MANLEY (T. H.)

DUP.

SURGEON GEN'L'S OFFICE, LIBRARY. 307.

SURGICAL THERAPY OF RECTAL CANCER.

BY

THOMAS H. MANLEY, M.D.

REPRINT FROM

"MERCK'S BULLETIN."

February, 1893.

TO EVERY PHYSICIAN.

Dear Doctor:

Contributions of Original Thought and Experiences, on Medical Topics, are desired by MERCK'S BULLETIN on the following conditions:

1.—Authors of Scientific Papers or Clinical Reports accepted by us will receive—according to their own preference, either:

a:—A number of REPRINTS of their article in neat pamphlet form (pocket size); or,

b:—Instead of the above, an Equivalent value therefor in CASH.

Please state, with each communication, which is preferred; and—if Reprints—how many are desired.

2.—All contributions are understood to be received only on the express understanding:

a:—That they have not been printed anywhere;

b:—That if they have been read anywhere to an audience, this fact be stated in full detail by a note on the manuscript.

Contributors will serve their own interest by heeding the following suggestions:

Write Concisely and Clearly.

What we desire to print, and what medical men like to read, is information, not verbiage. An article will stand better chances of acceptance, of recognition, and of being widely read and copied and discussed in Medical circles and Medical journals, the fewer its words are, in proportion to the facts or ideas it embodies. Of course, a thought too thinly clad must suffer. Use, therefore, cheerfully, as many words as appear needed to convey your meaning,—but no more.

Aim at Fact.

It is not to be expected that every Medical report should be a mere array of statistical data, hospital records, tabulated figures, or graphic summaries; some room must be allowed to theory, or even conjecture, in its proper place; but the true aim of theory should never be left out of sight,—which is, ultimately, to lead to fact; to a rule or result of practice.—And it should be likewise borne in mind that the Medical reader will attach little weight to mere generalizing statements (such as, that a certain remedy or line of treatment has uniformly proved efficacious, etc.);—to be convinced, he wants to see positive evidences recorded in clinical detail of cases: conditions found, course pursued, and results achieved.

Do Not Fear,

however, that a communication you may be inclined to make would be devoid of value because you have but little time to spend on writing it! If your thought be a good one to yourself and for your patients' benefit, it will be equally so to your colleagues and their practice, and will be worth communicating. It need not come in the garb of an elaborate Scientific treatise: a simple "Letter to the Editor" will often be just as acceptable.

Some Rules of Order we should like to have our esteemed Contributors comply with:

Do *not* write on both sides of the sheet.

Write as legibly as you conveniently can (*names* especially so).

Leave a liberal margin on the sheet, or space between the lines. (*Close* writing is not conducive to correct typography; and what you save in writing material has to be expended a thousand-fold by us in eyesight, labor, and expense for printer's corrections.)

Address:—P. O. Box, 2535,
New York City.

Yours, fraternally.
EDITOR "MERCK'S BULLETIN."

SURGICAL THERAPY OF RECTAL CANCER.

BY

THOMAS H. MANLEY, M.D.

REPRINT FROM

"MERCK'S BULLETIN,"

February, 1893.

SURGICAL THERAPY OF RECTAL CANCER.

By THOMAS H. MANLEY, M.D.

THE *New-York Medical Journal* for Nov. 12th contains a contribution from the pen of Dr. C. B. KELSEY, on the choice of operation in rectal cancers; which, emanating from so distinguished a source, must necessarily attract more than ordinary notice. It once more revives the issue which has been again and again discussed in the past, on the question of treatment by palliative or by radical measures, in cases of rectal carcinoma.

Dr. Kelsey is evidently a warm advocate of tentative measures, as against radical intervention; alleging that

. . . . . "In colotomy we do an operation with "scarcely any risk, but with no hope of cure; that "we invariably prolong life, sometimes for several "years; relieve pain, and secure the greatest pos- "sible length of days next to cure, and we lead our "sufferer gently down to the grave. In the one case "[excision] we aim high, and fail; in the other "[colotomy], we are satisfied with less, and accom- "plish more."

This certainly is a most extraordinary statement; which, if amply supported, should forever consign to Hades every sort of operation for carcinomatous obstruction of the lower bowel which involves anything further than tapping the colon above the impediment and establishing an artificial anus. For, if cancer invariably returns ; if resections fail of a temporary or permanent cure; and if an opening into the colon is in itself attended with no danger to life, and always relieves pain and prolongs life,—then there can be no dispute as to which should be selected ; —as, then, indeed, any sort of bowel resection would be an utterly indefensible operation.

There can be no question, however, but this assumption is untenable, and, in general, without warrant. Before, however, squarely meeting the issue and dealing with the premises, point by point, we should have a clear knowledge of the so-called clinical history—or what seems to me should be more appropriately designated

THE NATURAL HISTORY OF CANCER.

With the biological elements all are amply familiar, and it must be conceded that this latter knowledge has in no manner what-

ever thrown any light on treatment. In some respects it has rather been a hindrance. For, more than once, I have seen curable cases of cancer condemned as "beyond relief," simply because the biological examination of shavings taken from these neoplasms revealed an arrangement characteristic of malignant growth.

In a general way, carcinomatous disease must be regarded as an incurable malady. Sir JAMES PAGET, in his work on pathology, after making a most extensive investigation of the subject of cancer, says "that in many phases of cancer it is even yet a question whether or not operations prolong life." And it appears by his tables that in many cases the disease runs a very chronic course; while not a few patients have lost their lives in operations for its extirpation.

CANCER IN DIFFERENT STAGES OF LIFE,

in different regions and anatomical structures, presents widely varying phenomena.

Cancer in young subjects runs an acute course and tends to become rapidly disseminated throughout the system. In middle age its course is not so rapid, nor its tendency to spread so general. In those, in whom senile changes have commenced,—past 50

years,—it pursues a more chronic course and is less disposed to relapse after excision.

There is a most remarkable difference in the tendency to relapse, in the various structures. Cancer on the tongue in the male, and on the genitals of the female, runs a rapidly fatal course ; and hence all operations in these parts are, with few rare exceptions, but palliative measures.

On the contrary, cancer of the lip is practically a curable affection in men ; while, in elderly women, cancer of the mammary gland, largely infiltrated with fibrous tissue, may pursue a painless course for years.

It is almost unnecessary to add that, when cancer is interspersed to a considerable extent with embryonic cellular elements resembling sarcomatous tissue, it is always more acute and deadly in its course than is a hyperplasia, composed chiefly of epithelial cells.

Now, cancer of the rectum, late in life, is composed almost exclusively of tissue of the epithelial and fibrous type, and hence is not so prone to infiltrate as those largely interspersed with sarcomatous elements ; and consequently it pursues a slower, more chronic course.

It will be of importance in all cases to exercise the greatest possible care in diagnosis; —not to confound syphilitic or tuberculous ulceration, fibrous infiltration, hæmorrhage, or simple strictures, with cancer.

I have met with more than one case of old tuberculous excavating ulcer, or syphilitic vegetations, lining the lumen of the rectum with a villous vascular mass, stuffing-up the passage and studding the anus externally; in which I was unable to decide the precise nature of the rectal malady until the case had been under my observation for some time.

Differential Diagnosis of Rectal Cancer.

Although it was my original intention to confine myself to therapy alone, it occurred to me later that it might enhance the interest of the subject and perhaps extend its value, to touch in abstract on the subject of diagnosis; as it may be regarded questionable judgment to proceed with the treatment of a lesion before its precise nature is understood.

Let me say, right here, that the diagnosis of rectal cancer is usually attended with great difficulty,—cancer possessing no known specific element; hence the malignancy of a tissue is rather assumed from the heterogeneous elements present.

The microscope is equally powerless in the identification of syphilis ; and in tuberculous tissues — unless certain germs are present—it sheds not a ray of light. These being the principal pathological lesions encountered in the ano-rectal tract, we must strive to separate the one from the other.

What, then, must be our guide, to lead us into a safe path of diagnosis ? It must be a *physical examination* of the grosser structures, particularly with the senses of sight and touch—combined with what is the most vital of all : *Clinical Symptoms.*

Did the patient under observation—be it man or woman—ever have chancres ?—No matter whether married or single, orthodox or otherwise,—*distrust them all* till you have looked for scars about the genitals, felt their shins, and taken a look into their throats.

Has the patient tuberculous ulcerations with inflammatory hyperplasia ? This is often difficult to answer ; for the reason that these ulcers may be still eating their way through the deeper tissues, while as yet there is no impairment of the general health nor specific organic implications, to indicate their existence.

Has he cancer?—This word has a terrible significance and should never be uttered in the patient's hearing under any circumstances whatever, unless he demands a positive opinion.

My impression is, that many of these cases in the ano-rectal region, doomed as cancer, are not in any sense malignant formations at all; and that, if they had been gently touched with mercury in the beginning, they would have escaped the terrible ravages of untreated syphilis.

The clinical history of rectal cancer is essentially the same as that of cancer in any part of the body. Its most striking characteristics are its *insidiousness* and *painlessness* in its incipiency. A patient will complain that he has an attack of the "piles." He is probably using a pile ointment, when he says that he has a constant sensation as though there were something which he wants to clear out of his bowels, though he has but just left the stool. If the cell-hyperplasia has occupied the vesico-rectal septum, we will notice bladder symptoms, tenesmus, and pain in the back, well marked.

Assuming that the rectum has been properly cocainized, we now prepare for an in-

telligent examination. We search, perchance, for a cancer, and come directly on to a rectal polypus. Or, though we find the passage quite blocked, it is not caused by any *change within it*, but rather by an osteoma, or lipoma, quite outside the rectal wall.

IF CANCER IS PRESENT,

its stony hardness and excessively vascular surface are quite unmistakable. But let us be quite assured that we have cancer to deal with, before any sort of *cutting operation* is for a moment thought-of. Hence—in order to decide the precise character of the affection beyond question or peradventure—let us put our patient under active constitutional treatment, and watch his case daily until no doubt remains.

The most common site of cancerous masses is just within the muco-cutaneous border ; while, with syphilis and tubercular nodules, on the contrary, the lesion is found further up in the rectum. If a successful culture of the tuberculous mass can be made, it will prove a source of relief, and remove all apprehension of cancer in doubtful cases.

In all cases, then, let the examination—both as to hereditary antecedents and the

personal examination—be conducted with great rigor. In nine cases out of ten, a skillfully-instituted oral examination will decide the character of the case before we touch the rectum. The physical examination is valuable in connection with the interrogatory;—of itself, it is not to be absolutely relied-on.

General and Local Medical Treatment.

Many patients will come under the observation of the surgeon, who declare that they have "piles," and wish to be treated accordingly. But they abhor an examination,—sensitive women from modesty, and timid men from fear of pain; and hence, both have bitten at the bait of the charlatan—the "Pile Doctor,"—and have employed every sort of pile ointment; and *at last*, in despair, come to the *regular* practitioner for advice and treatment. As many of the symptoms of hæmorrhoids, syphilis, strumous ulcers, and malignant disease of the rectum, are much alike, something more than a casual examination is required—as above pointed-out—to distinctly differentiate them.

In cases which present unequivocal symptoms of cancer, *we must not despair* of aiding our patients, even in malignant disease,

through constitutional medication. I am firmly convinced, that if a remedy for this fell disease is ever discovered, it must be one which acts through the general system and through the circulation, upon the cells.

Many have such a positive aversion to any sort of operation, that they will consent to it *only* as a relief measure, towards the end, when local extirpation is out of the question. With these (and some other instances), the disease may run for years; hence we must endeavor to keep-up the strength by appropriate tonics, stimulants, and diet; keeping the bowels loose with vegetable laxatives; and using such remedies, locally, as will relieve pain, subdue hæmorrhage, and moderate the associated inflammation.

OF ALL THINGS, WE SHOULD AVOID

the employment, at the seat of the disease, *of every sort of irritant—chemical or mechanical.* In cancerous ulceration of the rectum, any sort of astringent or caustic is to be vigorously condemned,—except, possibly, in the event of hæmorrhage. *Dilatation of a cancerous stricture* is a cruel blunder. Many are the cases of those unfortunate beings, whose later hours have been made wretched and agonizing by the rectal bougie; which, when

employed, only resulted in producing torturing pain,—aggravating the condition it was intended to ameliorate. Whereas, when the rectal bougie is judiciously utilized in *syphilitic or tuberculous* stricture, it is often a valuable aid.

Relative Dangers of Colotomy and Excision.

A laparotomy for enterotomy, with construction of an artificial anus,—it goes without saying,—is always a much simpler and safer operation than an excision of the growth in certain districts of the rectum.

It must be remembered, however, that in the more modern operation, miscalled an "*inguinal colotomy*" (wherein the inguinal region is not touched, but the iliac is the seat of incision), the general cavity of the peritoneum is always opened, and the danger of fæcal leakage into the peritoneum is prevented only by adhesive inflammation produced by performing the operation *à deux fois*. A case has come to my knowledge very recently, in which the patient died within forty-eight hours after the performance of an iliac colotomy by one of our most skillful operators. Iliac colotomy, then, is by no means an operation free from danger to life.

The operation through the lumbar region is no doubt much the safer procedure. But, in either of the two methods, we always have a residuum of fæces in the rectum ; and there is a constant tendency to *eversion* of the mucous membrane, or a rolling-out of the bowel through the incision.

In feeble, delicate subjects ; and in those in whom the growth is very high up in the rectum ; or in those in whom the cancer has infiltrated into the vaginal septum, or into the prostate gland and the base of the bladder,—

COLOTOMY, ALONE, IS THE PERMISSIBLE PROCEDURE

in the vast majority of cases. This gives easy escape of the fæces ; but, unhappily, the cancerous growth remains *untouched.* The operation, however well it may have succeeded, leaves in the mind of the patient still the torturing dread of death from cancer ; and the unceasing pain yet remains. There is no more physical impediment to evacuation ; but that boon, so desirable, has not been attained : "mental rest."

When the cancer is within easy access through the sphincter,

EXCISION IS THE IDEAL OPERATION.

When, however, it is up more than three

inches, or has extensively infiltrated the adjacent tissues,—though it may yet be largely swept away by an operation,—surgical interference is nevertheless attended with so much danger to life, that few surgeons care to undertake it at this stage. *When* the patient does safely survive the operation, he may live for years in the greatest comfort. I am acquainted with a case of the latter description, in which many of the best surgeons in both America and Europe had refused to operate; but a bold young New-York surgeon took the case in hand, removed the neoplasm, and the patient survived thirty-five years after the operation, with no further rectal trouble.

When a cancerous mass develops in such a manner as to leave the sphincter *untouched*, and is not too high—then,

"KRASKE'S OPERATION"

(of coccygeal and sacral resection) is of immense value; for it enables the surgeon to cut-away the growth, preserve the sphincter ani and bring the two divided ends of the intestine together, as in any enterorrhaphy.

The principal steps of Kraske's operation are: *Firstly*,—the *resection* of the caudal extremity of the spinal column,—the entire

coccyx and lower segments of the sacrum. This enables one to readily enter the recto-ischiatic fossa, and manipulate the deeper parts at will. *Secondly*,—to *cut-away* the cancerous mass completely, but spare the anal sphincter. *Thirdly*,—the *approximation* of the proximal end above and the anal sphincter below.

This operation is to be recommended in localized cancers, which have not infiltrated and are low down. The operation, as we might expect, is a bloody one. Eliminating infection,—the loss of blood is the only real danger in operating upon the rectum by this method. (*)

The French have lately recommended "*raclage*" and "*grattage*" for rectal cancer low down,—not as a substitute for resection, but to be employed when there are impediments in the way of total extirpation.

ILIAC AND INGUINAL COLOTOMY

for the relief of rectal cancer are justified on the same surgical principles as are tracheotomy and laryngotomy in malignant stenosis of the upper air-passages. Certainly no one will argue that this breach in the walls of the air-tube is anything more than a *dernier*

* *Mercredi Méd.*, Août 7 1892.

ressort, which makes *no impression on the growth*, and cannot be compared in its results to a laryngectomy or a total extirpation.

At this time of writing, there lies, in my service at the HARLEM HOSPITAL, an unfortunate fellow, suffering from a spontaneous inguinal colotomy, which resulted from a hernia involving the colon, that became strangulated and was mistaken for an abscess. In his present condition, he is a terrible nuisance, not only to himself, but to every one in the ward; for, in spite of every deodorizer which has been employed, the unbearable fæcal stench is something horrible to endure. Perhaps, should he survive, something may be done, by a plastic operation, to enable us to dam-back the fæces and confine them within the normal channel.

The technique of a colotomy may be found in all of our modern text-books on surgery, and hence will not be considered here.(*) DUPLAZ and other French authors recommend

A PRELIMINARY ILIAC COLOTOMY,

in many cases, before we undertake the operation of rectal extirpation;—their theory be-

* *Gazette Hebdomadaire*, Juin 12, 1890

ing that, by directing the fæces through a vent above, the parts at the seat of incision are not exposed to infection or irritation, through the passage of foul fæces over them, until the healing processes are completed. No doubt, this course increases the dangers of operation; but it greatly enhances the prospects of a radical and satisfactory recovery after extirpation. When all healing and repair is complete below, then the breach above is again closed and the fæces allowed to pass through the natural, rectal passage.

THE COMPARATIVE VALUES OF THE DIFFERENT OPERATIONS FOR RECTAL CANCER

—tentative and radical—may be gathered from the published records of various surgeons.

In the LONDON HOSPITAL, from 1872 to 1880, thirteen

COLOTOMIES

for cancer were performed, with 9 deaths. During the same time, says CRIPPS, (*) 26 such operations were performed at GUY'S HOSPITAL, with 11 deaths,—a mortality of about 42 per cent. It does not appear whether this was an

* CRIPPS on Rectal Cancer; Ed. I., p. 212.

operative mortality ; or whether those were simply classified under "mortality," who died before leaving the hospital. ALLINGHAM gives 27 colotomies, with a mortality of 11 per cent.

Cripps says of colotomy, that in some it affords relief from pain ; while in others it has failed to do any good. Of course, in *complete* intestinal obstruction, a colotomy *must* be done.

Of later years, in France, PINAULT, VELPEAU, RÉCAMIER, MASSÉ, CHASSAIGNAC, MAISONNEUVE, and in Germany FREINONZE, NUSSBAUM, and SCHUH, revived the operation of

for cancer ; and in England, PAGET, JORDAN, HOLT, ALLINGHAM, GRAY, and HOLMES, gave it their support.

In Cripps's Jacksonian essay on 36 recorded cases of extirpation—*per-rectum* defæcation became normal in 23 ; could not be retained when fluid in 6, and incontinence continued in only 7.

In all cases it appears that incontinence is the rule immediately after operation ; but, as the wound heals, control is regained. Retention of the fæces, however, *is possible*

in many instances even after the entire sphincter has been cut away.

In another table of Cripps, we find, of 66 recorded cases of extirpation : 44 recovered and 11 died,—a mortality of 17 per cent.

PRÉCHAUD's tables,(*) made up from his own cases and the records of several other operators, give 149 observations on rectal-cancer extirpations, of which there were 103 operative cures (69.13 per cent).

Immediate relapse in		3.
Doubtful result in		7.
Operative Deaths in		36.
69 relapsed after		1 year.
15 " "		2 years.
2 " "		3 "
5 " "		4 "
5 " "		5 "

Hence, from the above, we must assume that, five years after operation, none but six could be accounted-for,—or about 4 *per cent* of all

CHARRON gives us a table of results in 139 cases of colotomy(†). Of these,—

8 were missing and could not be accounted for.
54 died within 2 months.
65 lived from 2 mos. to one year.

* PRÉCHAUD's "Cancer du Rectum," p. 126.

† CHARRON : "Maladies du Rectum," p. 113.

5 lived from 12 mos. to 18 months.

3 lived from 1 year to 2 years.

6 lived 2 years or more.

It would appear from the above table that, in the results as far as prolongation of life is concerned, there is little difference ultimately.

It does not appear from these tables whether those who died, succumbed through a *local* recurrence of the malady,—or as the result of a generalization, or metastasis.

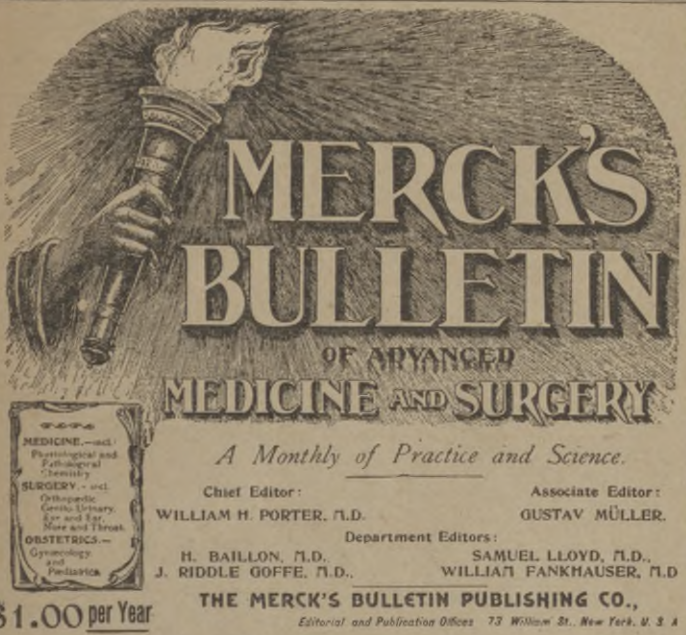
It is a matter of common observation that, when local, superficial epithelial growths are completely swept away by caustics or the knife, the disease most commonly recurs *rather in the internal viscera* than at its original site.

The Question, then, to Determine,

in a given case of cancer, is *not*,—"what operation will eradicate the malady"; for *that* is clearly quite out of the question;—but rather,—"which will afford a temporary cure, and give the patient the greatest amount of *mental quiet* and bodily comfort; so that, when the end comes, it may be painless"; as we know is commonly the case when death is due to cancer of the internal organs.

On the main points which the question involves, modern surgery has made possible a quite general accord of opinion among operators.

302 West 53rd St., New York City.



MERCK'S BULLETIN—a journal by the aid of which the science of medicine is constantly being made more accurately practical at the bed-side, and which continually furnishes to the busy practitioner new and practicable methods of therapeutics by which he can more intelligently and successfully combat diseased processes; while strictly *discountenancing* with equal severity both the empiricism of ignorance, and the quackery of speculation, in its advertising as well as reading columns.