A DEMONSTRATION ON ANAL FISSURE OR ULCER

In the Out-Patient Department St. Bartholomew's Hospital.

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GENTLEMEN,—As we have now finished seeing our out-patients, I will take the opportunity of briefly referring to the two rectal cases we have examined, for they afford excellent examples of one of the commonest forms of rectal trouble, namely, anal ulcer or fissure.

When a patient complains of rectal disorder, it is possible by a few selected questions to form a fairly accurate view as to the nature of the trouble. Of course a positive diagnosis can only be arrived at after a careful and thorough examination of the part. In calling your attention to the questions that I asked the patient, you must not for a moment be led into the error of supposing that it would be right to treat any rectal disorder unless the diagnosis had been confirmed by a physical examination. Patients with rectal disease nearly always assert that they are suffering from piles, and unfortunately no inconsiderable number, who from a false modesty have objected to an examination, have been taken at their word, and treated for supposed hæmorrhoids, when in reality they had nothing of the kind, but were suffering from ulceration, polypus, or even cancer. The following are the chief questions which, before making an examination, the patients may be asked with advantage:

1. How frequently do you go to the closet?
2. Do you pass any discharge from the bowel, and what does it look like?
3. Do you have any pain, and does it come on immediately after passing a motion?
4. Does any part of the body come down at stool?
5. Do you pass any blood?
6. Is the pan ever sprinkled or splashed with blood as if it had come out in a fine jet?

The foregoing questions have the following significance: If patients say they have frequent calls to the closet extending over some months you will almost certainly find (if the trouble originates in the rectum) there is either ulceration, cancer, or stricture. On the other hand, if they complain of constipation or do not go to the closet more than once a day you may be pretty sure that none of these diseases are present. It is a common error for students to consider constipation as a symptom of stricture. In reality it is just the reverse, and patients with stricture nearly always complain of diarrhoea. If a discharge is complained of it is necessary to ask whether this comes from the interior of the bowel on going to the closet or whether it comes from the outside, as evidenced by stains on the linen. If from the inside and clear, like the white of an egg, it may be mucus from internal prolapse or piles. If the quantity is considerable, a villous growth or polypus may be suspected. If the discharge from the bowel is purulent or has a coffee-ground appearance there is possibly internal ulceration, fibrous stricture, or cancer. Discharge originating external to the bowel and staining the linen generally comes from fistula. When part of the body comes down at stool it will be either prolapse, internal piles, or polypus. Bleeding is common to almost all forms of rectal disorder, but there is one particular form of bleeding which is almost characteristic. If the pan is sprinkled with blood, whatever else may be the matter with the patient, internal piles are almost certainly present.

PAIN.

Any disease situated about the anus or the last inch of the rectum gives rise to pain, whereas extensive ulceration or cancer situated above the internal sphincter may be almost painless. There is a particular form of pain, however, which is of peculiar interest as regards the subject we are discussing, and when present is most suggestive. Let us consider the answer which the first of the two patients gave to this question. The pain was what brought him to the hospital. He says that for some months every time on passing a motion

he has severe pain, sometimes this starts whilst he is actually passing a motion, though more commonly it does not come on for half a minute or so afterwards. At times he describes it as positive agony, making him break out into sweat, sometimes it only lasts a minute or two, at others it may be half an hour or more before it goes; when it is gone he feels fairly comfortable till the next motion, when the whole phenomenon is repeated. A motion is so dreaded from the pain it causes that he often abstains from passing motions for days together.

The second case was a woman. Her general description of her symptoms was very much the same as in the first case, though in a less degree. The pain was described as of a burning nature, though occasionally pretty sharp, was often comparatively slight, and sometimes for a week or two she would have no pain at all.

From the description that these patients gave us of their condition it was almost certain that they were suffering from anal ulcer, and such after examination has proved to be the case. These ulcers may be situated in any part of the anal circumference, but in 9 cases out of 10 they are in the middle line behind. They are never very large, being seldom bigger than half the size of a threepenny piece, and are placed so that half their circumference is on the mucous membrane and half on the muco-cutaneous surface. They vary in depth, the recent ones extending only just through the superficial membrane. In the older ones the submucous tissue is destroyed, so that the fibres of the external sphincter muscle are visible at the base of the ulcer. Sometimes on examination in place of an ulcer a little hole may be seen, and on passing a probe into this it will be found that the muco-cutaneous surface is detached over a little space, the ulcer being covered in as it were by the surface tissue. These cases are of the utmost importance, for the little orifice leading to the submucous ulcer is readily overlooked, and I have seen many cases where, on account of this, the patient has been told that there is nothing wrong with the part. The way to examine a patient with symptoms of fissure is to get them to the edge of a couch in a good light, and then, telling the patient to strain down, the anal folds should be gently drawn apart with the fingers. The lesion then can be clearly seen; generally, just external to the site of the ulcer, will be found a little rose-coloured oedematous fold of skin. On no account should the finger be passed at the time of the mere examination. The sphincter spasmodically contracts, and exquisite pain is caused. If there is any suspicion of disease higher up the bowel, it should be examined under an anæsthetic at the time of operating on the fissure.

If a patient has the characteristic pain caused by anal ulcer, and yet nothing can be seen at an ordinary examination, the patient should not be pronounced free from disease till a second complete examination under ether has been made.

TREATMENT.

This may be considered as palliative and operative.

Palliative.—If the case has been of comparatively recent origin, if muscular fibres are not exposed, and there is no undermined muco-cutaneous surface or sinus present, there is a fair chance of a cure being effected by simple remedies. The motions must be kept soft by a laxative; a teaspoonful of the conffection of senna early every morning is effective. Capsules of 15 to 30 drops of the fluid extract of cascara sagrada may be taken at bedtime, or the following dinner pill: Pil. col. co., gr. x; pil. rhei. co., gr. xx; mix, and divide into six pills, one to be taken at dinner time. The anus should be gently washed with soap and water night and morning, and on no account should paper be used in the closet, the part being cleaned with a sponge or cotton wool and water. Two ointments may be prescribed; the one a soothing ointment to be applied five minutes before the motion is passed, the other an astringent ointment to be used at night. It is better for the patient to apply this with his finger than by any form of ointment introducer, for the ulcer is just at the orifice, and if the patient strains down it can be effectually applied. Six grains of morphine to an ounce of unguentum petrolii is a good soothing ointment; for an astringent ointment subsulphate of iron, 10 grains to an ounce may be used, or tannic acid in the proportion of 20 grains to the ounce. Another ointment I have seen occasion-

ally effectual is 15 drops of carbolic acid, 10 grains of powdered camphor to the ounce of simple ointment or unguentum petrolii.

Operative.—Palliative treatment may have failed, or the case from the first may be one better treated by operation. If the ulcer is of old standing and the muscular fibres exposed, or if the edges be undermined or a sinus present, palliative treatment is mere waste of time, for by an operation properly performed the patient may be cured. It should be done as follows: At bedtime two days preceding that of operation the patient should take two pills (pil. col. co. gr. iv, pil. rhei. 10 gr. vi, mix and divide into two pills); this will ensure the bowels being well opened the day before the operation. On the morning of the operation, and an hour before its performance, the bowels should be washed out by an injection of a pint of hot water. The patient being under ether in the lithotomy position, the sphincter is gently dilated. The ulcer is now thoroughly examined with a fine probe to see if any fistulous tract exists, and the extent to which the edges may be undermined. If a sinus exists it must be laid open; if there is no sinus, or if present after it has been divided, a speculum is introduced into the rectum. The surface of the ulcer is then divided in the middle by a clean cut. The incision should commence on the mucous membrane half an inch above the ulcer, and end on the skin half an inch or a little more below it. The depth should be such as partly to divide the external sphincter, and to accomplish this it would have to be at least a third of an inch in depth in the middle. It is quite true that in many cases a more superficial incision will suffice, but as superficial incisions are often insufficient, it is better to make a bolder one at once. Moreover, the depth of the wound makes little difference in the time taken in its healing. After the incision has been made, a narrow strip should be cut with a pair of scissors off the two edges, which will otherwise overlap and interfere with the healing. A strip of lint smeared with eucalyptus ointment laid in the cut, and covered with a pad of aseptic cotton wool, completes the operation. For a fortnight the patient should be kept in the recumbent position, and as in all other rectal operations, the wound should be thoroughly washed and redressed night and morning. A dose of castor oil is given to open the bowels on the fifth day, and after this a mild laxative every alternate evening. When the patient is allowed to get up, it will do him no harm to walk about a bit, but he should sit as little as possible till the wound is completely healed. Nothing retards the healing of a rectal wound so much as the congestion produced by long sitting.

Gentlemen, no doubt you will think that the operation and subsequent treatment is rather elaborate for so small a lesion as an anal ulcer. It is quite true that many of these cases are cured by caustics, slight scarification of the surface, or simple dilatation; but if you wish to do the best for the patient and yourself by making a certainty of the cure, let me advise you to try no half measures, but perform a carefully-planned operation, as otherwise you will certainly from time to time have a percentage of failures.

CELIOTOMY FOR VOLVULUS OF THE SIGMOID IN A MAN AGED 85: INTESTINAL DRAINAGE: RECOVERY.

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THIS case seems worthy of a short notice from the great age of the patient. In recording the case the opportunity is taken of giving a short description of the method of intestinal drainage which is believed to be most suitable in such cases.

The patient was under the care of Mr. Charles E. S. Flemming, of Freshford, Somerset; operation was performed on January 30th, 1895. There had been complete obstruction for a week. The symptoms were of the usual

character, and need not be detailed. The abdomen was distended to its utmost capacity, the parietes being hard and drum-like. There was a small umbilical hernia, which was very tender but not tense. The diagnosis was made of volvulus of the sigmoid flexure of the colon, but the presence of the umbilical hernia was recognised as a possible *vera causa*, and the parietal incision was made to enter the umbilical opening and to extend for 2 inches below it. Anæsthesia with the patient's stomach full of fluid was not free from risk, but Mr. Terry, of Bath, skilfully succeeded in establishing and keeping up without mishap complete unconsciousness with chloroform.

The umbilical hernia was only omental, and was easily detached. The fingers easily reached the sigmoid, which was enormously distended, and seemed to fill the whole pelvis and much of the lower abdomen. A fold was pinched up, pulled through the wound, and incised, when enormous quantities of gas escaped. The whole of the involved gut, as soon as it was small enough, was delivered through the wound, when the twist was at once manifest. There was one complete twist, perhaps a little more; the gut was only slightly inflamed at the seat of twisting, completely collapsed, and almost cord-like below, and ballooned up to great size immediately above it. The untwisted gut was further emptied, and replaced in the abdomen. As the abdomen was still greatly distended, it was decided to fix and drain the bowel for a few days.

The arrangements for drainage were made as follows. A piece of rubber tubing, about two feet long, and of the calibre of a crowquill was introduced, stretched over the point of a probe, through the small opening already made in the gut; this it fitted tightly, putting it on the stretch. Then a safety pin was made to transfix the peritoneal and muscular coats of the bowel by the side of the tube, and to pass through the side of the rubber tubing. This pin served to keep the tubing and gut attached, and, when the dressing was arranged, to prevent indrawing or extrusion of the gut. The peritoneum was not drawn forwards. Sutures were placed closely above and below the drainage opening, which were not to be tied till the gut was returned inside. Rolls of boric lint were placed around the gut under the pin, and one roll above it (Fig. 1). Over all was placed a broad strip of strapping carried round the back and split in front so as to interdigitate. This strapping effectually keeps the parts at rest, and prevents any chance of extrusion of the bowels (Fig. 2). The free end of the tubing was placed in a bottle which lay by the side of the patient.

Fig. 1.—Diagram to show method of draining the intestine. B, bowel; M, mesentery; r, rubber tubing; p, peritoneum pulled outwards. 1. Strapping; 2, pin holding tube. On the right (x) an enlarged drawing shows the details of fixation. 3. Dressing.