SURVIVAL AFTER OPERATION FOR ANNULAR MALIGNANT DISEASE OF THE LARGE BOWEL.

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The cases here recorded encourage a resort to surgical treatment:

CASE I.—Lived Seven and a Half Years with a Fistula.

A man, aged 78, of powerful physique, seen with Dr. Andrew Elliot and Dr. R. P. Cockburn, had suffered for many months from an increasing intestinal obstruction located in the transverse colon. Operative treatment was recommended, but no guarantee could be given that the formation of a fistula would be avoidable, and nothing was done until a bout of vomiting with increasing abdominal distension seemed likely to terminate in death. During this attack, on June 15th, 1913, I opened the abdomen in the middle line above the umbilicus, and felt an annular constriction of the transverse colon near the splenic flexure. A lateral fistula was made in the presenting portion of the enormously dilated large bowel, which was afterwards identified as ascending colon. Further treatment was considered unwise at that time.

The patient bore the operation well, and recovered satisfactorily with hardly any vascular or other disturbance. From the first he was subject to attacks due to accumulations in the transverse colon which were accompanied by pain, discomfort and high temperature, until an offensive discharge took place through the fistula. Dr. Cockburn kindly informs me that after about four years these attacks began to be associated with escapes of irritating matter, mainly mucus, through the anus, by which small quantities of faeces were passed at intervals to the last. Between the attacks the patient was wonderfully well and able to go out until the end of October, 1920, about which time secondary nodules were discovered, first in the hepatic flexure, and later throughout the abdomen. The patient died on January 6th, 1921, more than seven and a half years after the operation.

It was proposed to short-circuit this patient's ileum into his sigmoid flexure and, if possible, to remove the strictured bowel when he recovered from the fistula formation. Elderly people of strong physique, especially those with powerful hearts, bear operations well, and this patient appeared to be capable of undergoing successfully the necessary interference, but he refused further surgical treatment. His record shows that an annular malignant stricture of the colon may long remain local, and clearly the full advantages which surgery may give were not obtained in this case. After a successful second operation the man might have been quite well now, but such results cannot be secured without risk.

CASE II.—Apparently well 23 Months after Hysterectomy and Proctectomy.

A woman, aged 44, married five years but never pregnant, was sent to the Samaritan Free Hospital under my care by Dr. Reginald Clark. An abdominal tumour apparently existed before her marriage and greatly increased in size in the last few months, during which the patient rapidly lost weight until emaciation, anaemia, and feebleness were extreme. There was no intra-abdominal pain or tenderness, but vaginismus prevented a satisfactory examination. On March 28th, 1919, under anaesthesia, an oval tumour was defined rising to the ribs from low in the pelvis, and so fixed by its size that its origin could not be ascertained. A uterine sound was not used. In the rectum, three inches from the anus, an ulcerating growth completely encircled the bowel, but caused no constriction and little discharge. A piece of this, removed for examination, showed the structure of a carcinoma. The rectum moved freely behind the large tumour, which was thought to be ovarian and probably malignant.

The proper treatment was to operate if the rectal condition had not existed, and the rectal growth, apart from the other, appeared to be removable. The propriety of interference with these doubtful conditions had to be the more seriously considered because of the feeble condition of the patient. She, however, expressed a very strong desire to take any risk on the chance of getting relief from her discomfort and sense of weakness. It was therefore decided to explore the abdomen, the patient being told that if the large tumour could be removed it would be wise to treat the rectum by a second operation later.

First Operation.—On April 1st, 1919, an incision exposed a large fibromyomatous uterus, with its base deeply buried in very oedematous broad ligaments. The oedema seemed to be due to pressure. The whole uterus and the left ovary and tube were removed. Before closing the abdomen the rectal growth was examined and no sign of its extension beyond the bowel was found. The liver also seemed normal. The patient, although somewhat collapsed for a few days, recovered well.

The highest temperature was 100.4° F., the highest pulse 110. The tumour contained many cysts full of degenerating fluid, but no malignant growth was found in it.

Second Operation.—Five weeks later, on May 6th, 1919, the patient's condition being much improved, the abdomen was again opened. After freely separating the rectum from its connexions, an attempt was made to bring the upper end of the divided sigmoid flexure down to be joined to the bowel close to the anus. This was impossible without either undue tension or division of a large vessel which nourished the greater part of the sigmoid. The attempt to make an end-to-end anastomosis had therefore to be abandoned, and the divided upper end of the sigmoid flexure was brought out on the groin as a fistula. After removal of the rectum and the anal mucous membrane down to the external sphincter, the pelvic floor was closed with difficulty, because of the absence of the uterus. The right ovary and tube helped to fill the gap, but a very large cavity remained and was packed with gauze round a drainage tube introduced through the anal wound. The abdominal incision was then closed.

After-history.—The patient was much more feeble after this operation than after the first, and a great deal of discharge escaped from the anal opening, but it gradually ceased. The temperature rose to 103° F. on the third day, the pulse to 120. Both then fell until the fourteenth day, after which they were normal and the patient went home, almost healed, fifty-one days after the second operation. A month later (July, 1919) she weighed 6 st. 7 lb. On December 21st, 1920, she weighed 11 st. 13 lb., and had every appearance of robust health. The pelvic parts were all soft and the fistula acted well.

Dr. W. H. Baker tells me that her condition is still quite satisfactory. Of course, within two years of an operation for cancer a patient's future must be considered uncertain, but the first of these histories shows that a bowel cancer may be localized for a long time. In the second it seemed certain that a wide removal of the disease had been effected, and in any case the result to the patient has already amply justified the operative interference.

THE HOSPITAL TREATMENT OF FRACTURES:

A SUGGESTION FOR CENTRALIZATION.

BY

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In 1908, in an address before the Medical Society of London, on the "After-effects of injuries," the late Mr. Clinton Dent made some statements as to the results of fractures amongst members of the Metropolitan Police Force. These men, who, before their injuries, were physically almost perfect, were treated in various metropolitan hospitals, and Mr. Dent, as consulting surgeon to the police, had to pass judgement on the final result and estimate the functional recovery. He stated that the results were much less favourable than was generally imagined, and he made a strong plea for the better care of fractures. He particularly pleaded that early fixation in plaster-of-Paris for a period judged to be long enough to ensure sound union should not be adopted as a routine line of treatment. He found that, after fractures of the lower limb, 30 per cent. failed permanently to get full functional recovery, and very few had fully recovered in six months from the time of the injury. It is probable that this figure represents fairly accurately the state of affairs to-day.

In 1908, and since that time, the fractures admitted to most of our general hospitals went to the wards which happened to be receiving urgent cases, quite regardless of whether the surgeon in charge of those wards had any special interest in the treatment of fractures or not. In most busy general surgical units a serious fracture is not looked upon as a welcome visitor. It is a case which is certain to hold up a bed for a long period, and which will interfere with the admission of more interesting general surgical cases. In the present state of busy wards and long waiting lists, it becomes almost the first business, therefore, to get the fractures disposed of as quickly as possible. Two chief methods offer themselves: First, transfer to a Poor Law hospital with its multitudinous beds, or, secondly, discharge to the patient's home after fixation on some form of splint which cannot be interfered with, such as plaster-of-Paris.

When one remembers that an inferior result after a fracture of the lower extremity may permanently reduce