TIFFANY (L. McL.)

Left lumbar colotomy xxxxx

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REPRINT FROM MARYLAND MEDICAL JOURNAL OF AUG. 4, 1883

LEFT LUMBAR COLOTOMY AND THE POSITION OF THE DESCENDING COLON.

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Lumbar colotomy is so often done at the present time, and directions for operating are so clearly laid down in all text-books, that a single case scarcely offers food for comment. The following instance, however, when considered with others which I have reported (*Am. Journ. Med. Sci.*, cxlviii, p. 413; Trans. Med. and Chir. Fac., Md., 1882, p. 90) suggests strongly that the usual theoretical line for the colon is not in all instances quite accurate, namely, the anterior border of the quadratus lumborum muscle. Indeed, if I rely on my own experience exclusively, I should expect to find the gut always posterior to the above line. I have had occasion to do lumbar colotomy four times always through the left loin; all the patients have been greatly relieved and have recovered from the operation. All the patients suffered from obstruction of the rectum by cancer, the lumbar anus being established as a palliative measure.

In every case the quadratus lumborum was freely divided, twice because the gut came into view peritoneum intervening, and twice because the gut was felt to be posterior to the edge of the muscle. In one case I found it necessary to hook the colon forwards with my finger from the kidney so as to make it present at the wound. It may be that when the rectum is obstructed the descending colon becomes heavy with retained excrement, and so moves nearer the spinal column by its weight when in the usual colotomy position, but I am greatly inclined to think that the colon generally lies under cover of the quadratus lumborum rather than at its edge. It is always agreeable to find one's opinion supported by authority, though of minor importance, in addition to the living body, and this Braune does in his Topographical Atlas, edited by Bellamy, plate xvi, with accompanying text, in which the extra-peritoneal portion of the descending colon is made to look backwards towards the spinous process of the fourth lumbar vertebra, and corresponding advice about operating is given. Again a no less excellent anatomist than Harrison Allen says of the quadratus lumborum that it is "to be "incised in colotomy," a statement by the way to which exception is taken in a recent review.

CASE.—Patient stout, aged 35 years, mother of three children, the youngest three years old. The history obtained was that Mrs. —— had suffered from disturbance of the bowels, more or less pronounced, during the past eighteen months; sometimes diarrhœa sometimes constipation existed; gradually defecation became more difficult, and was effected only with much straining; tenesmus was developed, blood and pus were noticed in the stools, and pain became very great. Dr. Aronsohn, of this city, when the patient applied to him for treatment, made a rectal examination, recognized cancer and asked me to see the sufferer. Sept. 14th, 1882, I found a rectum surrounded with cancer, epithelioma in all likelihood, not involving the sphincter ani but extending along the bowel beyond the reach of the finger. About three inches from the anus the lumen of the rectum was so much diminished as not to admit more than the tip of the index finger. Through the vagina there could be felt a hard tumor, oblong in shape, occupying the place of the rectum; uterus not over movable; no enlarged glands to be felt in the groins. Extirpation of the growth was not thought to be indicated, owing to its extent and probable attachments, so palliatives were made use of, namely, simple nourishing food, rectal injections, and opium, with colotomy in the future, if pain became unbearable or obstruction pronounced. June 4th, 1883, I again saw Mrs. M. with her physician, Dr. A. Complete obstruction had existed three or four days, and the pain was intense. It was thought best to do left lumbar colotomy the following day. Nothing of moment took place during the operation. It was done in the usual way by oblique incision the centre of the incision corresponding to a vertical line drawn half an inch behind the middle point between the anterior and posterior superior iliac spines. The patient was very stout, notwithstanding the length of time that the rectum had been diseased, and the wound correspondingly deep. A more than usually thick subperitoneal layer of fat existed; cutting through this at the anterior edge of the quadratus lumborum, I saw the gut very soon, moving freely with respiration. I was able also to pinch up and move from the gut the overlying tissue at the bottom of the wound and therefore judged that I had peritoneum between the gut and my knife. I then divided the quadratus lumborum transversely to the extent of an inch or an inch and a half, cut through the subjacent connective tissue, came upon gut, rolled it forward so as to bring the postero-lateral aspect to the wound, recognized a couple of transverse creases by sight, also a contained bit of feces by touch and finished the operation in the usual manner by passing my stitches and then opening the intestine. A great deal of fecal matter flowed at once. A pad of oakum with great cleanliness constituted the after treatment. All went well, and convalescence from the operation calls for no comment.