A CONSIDERABLE portion of patients seen in private or clinic practice complain of disorder of colon function. Symptoms have to do mostly with passage of excess flatus and mucus and constipation under sympathetic stimulation which results in dehydration and less frequent evacuations. These may express themselves by decreased activity of the bowel under sympathetic stimulation which results in dehydration and less frequent evacuations, i.e., chronic constipation. Chronic non-inflammatory diarrhea, the passage of excess flatus and mucus and constipation alternating with diarrhea are less frequent manifestations of increased secretion and motility of the large bowel acting under the influence of parasympathetic stimulation. The inclusive term, "unstable colon" was introduced by Kantor (1) to apply collectively to these disturbances.

Chronic constipation has been classified as "colonic" and "rectal." Colonic constipation results from inadequacy of purposeful caudad peristalsis in the large bowel; it is most often spastic though the atonic form introduced.

Rectal constipation denotes a failure of the rectum to empty itself. Hurst termed this type of difficult defecation "dyschezia." It most commonly results from the loss of sensitivity to the defecation reflex, the "call of nature." Repeated "holding back" to suit the hurried pattern of contemporary urban life soon results in increased passive tolerance of the normally empty rectum to mechanical distention by the fecal mass.

SIGMOIDO-RECTAL INTUSSUSCEPTION

AND THE UNSTABLE COLON*

EMIL GRANET, M. D.
New York, N. Y.

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Lack of response to distention of the rectum results in failure to "spark" the defecation reflex. This physiologic myoneural response consists of contraction of the diaphragm and abdominal muscles, the longitudinal striae and circular musculature of the rectum, the levators and concomitant relaxation of both anal sphincters. It results in the expulsion of the fecal bolus.

Anorectal lesions such as anal fissures, thrombosed hemorrhoids, cryptitis and papillitis are painful inflammatory lesions which cause reflex spasm of the anal musculature. Rectal stasis is usually present in these conditions because anal relaxation, the final phase of the defecation reflex, does not occur. It is inhibited by the strong reflex contraction of the anal sphincters.

Rectal constipation results from still a third condition, sigmoido-rectal intussusception, a common clinical condition which manifests itself by specific symptoms. Although described seventy years ago by Allingham (2) and repeatedly since then in most textbooks dealing with proctology, (3) the syndrome of sigmoido-rectal intussusception is generally unknown. The reason for this relative obscurity will be discussed presently.

Sigmoido-rectal intussusception is a true intussusception because a redundant, mobile sigmoid loop invaginates into the ampullary portion of the rectum through the rectosigmoid junction. It differs from other types of intussusception in that it rarely becomes strangulated or completely obstructed. On the contrary; the intussusception is intermittent and it reduces itself spontaneously. It has been termed a procidentia of the sigmoid, by which is meant a prolapse of all the coats of the bowel.

The clinical picture resulting from the descent of the sigmoid into the rectum varies widely in individual cases and is often bizarre. It can best be presented by the early description of Harrison Cripps (4) who in 1890 wrote, "the chief symptom is a peculiar difficulty in passing the motions; in other cases in addition to this there is a certain amount of mucoid discharge. The patients generally complain of constipation, for which they have acquired the habit of taking various purgative medicines. They complain that on going to the closet, he strains the bowel seems to become closed, and that the more they strain, the more they strain, the greater is the difficulty." He further states that, "If, after the bowel has been washed out with an injection, the finger is passed within it, and the patient requested to strain down, folds of loose mucous membrane can be felt crowding down on the finger. By a little manipulation it may be ascertained that these folds are nothing more than the upper and middle part of the rectum invaginated into the lower portion."

Charles Kelsey (5) in 1893 wrote, "The thing most decidedly complained of is a peculiar straining and difficulty in defecation. The patient will say that when he strains the bowel seems to become closed, and that no amount of effort will overcome the obstruction; that to have a passage he has to assume an unnatural position. One of my patients could only relieve himself in the knee-elbow position and the other only when lying down."

In this syndrome characteristically a sense of unsatisfactory and incomplete evacuation remains after defecation. There is a feeling that something remains that should be expelled; consequently the patient sits and strains inordinately. This aggravates the tendency to intussusception. As a result of its frequent descent and recession, congestion and superficial erosion of the mucosa at the apex of the intussusceptum occurs, to result in the discharge of glairy or even bloody mucus. A heavy dragging sensation in the pelvis and in the lumbo-sacral region may be present together with a dull aching pain referred to the perineum and down the thighs.

When the sigmoid prolapses into the ampullary rectum, the lumen of the invaginated bowel is markedly reduced in caliber. Such patients have found, through years of experience, that in order to attain evacuation through the narrowed lumen, the feces of necessity must be semifluid in consistency. Laxation with senna, cascara, prune juice which contains isatin, various salines and mineral oil becomes a daily ritual. The ill effects of prolonged usage of these cathartics are well known. Hyperirritability of the proximal colon with symptoms including flatulence, abdominal distention, crampy abdominal pain and attacks of mucous diarrhea results from overlong use of harsh cathartics. Winkelstein (6) describes gastric symptomatology with complaints including heartburn, belching, vomiting and epigastric pain. These gastric symptoms have been termed "intestinal dyspepsia." They may be direct or reflex effects of colon dysfunction. When direct, the gastric symptoms are caused by distention of the splenic flexure by intestinal gas. Pressure of the distended sigmoid against the posterior wall of the stomach produces the familiar "cascade stomach" which probably gives rise to gastric symptoms.

Reflex gastric symptoms may result through neural pathways stemming from local stimulation of the neural plexuses of Meissner and Auerbach in the anorectum by inflammatory anal lesions such as those previously mentioned. (7). Anal lesions such as cryptitis, abscesses and fissures have been shown to occur much more frequently in individuals who constantly use laxatives. In these persons, the semi-liquid feces readily enter the anal crypts thereby affording access of fecal pathogens to the anal ducts and intramuscular glands, the common source of anal inflammatory disease. (8).

In certain patients with sigmoido-rectal intussusception, the chief complaint appears to be "loose bowels." Typically the patient states that at defecation a thin semi-solid stool is passed. This is followed by a sense of tenesmus and repeated passages of mucoid, sometimes bloody, dejections. If one inquires into the past history, a story of many years of constipation and use of harsh catharsis is elicited. The eventual result of this constant chemical irritation is the development of a granular, hemorrhagic proctosigmoiditis, tenesmus and frequent ineffectual evacuations. With severe tenesmus a number of patients suffer post-defecatory proctalgia at times. A history of proctalgia fugax (paroxysmal rectal cramp) can be elicited in about one third of the patients with sigmoido-rectal intussusception.

Mechanically the intussusception depends on three anatomic features: 1) abnormal mobility of the sigmoid due to redundancy and a long mesentery, 2) rigid fixation of the rectosigmoid and rectum by the pelvic and sacral fascia, 3) the narrow caliber of the sigmoid as compared to the voluminous lumen of the rectum. The fascial supports of the rectum reach higher on the posterior wall thus leaving a weak anterior rectal seg-