THE SURGERY OF THE RECTUM

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The Surgery of the rectum by Henry Smith

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HENRY SMITH

THE SURGERY OF THE RECTUM

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SURGERY OF THE RECTUM.

BY

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SURGEON TO KING'S COLLEGE HOSPITAL; LATE PRESIDENT OF THE MEDICAL SOCIETY OF LONDON.

FIRST AMERICAN FROM THE FOURTH ENGLISH EDITION.

WITH ADDITIONS.

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TO

JOHN GAY, F.R.C.S

SURGEON TO THE GREAT NORTHERN HOSPITAL.

THE FOLLOWING PAGES ARE INSCRIBED,

AS

A Slight Tribute of Regard for Him

AS

A MAN AND A SURGEON,

BY HIS AFFECTIONATE FRIEND,

THE AUTHOR.

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PREFACE TO THE AMERICAN EDITION.

IN presenting to the profession, in a popular form, these lectures of a distinguished surgeon, it has been thought conducive to clearness to preface them by a few general remarks on rectal disease, and to describe briefly some of the instruments employed in facilitating examination and in operative treatment. To make the work more complete, a chapter has been added on "Pruritis Ani" and "Neuralgia of the Rectum."

PREFACE TO THE FOURTH EDITION.

IT will be seen that, in preparing a Fourth Edition of this work, I have mainly adhered to the original plan of confining myself to the three Lectures delivered before the Medical Society of London. I have, however, in the present issue, thought it right to append a chapter on the Painful Ulcer of the Rectum, a disease which is very frequently met with, produces the most intense suffering, and yet, when properly treated, is more readily and easily cured than any other similarly painful malady.

I have added to the first two Lectures; and the third Lecture, which treats entirely of the subjects of Hemorrhoids and Prolapsus of the Rectum, I have materially enlarged; for, during the five years which have elapsed since the issue of the last edition, I have had a very large experience of the treatment of these diseases with the clamp and cautery, and, without entering into minute details, I have given the main facts of this extended experience.

The treatment of these diseases, when requiring operation, by means of the clamp and cautery, has been accepted by the majority of surgeons as a considerable improvement in this department of surgery, and I trust the results of my additional experience here offered will tend further to strengthen this conviction.

82 WIMPOLE STREET. *June*, 1876.

PREFACE TO THE FIRST EDITION.

THE Three Lectures of which this work consists were delivered before the Medical Society of London, in my capacity of Lettsomian Professor of Surgery for the year 1864-65. My observations were on each occasion so favorably received by a large and attentive audience, that I hesitate not to publish them just as they were delivered. The entire subject of the Surgery of the Rectum could not, of course, be discussed within the time allotted for Three Lectures, and therefore my object has been to draw attention to some of the more important points connected with this department of Practical Surgery, especially to those points upon which the information contained in books of special writers is somewhat scanty. It will be perceived that the use of my improved clamp in the treatment of hemorrhoids and prolapse of the rectum is fully explained, and, together with the record of my experience of the method recommended, forms the subject of the whole of the last Lecture; and I trust that these details will assist the members of our profession in coming to some conclusion regarding the value of a plan of treatment safe and better, in my humble opinion, than any other hitherto practised.

82 WIMPOLE STREET, CAVENDISH SQUARE, W.

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ON THE
SURGERY OF THE RECTUM.

INTRODUCTION.

DISEASES of the rectum are, perhaps, as common in their occurrence as any which afflict man; and, as a rule, their pathology, symptomatology, diagnosis, and treatment are not well understood. In a majority of cases they give rise to a degree of suffering, accompanied with anxiety of mind and mental depression which are wholly out of proportion to the gravity of the local disorders themselves. Arising, as they do, for the most part, from habits which are prejudicial to health, such as sedentary pursuits or occupations, over-indulgence in the luxuries of life, and so on, we find them to be most prevalent in the upper or middle classes of society. There are very few diseases more amenable to treatment, when properly appreciated, or which, in their results, give greater satisfaction to the practitioner. However, when such diseases are treated on the expectant plan, or when an attempt is made to manage them by calling everything in the region of the anus either fistula or piles, and blindly prescribing ointments, lotions, and laxative mixtures, there are few diseases likely to prove more obstinate, or to bring greater reproach upon the skill of the physician. The very first thing to be done is to obtain a perfectly clear history of your patient's case, by putting to him a few well-timed questions, such as, how long has this trouble existed? Is there any pain? If so, is the pain constant or is it intermittent? Is the pain increased by the act of defecation? Does it come on immediately, or not until some time after the stool? Is there any discharge from the rectum, either of blood, mucus, pus, or serum? Does anything protrude from the rectum on going to stool? If so, does it return spontaneously into the bowel, or has the patient to return it artificially? Is there any diarrhœa or constipation? Is there incontinence of wind or fæces? Inquire, also, into the condition of the liver, since a congested state of the liver, or what is commonly called a torpid, inactive liver, which has reference principally to the state of the portal circulation, frequently gives rise to an attack of piles or hemorrhoids. In all cases where you contemplate an operation upon the rectum, examine the patient's urine, with reference to the state of the kidneys, since in the advanced stage of kidney disease an operation of any severity would, in all probability, be contradicted. Lastly, inquire into the patient's habits as to diet, the use of alcoholic drinks, exercise, etc.

These interrogations will go very far toward giving you a sound basis to start upon in making your diagnosis.

Having finished them, proceed to make the examination. There are various postures in which the examination can be conducted. Some surgeons prefer to have the patient kneeling upon a chair with the body bent over the back. Others to kneel upon a table, a couch, or a lounge, with the head lower than

the buttocks. Others again prefer the lithotomy position, the patient lying upon his back with his thighs drawn up toward the abdomen, and perhaps his feet and hands fastened together. But probably the most convenient position, so far as the facility of the surgeon is concerned, and certainly the most delicate for the patient, especially if a female, is to lie upon the side with the legs drawn up toward the abdomen and the buttocks close to, or even projecting a little from, the edge of the table.

Before putting the patient in position, the rectum should be emptied, and, if possible, well cleansed by the use of a large injection of warm water. This accomplishes two purposes. First, it enables the examiner to obtain a perfectly good view of the condition of the mucous membrane of the lower part of the gut. In the second place, and perhaps more important than the first, it enables the patient to strain the parts to be examined down into view without the danger or fear of his becoming "a victim of misplaced confidence." If you have had no experience in examining diseases of the rectum, you will have something to learn when you come to your first female patient. You will find that with a woman the fear of passing wind in the presence of the physician, and, above all, the fear of voiding a small quantity of liquid fæces, while he is making the examination, is, ofttimes, so great that, in order to avoid it, she will contract all of her muscles, especially the sphincters, and a satisfactory exploration will be utterly impossible. For these reasons the rectum should be emptied and washed out before you begin. As a preliminary to the physical examination, note what is to be seen externally, such as discoloration of the skin, the condition of the anus, whether patulous or contracted; observe the presence of ulcerations or fistulous openings. Next feel around the anus for indurations; by this means the situation of an abscess or a sinus may be discovered. Notice what protrusion has taken place, if any, since the injection was voided; notice its character, structure, vascularity, mode of protrusion from the bowel, by peduncle or otherwise.

Finally examine the interior of the bowel with the finger. Never neglect this under any circumstances. Anoint the verge of the patient's anus and your own index finger very thoroughly with vaseline, cocoa-butter, lard, sweet oil, or some other bland lubricant. Then introduce the finger slowly, stopping occasionally until the sphincter becomes quiet and accustomed to the presence of the foreign body. Ask the patient to bear down a little from time to time, and so force the rectum over the finger. In this way the sphincter will yield and allow the finger to pass on without pain.

By this examination you will learn very much, especially if your finger has become accustomed to feeling the interior of these parts, and will often obtain all the information that is needed in detecting internal fistulous orifices, polypi, ulcerations, fissures, hemorrhoids, etc. Since it is to be remembered that, with some rare exceptions, the parts requiring this kind of interrogation are situated low down, within an inch and a half of the verge of the anus, and very frequently within the circle of the external sphincter. I think a very common mistake is made in conducting this examination of searching for the disease too high up. The seat of the lesion in this way is passed by, and if we find nothing at the full extent of the index finger, we conclude there is nothing there. Now, recollect, as a practical point, that in the majority of cases of disease of the rectum you will find the lesion within an inch and a half of the anus, frequently just within that dilated portion of the gut which is between the internal and external sphincters. Frequently, also, within the grasp of the external sphincter. In examining for mischief high up in the bowel, and beyond the reach of the finger with the patient in this position, it is sometimes of advantage to allow him to stand upright on the left foot, with

his right foot resting on a chair, and requesting him to strain. By so doing the weight of the abdominal viscera, assisted by the patient's own efforts in bearing down, will often bring within the reach of your finger, parts that are wholly inaccessible in any other posture, and will enable you to make a very satisfactory digital exploration.

Useful, however, as these means are, in order to diagnose the existence of ulceration, strictures and malignant growths too high up in the bowel to be reached with the finger, you will sometimes be obliged to administer an anæsthetic, elevate the hips so that the intestines will gravitate toward the diaphragm, and then gently and gradually, by palpation, dilate the sphincter, using four or five minutes to accomplish the purpose.

Having anointed the anus and the finger of the right hand, introduce first one finger into the rectum. As the sphincter muscle becomes accustomed to the presence of this finger slip in another, in a few moments introduce a third, and finally a fourth. If you do not succeed in this manner you may then introduce the thumbs of your two hands back to back, spread out your fingers so as to grasp the buttocks on either side, then separate your thumbs so as to paralyze, temporarily, the action of the sphincter muscles. When thoroughly done you will find that, aided by the use of a couple of common retractors and the bowel being cleansed by sponges mounted on holders, nothing can escape careful observation, especially as you can then introduce even a large bivalve or Sims' vaginal speculum, so that even recto-vaginal and recto-vesical fistulæ can readily be closed. In some rare cases, also, in which the disease is situated high-up in the gut, very valuable information is derived by introducing the whole hand and arm into the rectum. But to do this safely the operator must have a small hand, must use an abundance of grease, and take plenty of time.

Again, in certain diseases of the anterior wall of the rectum in married women, or in those who have borne children, this part can be very easily everted, turned out of the anus altogether, by introducing one or two fingers into the vagina and hooking the part down through the anus; making firm pressure on the posterior wall of the vagina from above, downwards and backwards, forces out the anterior wall of the rectum.

Recollect, however, that this method is limited in its application to the anterior wall of the rectum, low down, and is utterly useless in young women, or in those who are unmarried and have not borne children.

We sometimes make use of the speculum in examinations of the rectum. These instruments are of various kinds, and some of them are ill-adpated for

FIG. 1.

the object in view. Thus, some of them are of very little use in consequence of the bulging of the mucous membranes betweeen the narrow blades of the instrument. In examining for diseases which are situated very low down in