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With the compliments of the Author

RECTAL DISEASE

OF UTERINE ORIGIN.

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[*Reprinted from the Boston Medical and Surgical Journal, of February 18, 1886.*]

BOSTON:
CUPPLES, UPHAM & CO., PUBLISHERS,
Old Corner Book Store.
1886.

RECTAL DISEASE OF UTERINE ORIGIN.[1]

BY C. P. STRONG, M.D.

NEARLY every subject in gynæcology has been so thoroughly written about and illustrative cases so multiplied that it was with surprise I noted the lack of definite and detailed information regarding the causative influence of uterine disorders in cases of rectal disease. The literature of the subject, as found in the larger text-books is but the most general statements, while in monographs it is treated more from the point of view of the rectal specialist than the gynæcologist. It being my fortune to have several patients whose symptoms were mainly or entirely rectal, I sought to find some classification of symptoms or of lesions recorded, that would aid me in determining just how far I was justified in attributing their condition to uterine disease. My search was so unproductive that I have been encouraged to contribute the results of my personal observations and a few illustrative cases with the hope of adding, although it be but little, to the general knowledge.

There are certain symptoms that suggest at once rectal examination; constipation alternating with diarrhœa, frequent and ineffectual attempts at defecation, painful defecation, hæmorrhage, muco-purulent discharges, sensations of fullness in the rectum with general reflex disturbances of the digestive tract; and when one finds, associated with these symptoms, the lesions, internal hæmorrhoids, subacute and chronic proctitis accompanied usually with fissure of anus and often with ulceration of the rectal mucous-membrane, certainly an investigation of the uterus and its adruxa

[1] Read before the Obstetrical Society of Boston, December 12, 1885.

is demanded. I do not intend to imply that these conditions necessarily mean uterine disease, for there is a vast number of other sources from which they may arise, but rather, that when uterine disease does cause rectal trouble, these are the symptoms, and these lesions present, and that cure will be more certain and speedy, and relapses less frequent, proportionally to the attention paid to the uterine complication. Certain conclusions, too, I formed as to the nature of the uterine disorders that would produce these lesions: first, uterine malpositions, especially retroflexion when adherent, and retroversion, prolapse associated with laxity of the vaginal walls; second, periuterine cellulitis, most markedly when retrouterine and hardening and fixing the anterior rectal wall.

There are several reasons for the disturbing effect of uterine malposition upon the rectum, but the important one is the disturbance of the veinous circulation in the lower part of the bowel, which has both a mechanical and physiological explanation. The internal hæmorrhoidal veins, valveless and thin-walled, as they emerge from beneath the mucous membrane through the muscular coat of the rectum, pass through openings that are readily compressed; also, this lower part of the rectum is especially rich in its nerve supply, and the mal-placed uterus, depressing the rectal wall at this spot, acts as a stimulus, producing contraction of the muscular coat of the intestine, which occludes the veins and dilates their terminal branches. So far the conditions are analogous to those occurring during normal defecation, and if now the uterus were raised all would be well, but it maintains its place and under the stimulus of its presence the contractions of the muscular wall become constant, the dilatation of the veins is permanent, and internal hæmorrhoids are produced. Passive congestion of the area drained by

the veins ensues, and with this a sub-acute inflammation of the mucous membrane leading to increased secretion and loss of epithelial covering, thus adding new factors for further disturbance. Coincident with these changes the usual alterations in the uterus consequent upon its displacement, continue rendering it more and more a source of irritation to the rectum. When the uterus is in its normal position and movable, although it may press firmly against the rectal wall it stimulates no contractions, because of the deficient nerve-supply at this point of the rectum, and because its position is so constantly varying; if, however, it is fixed by adhesions a new element is introduced, the condition is then analogous to a rectal stricture, formed by retro-uterine cellulitis, an obstacle is opposed to the normal descent of fæces preventing the regular and complete emptying of the rectum, irritating masses may be retained in the dilatations above and below, causing ulceration of the mucous membrane, and starting a new series of evil results.

There are two conditions that I pass over, content with merely naming them, their dependence upon uterine complications and their treatment being so obvious, hæmorrhoids during pregnancy, rectocele from a prolapsed uterus.

I have preferred not to enter too minutely into the various pathological changes that may occur in the rectum in consequence of uterine disease, because that would involve considerable theoretical discussion and necessitate a consideration of the mutual reflex disturbances, and my purpose in this paper has been only to record the results of my personal observations, therefore I pass at once to the cases I have selected as illustrative of the types of uterine disease whose symptoms are mainly rectal.

Case I. Hæmorrhoids, internal and external, with

profuse hæmorrhages and chronic proctitis. Caused by an enlarged and retroflexed uterus. Recovery without rectal treatment.

Mrs. X., widow, five years past the menopause, complexion anæmic and sallow, suggestive of malignant disease. For ten years has suffered from hæmorrhoids, which during the past two years have given her no rest night or day. Severe constipation, partly acquired as each dejection was accompanied by loss of blood, not infrequently to such an extent as to cause syncope. Protrusion of masses from the rectum at each defecation with abundant mucous discharge. Frequently confined to bed for several consecutive days. She had about exhausted the medical treatment of the rectum, having sought relief from many sources and refusing the operation that was finally urged upon her by all whom she consulted. As to the uterine symptoms, she had none, except backache, which of course could be readily explained by the condition of the rectum and her general poor health. The anus was surrounded by a fringe of hæmorrhoids, not inflamed but full of blood. Slight straining on the patient's part protruded about three quarters of an inch of the rectum turgid, streaked with blood and mucus; the numerous veins dilated to their utmost limit. The mucous membrane was thickened and here and there denuded of the epithelium, bleeding at the gentlest touch. Passing the finger up the rectum at the distance of an inch and a half to two inches it came against a firm globular mass occupying the whole calibre of the canal, suggesting at once a large rectal polypus, but noticing its apparent relation to the cervix as felt through the rectal wall, the diagnosis of retroflexion with adhesions was made and confirmed by vaginal examination. The uterus was much enlarged, three and a half inches was the internal measurement, although the catamenia had

not appeared for five years. Both walls of the vagina were also lax. Owing to the tenderness of the rectum it was a matter of considerable difficulty to replace the uterus, but this was successfully accomplished by packing for two months, and then a retroflexion pessary readily retained it in its normal position. The amelioration of the symptoms when the pessary was substituted for the packing and the uterus lifted well forward was most marked and immediate. Bleeding ceased at once and has never recurred during the fifteen months she has been under my observation. Regular daily dejections, without pain, have been established. The internal hæmorrhoids have almost disappeared and the external ones form merely a fringe of hypertrophied skin. The uterus has decreased one-half inch in size and the patient's general health and strength has improved in a corresponding degree.

This case is especially interesting, because from the first visit to the last, a week ago, the only treatment has been directed to the uterus, notwithstanding all the symptoms were rectal. There has only once been any indication of a relapse. After an absence of three months, the patient returned and stated that for a few weeks past she had been troubled by the old sensation of fullness in the rectum, unaccompanied, however, by any graver symptoms. Examination showed that the uterus had bent backwards over the upper bar of the pessary and was pressing into the rectum. Replacement of the uterus and the insertion of a slightly longer pessary effectually cured this symptom.

Case II. Subacute proctitis with fissures of the anus, dependent upon a slightly prolapsed uterus. Rectal treatment ineffectual until the uterus was replaced. Cure.

Mrs. X., aged forty, multipara, of exceptionally nervous temperament, has suffered since puberty with

various uterine disorders, and has been under constant treatment for years. When she first consulted me, two years ago, there was dysmenorrhœa, leucorrhœa, inability to stand or walk, backache, and a host of kindred uterine symptoms, but during the past two years or more these had been overshadowed by rectal disturbances; constant pain in the rectum, acute suffering so intense during defecation that the act was postponed to as infrequent intervals as possible, profuse muco-purulent discharges, slight staining of the stools with blood. One of the most prominent symptoms, which she called "rectal neuralgia," was pain of severe character about the anus and lower part of the rectum, induced by surface chilling of the body, so that even in summer she never approached an open window without protecting herself by a thick shawl. Ether was necessary for an examination, and there was found the following conditions: a slight fissure of the anus; subacute inflammation of the rectal mucous membrane, extending quite as high up as the rectum could be exposed to view, the surface streaked with lines of pus and thick glairy mucus, and studded with minute, red, granular elevations, looking not unlike grains of red pepper. The uterine condition was not encouraging. Both tubes were dilated, especially the left one, which appeared about three-quarters of an inch in diameter, and outside these tubes there was considerable inflammatory deposits. The uterus lay about an inch below its normal level, pressing back firmly into the rectum. Rectal treatment was at once begun by stretching the sphincter, cleansing the mucous membrane and applying a strong solution of nitrate of silver. For several weeks a varying treatment was employed, including absolute rest in bed, hot rectal douches and astringent applications, but beyond the improvement caused by the healing of the fissure,

her symptoms were but little benefited. Then the uterus was raised and kept free from the rectum by a pessary, and coincident with this manœuvre there was steady gain. The purulent discharges ceased and the pain disappeared. An examination four months ago showed a perfectly normal appearance of both rectum and anus. There has been no relape. The uterine condition and enlarged tubes have also improved, contrary to my expectations, under mild treatment, and except considerable dysmenorrhœa, the patient declares herself perfectly well, althongh it will be some time yet before I shall venture to permanently remove the support. The so-called "rectal neuralgia" is now never noticed. The rectal treatment of this case that was attended with the most benefit was the employment of suppositories of iodoform and hydrastin night and morning.

Case III. Chronic proctitis, with anal fissure depent upon cellulitis, extending behind the uterus and involving the anterior rectal wall, combined with prolapse of the uterus and left ovary. Improvement.

Mrs. X., thirty-six years. As with the preceding cases, the symptoms for which relief were sought were rectal. As stated by the patient, there was pain, discharge from rectum, resembling the white of eggs, or else yellow; inability to have a movement without employing both physic and enema, and often three or four enemata were required. The pain accompanying defecation is excruciating, often patient faints; and the rectum is never free from a feeling of fullness and soreness. The rectal symptoms were not very chronic, having lasted but six months, but for about a year, in consequence of a fall, patient had suffered from serious uterine troubles, for which she had received beneficial treatment. Previously to this accident she had been in good health. For the past three months, she had

been in bed most of the time. Examination under ether revealed the presence of several superficial fissures in the posterior part of the anus; the rectal mucous membrane was thickened, of a dusky hue, and thickly sprinkled over the surface were minute ulcerations, varying in sizes from a pin head to a split pea. Pus and mucous abundantly present. On the anterior wall was a projection caused by the fundus of the uterus, which was firmly bound there by cellular inflammation, thus acting as a direct mechanical obstacle to the descent of the fæces. The rectal wall was so thickened and undurated, it could not be depressed to permit examination above. The uterine conditions were, a hypertrophied uterus over three inches in depth, lying low in the pelvis and rendered immovable by a mass of cellulitis, which involved as well the left ovary and the anterior rectal wall. From the sequence in time of the rectal and uterine diseases, it was quite evident that the former was dependent upon the latter; but until there was some improvement in the condition of the rectum it was hopeless to attempt any manipulations leading to re-position of the deplaced organs. Fortunately the most acute and troublesome rectal symptoms, the painful defecation and discharge of pus, improved by the dilatation of the sphincter, the use of hot rectal douche with weak solutions of nitrate of silver, and employment of the iodoform suppositories, so that very soon it was possible to treat the uterus directly. The gain was so rapid when the cellular effusion was absorbed and the uterus became movable, that rectal treatment was then entirely abandoned. At the end of five months the only reminder of the previous trouble were constipation, which was easily controlled by a laxative, and the presence of considerable mucous discharge, if the patient was long on her feet, showing that the rectum was still affected by the pressure of the prolapsed uterus and ovary.

The patient refused to wear a support, and so I have reported this case as improved, not cured, for I have no doubt that a recurrent attack of cellulitis will bring on her rectal symptoms again. It is about a year since she passed from my immediate observation, and there has been no opportunity since that time to make a local examination, but I have been informed that she is attending to her duties, and is not apparently an invalid.

Case IV. Chronic proctitis, with deep ulcerations and fissure of the anus, dependent upon a retroflexed and adherent uterus. Rectal treatment ineffectual until supplemented by replacement of the uterus. Cure.

Mrs. X., thirty-two years, multipara. Consulted me in November, 1883. Her symptoms were both uterine and rectal, but the latter assumed the greater prominence. From the graphic and intelligent history she furnished, I make an extract of the important points. Since the establishment of her catamenia, at the age of seventeen, she suffered greatly from dysmenorrhœa, backache, and bearing-down pains; symptoms exaggerated by constantly standing, as her duties as teacher demanded. In 1871 constipation became a symptom of increasing prominence, and to this was joined hæmorrhage at each defecation. Usually she made several abortive attempts to secure a dejection before being successful, and was subject to constant pain in the rectum. For four years she was under treatment by diet and medicine, and then, passing into other hands, was examined and cured of fissure of the anus by dilatation of the sphincter. There was very great gain in the rectal symptoms after this treatment for several months, but the uterine symptoms remained unchanged, and slowly the rectum returned to its former condition. In 1879 she had an attack of peritonitis, and after con-

valescence from this she thus describes her condition: "There were five or six daily attempts at defecation, the fæces were hard, dry, and in small pieces, not over an inch and a half long and shaped like the handle of a silver dinner knife, having on one edge a streak of bright red blood and considerable amount of greenish yellow matter on the end." With these conditions unchanged the patient was married two years later, that is, in 1881. Marital life and duties exerted a most pernicious effect. She failed steadily, and when I first saw her, two years later, she was in a deplorable condition: emaciated, exhausted by pain, spending most of her time in bed, unable to walk or even stand for any length of time. She said she did not mind the backache or dysmenorrhœa, but that the trouble in the rectum was "killing her." At first I thought there must be malignant disease of the rectum to produce such depressing symptoms, but recognizing the sharply retroflexed uterus pushing into the rectal walls, and the presence of adhesions, I determined to try uterine treatment alone. A few attempts convinced me of the impracticability of accomplishing anything by this plan until there was greater tolerance of the rectum toward the necessary manipulations. Under ether the sphincter was dilated, showing several superficial and one deep fissure, and permitting the escape of a gush of blood and pus. When the sphincter was fully opened and the speculum in position, a single ulceration appeared, extending from the anus to a point about five inches up the bowel and involving the entire circumference of the rectum, except a strip of mucous membrane, varying from one-half to three-fourths of an inch in width, on its anterior aspect. This little strip of membrane was swollen and boggy from infiltration, and there were deposits of lymph on the surface from which the epithelium was very easily de-

tached. A dark, grayish, dirty-looking coating covered the surface of the ulceration, exposing an easily bleeding granular base on its removal. Whatever the remote cause of this state of affairs might be, there was evidently but one course of treatment to pursue, and that was to promote as rapidly as possible the cicatrization of the rectum. I thoroughly curretted through the slough and granulations to a firm base and then brushed over with nitric acid, using the greatest care not to encroach upon the little remaining strip of mucous membrane. For three weeks the patient was kept absolutely recumbent in bed, and then for an equal space, allowed to move only about her room, spending most of the time upon the lounge. The medical treatment was a broth and beef-tea diet, aloin as a laxative, and enemeta of hot water, and iodoform suspended in liquid vaseline. The rectum at first would reject two ounces of hot water immediately, but at the end of six weeks would retain three pints and more for about fifteen minutes. At the end of ten weeks there was most gratifying improvement, but still the symptoms were not all gone. Blood and pus had disappeared from the dejections, there was almost no pain accompanying them, but the fæces retained their peculiar shape, and there was still the sensation of fullness in the rectum, inducing frequent attempts at defecation.

Examination showed, that the rectum was now completely cicatrized and the fissure healed. There was no change in the uterine condition. The patient was competent to attend to the rectal treatment and faithfully obeyed all my instructions, but after resuming her household duties, and being upon her feet a considerable portion of the day, she reported in July, five months subsequent to the operation, that the old rectal symptoms were returning, and she was alarmed lest she should relapse into her former state. Under its

improved condition the rectum was tolerant of the course of packing that was necessary to raise the uterus, and this treatment was carried out until the adhesions were so far stretched that a pessary could be introduced to complete the cure. I abandoned the packing for the pessary sooner than is my custom, because of the irritating effect upon the rectum, and also because vaginismus made the operation of packing both tedious and painful. Immediately upon the successful replacement of the uterus, the remaining rectal symptoms disappeared and have never since returned. I saw the patient two weeks ago, and she said that she now had a regular daily evacuation of perfectly formed fæces, unaccompanied by pain or mucous discharge, that there was no abnormal sensation whatever referable to the rectum, that she never took a laxative to secure a dejection. In a word, as she stated it, "I never should know I had a rectum."

In reporting the foregoing cases, I have purposely refrained from entering upon the particulars of either the uterine or the rectal treatment, that the attention might not be drawn from the point under discussion by a confusing mass of details, and for the same reason have omitted mention of uterine complications that had no especial significance in this connection.

The cases have been selected from among a number as especially illustrative of the type of rectal diseases, that are dependent upon a uterine cause. That the cause of the rectal trouble was a direct consequence of the removal of the existing uterine lesions, not a coincidence, is shown by the fact, that, with one exception, Case III, the patients had previously received rectal treatment for years, improving but never getting thoroughly well, and always relapsing.