A CASE OF CHRONIC MEMBRANOUS COLITIS OF OVER TEN YEARS' DURATION CURED BY RIGHT INGUINAL COLOTOMY AND SUBSEQUENT CLOSURE OF THE ARTIFICIAL ANUS.*

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Cases in which membranous colitis has been treated by colotomy are sufficiently rare to induce me to record the following. It was only while looking up the literature of the subject for this purpose that I discovered I was not the first to carry out this treatment:

Mrs. B., aged 47, was sent to me on January 11th, 1897, by Dr. Edgeworth of Bristol. She stated that in November, 1885, hysterectomy was performed by the late Mr. Greig Smith. From this operation she made a good recovery, but some three months later she began to suffer from intestinal trouble, which took the form of frequent attacks of diarrhoea, with great pain in the large intestine and the passage of mucus. As time went on she became worse. Large mucous casts were passed, and pain became severe and almost constant, aggravated at times by distension of the abdomen. Troublesome constipation alternated with diarrhoea, which was excessive and of a most offensive character, whilst vomiting was frequent. She became a chronic invalid, and was generally in bed and constantly under medical treatment; but none of the many remedies tried had any permanent effect. Then the diarrhoea and sickness became more constant; no food of any kind could be retained, and she required to be fed by nutrient enemata, whilst the pain was so intense that nothing but injections of morphia gave her relief.

I may supplement this description with Dr. Edgeworth's notes: "Sometimes she would be constipated, with scybalous motions; then diarrhoea would come on—often very acute—with jelly-like motions, shreds and casts of the intestines. Under treatment and strict dieting she would get a little better, the improvement perhaps lasting for two or three months, after which the old symptoms would return. At last nothing seemed to control the mucous diarrhoea, and this was accompanied by severe vomiting, which was only relieved by hypodermic injections of morphia." She lost her appetite and rapidly wasted, becoming weak and anæmic." As will be gathered from the foregoing, her condition when she came under my care was deplorable, and the journey from Bristol was accomplished with the greatest difficulty, although she was accompanied by her medical man. She was much emaciated, and worn out with pain, sickness, and diarrhoea. Before leaving Bristol she had again to see Mr. Greig Smith, who advised right inguinal colotomy. I concurred in his opinion, and decided to carry out this procedure without delay.

Operation.—On January 17th, 1897, the abdomen was opened in the right inguinal region with the usual incision; the peritoneum was caught up and fixed with a few stitches to the edges of the skin. The cæcum was sought for, and after a little difficulty pulled up into the incision. The mesentery was perforated about half an inch from its attachment to the bowel and a glass rod passed through, long enough to rest on each side of the wound and support the intestine in the centre. By a few stitches which passed through only the peritoneal and muscular coats, the bowel was fixed to the skin and the extremities of the wound were brought together with silk-worm gut sutures. The wound was dressed and the bowel protected by a high collar of iodoform gauze, which surrounded the bowel and carried off any pressure, a large pad of gauze was then placed over this circular dressing, and the whole retained by broad bands of plaster interlacing over it. The bowel was opened on the eighth day with Paquelin's thermo-cautery and its contents evacuated, a good spur was formed.

After-History.—The immediate results of the operation were very satisfactory. The pain all disappeared and the rectal discharges ceased, the bowels acting regularly through the artificial anus. The patient began to eat well, putting on flesh and gaining strength, and later on she had some natural evacuations by the rectum.

Closure of Artificial Anus.—Nearly seven months after the operation I closed the artificial anus in the following manner: August 8th, 1897. Two incisions were made in the parietes, with the fistula as a centre, down to the subperitoneal areolar tissue. Their direction was oblique in order to avoid division of the fibres of the external oblique muscle and aponeurosis. The incision came up to but did not pass through the fistula. The fistula with the cicatricial tissue surrounding it was bodily removed.

The parietal incision went down to the subperitoneal areolar and fatty tissue, but did not go through it. Then with finger and scissors the parietal peritoneum with its fat was detached from the muscle all round the fistula for a distance of about 2 inches. When the separation was completed the fistulous tract was removed down to the gut. The bowel remained attached to the parietal peritoneum by adhesions around the fistulous opening. The bowel with its attached peritoneum was now lifted out through the incision in the parietes. The opening in the gut was then closed by infolding of the raw areolar surfaces around the fistula and sutured by Lembert's method. The line of closure was transverse in order to increase the calibre of the contracted gut. The sutured gut and peritoneum were now dropped inside and the parietal wound was closed over by silk-worm-gut sutures in the ordinary way. A small drainage tube was inserted for a few days. The wound healed well, but owing to a severe attack of vomiting partially reopened. This necessitated a further operation, which was performed on November 7th, 1897.

Present Condition.—The final result was all that could be desired, union was complete, and the wound healed firmly. The present condition will be sufficiently gathered from the two following extracts:—

(a) Extract from a letter to me from the patient some time later: "I am

* Read before the Do. set and West Hart's Branch.

now in good health, entirely free from pain, can eat and sleep well, and have a good natural action of the bowels daily without inconvenience of any kind, and am in every respect in better health than I have been at any time during the last fifteen years of bad suffering."

(b) Extract from a letter from Dr. Edgeworth to me, February 8th, 1898. "She appears now to be quite well, with regular motions, no pain, good appetite, and gaining flesh rapidly. I feel sure that if this operation had not been done she would have quickly succumbed."

REMARKS.

It might seem on first thoughts that colotomy was a somewhat heroic measure to adopt for the treatment of membranous colitis; but when we consider that a case may go on for many years with a gradual deterioration of health, and obstinately defy all medical measures, it will be realised that the condition is a serious one and justifies a serious procedure for its cure. Moreover, the treatment is in entire accord with the well-established surgical principle of physiological rest for diseased structures, and one is inclined rather to wonder that it has not been tried more frequently. It was under the influence of such considerations, with the sanction of so high an authority as the late Mr. Greig Smith that I was induced to try colotomy in this case.

Passing on to the consideration of other cases similarly treated, I may refer to a paper by Dr. Hale White and Mr. Golding Bird in the *Transactions of the Clinical Society*, vol. xxix, 1896, pp. 45-50. An abstract will be found in the *BRITISH MEDICAL JOURNAL*, 1895, ii, p. 1559. This case had a history of ten years' duration, in which all kinds of drugs had been tried in vain. Right colotomy was performed, and five weeks later, as all the original symptoms had disappeared, the colotomy wound was closed. The general health and strength improved and two and a half months after the operation she went into the country. She died two months later. In the discussion following the paper, Dr. Adeney, of Tunbridge Wells, completed the clinical history and said that her final illness presented the symptoms of acute suppurative general peritonitis, due apparently to the rupture of something in the pelvis, possibly a suppurating gland.

No *post-mortem* examination could be obtained, but it would appear that the cause of death was quite independent of the operation. In this same discussion Mr. Godlee and Dr. Turney each mentioned a case in which colotomy had been performed for dysentery, Mr. Ballance being the operator in the latter case. Mr. Goodlee's patient eventually died of a return of phlebitis, from which she had previously suffered, while Dr. Turney's case proved fatal from hypostatic pneumonia a week after the operation. These last two cases were operated upon on the same principle of securing rest for the diseased structures, but the condition was different from one of membranous colitis, so that the case of Dr. White and Mr. Golding-Bird remains the only one that I have been able to find a record of, besides my own case.

It will be observed that whilst Mr. Golding-Bird closed the colotomy wound five weeks after the first operation, the interval in my case was nearly seven months. I think the longer interval is desirable, in order to avoid any chance of recrudescence of the old trouble by the too early irritation of the colon by fæces and by distension of this part of the bowel by fæces or flatus. I cannot, of course, say whether to this longer interval is due the fortunate result in my case.

I need not enter into the pathology of membranous colitis, since the condition is a very obscure one. That it is associated in many cases with a pericolic abscess seems well established, and, as Dr. Herringham remarked, a German author had proposed to name the condition "pericolitis sinistra," asserting that it was as common as suppuration of the appendix. Membranous colitis must be distinguished from "mucous colitis," in which the mucous membrane remains unaffected and the casts are structureless and composed entirely of mucus; in these cases there is no hæmorrhage. But in membranous colitis the casts are mixed with pus, and contain a certain number of leucocytes; diarrhoea is a marked feature, and hæmorrhage often occurs when ulceration is present. Again, both these conditions must be distinguished from dysenteric casts, which are practically sloughs, and invariably accompanied by hæmorrhage.

NOTE.

¹ The description of this operation is taken almost word for word from Greig Smith's work on *Abdominal Surgery*, under "Operations for Artificial Anus"; this being the method that was closely followed.