ADLER (L.H.) jr.

Extirpation and colotomy in cases of carcinoma of the rectum

[Reprinted from THE MEDICAL NEWS, July 20, 1895.]

EXTIRPATION AND COLOTOMY IN CASES OF CARCINOMA OF THE RECTUM.[1]

BY LEWIS H. ADLER, JR., M.D.;
PROFESSOR OF DISEASES OF THE RECTUM, PHILADELPHIA POLYCLINIC AND COLLEGE FOR GRADUATES IN MEDICINE; SURGEON TO THE CHARITY HOSPITAL AND TO THE OUT-PATIENT DEPARTMENT OF THE EPISCOPAL HOSPITAL, PHILADELPHIA.

COLOTOMY and extirpation are two recognized procedures for the relief of malignant disease of the rectum. Both operations offer the patient a chance of prolonging life; and, in addition, extirpation holds out the possibility, in selected cases, of effecting a radical cure.

The choice between these two methods is a question of uncertainty only in a relatively small group of cases. Extirpation is not to be considered in the majority of instances, for the reason that the disease is usually an incurable one, and, by virtue of its concealed position within the rectum, its presence is not revealed or even suspected until the growth has existed for some time. Furthermore, it is rare for carcinoma of the rectum in its incipiency to manifest itself by any symptom pointing to a lesion within the bowel. This is a familiar observation to all surgeons.

It frequently happens that a patient comes complaining of slight diarrhea or other mild rectal trouble, and an examination unexpectedly reveals

[1] Read before the Surgical Section of the American Medical Association at Baltimore, Md., May, 1895.

the fact that carcinoma is present to such an extent that it is obvious that the neoplasm has existed for a considerable period. Consequently its complete removal is often rendered impossible. Again, the patient's vitality is such that so grave an operation as excision, requiring considerable time for its performance, is contra-indicated.

In arguing thus I would not convey an impression that I am opposed to extirpation for malignant disease of the rectum in suitable cases. On the contrary, I firmly believe it to be a perfectly justifiable operation when the growth is circumscribed and confined to the lower four or five inches of the bowel; provided, however, that the tumor does not involve all the coats of the intestine, that it has not attacked the viscera which are intimately associated with the anterior wall of the rectum, that it has not invaded the pelvic glands or, by metastasis, any of the other organs of the body, and, finally, that its growth be not rapid or have a tendency to spread widely. From these considerations it naturally follows that the number of patients who can be benefitted by excision of the disease is comparatively small.

Colotomy, on the other hand, is indicated in a large number of instances in which it is quite impracticable to attempt an excision. The advantages of the operation lie partly in the relief it affords to symptoms and partly as a means of retarding the growth of the neoplasm.

To indicate the relief afforded such patients by colotomy I cannot do better than quote the opinion of Kelsey on the subject, as expressed in the fourth edition of his work, *Diseases of the Rectum and Anus*.[1] This authority is not only a

strong advocate of the operation, but is also in a position to judge of its merits by reason of his large experience. He thus states his views:

"As to the benefits arising from the operation too much can scarcely be said. That it prolongs life by the relief of pain, the preventing of obstruction, and retarding the growth of cancerous disease, is beyond question. That it substitutes in many cases a painless death for one of great agony is indisputable. The idea that it is as well to let a patient die as to subject him to a colotomy has no supporters among surgeons who have had any experience with these cases. Indeed, I think that the practitioner who to-day sat by and allowed a patient to die of obstruction because of any sentiment against this procedure would hardly be held blameless. I can only say that, after trying every other means of treatment and being obliged to admit the fruitlessness of them all, I have come, with most others, to admit the great benefits of colotomy, and *have never performed it in any case in which either the patient or myself has afterward regretted it.*" (Italics mine.)

In another article Kelsey[1] mentions even more minutely the advantages of this operation, as follows:

"Colotomy, especially inguinal colotomy, relieves pain; does away with the constant tenesmus and discharge from the rectum, which, by their exhausting effects are the immediate cause of death; delays the development of the disease by preventing the straining and congestion of defecation; prevents absolutely the complication of intestinal obstruction, which is another cause of death; enables the patient to sleep, eat, and gain flesh, and often makes him think himself cured in

[1] Pp. 409 and 410.

spite of the plainest prognosis to the contrary. Instead of passing his days and nights upon the commode, wearing out his life in the effort to free the bowel from the irritation, he has one or, perhaps, two solid fecal evacuations from the groin in twenty-four hours."

In conclusion, I would allude to one more topic, to wit: The choice of sites of opening the colon. I mention this subject with the sole purpose of eliciting the present views of the members of this society. My own belief is that the inguinal region is to be preferred in the majority of cases. Its advantages over the lumbar operation are, to my mind:

1. The smaller incision and lesser depth of the wound requisite to reach the colon, and the minimum amount of disturbance of the structures overlying the seat of operation.

2. The greater facility offered for the exploration of the abdomen, when such a procedure is required.

3. The better position for safe anesthesia during the operation.

4. The comparative ease with which the colon may be identified in this position and the little difficulty experienced in fixing the bowel to the skin without undue tension on the stitches.

5. The greater readiness with which a good spur may be formed.

6. The convenience to the patient of the site, for purposes of cleanliness and for the adjustment of pads; and

7. Recent statistics seem to indicate that it is the less dangerous operation.

1610 Arch Street.

[1] New York Medical Journal, November, 1892.