ENTERECTOMY FOR THE CURE OF FÆCAL FISTULA.*

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The case which I bring before this Association is of interest both from its mode of origin and from the means used to cure it.

Madame V. entered the Winnipeg General Hospital on May 4th, 1892, with a large wound in the left groin, from which fæcal matter was escaping. The skin around the opening was intensely inflamed, hard, brawny and excoriated. The inflamed area included the upper third of the front of the thigh, the left vulva and the lower third of the left side of the abdominal wall. This surface was very tender and painful.

The history of the case, as obtained from the patient, was that for many years a lump occasionally appeared and disappeared in the left groin. It was not painful and caused her no trouble. Although she never showed it to a physician, I have no doubt that it was a small inguinal hernia. During the spring of this year the patient fell in the yard and struck her groin against some hard substance. The blow was strong enough to cause discoloration of the parts, and the lump then became permanent and also painful. The injury converted the reducible hernia, hitherto existing, into an inflamed, irreducible hernia. No vomiting, constipation or other symptoms of obstruction of the bowels supervened. Because of the presence of the tumour and of the pain which it produced, she decided to deal with it surgically on her own account. A poor widow, twelve miles from a doctor, she could not afford to secure professional assistance; so, with a razor, she made an incision over two inches long into the tumour, and succeeded admirably in performing a left inguinal enterotomy.

The patient was born in Belgium, came to Manitoba in 1889, is 46 years old, is the mother of four healthy children, has had no miscarriages. Before this trouble arose she had always been perfectly healthy, and never consulted a doctor for any form of sickness. Her husband died two months after she came to Canada, and since then she has had to work very hard to support her family. She is a strong, well-nourished woman. Her appetite and digestion are good. The bowels have always been regular before she made the artificial opening into them.

During the two months that she was in the hospital before the operation was performed, the fæces poured out of the opening in the groin. No form of dressing that we could devise would keep her even relatively clean. The inflammation of the skin was not only very painful but also kept the temperature above the normal. The fact that she did not emaciate showed that the opening in the bowel was not high up, but must involve either the ileum or colon. A small amount of fæcal matter would pass into the bowel below the opening so that every few days she had a small natural motion per anum. The opening was exactly in the fold of the groin, but no portion of the bowel could be seen externally, and no spur could be felt by the finger in the wound. Nothing appeared to check, in the least, the amount of discharge from the bowels, while the condition of the patient was pitiable, indeed—a burden to herself and a source of disgust to those about her.

As the state of the patient was not improving in the slightest, as there was no tendency in the wound to grow smaller, and as the quantity of fæces passing through the lower bowel was constantly decreasing, I suggested the need of operative interference. After explaining to her the risks involved, she urged that one be undertaken, as she preferred death to her loathsome condition. Greig Smith, in his work on "Abdominal Surgery," gives three plans of dealing with these cases:

1. Closure by plastic operation.
2. Division or removal of the spur.
3. Re-section of the bowel.

The first was not possible in my case because of the position and size of the opening, and because the inflamed tissues would not yield good results in a plastic operation. The second was not possible because there was no spur to be felt or seen. The third plan was therefore decided upon. Greig Smith says, "In cases of large loss of substance of one side of the bowel, without flexure and without the existence of a spur, re-section may from the first afford the only prospect of cure." No words of mine could more accurately describe the condition of affairs in my patient, and the specimen

*Read at meeting of Canadian Medical Association, Ottawa, September, 1892.