Kelsey (C. B.)

The Third Year's Work at the Clinic for Diseases of the Rectum in the New York Post-Graduate Hospital.

BY

CHARLES B. KELSEY, M. D.

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By CHARLES B. KELSEY, M. D.

At the end of this, the third year's work of the clinic, it will perhaps be profitable to spend a short time reviewing some of the cases you have seen and the results of treatment.

I show you here, under ether, the young physician whose rectum I amputated several weeks ago. You will remember the case was one of non-malignant but extensive and incurable ulceration—incurable, I mean, by any topical applications or minor surgical operation.

The cause of the ulceration, which had completely destroyed the lower two inches of the gut, it was impossible to determine positively. He thought it might be syphilitic, but he had never had any other sign of syphilis, and the argument was evidently in his own mind from the effect back to a supposed necessary cause, and not *vice versa*. He had been operated upon years ago for fissure, but had not been cured; he had been curetted and cauterized without effect; he had taken mercurials without benefit, and all the

time the ulceration of the rectum had been progressing. This sort of history, as you know, is common enough. Some slight lesion causes an abrasion of the rectum or anus; this, under one treatment or another, progresses and does not heal; operations are done and antisyphilitic treatment is prescribed without result; and finally the patient, after about five years of suffering, comes before us with more or less destruction of the rectal tissues and an unfounded diagnosis of syphilis.

This patient had absolutely no sign or history of syphilis. He had ulceration of the rectum as he might have been bald. It would be as sensible to accuse every bald man of syphilitic alopecia as to accuse this man of syphilis because he had ulceration of the rectum. However, the disease was incurable by local treatment, and you saw the operation of extirpation and amputation of the diseased portion of the gut.

I told you at the time that a colotomy would be attended by much less risk and would give as good an ultimate result, but that the patient preferred an anus without sphincteric power in the perinæum to one of the same sort in the left groin, and at a considerable risk of life we would give it to him. I therefore amputated about two inches and a half of the rectum, drew down the stump and stitched it to the anus, where the external sphincter had been carefully preserved.

The case has done badly from the time of the operation.

Had I done a colotomy the man would have been home at his work, as many of our other patients with the same trouble now are. But here he is. Two days after the operation his temperature was 105° F. We had no sooner brought this down than he had a severe hæmorrhage from the wound, which left him in collapse. To stop this, all

stitches were broken loose and the wound plugged. After lying between life and death for weeks he is now steadily improving, and I have brought him to the operating-room to try and overcome the faulty condition of the parts.

At the time of the operation great care was taken to preserve as much of the sphincters as possible, and the end of the bowel was carefully stitched to them. When the secondary hæmorrhage occurred there was already some union of the surfaces, enough to have prevented what has happened, but this was necessarily broken down in packing the wound. The gut has retracted and now ends two inches from the perinæum. In the cavity thus formed solid fæces are prone to become lodged, and as the skin incision heals their removal becomes more and more painful and difficult. This can be avoided by laxatives; but to avoid future stenosis I propose now to try and loosen the gut once more and bring it down to the skin.

The attempt is a failure. I can not loosen the bowel without practically doing another resection, so firmly has it become united to the tissues, and this would not be justifiable in his present exhausted condition. It will be much better for him to allow the parts to heal as they will, and to trust to healing over a bougie.

This is not an unusual result after resection. All cases are followed by more or less stenosis or incontinence, and there is never a very useful anus. So that the choice between colotomy and extirpation in these cases is more a choice of the place where an anus over which the patient will have no control shall be located than a choice between a useful anus and incontinence or stenosis. Colotomy, properly performed, is never followed by stenosis, but always by loss of control.

You see, then, the price this man has paid rather than have a colotomy. He has been very near death from an

operation which, in the best of cases, has a mortality of twenty per cent. rather than have a colotomy which would have been almost without risk, and how much he has gained in utility of the parts is very problematical.

One case of extirpation during the year was fatal—a case of cancer not very great in extent, but involving the neck of the bladder and part of the prostate. All the disease was removed, of course, and the bladder widely opened, and yet it seemed for several days as though he might recover, but he died on the tenth day from hiccough. It is probably the last case of cancer you will ever see removed at the clinic by me where the disease is not strictly limited to the gut itself.

In one other case you saw me abandon an attempt at extirpation of a non-malignant stricture because of a peculiar condition of the parts. The constriction was two inches from the anus, was very hard and tight, and could not be passed by the finger without incision. The gut being perfectly normal up to the stricture, I made the diagnosis of congenital malformation, and expected to resect the part and suture the ends. But after we came down upon the disease by Kraske's incision, I found two unexpected complications. One was that the gut above the constriction was enormously dilated. It was large enough easily to contain a fœtal head. The other was that the stricture, instead of being limited to a small section of the gut, as I had supposed, extended farther up than I could reach.

It being impossible, therefore, to do what had been planned, the wound was closed and the patient left for a future colotomy. We might have excised, but the operation would have been very extensive, and it would have been impossible to have sutured the ends of the gut as I had hoped.

Of the seven colotomies, some have been of remarkable interest. Among others you have seen me lose my first patient whose death could be attributed directly to the operation, and that too from an accident which could easily have been avoided. I recall it to your minds both because of its interest and because no other such accident has ever been recorded.

It was a perfectly simple case of colotomy for cancer of the rectum in a man in good condition. I remember at the time of the operation the physician, who had brought us the case from a distance, leaned over the rail and asked me what the risk of the operation was, and I answered before you all that there was no risk; that in colotomies such as this the mortality was below one per cent.; and that the patient would be able to return home in about three weeks. In three days he was dead. He did well for forty-eight hours, when it was discovered that the dressing was wet through with serous discharge. This alone to an experienced dresser would have excited suspicion; but, as the attendant said, he had seen so many colotomies in this clinic, and all the patients get well without an accident, that he did not imagine anything could be wrong. This was in the evening. Next morning it was evident something had gone wrong. The patient was vomiting and partially collapsed, and all of the bowel that could get out through a two-inch incision in the left inguinal region was out of the body and mixed up with the dressings. It took me an hour and a half to separate the bowel from the bichloride gauze by careful dissection, so firmly were they united by plastic exudation. Then the original incision was enlarged and the bowel returned, but the man died of shock.

And now I want to tell you that I have had in my own practice the same accident once before, but without fatal

result, and with a surgeon's usual luck the two cases came within two weeks of each other; and that these two cases are the only ones on record. Other operators may have met with the same thing, but, if so, they have not cared to report it. If they were merely accidents without special bearing upon the operation, I also might not care to report them; but the accident, though always liable to happen after colotomy, can also always be guarded against when once its liability has been noted.

In my other case the evisceration was also marked by a sudden, unusual, and unaccountable gush of serum, which soaked the dressings twenty-four hours after the operation. In this case I accounted for the evisceration by the fact that there was considerable distention and obstruction at the time of the operation, but in the other case these conditions were absent. Fortunately, my assistant called soon after the bandages had become soaked, and, noticing that something unusual had happened, insisted upon removing them. Three or four feet of gut had escaped and were strangulated and cold; stitches were cut, the wire suture removed, circulation returned, and the bowel reduced. On my arrival the sigmoid was still in place, holding by the sutures on one side. It was at once incised to allow of the escape of gas and fæces and to prevent further accident, and after this the gut was stitched to the edges of the wound by sutures passing through its entire thickness. The patient recovered without a bad symptom. The other one would probably also have recovered had the evisceration been discovered when it occurred.

What is the lesson from these two cases? Shall we always open the gut at the time of the operation instead of waiting forty-eight hours, as has been our custom? Or shall we suture the gut to the skin wound more firmly? Rather, I

think, the latter. These two accidents have been due directly to the reports which I have heard and read of certain operations abroad where no sutures at all were used, a glass rod being passed through the mesentery of the gut, and kept in position by straps of plaster till the incision had been closed by plastic exudation. No accidents having been reported, I have gradually reduced the number of sutures in my own cases from twelve or fourteen to five or six—with the result of my first fatal case.

It may be noted that an accident exactly the opposite of this has been reported by Cripps. After one or two of his operations (in one I think even after the gut had been incised) the bowel tore loose from the wound, dropping into the abdomen, and had to be recovered. This, of course, could not happen with the silver suture which is passed through the mesentery in the cases operated upon here, and I had supposed also that hernia was impossible—but *experientia docet.*

You saw an operation not long since in a phenomenal case of hæmorrhoids. The tumors were the largest I had ever seen. There was an enormous mass on each side of the anus, which had to be first cut into smaller sections before the clamp could be applied.

I told you of the gentleman who had asked if we used the clamp in the mild cases what we did in the severe ones, and that this case would answer his question. I also offered it as a test case, explaining that if the clamp and cautery did not act satisfactorily in controlling the bleeding, we would abandon its use and go back to the ligature. I am glad to report that the results, both at the time of operation and subsequently, were perfectly satisfactory.

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