Case No. 4314
Symptoms—One year.
Family history—Father died of cancer.
Past history—No serious illness.
Present history—Pain in R. L. Q. during menstrual periods for 1 year but for the past week pain was between periods and accompanied by vomiting. Bowels constipated.
Urinary history—Burning and pain for last week.
Physical examination—Negative except for some tenderness over McBurney's point.
Preoperative diagnosis—Subacute appendicitis.
Postoperative diagnosis—Chronic appendicitis, elbow deformity and non-fused colon.
Findings—Long appendix, adhered to lateral colic fold. Non-fusion of colon with common mesentery. Gall bladder and stomach—normal. Small cysts of both ovaries.
Operations—Appendectomy and plication of caecum (Sir Henry Gray technique (Feb. 10, 1925).
Case No. 4131
Symptoms—2 years.
Family history—No chronic diseases.
Past history—No serious illness.
Urinary history—Frequent desire for urination of late.
Physical examination—Negative except for tenderness over epigastrum and R. U. Q.
X-ray report—Moderate ptosis of stomach and small intestines.
Preoperative diagnosis—Elbow deformity, chronic appendicitis and adhesions.
Postoperative diagnosis—Same, cholecystitis.
Findings—Chronic appendicitis and chronic cholecystitis and elbow deformity of colon. Gall bladder looked ashy gray and when cut open had typical strawberry appearance of chronic inflammation. The caecum was pigmented. Stomach normal, duodenum dilated because of elbow deformity of colon.
Operation—Cholecystectomy and appendectomy and plication of caecum.
Case No. 4276
Symptoms—Constipated all her life.
Family history—Father died of Bright's disease; mother died of apoplexy.
Past history—No serious illness.
Present history—Constipated and troubled with indigestion all her life. Three years ago severe attacks of pains in R. U. Q. Pains radiated to the back in both sides of the spine. Vomitus—green. Slight fever, became jaundiced 3 days later. Similar attacks 3 or 4 months but no jaundice. Constant pain for past 5 weeks. Passes a good deal of mucus by bowels, stools never clay colored.
Physical examination—Negative except for tenderness over McBurney’s point and gall bladder region.
Urinary history—Negative.
X-ray—
Preoperative diagnosis—Chronic appendicitis and chronic cholecystitis.
Postoperative diagnosis—Elbow deformity, chronic appendicitis and adhesions.
Findings—Dense adhesions about gall bladder—adhesions binding caecum to parietal peritoneal wall near hepatic flexure of colon. One strong band of adhesions from anterior longitudinal band near caecum to hepatic flexure of colon. Another band of adhesions from ascending colon to gall bladder. The caecum was of the flappy, dilated type. The stomach and sigmoid appeared normal. Small chronically inflamed appendix.
Operation—Freeing adhesions, appendectomy and plication of caecum.
Case No. 4225
Past history—Negative.
Present history—Pain in the stomach about 2 hours after going to bed, wakes her up. Steady pain. Belches. Forced vomiting, which relieves her. Brown fluid. Bowels constipated. Cascara every night. Feels like eating but is afraid to eat meats, etc.
Urinary history—Negative.
Physical examination—Negative except for tenderness over the descending colon.
X-ray examination—Shows the presence of a partial obstruction in the upper half of the second portion of the duodenum, apparently due to adhesions between the gall bladder and the adjacent viscera. The rest of the second portion of the duodenum was slightly dilated and there was a moderately delayed motility there. The appendix, too, was apparently chronically inflamed with apparently ileocecal adhesions.
Preoperative diagnosis—Chronic cholecystitis, chronic appendicitis, adhesions and elbow deformity.
Postoperative diagnosis—Elbow deformity, chronic appendicitis, attic adhesions and small multiple fibroid uteri.
Findings—Chronic appendicitis, flappy, dilated caecum and elbow deformity of ascending colon. Few fine adhesions around duodenum. Uterus had several small fibroids.
Operation—Freeing adhesions, appendectomy and plication of caecum.
mouth lesions as "ulcerative vulvitis and stomatitis, a systemic (disease)."

ETIOLOGY

There are few noteworthy additions to our knowledge of this disease to report this year. That the disease is a definite entity and the Frei test is specific have been established in the past; various current articles confirm this. That the disease is caused by a filtrable virus is generally but not universally accepted. Levaditi, Ravaut, et al., determined that the serum of patients with the disease neutralizes lymphogranuloma inguinale virus in vitro. Obame and Suskind succeeded by intracerebral inoculations of mice in transmitting the virus through 35 generations (sub-inoculations), with marked increase of its virulence and thus prepared an active mouse-brain antigen. The Reviewer has found it more potent than most of the antigens prepared from suppurating inguinal glands, but it may give false positive reactions.

THERAPY

There would be a clearer concept of therapeutic possibilities in the proctologists' field if certain facts emphasized by Collier Martin, among others, generally were known and appreciated. Dr. Martin notes that it is chiefly a Negro disease, best described as "incurable" thus far; that it expresses itself as a rectal stricture in the female, and as a rectal stricture in the male is an inguinal adenitis following a primary sore on the penis, the adenitis frequently suppurating. Fifteen of his cases . . . . "all had massive peri-rectal deposits of inflammatory tissue with marked contraction of the lumen of the bowel and multiple rectal and peri-rectal infections with fistulas involving the peri-anal area."

It is hardly to be expected that most of the medicinal anti-septic used and advocated for this disease could exert much effect on the tubular strictures and dense scar tissue we find in these patients. Dilatation with bougies, cautiously done, posterior linear proctotomy and, in the more advanced cases, colostomy, have definite value in the treatment of the rectal stricture.

Conservative surgical measures, i.e., incision and drainage of peri-rectal abscesses and curettage or the swabbing out of sinuses which may be readily explored, is helpful in some cases. The Reviewer does not hesitate to perform a fistulectomy on these patients if the internal orifice is at the muco-cutaneous juncture; they are benefited and the wound heals. Fistulectomy is indicated only in the exceptional case, however. Antimyos and potassium tartrate continue to have advocates: 5 c.c. of a 1% solution given intravenously twice a week is the usual dose. Balney gives 3 c.c. for the first dose and increases this up to 7 c.c. on the 5th dose if it is well tolerated, dosage is then maintained at 7 c.c. Intra-dermal injections of 0.1 c.c. of antigen twice a week, as advocated by Pilot, are being given in a number of cases. It is still too early to determine their value, but my own results are not encouraging.

My experience with any medication in this disease has not been encouraging. For the inguinal adenitis, roentgenotherapy is used by some authors; after suppuration occurs, simple incision, curettage or gland excision is variously practised. Weeks advocates radical excision of enlarged and suppurating glands. Hot moist dressings are then commonly applied.

Thomas and McCarthy report favorably on the use of a bouillon filter applied as a wet dressing to the suppurating glands.

MEGACOLON

Bouar designates as "pelvi-rectal achalasia" that type of Hirschsprung's disease apparently caused by failure of relaxation of the musculature at the pelvi-rectal flexure. A case is reported of a boy 3 years of age with this dysfunction who was treated by repeated intrarectal injections, of a saturated solution of magnesium sulphate. In the course of two years over 200 satisfactory bowel movements were obtained, abdominal distention was reduced, and nutrition and health were decidedly improved. While surgical diversion of the sympathetic nerve supply to the large bowel is the treatment of choice, Bouar suggests that the age and condition of the patient often makes preliminary medical treatment necessary, and that the procedure described may be a valuable adjunct, if his results are confirmed.

NEOPLASMS

The relation of polyps to rectal cancer continues to be investigated. The most careful and worthy work in the last year with which I am familiar is that of H. Weathres. His book "The Pathologico-Anatomical Basis of Surgery for Rectal Carcinoma" is reviewed in the December issue of the American Journal of Digestive Diseases and Nutrition. Although I do not fully agree with his classification of polyps, his material is different from my own and his findings are supported by much data.

Burgin and Dixon report on uncommon tumors in the large intestine. They found reported in the literature fibroma, fibromyoma, fibromyxoma, fibromyxangioma, adenofibromyoma, fibroleiomyoma, myoma, adenomyoma, angioma, lipoma, cholesteatoma, paraffinoma, taratoma, glioma, dermoids, and cysts. They report a case of fibroma in the cecum and one of myosarcoma of the rectum. They advise surgical treatment in all these conditions.

Coccygeal dermoids are discussed by Ferrari and Meyer-Burgdorf. Fletcher, Wolman and Adson present a study of sacrococcygeal chordomas. In his paper on rectal polyps David makes the points that a biopsy specimen from the base of the tumor is necessary, that the slightest evidence of ulceration or induration are suggestive of malignancy, and that the pathologist must have a history and definite idea of the tumor's gross appearance and the proper section for a diagnosis.

Newton Smith concludes that rectal polyps are comparatively rare in infancy. When they do occur they seem to grow rapidly and should be removed.

Poston reports an acute intussusception caused by a lipoma in an adult. McKenney's paper epitomizes current concepts of colon neoplasms. Kurz reports a lymphosarcoma of the rectum. Reid has performed a successful colon resection in a five year old child for a solitary adenomatous poly which had caused intussusception. A case of my own not yet reported, a single adenoma 2 x 2½ cm. was excised from the upper sigmoid by colotomy, recurrent partial obstruction but no intussusception preceded the operation. The child recovered.

Bowman describes a villous papilloma of the rectum with early malignancy, a rare benign tumor which undergoes malignant changes in 12 to 20% of cases. It should be removed when found. It has struck me that these papillomas resemble very closely intravesical papilloma.

OPERATIONS

See titles Prolapse, Sympathectomy, etc., for certain special subjects.

Stetten presented a 38 year old woman with post operative incontinence of 9 months duration who had a satisfactory result after approximation of the separated sphincter ends. The usual procedure was done through a crescentic skin incision.

When incontinence has followed a fistulectomy Collier Martin advocates excision of the depressed gutter which extends into or through the anal canal, together with the immediately adjacent perianal tissue. Free dissection is avoided. If there has not been too great an interval between the fistulectomy and the operation for incontinence, repair and return of function may result.

Valentine and Rogers report a case of recto-urethral fistula with involvement of the prostate and right seminal vesicle in a 40 year old man who gave a history of repeated catheterizations for urinary retention over a 6 month period when a 5 year old child. At the end of this period