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Reprinted from the Cincinnati Lancet-Clinic,
December 29, 1894.

COLOTOMY AND THE KRASKE OPERATION.[1]

BY

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Any operation for cancer of the rectum, like that of any other part of the alimentary tract, is purely palliative, and must be so considered by both the patient and the operator. There are four things, either one of which would justify surgical interference, viz., (1) To relieve pain; (2) prolong life; (3) prevent hemorrhage; (4) removal of offensive matter. That an operation will accomplish one or all of these in a given case, there can be no question.

The results thus obtained seem to be very much disregarded. The influence in this direction is very strong, and not to be wondered at when we consider the subject from a point of view of fatality. At no time during my year's service in the New York Skin and Cancer Hospital did I find a case of carcinoma of the rectum, uterus or breast that did not result in death, with or without operation. This experience, together with subsequent observation, leads me to believe that once carcinoma of the rectum always carcinoma of the rectum—at least so far as our present surgery is concerned.

I am fully aware that many cases are reported in which many years have elapsed without recurrence, but I am inclined to believe that an incorrect diagnosis was given, even though made by the aid of the microscope. I do not mean to decry the use of this most valuable instrument, for it is not so much the fault of the instrument in determining the character of a growth as it is in the eye that views the field. In consequence of this fact, I am more inclined to rely upon the clinical history and appearance of growths than to the character of the growth as found on the slide. There is less likelihood of a carcinoma being detected in the rectum or sigmoid, early in its course, than almost any other part of the body. In consequence then an early diagnosis and removal is not likely to be made; hence the invariable rule of fatality with or without operation.

There are two operations from which to select: (1) High; (2) low. The low operation has reigned supreme for many years, simply because of the supposed danger in opening the peritoneum. But since it has been found that this cavity can be opened with impunity, and the advantages of the high and the disadvantages of the low better understood, more favor is being given to the high operation. It has been determined by the most frequent operators in this class of cases that stenosis is sure to follow all excisions of the lower bowel, and as stenosis is such a terror, accompanied by the

1 Read before the Cincinnati Academy of Medicine, December 10, 1894.

greatest agony every time the bowel is evacuated or a sound introduced, one can well imagine some of its inconveniences. The removal of the rectum or the establishing of a low artificial anus by any means, is attended with the greatest mortality, suffering and loss of time, and the greatest care and attention on the part of the attendants.

LOW—RESECTION.	HIGH—COLOTOMY.
Disadvantages.	*Advantages.*
1. High mortality.	1. Low mortality.
2. Infection.	2. Less infection.
3. Pain.	3. Less loss of time.
4. Loss of time.	4. Less pain.
5. Stenosis.	5. No stenosis.
6. Fistulas.	6. No fistulas.
7. Shortening of life.	7. Life more prolonged.
8. Difficulty in making operation.	8. Ease of making operation.
9. More difficult to care for.	9. More easily cared for.

Unless immediate action is demanded the results are more favorable and the operation of colotomy simplified by making it at two sittings.

COLOTOMY.

Its indications when the sigmoid or rectum is involved: (1) Malignant growths; (2) non-malignant growths; (3) severe ulceration; (4) prolapsus; (5) congenital malformation. An artificial anus may thus be formed and closed as the case may require. The inguinal colotomy is to be preferred, especially in adults, as the descending colon is so often out of its natural position—a condition due to the elongation of the mesenteric attachment, which often allows the colon to reach the median line, thereby making the lumbar operation impossible without opening the peritoneal cavity. Besides, the inguinal opening is more easily cared for.

Having recently made each of these operations, I herewith append short reports.

CASE I.

Mr. H., aged sixty-four, white, a farmer, has complained for about fifteen months of trouble within the lower bowel. He consulted an advertising specialist, who touched his rectum occasionally with a red-hot iron for ulceration. He gradually failed, and finally consulted Dr. J. F. Heddy, of Glendale. His weight diminished from 212 to 120 pounds. He had the usual symptoms of malignant growth within the sigmoid. I was asked in consultation, and advised, about the 1st of April, a colotomy. This was refused, and the patient continued to suffer, owing to his inability to pass fecal matter through the bowels. His condition continued to grow worse until August 3, when, in the presence of Dr. Heddy, Dr. Edwin Ricketts, and others, while under surgical anesthesia, I proceeded to make a lateral colotomy. The gut was found, brought into the wound, and sutured with silkworm gut. An exploration downward showed that the growth was about seven inches below the incision into the gut. The patient rallied fairly well, and expired at the end of seventy-two hours from exhaustion. Temperature normal. During this time there were several fecal discharges. He was comparatively comfortable, but could not overcome the shock.

An autopsy was held and it was found that an ordinary lead pencil could not be introduced through the lumen of the gut at the point of disease. The bladder wall had become involved, and the entire sigmoid was also involved. It was also found that the anastomosis of the gut and the integument was complete, and that plastic matter had been thrown out, showing that the operation itself was a simple and perfect one, and had the operation been made thirty or forty days before I see no reason why death should have ensued.

CASE II.

Thomas C., referred to me by Dr. Wilkinson, of Sabina, aged forty-four, white, farmer, in a fair physical condition. He has complained for about ten months with some trouble about the rectum. A malignant growth was suspected. He had lost flesh, the pain upon evacuating his bowels became greater, and it was soon found that his bowels could not be evacuated without a strong cathartic at frequent intervals. On September 30, in the presence of Dr. Wilkinson and others, I proceeded to make the operation as suggested by

Walker, of Detroit, provided the conditions were favorable. I found that the malignant gowth was low down, involving not only the inner but also the lower sphincter. An incision was made from above downward, to either side of the coccyx, intending to divide the coccyx at its fourth ring, leaving the periosteum intact for a hinge, and turn it back with the integument. Upon reaching the rectum I found that at least three inches and a half of it was involved, and that it was necessary for me to abandon the idea of using the Murphy button. I removed the lower end of the rectum, leaving about three inches to draw into the wound. I removed all of the diseased tissue that I could find, making it as thorough as possible. I removed the coccyx and a portion of the flap, brought the rectum out of the lower end of the remaining coccyx, and sutured the walls of the integument as close down upon the rectum as possible, the sutures being silkworm gut. The patient has made an uninterrupted discovery, and he has had comparative ease. He left my private hospital for home at the end of the fourth week, in a very favorable condition—indeed, his suffering being practically *nil.* It has not been necessary to give opiates in any form but a few times during his entire convalescence.

A letter received from his attending physician a few days ago states that the patient has gained a great deal in flesh, and that he is walking about in a most excellent general condition. He has no difficulty in evacuating his bowel, over which he has control. Had I had a more thorough knowledge of the condition of this rectum before I operated, I should have made the inguinal colotomy; however, as the disease has probably existed for a year, I feel that the operation applied will answer every purpose until dissolution takes place, which I believe will be before any great amount of stenosis occurs.

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