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, Folduros, 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
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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 dis-

appears 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 sigmoid-
oscope. 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


not be followed. The lesion is excised down to muscle, with deep cuts to
allow the edges to approximate, and to permit the cicatriz to form in one day. Stitches, as,


frequency cause infection. I am not surprised to see it in

procedure, but sub-

text-books, to incidence,


Fig. 1. Correct position for sigmoidoscopy. The finger is inserted toward the perianal area.

Fig. 2. Incorrect position, the finger is inserted toward the anterior rectum.

if ever, be used in any disease of the anus. They are not useful.

In general I think hemorrhoids are not a disease to be cured long. Very frequent oper-

ations for hemorrhoidectomy are required if they are not merely to hospitalize.

In the cases to these patients it

Preoperative treatment is simply shaving the perianal
procedure, but subsequently. The old teaching, still advocated 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, 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 hypnoric 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

his aid to the surgeon who had draped over his knees

No soapy water, no scrubbing, no sheeting nor foot tub.

these errors on the patient being

comfortably seated on the patient

said and more comfort.

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

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.

The first dressing, as described by Dr. Lewis, is done by placing a round
of oedematous tags a little to each side of a little discomfort. A double
(fig. 2) a pad being

dressing is built up to

the apex of the pyramids
drawn down firmly

tied, a pad being placed

from the tip.

Fig. 5. The tails of

placed over


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.](image)

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. 1/4 with scopolamine 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.

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 a pile of fluff gauze after operation.

5. Catheterize bladder, and, if it reaches above the pubis, make an indwelling catheter. Percussion at back may give a urinary afebrile area.

6. Two tablets of aspirin or similar analgesics at bedtime.

7. Pass a colonoscope.

8. On the third day, if still in hospital, give an injection of morphia.

water through a tube introduced into the rectum, or through the toilet or commode, or even into the bladder by a rectal catheter if one be felt until it is expelled. Thereafter, water.

These orders, while seeming rather drastic, are necessary for the sake of the patient's comfort and to prevent the formation of a rectal or bladder calculus.
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 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 division, 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, 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.


This review covering 1938 includes the United States, Canada, and U. S. possessions. The content, only of interest or importance as a source of the actual results of the work is extended to other countries.

The preparation is an extensive task. The following points which

1. Abel: rectocele, 25% ; rectocele after operation: 60 days to 1 year. 10 to 30, 1; 62% between 20 to 30 days. 10; descending colon, 62% between 20 to 30 days. 10; descending colon, 62% between 20 to 30 days. 10; descending colon, 62% between 20 to 30 days. 10.

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