LITTLE THINGS OF BIG IMPORTANCE IN PROCTOLOGY

Presidential Address

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GENTLEMEN OF THE AMERICAN PROCTOLOGIC SOCIETY AND GUESTS:

The American Proctologic Society in the years since it was established under the leadership of the Father of Proctology, Dr. Mathews, has gained an enviable position among special medical societies and has succeeded in establishing proctology as a recognized specialty.

The presidency of this organization is an honor I deeply appreciate and I am especially grateful to be able to preside at this meeting because of the fact that I was prevented by illness from presiding at the Philadelphia session in 1931. Thus your kindness and fine courtesy has assuaged my disappointment of eight years ago.

Much of this address may be, and probably is, old stuff to many of you; but I hope that some of it may filter out into the practice of the occasional proctologist, the general surgeon and the general practitioner.

Neglect of details is a prime cause of poor results in medical and surgical practice, but especially in proctology because few general surgeons and general practitioners have had adequate training in this specialty.

Unnecessary pain in examination, treatment and postoperative care has convinced the public that it is hell to have anything done in this region, whereas the contrary is true, and practically all pain can be eliminated by attention to detail. The chief cause of delay in diagnosis of cancer of the rectum is this fear of examination. In my series of 420 cases it accounts for six of the eleven and a half months average delay after the appearance of symptoms before diagnosis is made. The balance of this delay is caused by several factors, among which are suppositories and lack of attention to the details of efficient examination when the patient consults the doctor. Suppositories are of no value whatever in the treatment of any rectal disease and I have dubbed several of the popular brands: Painusols, Paranoids, Silly-cones, Foldurols, etc. Instead of efficient examination many doctors rely on a negative X-ray report (although cancer below the rectosigmoid junction is never seen with the X-ray until far advanced); or stool examination for parasites (and if an amoeba is found it is just too bad); or perhaps "colitis" is diagnosed without examination. The result is that 47% of the rectal cancers in my practice were inoperable when first seen.

Digital and anoscopic examination should always be preceded by the application of a local anaesthetic dissolved in a water-soluble lubricant. If

applied first with an applicator, and then worked in with the little finger it will be found that much of the hyper-sensitiveness of the anal lining disappears in a minute. Rubber gloves and not finger cots should be used. When I see a doctor use finger cots for digital examination I am reminded of the man I once saw fishing in the Rogue River in Oregon: he had rubber boots up to the middle of his thighs and he was in up to his waist. The finger or anoscope should be introduced gently and slowly, time being given for the sphincter to relax. If an anal ulcer or other painful condition is present it will be necessary to paralyze the sphincter and anaesthetize the painful area by infiltration, preferably with one of the oil soluble anaesthetic solutions. A very grateful patient is the doctor's reward for attention to these details. Urologists would do well to adopt this procedure before prostatic massage.

The same topical anaesthesia should be used before passing the sigmoidoscope. The most important detail of procto-sigmoidoscopy is the position of the patient. The inverted posture introduced by Granville Hanes has many advantages over any other, and can easily be improvised if a special table is not available. It is more comfortable for the patient and examiner than any other, the pneumatic bulb is rarely necessary and most important of all is the fact that lesions may be visualized that are often overlooked in other positions. No patient should be discharged until a procto-sigmoidoscopic examination has been done, and this applies to all patients undergoing routine general examination. Many benign or early malignant lesions are found which can be cured without resort to radical surgery, and I have never been able to figure out why this cavity which has more disease than any other is usually neglected.

If no lesion is found within the range of the sigmoidoscope, but symptoms indicative of trouble farther up are present, always insist that the roentgenologist refrain from giving a barium meal until after a lesion in the colon has been ruled out by barium enema. A partial obstruction can easily be changed to a complete obstruction by putting barium above it. I have had several such cases.

Many minor surgical procedures can be done in the office, such as the removal of external thrombotic hemorrhoids, anal ulcers, skin tags, small condylomata, deep crypts, hypertrophied papillae, adenomata and even sometimes a prolapsed or prolapsing internal-external hemorrhoid, and many patients greatly appreciate the avoidance of loss of time and the added expense of hospitalization. These things should be done under infiltration with an oil-soluble anaesthetic not only to prevent pain in the

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procedure, but subsequently. The old teaching, still advised in some recent text-books, to incise an external thrombotic and squeeze out the clot should not be followed. An oval incision should be made and the entire tumor excised down to the sphincter, just enough redundant skin being taken to allow the edges to come into nice apposition and the incision will heal in one day. Stitches should never be used for they are unnecessary and frequently cause infection. No drainage should be used and I was greatly surprised to see it recommended in a recent text-book. Stitches should rarely,

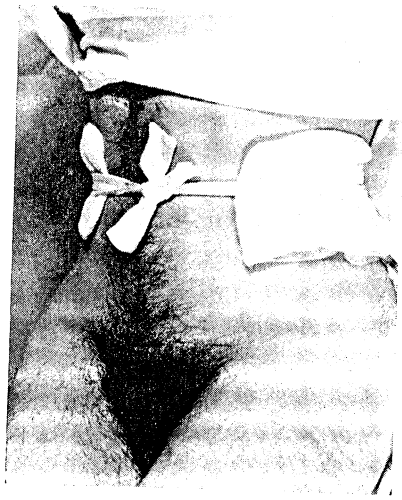


Fig. 1. Correct lithotomy position. Note the off-set in the crutch is turned toward the patient's head and the feet are high and out of the way.

Fig. 2. The T binder is tied tightly around the waist, with a pad over each iliac crest.

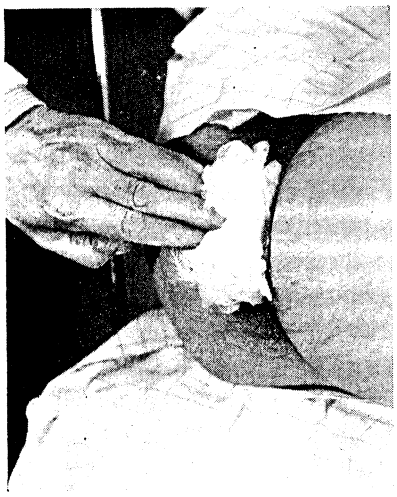
if ever, be used in the anal lining or perianal skin in any operation around the anus. They are a frequent cause of subsequent fistulas.

In general I think the hospitalization of minor anorectal cases is too long. Very frequently patients are kept in the hospital two or three weeks for hemorrhoidectomy or fistulectomy while in my practice they leave the hospital in from three to five days. This is a little thing of big importance to these patients if money is an object.

Preoperative orders for minor rectal operations should never include shaving the perianal skin, because when the hairs begin to grow out they

cause considerable irritation where the skin surfaces come in contact. Clipping the hair with scissors is all that is necessary. Cleansing enemas of plain water are ordered, and never of soap-suds because it doesn't require soap to wash a mucus membrane and all that soap does that water doesn't do is to inflame the lining of the gut. I advise nurses to translate an order for an S. S. Enema as salt or soda if any doctor is foolish enough to order it.

Low spinal with 50 mg. of procaine preceded by a hypnotic is to my mind the ideal anaesthetic for rectal operations. It is administered quickly without pain and patients are invariably delighted. The lithotomy position has several important advantages over any other for hemorrhoidectomy, fistula and other minor rectal procedures. I was greatly amused to read



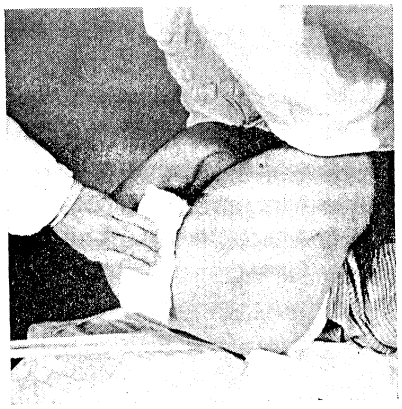


Fig. 3. A pyramidal pack of gauze is built up to a depth of 3 or 4 inches.

Fig. 4. A narrow pad is placed over the pyramidal pack of gauze, and the tails of the T binder pulled down firmly to take out the slack.

a diatribe against this position in a recent text-book. The author says: "Is there a medical student or physician who has not seen a patient trussed up in the lithotomy position with one assistant pouring soapy water over the perineum while another, after forcing the anal margins against the ischial tuberosities, is proceeding to scrub out the rectum and its bleeding outlet by a forceful rotary and piston-like motion? The stool, the rubber sheeting or Kelly pad, and the foot tub, are all in evidence and the patient is snorting in deep ether anaesthesia. Sterile stockings and sheets are placed and each assistant hugs a lower extremity while attempting to reach around and lend

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his aid to the surgeon who is seated on the stool, with rubber sheeting draped over his knees and the foot tub at his feet."

No soapy water, no snorting in deep ether anaesthesia, no forceful divulsion, no rectal scrubbing with either rotary or piston-like motion, no rubber sheeting nor foot tub is countenanced in modern proctology; but why blame these errors on the lithotomy position? With the thighs and legs well flexed, the stirrups holding the feet high out of the way, the surgeon comfortably seated with instrument tray on his knees, and an assistant comfortably seated on either side of him, the lithotomy position is more efficient and more comfortable for patient and surgeon than any other (fig. 1).

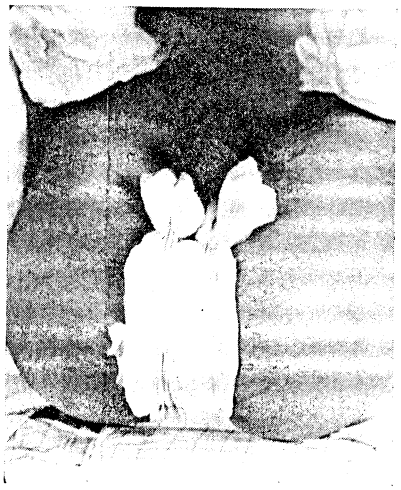


Fig. 5. The tails of the T binder are brought up snugly and tied, a pad being placed over the pubic bone on each side to prevent discomfort from the tight binder.

The first dressing should be put on before the patient leaves the operating table in a way to insure firm pressure on the anus for four hours. This is very important. If properly applied this pressure prevents the development of oedematous tags and thrombotics which cause much of the postoperative discomfort. A double-tailed T binder is tied tightly around the waist (fig. 2) a pad being placed over each iliac crest. A pyramidal shaped dressing is built up to a depth of three or four inches with fluff gauze (fig. 3), the apex of the pyramid upon the anus, a narrow pad applied, the tails are drawn down firmly to remove the slack (fig. 4), brought up snugly and tied, a pad being placed over the pubic bone on both sides to prevent discomfort from the tight binder (fig. 5).

The postoperative orders are as follows:

1. Morphine sulphate gr. ¼ with scopolomine gr. 1/150 is given before the patient leaves the operating room. The morphine is repeated in 20 minutes if necessary, and as often as necessary for comfort thereafter.

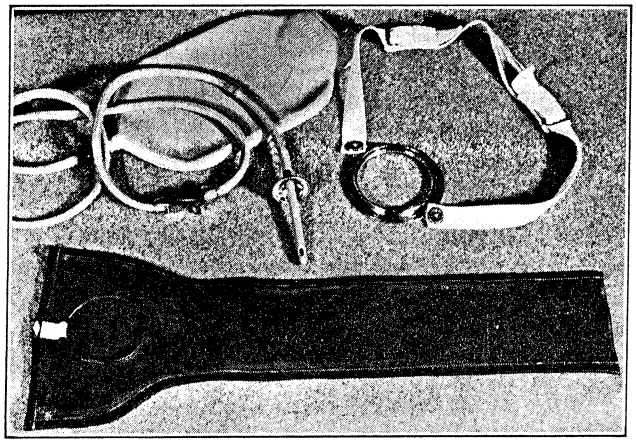
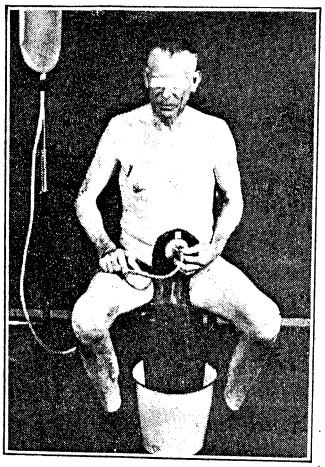


Fig. 6. The opening in the side of the rubber tube is placed over the flange on the metal ring, the edge of the inverted funnel is held tightly against the skin to prevent return of the water until colon is filled.



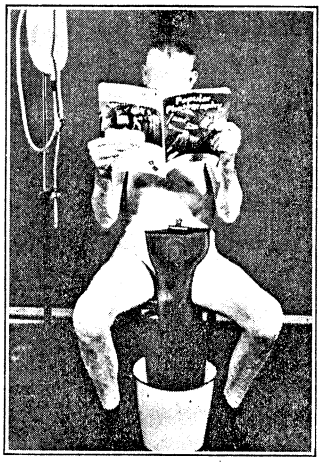


Fig. 7. The colon is filled with tepid water.
Fig. 8. He reads while the enema is expelled.

2. A tablespoonful of one of the plain emulsions of agar and oil twice daily with the morning and evening meal.

3. General diet except seeds.

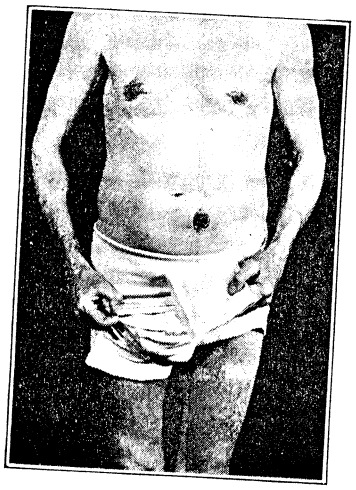
4. Remove all dressings in four hours and dress twice daily with soft fluff gauze after painting the perianal skin with a mild aqueous antiseptic.

5. Catheterize if the patient is unable to *empty* the bladder when it reaches above the pubic bone as determined by percussion. This necessitates percussion after voiding. Patient may stand or sit to void. If catheterized give a urinary antiseptic by mouth.

6. Two tablets of one of the combined analgesic and hypnotic preparations at bed-time.

7. Pass a colon tube if necessary for gas at any time.

8. On the third or fourth day, according to urgency, give a hypodermic injection of morphine sulphate, gr. ¼, and one hour later an enema of warm



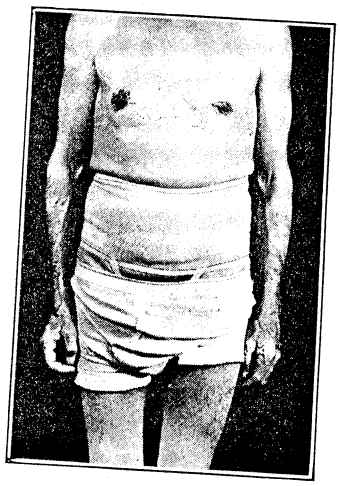


Fig. 9. The dressing.

Fig. 10. The elastic belt in place.

water through a well lubricated soft rubber catheter. Let patient sit on toilet or commode to expel contents of rectum which are always soluble in water.

It has always been a mystery to me why nurses are taught to *palpate* the bladder instead of to *percuss* above the pubes, for the bladder can never be felt until it is greatly over-distended, except in skinny patients.

These orders, if properly carried out will insure a happy, comfortable and grateful patient. The orders so frequently given for a restricted non-residue diet, which causes a hard lump to form in the rectum and then the attempt to dissolve the insoluble with warm oil, is so ridiculous that its

retention for so long in proctologic practice is amazing. It should be relegated to the limbo of the past along with the gauze-wrapped "whistle tube," the packing of fistula wounds, rapid sphincter divulsion, adhesive plaster dressings, and finger cots.

In closing I must call your attention to the little thing of biggest importance in proctology, and that is the proper management of colostomy. The great majority of colostomy patients are still wearing rubber bags or other gadgets and stinking their way through life, although attention to a few simple details of care would enable them to be clean, comfortable and happy. I am distressed to see in so many articles bearing upon this subject the phrase: "social isolation" and the "malodorous colostomy" when the entire problem was solved several years ago and reported by me at the New Orleans session of the American Medical Association in 1932,[1] and at the Memphis session of the American Proctologic Society the same year. When it is so easy to change despondency to happiness it is the duty of surgeons to do it. If the colon is filled with water and emptied completely no feces will pass through the colostomy for from 24 to 72 hours. The large majority are clean for 48 hours and a few for 72 hours. The apparatus shown in the illustrations (figs. 6-7-8-9-10) accomplishes the complete cleansing of the colon. A small gauze pad covered by a piece of glycerine treated parchment paper is placed over the colostomy and held in place by an elastic belt, or a two-way stretch girdle with hose supporters for women. No other dressing is required. The piece of impervious paper is advised because it is thrown away each day. Rubber should never be worn.

If a patient cannot afford the apparatus shown, the author's "ball and catheter" will keep the water from being expelled until the colon is filled and it can then be passed out into a basin. This is less convenient but equally efficient.

1. Smith, Dudley: Status of Colostomy J. A. M. A. *99:* 1129, 1932.