Grey Turner was born in Tynemouth, in the county of Northumberland, England, September 8, 1877. He was educated at a private school and graduated from the Newcastle Medical School of Durham University with first class honors in 1898. He obtained his M.S. in 1901 and his F.R.C.S. in 1903. After holding resident surgical posts at Newcastle, Turner went to London and continued his postgraduate studies at King’s College Hospital. After visiting a number of surgical clinics on the continent, he returned to Newcastle and to the staff of the Royal Victoria Infirmary. Grey Turner demonstrated special dexterity, daring, and an extraordinary capacity for work. His special techniques were recognized not only in the United Kingdom, but throughout the world. His operating theater became a center for visitors comparable to that of the great Lord Moynihan. At the outbreak of World War I, Turner was called up for service in the Royal Army Medical Corps. He served for two years in the Middle East, and then returned to England as consulting surgeon and specialist in chest surgery. In 1927 he was named Professor of Surgery at the University of Durham, and in the following year was named President of the Association of Surgeons of Great Britain and Ireland. At a time when most men would consider retirement, he, in 1931, accepted the offer of the newly formed chair of surgery at the British Postgraduate School at Hammersmith. Grey Turner was more of a “generalist” and was considered one of the boldest individuals because of his aggressive treatment of malignant disease. However, his advocacy of a conservative resection of the rectum (after Kraske and Hochenegg), the subject for this Classics presentation, appears to be a compromise of that dictum. Preservation of the “wonderful sphincteric apparatus” did appear to be a priority concern. Grey Turner was recognized through numerous awards and honors. He was Hunterian Professor on two occasions, and honorary fellow of the American and Royal Australasian Colleges of Surgeons. He was elected president of the proctologic and general surgical sections of the Royal Society of Medicine. He delivered the John B. Murphy Oration in Philadelphia and received the Bigelow Medal in Boston for the advancement of surgery. His name is eponymously associated with the sign that produces local discoloration of the skin of the flank in acute pancreatitis.

George Grey Turner passed away on August 24, 1951.

Turner GG. Conservative results of the rectum by the lower route. The after results in seventeen cases. Dis Colon Rectum 1990;33:252-258.


G. Grey Turner
Photograph courtesy of the Royal College of Surgeons of England.
CONSERVATIVE RESECTION OF THE RECTUM
BY THE LOWER ROUTE.
THE AFTER RESULTS IN SEVENTEEN CASES.

G. GREY TURNER,
Professor of Surgery, in the University of Durham.

When Einar Key, with his friends Gunnar Nyström and Gustav Pallin, did me the honour of paying a visit to my clinic in Newcastle in 1930 he expressed himself particularly interested in a series of cases in which I had carried out conservative resection of the rectum, and in some of which, I was able to demonstrate the later results. I am therefore glad to have the opportunity of bringing these results before your readers in this special number of your Acta "dedicated" to your great surgeon whom we esteem so highly in my country. First of all let me clearly explain that by "resection" I mean an operation in which a complete segment of the rectum proper is excised after which the canal is restored and its musculature preserved so that in the ultimate result the patient enjoys the normal function of the wonderful sphincteric apparatus with which a beneficent Creator has so happily endowed his peoples. My experience has taught me that there is no type of Colotomy over which the patient can exercise any sort of voluntary control. Many patients, and indeed most who must endure a permanent artificial anus, acquire a habit which diminishes the inconvenience to a minimum, but even so there is always the liability of accidents which may be so shocking as

".....to milk the heart out of a man and shame him before his kind."

(Kipling.)

An incontinent anus may be a reproach to surgery, and any plan by which it can be avoided deserves the careful attention of the profession.

Operations of this type have been carried out for many years and in many countries, but they have never become general, and in my own country have never been popular. The reason is not far to seek for the operation has nearly always been attempted for malignant disease, and often without much discrimination, and it is only too true that in most cases the selection has proved unhappy and the disease has recurred. But even if malignant cases are entirely excluded the operation still fulfils a definite indication and is well worth consideration. My own experience has been singularly fortunate, for I have carried out the plan 17 times during the last 17 years. There has been no mortality and every patient has made a complete immediate recovery. In three cases the operation was carried out for a non-malignant condition and all made a lasting recovery. On 14 occasions the condition was malignant, and of these cases five were clearly not suitable for this type of interference and though the patients recovered and with restoration of their rectal function, recurrence took place and proved fatal. In the other nine cases the indications seemed appropriate; one patient died suddenly nearly three years after operation, but without recurrence, one is alive, but with recurrence three years and eight months after operation, and seven are alive and well from five years to twelve and a half years after operation. All the cases are briefly epitomised in the above table. (Editor deleted.)

Let me emphasise the fact that in this operation the segment of rectum is removed with the para-rectal tissues and lymphatic glands inside the levatores ani whereas in all other types of radical operation these muscles are deliberately removed. This will be understood by reference to Fig. 1. which shows, in transverse section the actual amount of para-rectal tissue removed in one of these operations. Let me briefly describe the method. I have always employed general or combined anaesthesia as this leaves the surgeon free to discuss without embarrassment any difficulties that may arise during the operation. The case is so prepared that the rectum is as empty and as clean as possible. I prefer to operate with the patient in the left lateral position. An incision is made commencing at the side of the base of the coccyx and continued forwards as far as the posterior margin of the anus; from just beyond the tip of the coccyx it follows the median sulcus. Fig. 10.

The posterior raphe of the levatores ani muscles is then divided in the middle line until the rectum is exposed inside its muscular bed. The rectum, with the whole of its surrounding pararectal tissues is then completely separated by blunt dissection until the inner surface of the levatores ani muscles are left quite bare. This separation is carried out downwards as far as the upper border of the internal sphincter and upwards as far as the disease demands. In most cases this has meant opening the recto-vesical or Douglas's pouch and dividing the bowel two or even three inches above this.

Fig. 1. Transverse sections from a specimen obtained by the conservative method to show the amount of para-rectal tissue which is removed.