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THE RELATION OF IDIOPATHIC DILATATION OF THE  
COLON TO PHANTOM TUMOR, AND THE APPRO-  
PRIATE TREATMENT OF SUITABLE CASES  
OF THESE AFFECTIONS BY RESECTION  
OF THE SIGMOID FLEXURE.

BY  
REGINALD H. FITZ, M.D.,  
OF BOSTON.

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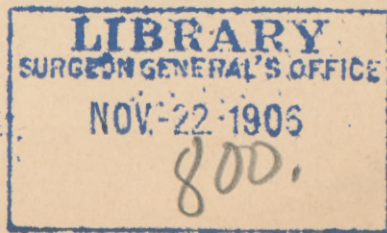
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IN 1838 Richard Bright (*Guy's Hospital Reports*, London, 1838, iii. 256.) published his "Observations on Abdominal Tumors and Intumescence," in which he stated that "there is one class of cases more particularly liable to lead the unwary and inexperienced into error respecting the disappearance of an abdominal tumor; I mean cases of hysterical distention of the bowels; for although the swelling in these cases is essentially tympanitic, yet, occasionally, from the singular way in which the intestines are partially distended, and remain so for days and weeks at a time, they sometimes give completely the forms of tumors; and sometimes indistinct fluctuation may arise from fluid feces, or even from the coexistence of a distended bladder; and sometimes the large accumulation of hardened feces has led to the belief of a more solid tumor." He reported the case of a woman, aged thirty, seen many years before in Guy's Hospital, with a supposed abdominal tumor, strongly resembling an encysted tumor. "But there were connected with this supposed tumor so many other ailments, embracing fits of hysterics, epilepsy, paralysis, abdominal and lumbar pains, so varied and so changing, that a little observation was sufficient to convince any experienced person of its real character." The patient, however, again entered the hospital in 1824, complaining of abdominal pain and having hysterical symptoms. She had been seen by a surgeon who had proposed to excise the tumor which produced the swelling. A median



incision was made for this purpose, but, a tumor not being found, the wound was closed, and was not wholly healed when Dr. Bright saw the patient. Her health was in a most unsatisfactory state from a frequent tendency to diarrhoea and from a succession of pains, with occasional distention of the abdomen. She remained in the hospital some three months, during which the swelling varied considerably, and on one or two occasions was reported to have subsided entirely.

In the course of the subsequent sixteen years, as appears in an article entitled "Cases Under the Care of Dr. Addison and Dr. Gull" (*Medical Times and Gazette*, London, 1854, ix. 343), several instructive examples of the affection in question were observed by these physicians, the latter of whom is stated to have been the first to apply the term "phantom tumor." Attention was called by them to the importance of spasmodic rigidity of a part of the abdominal parietes as "one of the most frequent sources of deception. An hysterical patient is quite capable of making a circumscribed portion of the abdominal wall rigid and hard, while the rest remains comparatively flaccid. . . . The recti muscles are peculiarly apt to be the seat of these contractions, which may, however, also occur in the lateral regions of the abdomen. . . . Hardened masses of feces are probably, however, the most frequent of the exciting causes of the affection."

Later, the idea of a phantom tumor became so extended as to comprehend any circumscribed mass in the abdomen which should appear and disappear from time to time. Greenhow (*Lancet*, London, 1857, i. 58), for example, reported five cases as "Phantom Tumors of the Abdomen." The first two were apparently pedunculate pelvic tumors, the third and fourth might have been a movable kidney, while the fifth, presumably, was a movable kidney or spleen. All were regarded as spasmodic, seated "probably in the abdominal muscles, although in every instance the tumor appeared to be in the abdominal cavity." Furthermore, evanescent tumors of the trunk and of the extremities have been reported by some writers as instances of phantom tumor. Dilated and prolapsed stomachs, intermittent hydronephrosis, and transitory indurations of the mammary gland also were thus designated.

We are indebted to our honored associate, J. M. DaCosta (*Medical Times*, Philadelphia, 1871, i. 449), for a restoration of the original conception of the term and also for a most important amplification,

namely, that phantom tumors are not necessarily limited to hysterical persons. According to him, "the chief element in their production is partial contraction of the abdominal walls, particularly of the recti muscles, with more or less tympanitic distention of either the stomach or the intestine. Then a certain amount of constipation, and a large quantity of subcutaneous fat in the omentum, will modify some of the phenomena; for I do not think that all cases are precisely alike or can be explained according to an exact formula. The frequent occurrence of these phantom tumors in hysterical persons is also to be taken into account, and the co-existence with hysteria may show itself in fits of hysteria, in convulsions, or in hysterical palsy. But do not fall into the mistake of supposing any necessary connection. I have met with these tumors in men who were not very impressionable."

These views concerning the nature and the method of origin of phantom tumors have prevailed with slight modifications up to the present time. Osler (*The Principles and Practice of Medicine*, third edition, 1898, 1114) and Tyson (*The Practice of Medicine*, 1896, 1072) adopt the explanation of Gowers, according to whom phantom tumors result from a relaxation of the recti, a spasm of the diaphragm and abdominal muscles, gaseous distention of the intestine, and an arching forward of the spine. Wharton Sinkler, in the Loomis-Thompson System (*American System of Practical Medicine*, 1898, iv. 705), states that "sometimes an enormous amount of gas accumulates in the stomach and intestines, which distends the abdomen to an extraordinary extent. This condition constitutes the so-called 'phantom tumor' sometimes seen in hysteria. Constipation is frequently present, and the bowels in some cases may not be opened for weeks."

In reviewing the reports of cases of phantom tumor published in the various medical journals, it is evident that the described tympanitic tumors are by no means of uniform significance. They vary not only in extent, involving more or less of the abdominal cavity, but they vary also in duration, in severity of symptoms, and in result. Though found usually in adult females, and simulating in shape and size the pregnant uterus at full term, or an ovarian cyst, they have been observed in young girls and in men. As a rule, of long duration and of slow and gradual formation, they may increase rapidly within

a few months or within a few days. Mattison's (*Medical and Surgical Reporter*, 1863, x. 201) patient supposed herself pregnant. Menstruation had ceased, morning sickness, quickening, enlargement of the abdomen and breasts, all were observed at the proper time and in regular course. Ramskill and Jones (*Medical Times and Gazette*, London, 1859, ii. 579) state that their patient, a girl of nineteen had been several years in attendance at the Metropolitan Free Hospital. Examinations made two years apart showed no material change in the size of the tumor, which eventually caused the patient to appear like one at the full period of pregnancy. Bright's original case was observed during a period of many years in which the tumor was thought to be an ovarian cyst, and the patient was operated upon for its extirpation. Storer's case, reported by J. C. White (*Boston Medical and Surgical Journal*, 1855, liii. 19), was a girl of fourteen, in whom the tumor had been present for a year, having increased rapidly in size within eight months.

Although chronic, persisting, or recurring constipation is the rule, acute intestinal obstruction sometimes is stimulated, as is illustrated in the following case coming under my observation: In 1894 a woman, aged twenty-one years, was referred to me by Dr. W. O. Hunt, of Newton. During early childhood she had occasional convulsive attacks. At the age of sixteen or seventeen she suffered for a year from nervous exhaustion. In the two years previous to my first visit she had repeated attacks of severe pain in the lower abdomen, each lasting some ten minutes, at irregular intervals, and without obvious cause. Recently they had occurred two or three times daily, and occasionally have been associated with a discharge of blood from the rectum. Dejections were usually well-formed, and as many as two daily. There was no loss of weight or color, and there was nothing abnormal found on physical examination. Three weeks later an attack of pain was followed by an arrest of intestinal peristalsis, neither gas nor feces being evacuated, despite the use of saline laxatives and enemata. At the end of four days, during which vomiting had occurred, the symptoms of obstruction still continued. The abdomen was markedly swollen, and a distended intestinal coil was to be felt in the left half. Three pints of water were injected into the rectum without causing discomfort. A large quantity of pale urine was voided. At this time Dr. M. H. Richardson saw the case and

agreed as to the expediency of an exploratory incision. After the patient was etherized the abdomen again was palpated, when gas escaped from the rectum; repeated firm pressure caused the continued expulsion of gas, until the entire abdomen became everywhere soft and yielding to the touch. Since then there has been no return of the previous symptoms.

It is recognized that the nature of the disturbance in this case is not wholly free from doubt, but a diagnosis of hysterical tympanites seemed the most probable. It was based upon the neurasthenic, almost hysterical, antecedents of the evidently neurotic patient, whose general appearance was that of one in vigorous health; upon the immediate relief afforded by pressure when she was etherized, although all efforts without anæsthesia were of no avail, and, finally, upon the subsequent complete immunity from all abdominal discomfort.

In the diagnosis of phantom tumors of the abdomen, especial stress is laid upon their disappearance under anæsthesia. O'Donnell (*Medical Times and Gazette*, London, 1855, ii. 47) had a male patient whose tympanitic abdomen was as large as that of a woman in the eighth month of pregnancy. Under chloroform the enlargement immediately disappeared, and the abdomen for a while remained in a normal state. Simpson previously had produced the same result in like manner in a woman who supposed herself ten months pregnant. Ramskill and Jones (*loc. cit.*) also administered chloroform to their patient who, for two years, was considered to have suffered from "hysterical tympanites or phantom tumor of very large size." As the patient became unconscious the abdomen at once flattened until there was not the slightest appearance of a tumor. As the effect of the chloroform passed away the abdomen quickly resumed its previous shape, and was nearly as prominent as ever when consciousness was regained.

A notable fact in the history of this subject appears from the investigation of the periodical literature of recent years. Reports of instances of phantom tumor are rarely to be found, whereas within the past fifteen years a considerable number of cases have been published which closely simulate in their characteristics those of phantom tumor, and in which the tumor has proved to be a permanent enlargement of the colon. Little and Calloway (*Transactions Pathological Society*, London, 1851, iii. 106), to be sure, had reported previously a case of

enormous dilatation with hypertrophy of the colon, especially of the sigmoid portion, in an imbecile thirty-four years of age. The abdomen was forty-five inches in circumference at the navel, and its enlargement was found to be due almost wholly to the distended large intestine. The transverse colon was about six inches in diameter, and the descending colon and sigmoid flexure formed an immense pouch extending from the left hypochondrium into the umbilical and hypogastric regions. Peacock (*Transactions Pathological Society*, London, 1872, xxiii. 104) also described a case of fatal constipation from excessive dilatation of the colon. The patient, twenty-eight years of age, had been constipated from birth and had suffered much from flatulence. Although he enjoyed relatively good health until within six weeks of his death, the symptoms of obstruction then became grievous, and the abdomen appeared like that of a woman just previous to confinement. The large intestine from the cæcum to the upper part of the rectum was found enormously distended and contained fully fifteen quarts of semi-solid feces.

In 1884, however, Gee (*St. Bartholomew's Hospital Reports*, London, 1884, xx. 19) published his communication on "Idiopathic Dilatation of the Large Intestine," which proved to be the immediate predecessor of a considerable number of articles on the same subject. He stated that "one kind of great and fatal tympanites is an extreme dilatation of the large intestine in whole or in part. The dilatation may be called idiopathic, inasmuch as it constitutes the whole of the disease, and the foregoing conditions or causes cannot be discovered. This disease may be compared with a like dilatation, also called idiopathic, which affects the œsophagus and the stomach. . . . . At present, for want of a better explanation, I think that mere constipation and retention of wind are the cause of the dilatation." His illustrative case is that of a boy of four and a half years who was constipated when three months old, and whose abdomen continued to swell from the time he was a year old.

The purport of these publications is to maintain that increase in the size of the large intestine at times occurs without any obvious organic or mechanical cause other than fecal accumulation, sufficient to produce discomfort, distress, and deformity and to prove repeatedly the immediate cause of death. The most constant symptom is constipation, and the most positive sign is abdominal distention. Two



types of this affection are evident: in the one the disturbance begins early in life, even in infancy; in the other it becomes manifest only at a more advanced age. The former often is called congenital, although the accuracy of this term is to be questioned. To be sure, Peacock (*loc. cit.*) and Hughes (*Transactions Pathological Society, Philadelphia, 1887, xiii. 40*) state that in the cases reported by them there were increasing constipation and abdominal enlargement from birth. One of Osler's (*Archives Pediatrics, 1893, x. 111*) patients, an infant of seven months, had but five or six natural evacuations previous to having been seen by him. On the other hand, although the case reported by Walker and Griffiths (*British Medical Journal, London, 1893, ii. 230*) was observed to have an unusually large abdomen within a few weeks from birth, nevertheless the bowels are said to have acted regularly. Rolleston and Haward (*Transactions Clinical Society, London, 1896, xxix. 201*) state that abdominal swelling began in their patient at the age of two months. In Formad's (*University Medical Magazine, Philadelphia, 1892, iv. 625*) case, on the contrary, the most remarkable on record for the degree of deformity, constipation first became noticeable at the age of two years. To these cases the following is added:

A girl, fourteen years old, came under my care at the Massachusetts General Hospital in 1894, on account of a swollen abdomen. She had been constipated all her life, and the enlargement began when she was two years of age, and continued to increase in size up to the date of her admission. Three years before this there was considerable sharp, intermittent pain in the left flank, and a needle was thrust into the abdomen somewhere below the navel on the right side. No fluid was withdrawn. Otherwise she has always been in excellent health. She has attended school regularly and has seemed as strong as other children. There was no complaint of any disturbance whatsoever, with the above exception. She was well developed and sufficiently nourished. The abdomen was much enlarged, measuring thirty-one inches in circumference. It was tympanitic throughout, except in the right iliac fossa, where there was a diffused dulness. The surface was in places slightly irregular and ridged from peristalsis of the underlying intestine. On palpation the abdomen was everywhere soft and without tenderness. The bowels were kept open by enemata, and although several evacuations might occur daily there was no material diminution in the abdominal enlargement. The injection of five pints of water caused dulness on percussion in the left half of the abdomen. She remained in the hospital nearly four weeks, and several months afterward her mother wrote that there was no improvement and that she was "as costive as ever." Recent attempts to discover her whereabouts have been unavailing.

If it be admitted that in certain of the above cases a congenital cause for the dilatation may have existed, it must be recognized also that absolute evidence on this point is lacking. It is apparent, furthermore, that in some of the patients the dilatation began at such an interval after birth as to render the congenital origin very doubtful.

Mr. Treves (*Lancet*, London, 1898, i. 276), however, in a recent article entitled "Idiopathic Dilatation of the Colon," maintains that all cases of this affection "in young children are due to congenital defects in the terminal part of the bowel, that there is in these cases an actual mechanical obstruction and that the dilatation of the bowel is not idiopathic." He bases this view on the evidence furnished by a patient with dilated colon from whom he successfully removed not only the descending colon, but also that part of the bowel corresponding to the sigmoid flexure and to the rectum, which were represented by a solid-looking, though pervious, tube, eight or nine inches long, and about the size of an adult's forefinger. Support is found for his opinion in the cases reported by Dodd (*Lancet*, London, 1892, i. 1299, and Atkin (*Lancet*, London, 1885, i. 203), in which there was marked stenosis of portions of the large intestine. He offers, also, in favor of his suggestion the observations of Osler, Walker, Formad, and of Rolleston and Haward (*vide supra*).

It may be stated in behalf of those who recognize the existence of a genuine idiopathic dilatation of the colon in young children, that there are repeated instances in which the affection begins in early infancy, progresses more or less continuously, and at a laparotomy or a post-mortem examination is without sign of any congenital malformation of the bowel. Such instances are to be found even among those referred to by Mr. Treves in support of his view. In but one of Osler's cases, for example, was the opportunity offered for a satisfactory physical examination of the intestine. After an abdominal section by Halsted, although the entire colon was found enlarged and "the sigmoid flexure was twisted on itself, but not so as to cause any obstruction," no stricture of the rectum could be determined. A post-mortem examination was made in the cases reported by Walker, Formad and by Rolleston and Haward, and no evidence of a constriction was observed.

It would seem more in harmony with the facts to recognize that there are two varieties of infantile dilatation of the colon. The one is due undoubtedly to a defect of development, hence is a true form

of congenital dilatation, the result of malformation of the bowel, existing at birth and then at once producing its disturbances. The other makes its appearance within weeks or months after birth, gives no evidence of any arrest of development of the bowel, and for purposes of classification should be called idiopathic. Infantile dilatation of the colon thus may be congenital or idiopathic, but a congenital idiopathic dilatation of the colon from this stand-point would be a misnomer.

The idiopathic cases properly so called are conceivably those in which defective expulsive power is the prime factor, leading gradually to more or less abundant accumulation of feces and consequent dilatation of the sigmoid flexure, with occasional complete evacuation of the bowel, as in the case reported by Hughes, but with recurring retention extending over a prolonged period. As the lower portion of the bowel, especially the sigmoid flexure, becomes enlarged, an acquired mechanical impediment to the emptying of the descending colon, and perhaps of other portions of the large intestine, is established, giving rise to dilatation and to hypertrophy of the muscular coat. This impediment is likely to become all the greater as the loop of the sigmoid flexure becomes elongated and dilated, with its liability to kinks, even to a twist, as proved to have occurred in the case reported by Osler. In fact, the significance of elongation and dilatation of the sigmoid flexure in the production of twists of this portion of the colon is too well known to require comment. The greater the degree of distention the more impaired becomes the action of the accessory muscles of defecation, especially those of the abdominal wall, and thus may arise the enormous degrees of distention which are the eventual outcome in the cases in question.

The published instances of idiopathic dilatation first made manifest in adult life are relatively few, but may take place under the same general conditions as in this variety of the infantile series. The case reported by Little and Calloway (*loc. cit.*) was an imbecile, one of a class notoriously liable to suffer from neglected defecation. Money and Paget (*Transactions of the Clinical Society of London*, 1888, xxi. 103) state of their patient that the bowels always acted regularly, with the exception that lately they were somewhat constipated. Nevertheless, a big, scybalous mass of stony hardness was found in the colon. The patient of Herringham and Clarke (*St. Bartholomew's Hospital*

*Reports*, 1895, xxi. 57) is stated to have been always constipated, at times without a defecation for eight days. Richardson's patient (*Transactions of the American Surgical Association*, 1897, xv. 585), a man of forty-seven years, was in good health until the age of forty, when constipation became apparent and increased in severity. Finally symptoms of acute obstruction arose, and a half twist of the sigmoid flexure was found, corrected, and stitched to the abdominal wall. Five months later another attack of acute obstruction occurred, and again this portion of the colon was found twisted. It then was resected successfully, with subsequent relief of the symptoms.

Occasionally cases may be encountered which occupy an intermediate position between the infantile and the adult groups. I am indebted to my colleague, Dr. F. B. Harrington, of Boston, for the notes of such a case.

His patient, about forty years of age, since childhood had a distended abdomen, with constant abdominal distress and much difficulty in emptying the bowels. At the age of twenty years he had an acute affection resembling intestinal obstruction and accompanied with enormous distention of the abdomen. At this time Dr. P. Wadsworth, of Malden, treated him by plunging a trocar through the abdominal wall into the intestine. A great quantity of gas escaped, the swelling subsided, and defecation soon was resumed. Thirteen years later a similar illness occurred, but of less severity. In the subsequent seven years there were four or five such attacks, each lasting from one to four weeks, during which time the patient was confined to his bed, suffering from vomiting and intense pain. Relief followed the passage of large quantities of gas and liquid feces.

The last attack began March 6, 1898, with severe pain and vomiting, unrelieved by rectal enemata or by doses of salts. When seen a week later by Dr. Harrington, the face was pinched and haggard, the temperature 102° F., and the pulse 120. The abdomen was so distended as to resemble that of a woman with a large abdominal tumor. It was everywhere tympanitic. A median laparotomy was performed, and the cause of the enlargement was found to be the dilated sigmoid flexure, which extended from the pubes nearly to the ensiform cartilage. It was tapped, and enormous quantities of gas and fecal matter were removed. This portion of the colon was then withdrawn from the abdomen and resected. The patient lived for a week, during which time there were frequent movements of the bowels and relief from pain. Death was due to septic peritonitis of a mild grade. The united ends of the large intestine were in good condition and there was no evidence of any leakage. Dr. Harrington states, "with a similar case in similar conditions I should make an artificial anus and wait for improvement before doing a resection."

In comparing the histories of cases of chronic phantom tumor and of idiopathic dilatation of the colon the similarity in the symptoms of the two affections is beyond question. In each there is marked constipation, frequently leading to the retention of feces. In each there is a tympanitic distention of the abdomen, often of extensive degree, and present throughout a series of years, although subject to variations in size, even to a return of the normal shape in anæsthesia. In each exacerbations of abdominal distress are apt to accompany temporary increase in the size of the abdomen. The phantom tumor is not necessarily limited to persons of hysterical tendencies, and the patient with a dilated colon may be hysterical or neurasthenic. With so striking a resemblance in the clinical characteristics it seems probable that the anatomical changes are identical. Fatal cases of phantom tumor have rarely been reported. Cullen's (*Virginia Clinical Record*, Richmond, 1871, i. 153) patient died of inanition. The abdomen had been distended for five years, and the symptoms so suggested ovarian disease as to lead to the thought of ovariectomy. It is stated that no tumor was found at the autopsy, but there is no mention made of the condition of the colon. Even in the case reported by Bright, in which the interior of the distended abdomen was exposed by a laparotomy, we learn merely that no tumor was found. It is obviously inconceivable that such extreme tympanitic distention of the abdomen could exist for so long a time without the presence of gas in the intestines, and from the probability that the function of the stomach and small intestine was, as a rule, but little impaired, it seems likely that the gas must have been accumulated in the dilated large intestine. Furthermore, as already mentioned, examples of chronic phantom tumor, as described by Bright and others, are no longer reported, but cases with similar symptoms are published with satisfactory evidence that dilatation of the colon is the constant characteristic.

The following statement is added for the purpose of confirming the above interpretation of the subject :

Miss —, thirty-seven years of age, entered the Massachusetts General Hospital in November, 1898. Since the age of fifteen, when "threatened with typhoid fever," she has been subject to periodical attacks of weakness, without obvious cause, occurring two or three times a year, rather increasing in frequency of late. The attack which took place eighteen months previous has never been wholly recovered from. During this period she has been unable to work, and has been confined to the bed a couple of months at

a time on four or five different occasions. The abdomen began to enlarge from the onset of this attack, and gradually has reached its present size. During the past year there has been more or less constant pain in the right iliac fossa, in which there is the sensation as of a lump. Of late the pain has extended upward into the right lumbar region, and in the past six weeks it has been worse than ever. For years she has been obliged to use some laxative two or three times a week, and several times a year would have no movement of the bowels for a week. The catamenia have been irregular and painful since the age of fifteen, a space of two years once having elapsed without their appearance. The interval between the successive periods may be from one week to three months. The use of the catheter is at times necessary to enable the bladder to be emptied. She has no appetite, is weak, suffers from constant abdominal pain, and attributes all her discomfort to the condition of her bowels, which causes nausea and short breath. Although there had been some loss of flesh, the face was florid, an appearance stated always to have been present. The waist was small, the epigastrium flat, but below the navel the abdomen was uniformly swollen, tense, and tympanitic to a marked degree, and measured thirty-three inches in circumference. There was diffused tenderness in the right flank. There was no alteration in the outlines of the stomach, spleen, and liver, as determined by percussion. Palpation of the region of the kidneys was rendered useless by the resistance of the overlying muscles. The pelvic examination was negative. There was neither albumin nor sugar in the urine, and the blood showed 68 per cent. of hæmoglobin, 5,616,000 red corpuscles, and 13,400 leukocytes three hours after dinner. The stomach had a capacity of twenty-five ounces of water, and its contents showed free HCl. Lactic acid also was present. When the rectal tube was inserted there was neither obstruction nor escape of flatus, nor did any change follow in the appearance of the abdominal enlargement. After the patient was etherized the abdominal walls became flaccid and the tumor disappeared, but there was no especial diminution in the circumference of the abdomen. There was merely a change of shape, the tumor-like character of which at once reappeared as the senses were recovered. There was much splashing on palpation of the region of the colon, and attempts to inject liquid and air into the bowel produced only a moderate degree of additional distention.

During the patient's stay in the hospital purgatives produced watery evacuations, but neither laxatives nor enemata caused any material alteration in the shape and size of the abdomen. She was informed of the probable cause of her condition and of the doubt of any permanent relief except by a surgical procedure of a severe and serious nature. Any reasonable attempt to enable her to resume an active life was welcomed. She was transferred to the care of Dr. C. B. Porter, who made a median incision, through which the greatly enlarged sigmoid flexure bulged. It was apparent that there was neither an organic stricture nor a fecal impaction, and as her pain had been referred to the right iliac region, and as the vermiform appen-

dix was closely attached to the abdominal wall, Dr. Porter decided to remove the appendix with the hope of relieving the pain.

This operation, speedily recovered from, gave no permanent relief, and she returned to the hospital, in accordance with my advice, for the purpose of having a portion of the colon resected. Dr. M. H. Richardson, who had succeeded Dr. Porter in charge of the surgical ward, reopened the abdomen April 5, 1899, and removed the enlarged sigmoid flexure, which represented the chief constituent of the abdominal swelling, although there was some dilatation of the rectum and the descending colon. Convalescence has progressed favorably and without interruption.

This case presented the essential characteristics, even in its reaction to anæsthesia, of a phantom tumor, occurring late in life in a woman of pronounced neurasthenic type. It likewise showed the features of idiopathic dilatation of the colon free from obvious congenital peculiarities, and having as its sole conspicuous antecedent a constipated habit, but no history of fecal impaction at any time. The phantom tumor proved to be a dilated colon.

In advocating resection of the sigmoid flexure for suitable cases of idiopathic dilatation of the colon or for chronic phantom tumor, in which the former condition presumably exists, I simply follow in the footsteps of Mr. Treves. It was his brilliant operation to relieve a patient from the effects of congenital malformation of the lower portion of the large intestine which first suggested to me the expediency of the above procedure in a case of genuine idiopathic dilatation of the colon.

The history of such cases shows that often under medical treatment the deformity and disability are permanent, generally progressive, attended by suffering and ending usually in death.

The resection of the dilated sigmoid flexure takes from the abdomen the chief cause of distention and of a fecal reservoir, which has become unnecessary, is burdensome, a source of pain and a menace to life.

It has successfully been removed, together with the descending colon, rectum, and anus, by Treves, in a case of congenital stenosis of the bowel, and the dilated sigmoid flexure alone has been removed by F. B. Harrington and by M. H. Richardson to relieve acute obstruction.

Resection may be preceded by colotomy, as in the case of Treves, and, as Harrington finds, indicated when symptoms of acute obstruc-

tion are present. Colotomy in such cases, however, should be merely a temporary expedient to relieve the patient from immediate peril and to permit him to enter into a state suitable for resection. The latter operation is best undertaken when the patient is comparatively free from all acute discomfort.



FIG. 1.



For description see case, page 7.

FIG. 2.



FIG. 3.



For description see case, page 11.









