CARCINOMA OF THE RECTUM: ITS DIAGNOSIS AND TREATMENT

Published @ 2017 Trieste Publishing Pty Ltd

ISBN 9780649279579

Carcinoma of the Rectum: Its Diagnosis and Treatment by F. Swinford Edwards

Edited by Trieste Publishing Pty Ltd.
Cover @ 2017

www.triestepublishing.com

F. SWINFORD EDWARDS

CARCINOMA OF THE RECTUM: ITS DIAGNOSIS AND TREATMENT

Trieste

CARCINOMA OF THE RECTUM

ITS DIAGNOSIS AND TREATMENT

BY

F. SWINFORD EDWARDS, F.R.C.S.

SENIOR SURGEON TO ST. MARK'S HOSPITAL FOR DISEASES OF THE RECTUM AND TO ST. PETER'S HOSPITAL FOR URINARY DISEASE; SURGEON TO THE WEST LONDON HOSPITAL, ETC.

LONDON
BAILLIÈRE, TINDALL AND COX
8, HENRIETTA STREET, COVENT GARDEN
1905

PREFACE

So great has been the advance in the surgical treatment of carcinoma of the rectum during recent years, that I have been tempted to place before the medical profession, briefly, in the following pages, my experience of this disease, with the results obtained by operations for the removal of the growths by the sacral route, based upon forty consecutive cases. In each of them upwards of eighteen months have elapsed since the operation was performed.

F. SWINFORD EDWARDS.

55, HARLEY STREET, W.
June, 1905.

CARCINOMA OF THE RECTUM

CARCINOMA of the rectum rarely occurs before the age of forty, and although I have seen several cases under thirty, each of these was of a rapidly growing and highly malignant type. It is more prone to occur in males than in females. Hæmorrhoids, fistula, and fissure of the rectum probably form predisposing factors to the development of cancer in that region. I can call to mind two instances of a villous tumour of the rectum subsequently undergoing malignant changes, and I have had under my care a case of malignant adenoma which appeared to start from a pre-existing fistula, whilst two cases of epithelioma of the anus certainly originated in fissure.

The most common *site* for carcinoma to commence in the rectum is from 2 to 3 inches from the anal margin, although any portion of the lower bowel may become affected. Commencing in the epithelial elements of the mucous membrane, the disease progressively infiltrates the tissues of the rectal wall, and ultimately reaches the perirectal tissues. Should it involve the peritoneal coat, it may set up a cancerous peritonitis or become adherent to, and finally involve, other viscera, such as the bladder, or other parts of the intestinal canal. When it spreads to the cellular tissue below the peritoneal reflection it fixes the rectum in the sacral concavity, becomes adherent to the vagina in the female, and, by its pressure

upon the nervous structures, gives rise to severe pain. The lymphatic system becomes involved, the rapidity of infection depending upon the variety of the disease, first making itself evident in a thickening in the position of the lymphatic tract passing from the rectum to the lateral pelvic walls. Enlargement of the lymph glands is first noticed in the pelvic group, in the hollow of the sacrum along the posterior rectal wall, and later in the pelvic and lumbar groups. The inguinal glands are only affected in cancer involving the anal margin, or late in the disease in association with its general dissemination.

Secondary deposits of cancer are most frequently found in the liver, and, in accordance with the general rule, the metastatic tumours reproduce the histological characters of the primary growth.

Varieties.

1. Columnar-celled or adeno-carcinoma.
2. Squamous-celled epithelioma.
3. Scirrhus.
4. Colloid carcinoma.

Of these forms, the columnar-celled carcinoma is by far the most common, the histological appearance being, in brief, a mass of epithelial tubules infiltrating the layers of the rectal wall and surrounded by a small-celled exudation. The squamous epithelioma is more uncommon, and it is most frequently found when the growth primarily attacks the anal margin. Scirrhus of the rectum is rare, but in my series of forty cases one was found to present histological features of this variety, the tubules of epithelial cells being enclosed in a dense fibrous stroma. Colloid carcinoma occasionally occurs as a degenerative change in a cancer.

Whatever the histological appearances of the growth

may be, carcinoma of the rectum progressively and gradually spreads. Commencing in the epithelial tissues as a small button of growth, the affected area becomes thickened and infiltrated, and the mass tends to spread laterally rather than upwards or downwards. In the earliest stages of the disease there is no symptom to call the patient's attention to the part, but as it advances the symptoms become manifest, the clinical features differing slightly according to the variety of the disease. Thus, with the progressive advance of the disease, the tissues of the rectal wall become infiltrated and the growth is at first freely movable as a whole; but after a time the surface of the growth gives way, leaving a ragged ulcer with characteristic, friable, infiltrated borders. In the relatively more quickly growing adenoid cancers it is more usual for the growth to sprout out from the surface and to form distinct tumours projecting into the lumen of the rectum. These are easily recognised when within reach of the examining finger, and indeed, are most commonly met with in this form. In the more slowly growing types there is progressive infiltration rather than fungation; the base of the growth becomes thickened, constricted and puckered; the surface presenting a ragged ulcer with everted, hard but friable margins.

Symptoms.

The symptoms of cancer of the rectum depend upon the type of the growth, its site and the stage of the disease. The symptoms at the onset are usually so slight and of such an indefinite character that valuable time is allowed to elapse, and it is not until pain or bleeding from the rectum occurs that the patient seeks advice. Frequently patients are found upon the first examination to have already an extensive carcinoma of the

rectum when the local symptoms do not point to the serious nature of the disease, although they may recall that for some months they have noticed indefinite griping pains and often constipation. I would here urge the practitioner to make it an invariable rule to undertake a digital examination of the rectum whenever he is consulted by a patient, within the cancer age, complaining of indefinite abdominal or rectal disturbances.

The change first noticed is a sense of uneasiness in the lower bowel, followed sooner or later by slight diarrhœa, which is generally most troublesome in the morning, when, after the first evacuation, the patient feels that there is more to come away, and has to return to stool. At this time the motions become streaked or mixed with mucus, and may contain in addition blood. Bleeding is a symptom that is rarely absent, but, on the other hand, is seldom severe, and, when present, may be taken as an indication that the surface of the neoplasm has commenced to break down. The muco-purulent discharge is at first white, but later becomes darker and often extremely fœtid.

Diarrhœa, a symptom frequently complained of, is usually of a spurious nature. In the adenoid fungating form of cancer the patient is troubled with frequent desire to defæcate, even, perhaps, soon after the passage of a satisfactory motion, and on each occasion passes flatus and mucus, with or without blood. This frequency is usually noticeable in the morning, and seems provoked by exercise, but the contrary may be the case. *Constipation*, on the other hand, is the more frequent symptom with the infiltrating form of cancer, in which the lumen of the bowel is actually encroached upon, with the attendant symptoms of intestinal pains, malaise, and sacral aching, and it may be the first symptom of the rectal disease.