Whither Surgery of the Colon and Rectum?*

ROBERT V. TERRELL, M.D.,
Richmond, Virginia

THE YEAR 1974 marks the seventy-fifth anniversary of the founding of the American Proctologic Society, and we are justly proud of the remarkable progress that has been made in this period of time.

Today we wish to pay honor to the memory of a very exceptional man, Joseph Mathews, in grateful acknowledgment of his inspired vision for proctology as a distinct specialty and his untiring lifelong efforts to accomplish this objective.

Dr. Mathews graduated from medical school without instruction in diseases of the anus, rectum, and colon. Yet almost immediately Dr. Mathews encountered, in his own general practice, patients complaining bitterly of precisely the same distressing ano-rectal problems with which you and I are so familiar today, and which we treat with such expertise. Unfortunately Joseph Mathews had little to offer his patients except harsh purgatives, clysters, salves, opium, and belladonna suppositories, or crude surgery. In a search for help he discussed the situation with his colleagues. Not only did he receive little help from them, but to his dismay he learned of the large numbers of such troublesome and complaining patients each had in his own practice, for whom little was being done. Mathews accepted this sad state of affairs as a personal challenge, and resolved that he would do what he could to improve the situation. Thus determined, he journeyed in 1877 to New York City seeking a clinic or course of study in this field, only to learn, to his chagrin, that no such facility existed in the New World. He did learn, however, of St. Mark's Hospital in London, which had been established in 1835 by Frederick Salmon for “The Treatment of Fistula and Other Diseases of the Rectum.” Undaunted, he sailed for England. There he was courteously and sympathetically received by a Mr. Allingham, who arranged for him to attend the rectal clinics regularly held by him and Messrs. Cooper, Gowland, Goodall, and others. These men did not limit their work to ano-rectal diseases, but instead were all general surgeons having a serious interest in the treatment of diseases of the terminal bowel, and who pioneered in giving proctology a prominent place in surgical practice.

Specialization as we know it today did not then exist; most physicians recognized no limit to the scope of their practices. Hospitals were held in fear and abhorrence, and patients entered them with great reluctance and trepidation. General practitioners performed a great deal of surgery, much of it done in the homes of their patients; often on the kitchen table with
an assistant dripping ether or chloroform as an anesthetic, while a member of the household held a lamp as the only means of illumination.

It has long been realized that superior skill is the direct result of the division of labor, and that specialization is the route by which we seek perfection. Therefore on his return home after a year in London, Dr. Mathews announced that henceforth he would strictly limit his practice to the treatment of diseases of the colon, rectum, and anus; he was thus the first physician to so limit his work. His friends admonished him that he had chosen a field too restricted for his proper support, though doubtless they were glad to be able to rid themselves of bothersome and unsatisfactory patients by referral to him. Though often discouraged, he never wavered, and his practice and reputation grew.

He eagerly taught other physicians, the first being George B. Kelsey of New York, and together they stimulated the interest of others, leading to the establishing of courses for anorectal study. The first rectal clinic was held by New York Polyclinic, where it soon led all others in popularity. In 1883, proctology was introduced into the curriculum of the Kentucky School of Medicine, with which Dr. Mathews was affiliated; others soon followed.

The ease with which we can examine the terminal bowel today, and the high degree of accuracy of our diagnoses following such examinations, make it difficult for us to comprehend the fact that rectal examinations were rarely done in 1877. This reluctance to do anorectal examinations was doubtless in part due to the fact that the rubber glove was not invented until 1895; yet for years after this, proctologists disdained to use gloves because of interference with the delicacy of tactile sensation. There were almost no instruments or specula for rectal examination, and those available were crude, ill-designed, and their use often a traumatic, painful, and unsatisfactory experience. For the most part specula were bivalve, forerunners of the Pratt scope. Howard Kelly produced the first tubular proctoscope, totally lacking means of illumination or inflation, in 1895. A device for inflation was added in 1910. Mathews himself rarely used a speculum, but relied on a bougie for examination of the "sigmoid flexure," a term which he used with relish. We can only speculate on what he might have done with the sophisticated flexible fiberoptic colonoscope now coming into wide use. When instrumental examination was deemed necessary, "Uncle Joe" preferred light from a window to that from a candle or mirror.

Mathews distrusted the microscope, and when cancer was suspected, especially in cases of obstruction, it was his custom to insert the entire hand into the rectum with the patient under anesthesia. Cancer was almost always late and often inoperable on discovery, death usually ensuing within two or three years after the diagnosis. When it was considered operable, the Kraske operation was the usual procedure. This mutilating procedure carried with it an operative mortality approaching 60 per cent, and five-year cures were rare indeed. The treatment of anal fissure was simple divulsion of the anal sphincters under anesthesia. Strictures were considered syphilitic, and most fistulas were thought to be tubercular; actually many were due to acid-fast bacilli for "pulmonary consumption" was then commonplace. Many operations not only failed to cure, but often the condition of the patient was made worse, for little attention was given to crypts, and incontinence too often followed surgical injuries to the sphincters. Many ingenious devices were conceived to avoid the use of surgery; fistulous sinuses were threaded with silk, wires, or elastic bands, and bis-