INCONTINENCE FROM ACCUMULATION OF FAECES IN THE RECTUM

BY

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Incontinence of faeces during an illness is a very tiresome feature both to the patient and to the nurses. This incontinence may be due to an accumulation of faeces impacted in the rectum, so large and hard that it is impossible for the patient to pass it. That this is an occasional cause is not, in my experience, generally recognized; fortunately it is one which is readily amenable to treatment. Comparatively recently I have seen four such cases of faecal incontinence which, while presenting the same urgent symptom, have stimulated totally different diagnoses. They appear to be interesting enough to merit a short description.

Case I: Perforated Duodenal Ulcer; Query "Organic Nerve Disease"

A man aged 48 was suffering from general peritonitis and severe abdominal distension three days after the suture of a perforated duodenal ulcer. I was asked to see him because he was *in extremis*. I advised sedatives and heat to the abdomen, continuous gastric lavage and intravenous salines, and no aperients, enemata, or injections. He steadily improved. I saw him again sixteen days later because he was incontinent of faeces; a bad prognosis had been formulated, querying an organic nervous disease as well as a peptic ulcer. A glance at his tranquil countenance, his moist clean tongue, and his equal reacting pupils, with a normal pulse and temperature, tended to negative this suggestion. The abdomen was doughy and soft but not distended, and a finger in the rectum found a hard mass the size of a foetal head; it was too large and firm to pass through the anus. During the course of the next few days this was removed by digital morcellement, with complete recovery.

Case II: An Unusual Case of Acute Intestinal Obstruction

I was called to hospital to see a woman of 37 with an acute intestinal obstruction. She was already in the ward under the care of my physician colleague for indigestion and anaemia. She was now suffering from acute abdominal pain, vomiting, and a distended but not tense abdomen, and had been constipated for the previous four days. Two enemata had been given with but coloured faecal results, and little or no flatus was passed. The diagnosis appeared to be a clear one of mild acute intestinal obstruction. Further, she had developed incontinence of urine in the previous twelve hours. The routine examination of her rectum revealed a mass even larger than a foetal head. The house-physician said he had done a rectal examination and that he didn't know what to make of it—he had never felt anything like it before. Removal of the accumulation with the gloved finger and olive-oil enemata gave complete relief.

Case III: Enlarged Prostate; Retention of Urine; Query Uraemia

A man aged 67 was admitted to hospital with retention of urine from enlargement of the prostate. His bladder was decompressed, suprapubic cystostomy was performed, and he progressed well for three weeks, when my house-surgeon ventured the opinion that uraemia was beginning, for the patient didn't seem so well, had a threatening bedsores, and had become incontinent of faeces. The ward sister stated that the bowels had been opened on alternate days by an enema. An examination of the rectum revealed a mass quite the size, and almost the consistency, of a cricket ball; this was with difficulty removed with the gloved finger, after which continence returned.

Case IV: "Inoperable Carcinoma of the Rectum" with Intractable Pain

I was asked to see an old lady aged 82 who was suffering from chronic intestinal obstruction which had become acute owing to "a huge inoperable carcinoma of the rectum." For two weeks she had been incontinent of faeces and urine, groaning day and night with pain, which was only partially relieved by frequent morphine injections. The relatives were strained to the utmost with the nursing, and the doctor was seriously embarrassed by calls every three to four hours for sedatives, day and night. The question raised was whether an intrathecal injection of absolute alcohol would be of service. The patient was *in extremis*, with a wooden dry tongue and a pulse of 120; and the respirations were shallow and slow. She was vomiting freely, and the problem of her nourishment and nursing was an acute one. A finger in the rectum met with a surprise in the shape of a huge faecal mass which had been mistaken for an inoperable carcinoma of the rectum. It was an enormous aggregation that could be ballotted bimanually; this also explained the urinary incontinence.

It was gradually extracted, together with daily warm olive-oil enemata. A very anxious time followed detoxicating the patient from the large amounts of morphine and hyoscine she had had.

Commentary

These patients illustrate four possible manifestations: after a major gastric operation, raising the question of central nervous disease; acute intestinal obstruction in an obscure case of indigestion; uraemia after retention of urine from an enlarged prostate; and intractable pain from an inoperable carcinoma of the rectum. In two instances, Cases I and III, the rectal examination had been omitted, recalling the aphorism that "if you don't put your finger into the rectum you will put your foot in it." In Cases II and IV a finger had investigated the rectum without the condition being recognized—a *raison d'être* for this note, and suggesting the necessity for educating the finger in rectal pathology by assiduous practice. In these days of slogans the following might prove an apt reminder: "Put your finger into the rectum; you may find a brick in it."

The incontinence takes the form of a continuous discharge of faecal coloured fluid, a mixture of mucus which dissolves faeces from the mass. The mucus is poured out in response to the mechanical irritation of the bowel. It is this discharge which suggests that the bowel lumen is patent and tends to conceal from the observer that extreme constipation is the actual cause.

Treatment

The treatment of the condition is simple, being that of digital removal of the hard faeces, assisted by olive-oil enemata; the rectum is usually clear in two days, but it may take a week before the colon is empty and continence returns. The procedure must be carried out with gentleness, lest the anal canal be lacerated and bleeding or a perianal abscess be thereby excited; for these subjects are usually debilitated, and sepsis starts readily in this area, which is already catarrhally inflamed. For this reason spoons and forceps are never used; only a gentle intelligently directed finger.

The *Annales de la Société Belge de Chirurgie et Journal de Chirurgie* has recently issued a volume containing articles by Dr. Oct. Coquelet on "Surgical Affections of the Lung and the Bronchi," by Dr. Jean Govaerts on "Tumours of the Lung," and by Professor Christophe and Dr. Laduron on "Reparative Surgery of the Peripheral Nerves."