STRICTURE OF THE RECTUM.

BY R. W. STEWART, M.D., PITTSBURGH, P.A.

The following case presents some unusual difficulties in treatment, the method of overcoming which may prove instructive.

Mrs. E. S. was referred to me for treatment by Dr. Mercur. She gave a history of having suffered for six or seven years from constipation. She had previously suffered from ulceration of the rectum, which was probably of syphilitic origin, although no history of syphilis could be obtained. About a year and a-half ago, her uterus, tubes, and ovaries were removed *per vaginum*, partly under the supposition that the constipation she was suffering from was due to the pressure against the rectum of a retroflexed uterus. Her general health improved after the operation and she gained in weight; but the constipation remained unrelieved; in fact, steadily increased so that an evacuation of the bowels was an operation that required all the tact of the patient, and all the resources of the materia medica.

An examination showed a stricture, caused by a cicatricial deposit on the right anterior portion of the bowel. The stricture was situated about four inches from the anus, too high for the finger to be inserted into it, although by bi-manual examination an ill-defined mass could be touched with the tip of the finger. This mass was composed partly of the cicatricial tissue referred to, and partly of a fecal accumulation that was lodged above the stricture.

By no manner of means could a bougie, either rectal or urethral, be insinuated through the stricture. An attempt was made, with the aid of a Kelly speculum and headlight illumination, to pass a bougie, but this attempt, like its predecessors, failed.

After all hopes of penetrating the stricture by this means had been abandoned, the only alternative that presented itself was by operative interference, to which the patient readily assented.

In considering the operative procedure to be adopted, there seemed but two courses to pursue: first, to attack the stricture directly by a Kraske's operation, or some modification of it; but as this would probably be followed by a fistulous tract, and the subsequent treatment in maintaining the patency of the bowel would be tedious, I decided on the second method, namely, to bring down the sigmoid flexure and form an anastomosis between it and the rectum at a point below the site of the stricture thus eliminating the diseased portion of the bowel from functionating, by diverting the feces from their natural channel. I fully realized that the necessary manipulations would have to be carried on in the deeper portion of the pelvis, but by using the Murphy button the difficulty did not seem to be great.

Accordingly, on April 16th, the patient being in the Trendelenberg position, I opened the abdominal cavity by a median incision and drew the sigmoid flexure out of the wound. A point was then selected where this portion of the bowel could be approximated to the rectum, and was opened sufficiently to admit one-half of the Murphy button.