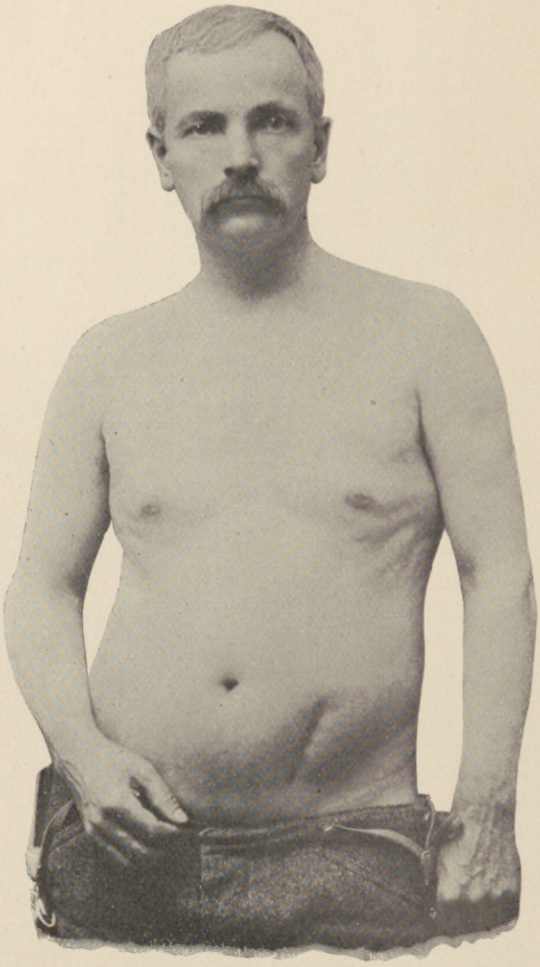

J. H. M., nine months after operation.

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J. H. M., aged 52 years, a grain-broker, native and resident of Western Pennsylvania, a patient of Dr. William L. Lowrie, of Tyrone, Pa., was seen in consultation by Dr. Musser in August, 1895, at his home.

His father died of apoplexy when 57 years of age; mother is living, aged 79 years. Two brothers are living and well. A sister died of hip-disease in her thirtieth year. He has five healthy children, and lost one, aged 10 years, of epilepsy.

He had had no previous illness of note, excepting attacks of rheumatism in 1885 and 1889, and for twenty years has been subject to frequent attacks of "nervousness." These seizures were marked by curious feelings in the splenic region and back, and accompanied by vertigo and coldness of the extremities. They have gradually grown more marked. During the latter half of this long period he has much of the time observed a condition of "uneasiness" in the region indicated; also for several years has felt something like a hitch or slight obstruction to action of the bowel referred to that point. A "knotting" of flatus in that region has also been vaguely felt for a long time. Twenty years ago he had a severe attack of pain in the same portion of the abdomen. He was then freely blistered just below the ribs. This pain was dull and aching in character, and has recurred more or less severely at irregular intervals ever since. During the past two years it has been more severe and frequent. For nearly fifteen years the bowel movements have always been of small diameter, and for eight months never larger in diameter than one-third to one-half inch. For a year he had a constant feeling of

obstruction upon the left side, accompanied with a sense of fulness upon the right. Five years since he first noted blood in the movements. It continued to be present with each stool in small amount for three weeks. Again, eight months before coming under observation, he began passing clotted blood in considerable quantities. It had appeared especially after the bowels had been inactive, but disappeared when free catharsis was induced. He has always required medicine to produce a satisfactory movement. Twenty pounds of weight have been lost in the preceding eight months. Appetite has been constantly good. Great loss of strength, palpitation, breathlessness upon exertion, and other symptoms of anemia have been present for some months. Vomiting frequently accompanies an evacuation of the bowels. Defecation has latterly been preceded by much pain and colic in the left hypochondrium. Mucus and foul odor have appeared with the stools within a few weeks.

The striking objective signs at the time of the consultation were pallor, undoubted anemia, emaciation, and loss of strength, and a curious appearance of premature old age. The physical examination of the heart, lungs, and urine was negative. The abdomen was moderately distended; tympanitic except in the course of the colon. By ordinary methods of examination nothing unusual was found. The rectum contained some feces. The fecal matter discharged in the morning was small in amount, made up of many small pieces, some tinged with blood and mucus, and free mucus and blood followed the fecal evacuation. The colon appeared to contain feces, and hence high enemata were given till the bowel was empty and nothing but water returned. After emptying the colon of a large accumulation of feces, the patient was turned on the left side. In this position about the seat of pain, and in the course of the descending colon, an obscure induration was detected. The mass seemed to be half the size of the fist. It seemed to recede on deep palpation. After the high enemata were administered, the auscultatory phenomena seemed to indicate that the fluid was passing through a constricted orifice into the dilated colon above. There was more marked tympany in the course of the colon, replacing the dulness above noted. The stomach was evacuated of its contents, and its size determined by the usual methods of physical examination. It was decided to be free from disease.

There were frequent movements of the bowels, the discharges being small in amount and containing some blood. Pain was the chief subjective symptom. This was situated in the left hypochondria, extending towards the sigmoid flexure. It was increased by pressure, and apparently aggravated by movement and position, a

peculiar position having to be assumed with sitting up in order to relieve the affected side.

Diagnosis of cancer of the descending portion of the colon was made. This diagnosis was based upon the age of the patient; the exclusion of organic disease in all the other organs and structures of the body; the occurrence of emaciation and anemia, the cause of which could not otherwise be explained; the subjective symptoms; the occurrence of blood in the stools; the character of the stools otherwise; and the physical signs of an obscure tumor in the region above indicated.

The patient was advised to come to Philadelphia for surgical advice and treatment. He accordingly came to the city on August 21, and was placed in charge of Dr. Morton, who, having confirmed the diagnosis, urged abdominal section and, if possible, excision of the growth.

On August 22, under ether narcosis, an incision three inches in length was made through the left linea semilunaris. Through this opening a mass could be felt intimately connected with the colon, beneath the ribs, and affecting that portion of the gut immediately below the splenic flexure. The incision was then enlarged one inch upward and the whole mass easily delivered outside the wound. It proved to be a neoplasm involving the entire circumference of the colon just below the splenic flexure and about the size of an orange. No adhesions were present and but a single mesenteric gland was enlarged. The latter was located close to the tumor. The wound and abdominal cavity were then effectually walled off by gauze pads isolating the mesentery, bowel, and tumor. The colon was clamped in two places above and two places below the growth, but very wide of all infiltration, after feculent material had been well milked from those portions of gut between each pair of clamps. While a stream of salt solution was permitted to flow over the parts, the bowel was divided above and below between the clamps. Then the mesentery was divided cautiously from above downward and each vessel taken up with a hemostatic forceps either before it was cut or immediately after. The tumor, with one and a half inches of uninvolved gut above and below it, was thus removed without especial difficulty. The mesenteric vessels in the grasp of the hemostats were next ligated individually and the previously noted mesenteric gland dissected out. All the parts having been again thoroughly washed with salt solution, one-half of an inch-and-a-quarter Murphy button was slipped into each end of the open bowel. The lower bowel end gave no trouble in adjusting the button and drawing over the intestinal walls by means of the purse-string, but the upper end was found thin and much

dilated or "ballooned," and quite attenuated. With a little manœuvring, however, this difficulty was overcome and the purse-string suture drawn tight about the shank of the half-button, which was then pushed together. The considerable amount of tissue upon the upper portion of button interfered with firm and secure closure unless considerable force were employed. Hence thick pads of gauze were placed between the fingers and bowel holding the button before the halves were squeezed together,—thus so distributing the force as to spare great pressure upon any particular portions of the included bowel. It was considered best to run a continuous silk stitch about the anastomosis, bringing together serous surfaces over the junction line of the button. After another wash, the anastomosed bowel was permitted to drop back into the abdomen. The omentum was drawn down about most of the involved region, and, because of the great attenuation of the upper portion of the divided bowel, a small wick of acetanilid gauze was carried through the wound and its end left in contact with the gut just above the anastomosis. This was done to facilitate drainage if the thinned bowel wall should ulcerate or become gangrenous. The parietal wound was closed with silkworm-gut sutures, leaving a small space in the centre for exit of the gauze wicking.

The patient bore the operation well and exceedingly little blood was lost. He progressed well until the second day, when a rise of temperature to 101° F. demanded inspection of the wound. A little serum was found to be escaping along the drain. It was removed and about a drachm of turbid fluid escaped. A small amount of foul serum continued to escape for two days, and was then followed by occasional bubbles of flatus and a little feculent material. Temperature fluctuated from 100° to 101° F. for two or three days and, coincident with diminution of fecal discharge from the wound, then fell to normal. Very little pain was complained of at any time. Several movements of fluid feces—evidently having passed through the button opening—occurred during the first four days. Liquid food was freely taken after the first twenty-four hours. Gas constantly escaped from the anus after the first day. On the tenth day the patient complained of a full feeling in the rectum and, upon inserting a finger, the button was discovered and withdrawn. Its opening was partially occluded by a putty-like mass of fecal material. The small fistula leading out of the abdominal wound now rapidly closed and gave no further trouble. It had evidently been caused by a small perforation of the thinned intestine above the button. The passage of the button was soon followed by a very large formed bowel movement, which was repeated, by the aid of enemata, every day. In ten days he

was placed upon full diet and afterwards progressed in strength and increase of weight in a most gratifying manner. In three weeks from the time of operation the bowels were moving naturally and the calibre of the stools was at least an inch and a quarter.

Five weeks after operation he was able to take a long railway journey to his home. Since then he has, from time to time, written most enthusiastic letters stating that he is as well as ever, is attending to a large business, is travelling all over his portion of the country, that his old nervous feelings and anemia have departed, that the bowels are moving without effort like clock-work, and that in calibre the stools continue to be very large. He has gained much in strength and has gradually mounted in weight until at the present time (May, 1896), more than nine months since the operation, he registers 170 pounds, or twenty-five more than when he came under our care, and considerably more than he had ever previously attained.

The growth removed proved, upon examination by Dr. Thomas S. Kirkbride, Jr., to be large-celled carcinoma, involving the entire circumference of the bowel. The specimen measured in length six inches, of which one and a half inches of intestine, on either side of the tumor, was free of involvement in the cancer.