PROCTOLOGY IN A WAR HOSPITAL*

LOUIS J. HIRSCHMAN, M.D.
DETROIT

When base hospital units were being organized to accompany the American Expeditionary Forces, I joined Unit No. 17 (Harper Hospital, Detroit) with the hope of being of service to the Army in a general way and, perhaps, having occasional demands made on my special knowledge of enteroproctology.

When our unit arrived in France early in July, 1917, we were stationed in the city of Dijon, the capital of ancient Burgundy. This city was located on the main railroad line over which the bulk of the American troops had to pass from the base ports to the training centers and fighting front. Many thousands of troops were encamped and billeted in the villages surrounding Dijon, and it was a very important center of the American activities.

A great deal of construction work was carried on; immense warehouses and depots for quartermaster, ordnance and the supplies of other departments were being erected by thousands of engineers and labor troops. Heavy work, continual drilling and training, coarse foods and inadequate latrine facilities were some of the factors which very soon indicated that in our hospital at least, the proctologic service would be not an inconsiderable one.

Before the Americans were actually in the trenches, the base hospitals, which had been established early, were fairly well filled with patients suffering from the ordinary diseases encountered in civilian activities.

The work of the medical staff was subdivided so as to render any special skill possessed by its members available for all patients who required it. My service, embracing abdominal surgery and proctology, consisted, during this phase of hospital activity, of the treatment of hernia, appendicitis, rectal and colonic diseases. The work was so classified that individual wards were devoted to each of these classes of disease.

The vast majority of cases of appendicitis were of the acute variety, many of which were suppurative and not a few ruptured. When one stops to recall that our patients were all young men of the age when appendicitis is most commonly found and their living conditions were such as to intensify any predisposition to that disease, the frequency with which appendicitis affected our boys was not unusual. Patients who were tired and hungry and had plainly been sick for some time before the seriousness of their condition was recognized, were taken off troop trains after a two or three days' journey from the sea port, in a box car, with a straw-covered floor.

Other patients, suffering from ruptured appendixes and general peritonitis, were brought in by ambulance from camps from 30 to 50 kilometers distance.

The number of hernia cases was exceptionally large. One could always tell when a new convoy of troops arrived from the United States by the flood of patients suffering from hernia and chronic hemorrhoids, who would arrive at the hospital in groups of from fifteen to fifty at a time. So many of these patients gave histories of long continued existence of hernia, hemorrhoids, or both, that it was perfectly clear to us that somewhere in the chain of physical examinations in the United States there was a weak link or two.

Our acute proctologic cases consisted of thrombotic hemorrhoids, fissures, abscesses and impactions. It is interesting to note at this point that the rarest proctologic condition, with the exception of carcinoma, was that syndrome known as pruritus ani.

In the operative treatment of all cases of hemorrhoids, acute or chronic, fissure, polypi and most cases of abscess and fistula, the anesthetic of choice was the infiltration of 0.25 per cent. solution of procain. All patients were given an enema the night preceding operation, and this was repeated the following morning. A quarter grain of morphin and 1/150 grain of atropin were administered hypodermically forty-five minutes before operation. Skin sterilization was accomplished by the use of alcohol followed by iodin. The patients were placed in the exaggerated Sims position.

External thrombotic hemorrhoids were removed by infiltration, excision, evacuation of clots, and closure without suture. Prolapsing internal hemorrhoids were removed by the author's technic of high ligation and excision. Fissures were treated by incision or excision, depending on their extent and chronicity.

Abscesses, when very extensive, were sometimes punctured under local anesthesia, allowed to drain and contract for a couple of days, and then opened to their widest dimension.

Fistulas were incised if simple, or their tracts excised, if chronic or multiple. It is interesting to note in this connection that at one time I had under my care seven patients suffering from old chronic sinuses resulting from sacral or coccygeal dermoid cysts. All of these patients claim that the condition existed when they were still in the United States and that medical officers knew of the condition, but allowed them to go to France, nevertheless, and clutter up hospital beds needed for more urgent cases.

Our work was so well organized that we were able to handle our cases of rectal surgery with much expedition. Under local anesthesia, we handled four cases an hour in the operating room, and had the majority of our patients on their feet and in the mess line on the third day. Rectal patients do much better on their feet and outdoors, than lying around the hospital ward.

As the American forces took their places on the fighting fronts, the character of the work in an advanced base hospital, such as ours, took on a different aspect. All patients with hernia and chronic hemorrhoids were evacuated to hospitals nearer the sea ports and farther removed from front line activities.

The proctologic surgeon along with other specialists took over a certain number of general surgical wards, but in addition took special charge of all wounds involving the intestinal tract. All types of ammunition and projectiles were responsible for these wounds. Direct penetrating wounds of the abdomen, when the patient's condition did not contraindicate operation, called for laparotomy, location and closure of intestinal wounds.

In extensive tears of the intestine, it was found better in some cases to perform temporary enterostomy. In penetrating gunshot wounds of the rectum, simple cleansing and drainage of them sufficed. On the other hand, extensive lacerated wounds in which the sphincter was involved would call for temporary colostomy until the lower wound could be repaired, if at all.

* Read before the Section on Gastro-Enterology and Proctology at the Seventieth Annual Session of the American Medical Association, Atlantic City, N. J., June, 1919.

In wounds of the buttocks communicating with the rectum, it was occasionally found necessary to convert these into open or gutter-wounds. After irrigating for several days with surgical solution of chlorinated soda (Carrel-Dakin solution), we were able to accomplish secondary suture with marked success.

It might be mentioned in this connection that we were able to follow the same procedure with a number of our fistula cases. The use of the Carrel-Dakin solution, with daily bacterial counts in the surgical treatment of fistula, is a valuable addition to the treatment of this condition. It is surprising how a wound in this locality can be cleaned and kept clean if the Carrel-Dakin technic is carefully carried out. Secondary suture of fistula wounds will, I believe, become more commonly practiced when the employment of this technic becomes more generally known.

During several epidemics of dysentery, the proctologist became of great service to the internist in the differential diagnosis between the various types of dysentery and between these and other colonic diseases. Several cases of true amebic dysentery were recognized by smears taken from rectal and colonic ulcers and examined on the warm stage.

The possession of a sigmoidoscope by a medical officer skilled in its use was of great advantage to the base hospital with which this officer was stationed.

On account of conditions mentioned above, fecal impaction was frequently encountered. The use of 25 per cent. hydrogen peroxid enemas proved to be of the greatest service in their treatment.

As is well known, mustard gas burns were found most frequently in the region of the genitals and buttocks. The treatment of these cases fell to the lot of the proctologist. Alkaline baths, free opening of blebs and blisters, exposure to sunlight, which was one of our rarest therapeutic agents in France, and protecting with zinc oleate or stearate proved very efficacious in our hands.

As has been mentioned above, pruritus ani was one of the rarest diseases encountered among our troops. Pruritus ani is supposed to be caused by practically every disease affecting the anal region; but in spite of our large proctologic service, pruritus was a condition conspicuous by its absence.

Those soldiers who did complain of itching in the region of the rectum and who did not present evidence of parasitic infestation were found to be suffering from proctitis, fistula, fissure or ulcer. The indicated surgical treatment for these conditions very quickly cured the pruritus.

In all of our proctologic work, the employment of local anesthesia was the greatest single factor in lessening the length of a soldier's hospitalization. He was returned to his command in from one-third to one-half the time ordinarily required for convalescence from operations performed under general anesthesia. As every day saved in a soldier's absence from duty was of direct assistance in keeping up the man power of the Army, local anesthesia in proctology did its little bit in winning the war.

When a surgical team was sent from the base hospital to the front, medical officers representing all of the different specialties took their turn on the team. The proctologist was no exception to the rule, and on account of his experience in abdominal surgery, he served a very useful purpose. Whether called on to remove a piece of shell from the brain, to sew a lacerated pleura, to remove a tight tourniquet and save a limb, or to perform the most delicate of intestinal repair, he always gave the best that was in him.

The attention to detail in after-care, which the surgical specialist is wont to give in his own special field, always stood him in good stead when doing his share of general war surgery in an advanced hospital unit.

After all, the proctologist, in whatever he did in the medical service during the war, represented only one class of specialist. They were all alike; although most of them were beyond the so-called military age, they were all willing and anxious to do anything in the realm of medicine and surgery to help win the war. Whether acting as interns or consultants, they were always medical officers in the Army of the United States, and always tried to be good soldiers.

ABSTRACT OF DISCUSSION

DR. ALOIS B. GRAHAM, Indianapolis: There is no essential difference between military and civil practice in the ordinary proctologic cases. The same fundamental principles that govern the one govern the other. It is very true, as Dr. Hirschman has said, that a surprisingly large number of proctologic cases occupied beds in base hospitals that could have been used to much better advantage in caring for soldiers suffering from gunshot wounds. We did most of our proctologic work in Base Hospital No. 32 under local anesthesia. In a few cases we employed nitrous oxid and oxygen. We also used a modification of Depage's anesthesia (ethyl chlorid, ether and chloroform) and it proved most satisfactory.

DR. D. C. MCKENNEY, Buffalo: Dr. Hirschman has covered the subject of war proctology very fully, and I agree with everything he said. There is absolutely no question that many men, who ought not to have gone, slipped into the army and were sent abroad with their rectal conditions not remedied. Each man so disabled took one man from the fighting front, besides requiring the employment of other men needed for other work to take care of him at some hospital. I saw very little constipation in the army and I am not sure that the squatting position during defecation, that was employed so generally all over France, had something to do with it. About the wounds, although many cases involved the rectum, an interesting observation was that with most horrible wounds of the buttocks, the rectum frequently escaped injury. Wounds that involved the rectum very often also involved the bladder, so that it was necessary to do a laparotomy and repair the wounds inside the abdomen as well as do a colostomy to allow the rectal wound to heal. Frequently it was necessary to add a suprapubic bladder drainage.

DR. JOHN L. JELKS, Memphis, Tenn.: A boy with an enormous mass of hemorrhoids, bleeding, oftentimes inflamed, passed the board A-1, went to France and fought and bled—but not from bullet wounds. Another man with a tuberculous fistula also passed the board. He was in the hospitals for months, an expense to his country, a burden to the shipping capacity, and finally, after months of no service, at an expense to his government, with loss of health to himself, he returned to Memphis, and I have been treating him ever since for the tuberculous fistula. These two cases illustrate how little attention is paid rectal conditions. I have known of several men who went into the army with infectious diseases of the rectum and colon. Not only were they an expense to the army but they were a menace to those with whom they came in contact. Therefore, I emphasize the importance of not allowing these men to go unexamined.

DR. DWIGHT H. MURRAY, Syracuse, N. Y.: In my address as retiring chairman of this section I recommended that a committee of five members be appointed, and a committee was appointed consisting of Martin E. Rehfuss, chairman, Dr. Dudley Roberts, Dr. William Gerry Morgan and myself. We went to Washington for the purpose of putting this thing before the army medical officers, and we did it. The final result was that thirty-two gastro-enterologists and proc-

tologists were appointed. Dr. Graham was one of them. Some of them were proctologists, but most of them were gastro-enterologists, and one was assigned to each base hospital in this country. There is no doubt that the army could have done much better if it had appointed a proctologist with each gastro-enterologist.

DR. J. COLES BRICK, Philadelphia: I wish to relate an instance which I think would be a proper basis for a plea that this society make in Washington, as a matter of record, in case of a future war, for the appointment of a reference board for the examination of rectal cases, and I will mention a case which I think will justify it. A man was passed in Class A and he was ready to go to camp when he made the statement to his physician that he had a marked rectal prolapse. The examining surgeon failed to locate any rectal trouble. The man came to me and I gave him an enema in order to demonstrate the degree of prolapse, and found a procidentia. The rectal wall came out four inches, making eight inches outside of the anal margin. I gave him a certificate stating that this could be produced at will by giving an enema and having him bear down. The examining surgeon declined to accept it, still putting him in Class A, unless I would make an affidavit that he was unfit under military conditions, which I did. In other words, "he passed the buck." Now, it seems to me if this society sees fit to make certain recommendations to the authorities at Washington for the appointment of a reference board to determine the rectal conditions with reference to military service it would be apropos.

DR. A. CHARTIER, Sorel, Quebec, Canada: I cannot let this occasion go by without telling you the way we acted in Canada, especially on rectal cases. The instructions received by the examiners were that men suffering with rectal diseases, such as hemorrhoids and fistulas, should not be placed in class A; and, therefore, they could not go in the fighting line and become, if I may put it that way, a burden to the hospitals at the front. The men were placed in classes B, C and E, depending on the seriousness of the trouble. As for being in the trenches and unfitted for the work by rectal troubles, I believe that very few were there, because the medical boards all through our country had received instructions on the classing of men and the examination of the rectum was never neglected.

DR. J. DAWSON REEDER, Baltimore: In defense of some of the surgical records, I feel that perhaps a little injustice has been done us. I was a member of the Medical Advisory Board, No. 1, of the state of Maryland, and have been limiting my practice to proctology for at least ten years. I had nothing to do with the assignment, but was assigned as a genito-urinary expert on this board, and a gynecologist was assigned to make the general inspection, carry out the orders of the War Department, which included the inspection of the anorectal region. Some of the mistakes that have been presented here today were due to the faulty assignments in the various medical advisory boards throughout the country.

DR. LOUIS J. HIRSCHMAN, Detroit: If a criticism of the method of examinations seems to be implied in the paper it was absolutely meant as a criticism—not a criticism of the individual medical officer who did his bit, whether he did it on an examining board or whether he did it on the front line, but a criticism of our military methods. The War Department was warned by a committee sent by this section, as Dr. Murray has told you, and instead of heeding the warning given early they did not profit by it, and "by their fruits you shall know them." Every man who was in a base hospital in France will tell you the same story that I told you, that we had beds littered up with rectal cases that should have been taken care of at home. Class C men should have been made into Class A men by being operated on at home and then sent over, and they would have saved a great loss of man power. So far as our duty in the matter is concerned, it is very clear. It is up to us, in some way, shape or manner, perhaps through our delegate who represents the section in the house of delegates, to bring up some sort of a resolution calling the attention of the War Department to the fact that through our histories received from patients we discovered that many of them were not examined at all for rectal diseases, and that those that were examined were examined very superficially. I have had officers tell me they were examined by sergeants who were not even medical men, and a note was made on the medical history. We should ask for a recommendation of this kind, that a proctologist should be appointed for each training camp for medical officers, and if he does not do another thing he should teach the medical officers the way to make a proper examination of the rectum and the reason for such an examination. By showing figures which can be compiled very easily from the Surgeon-General's report of the thousands of operations done in France, which should have been done at home, we can make our point. We can instruct men who are assigned to rectal operations how to do them, and in that way we can get some service for our men in the next war. In the British army the examination was very thorough. In the American army, however, we would not put a man with prolapsing hemorrhoids or any rectal disease even in Class B, because our Class B men were sent in the service of supply that had to do with supplies and transportation, and if you can imagine a Class B man with a big prolapse of the rectum carrying a big 100-pound sack of flour on his back, you will see he was working just as hard in the Class B service as in Class A. So I still maintain that the complete treatment and the complete relief of proctologic conditions should take place not anywhere near the zone of war, but at home before the men are sent away.

CIRCUMSCRIBED PHLEGMONOUS GASTRITIS (SUBMUCOUS ABSCESS OF THE STOMACH)

REPORT OF A CASE WITH RECOVERY AFTER RESECTION OF THE STOMACH

EMIL NOVAK, M.D.
Instructor in Clinical Gynecology, Johns Hopkins University Medical Department
BALTIMORE

Phlegmonous gastritis is one of the rarest of diseases encountered by the abdominal surgeon. It is almost always fatal, and in only a very few cases have surgical measures been employed for its relief. Indeed, so far as I have been able to learn from a fairly thorough review of the subject, the case I am about to report is only the second in medical literature in which radical cure of the disease, by resection of the stomach, has been resorted to.

REPORT OF CASE

History.—C. E., a girl, aged 19, unmarried, who was referred to my service at the South Baltimore General Hospital by Dr. J. A. Miller of Baltimore, and whose family history was uneventful, had enjoyed good health, with the exception of frequent attacks of tonsillitis, up to the time of the onset of the present trouble. In January, 1918, she was operated on at another hospital for chronic appendicitis. At this operation, which was performed through a McBurney incision, the appendix was found to be very much adherent. The upper abdomen was not explored at this time. For about three years previous to her admission to the hospital, the patient had suffered with pain after eating, the distress coming on sometimes even while eating, and lasting from about one half to three quarters of an hour after meals. The pain was confined to the epigastric region, although there was said to be a slight "pulling" pain in the right iliac fossa previous to the operation for appendicitis. Following the operation, this pain in the right side disappeared, but the stomach symptoms above described still persisted.

For the six months previous to admission, pain in the epigastrium had been constant, although, as a rule, it was made