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ADDENBROOKE'S HOSPITAL, CAMBRIDGE.

THREE CASES OF STRICTURE OF THE RECTUM TREATED BY INCISION.

By GEORGE MURRAY HUMPHRY, Esq., Surgeon to the Hospital.

CASE I. W. H., aged 30, a healthy looking man, was admitted Dec. 17th, 1852, with the usual symptoms of stricture of the rectum. Of these the chief was great difficulty in passing motions, which were never larger than a tobacco-pipe. Sometimes they were loose; at others, nothing passed without the aid of medicine. The stricture was situated about two inches from the anus, with a sharply defined edge encircling a narrow orifice that would not admit the tip of the finger. Several warty excrescences surrounded the verge. There was a fistulous opening in the perinæum, discharging feculent matter; and the presence of the same matter in the urine, with dirty purulent discharge from the urethra and pain in making water, proved that a communication existed between that canal and the rectum.

He said that, about seven years ago, when serving as a soldier in India, he had an attack of dysentery. Shortly after his recovery, he was troubled with "piles". A difficulty in passing the motions soon followed, and increased till a twelvemonth ago, since which it had continued about the same. The piles were cut in 1848, which, he thought, aggravated his symptoms. He stated that he never had syphilis.

For some weeks I persevered with the cautious use of the bougie; but, making little or no progress, I determined to divide the stricture with the knife. Accordingly, having passed my left forefinger through the narrow orifice, I introduced a blunt-ended bistoury upon it, and freely divided the stricture and adjacent wall of the rectum on one side, including the sphincter ani. This was followed by very great relief. He was soon able to pass the motions with ease, and continued so much better that, in the latter part of February, he was discharged for a time, at his request. In April he returned, stating that he was still able to pass motions without difficulty or pain; but the fistula in the perinæum remained, and there was still a brownish discharge from the urethra. Accordingly, I laid open the fistula into the bowel. In June he had nearly reacquired the complete control over the sphincter; though, when the motions were loose, they sometimes escaped. He had no difficulty in passing the evacuations, and the discharge from the urethra had ceased. Still there was some contraction of the bowel in the situation of the stricture.

I have not been able to hear any more of this patient.

CASE II. A stout woman, aged 35 years, admitted in January 1855. She had syphilis ten or twelve years ago, and suffered from pain and difficulty in defecation, with discharge from the anus, for eight or nine years. About three years ago, a gathering formed, burst beside the bowel, and left a fistula. Others had subsequently formed and burst. There were several integumental excrescences about the anus. The finger found the lower part of the

bowel uneven and indurated, and encountered a tight stricture about two inches and a half above the anus. The left side of the buttock was indurated; and there were three fistulous orifices; one, four inches behind the anus, through which the probe entered the bowel a little above the external sphincter; a second, three inches to the side of the anus; and a third, more in front. The probe introduced into these did not enter the bowel.

Jan. 27th. When the patient was under the influence of chloroform, I laid open all the fistulae, tracing their course with the probe as I cut along, to be sure of following them out. Two entered the bowel below the stricture; the third was continued up alongside the stricture. As I could trace it no further, I pressed my finger through the stricture; and, pushing the bistoury alongside it in the ischio-rectal fossa, from the termination of the fistulous track, completely divided the stricture, and laid open the bowel in its lower three or four inches. The incisions requisite to effect all this were very extensive. One vessel bled freely, and was secured by a ligature. A slight attack of erysipelas followed. It did not last long, or extend far. When it had nearly subsided, I introduced my finger, and, finding the passage quite clear, inserted a small speculum vaginae, securing it there for twenty-four hours by a bandage. Two days afterwards, I passed a large rectum bougie into the colon. No other treatment was adopted, except the occasional introduction of the bougie by herself. Gradually the wounds healed; she acquired the power of retaining the motions, and has not from the time of the operation experienced any difficulty in passing them. She reported herself quite well when I saw her about a month ago.

CASE III. S. H., aged 35 years, a delicate woman, admitted in July 1855, had suffered six or seven years from stricture of the rectum, which had gradually become worse, in spite of the ordinary treatment resorted to on several occasions. Each introduction of the bougie was followed by so great an increase of irritation, that its use was discontinued, and she derived more benefit from cold water clysters than from any other means. Her distress from discharge, frequent worrying action of the bowels, and straining to void the motions, was so great, that she was quite incapacitated for work, and obliged to live by herself. The aperture of the anus was granulated; the lower part of the bowel rather indurated; and the stricture, about two inches above the anus, was so tight, that I could scarcely find the orifice. Encouraged by the case last narrated, I passed my finger through the stricture, when she was under the influence of chloroform, and, guiding a bistoury upon it, cut through the stricture. I endeavoured to insert a tube into the bowel, but relinquished the attempt on finding that it had a tendency to pass into the exposed cellular tissue, where the stricture had been divided, instead of continuing its course in the bowel. Unfortunately, the bowels continued in a highly irritable state, and the frequent passage of the motions caused much pain and purulent discharge. These symptoms were combated, to a certain extent, with opium; but the case did not go on so satisfactorily as I could wish. I made no attempts to pass bougies after the operation, because the introduction of my finger, on one occasion, increased her pain for some days. She gradually recovered; and though she still suffers a good deal from slimy discharge and irritation, consequent on a diseased state of the lower bowels, she is able to pass the motions with much less difficulty.

REMARKS. I was induced to resort to the operation in these

cases because of the very indifferent success which has attended the treatment of strictures of the rectum by bougies, in my own hands, and, I may add, in the hands of those whose practice I have had an opportunity of observing. I was further encouraged by the reflections on the contractile properties of cicatrices, conveyed in the report on the division of strictures of the urethra, in the last number of the JOURNAL. The result of the proceeding is certainly such as to encourage me to its repetition. In Case II, which was a very bad one, the stricture being tight, of long standing, and complicated with numerous and extensive fistulous tracks, the cure appears to have been complete. In the other cases, although the result was not so entirely satisfactory, the passage of the motions was rendered more easy than it had been before the operation.

The experience derived from these three cases suggests the following hints for the future, when it is proposed to resort to the operation. First, having secured, if possible, the complete evacuation of the bowels by means of aperients and clysters, to prevent their action for some days afterwards by the administration of opium. Secondly, to make a free division of the sphincter ani as well as of the stricture. I think it would have been better in case III if this had been done. Thirdly, to endeavour to insert a tube into the bowel after the division of the stricture. The small-sized, tubular, vaginal speculum, expanding at one end in a funnel-like manner, which was used in case II, answered very well. It was confined by a bandage, and a cork, removable at pleasure, supplied the office of the sphincter. There will be less difficulty in placing and retaining the tube, if the sphincter have been divided. In case III, where that had not been done, the extremity of the instrument would, if pressed on, have run into the cellular tissue, external to the rectum. I need scarcely say that care must always be required to prevent this occurrence.

All the simple, that is, non-malignant strictures of the rectum that I have met with, have occupied the same position as in these cases; namely, two or three inches above the anus; and all, with the exception of the first of the cases here given, have been in females. Often the disease was traceable to some vaginal irritation, which, in several instances, was dependent upon gonorrhœa or syphilis.

ROYAL FREE HOSPITAL.

ULCER OF THE STOMACH, COMPLICATED WITH AMENORRHŒA, TREATED SUCCESSFULLY.

By WILLIAM BRINTON, M.D., Physician to the Hospital.

CASE. E. D., an unmarried female servant, aged 19, was admitted as an out-patient of the Royal Free Hospital on the 11th of May, 1855. She had always enjoyed excellent health until about nine months prior to the above date. Her menses commenced at the age of 16, and occurred regularly up to this time, or during about two years. Towards the end of July 1854, the present illness began, by a violent attack of symptoms, which were regarded as due to indigestion. These symptoms consisted of severe pain in the epigastrium, which came on immediately after eating, and, if not interrupted by vomiting, lasted about an hour and a half: and vomiting, which expelled the food previously taken, sometimes with a small quantity of blood, that was rarely more than enough to streak the other substances present. After a short time, the appearance of blood in the matters vomited became less frequent. The vomiting also diminished in frequency; but it was never absent for any considerable period since: and, when absent, it was generally replaced by more or less nausea. The pain also remained, with scarcely any remissions, except such as are procured by an almost complete abstinence from food. Latterly, indeed, both these symptoms had resumed their original frequency and se-

verity, so that almost every meal was followed by severe pain, which only terminated when the food had been rejected from the stomach.

The first access of pain occurred in what should have been an interval of two menstruations; but it was followed by complete amenorrhœa. This had not lasted long before the patient's friends noticed her altered appearance: she became somewhat thinner; and her complexion, naturally ruddy and fresh, acquired a marked pallor. Both the amenorrhœa and the pallor have continued up to the time of admission. The periods corresponding to those of the previous catamenia were not marked by greater severity of the gastric symptoms.

On examining the abdomen, the greatest intensity of the pain was referred to a place in the median line, about two inches below the apex of the ensiform cartilage. Around this as a centre, there was an exceedingly sore and tender spot, of circular shape, and about two inches in diameter. The tenderness was almost limited to this region. But from the periphery of this circle the pain extended, indistinctly, into both hypochondria, at the time of the paroxysm; and often ended by reaching downwards nearly to the umbilicus—an extension which was stated by the patient to be attended with a feeling of tumefaction in the front of the belly. There was a moderate amount of pain in the interscapular region of the spine, at about the level of the tenth dorsal vertebra. This she could distinguish from the lumbar pain that had sometimes preceded menstruation, prior to the present illness. Her decubitus was on the left side; and lying on the right side brought on severe pain in the left margin of the epigastric region just described; soon, however, alleviated by turning so as to bring the left side undermost. The bowels were generally constipated; the appetite capricious, though sometimes very voracious.

The only difference which I could detect between her aspect and that of an ordinary case of chlorosis consisted in the pallor being devoid of that green tinge which names the latter disease; and in the shortness of respiration on exertion being perhaps less marked, as well as the first sound of the heart less affected. But all these peculiarities would have been so readily explained as due to a minor degree of this cachexia, that, in the absence of the gastric symptoms, I should doubtless have looked upon the case as a fair example of chlorosis in moderate intensity.

DIAGNOSIS. The above symptoms, taken in conjunction with the account which the patient gave of herself, afforded fair grounds for the conclusion that she was suffering from an ulcer of the stomach. The character of the pain, the frequency and severity of the vomiting, the hæmorrhage which accompanied their access, and the amenorrhœa and pallor they had produced, left little doubt that such a lesion was present.

There was nothing, however, to justify any conjecture as to the situation of the ulcer. From its duration, it might perhaps be guessed that the lesion could hardly be low down on the anterior surface of the organ, where adhesions are rarely strong enough to form any efficient protection against perforation. But as there are records of instances in which an ulcer in this wall of the stomach appears to have lasted nearly as long as the nine months just specified, before finally penetrating the peritoneal coat of the organ, we cannot lay much stress on so feeble an argument. Taken in conjunction with the decubitus, and the rapidity with which the pain followed a meal, it can at most afford us a vague presumption that the ulcer was placed near the lesser curvature, and the cardiac aperture, of the organ. Such a presumption is so far confirmed by the numerical results of the necropsy of the ulcer* as that the lesion is very frequently placed in this situation.

A far more important point, however, suggested itself with reference to the supposed lesion. The age of the patient, and the disorder of menstruation which accompanied the gastric symptoms, fully entitled me to suspect that the

* See the author's essay, "On the Gastric Ulcer". (British and Foreign Medico-Chirurgical Review, January 1856, p. 172.)