Section of Proctology

President—CLIVE BUTLER, F.R.C.S.

[*January* 30, 1952]

The following Cases and Specimens were shown:

Mr. RUPERT CORBETT.

(1) **Colon and Terminal Ileum showing Regional Ileitis and Regional Colitis with Stricture Formation** from a woman of 47 with intestinal obstruction. Following a subtotal colectomy rectal control was re-established. (2) **The Fate of a Dragstedt's Ileostomy.** Four months after formation, the ileostomy completely disappeared into the abdomen. Function was maintained and on re-fashioning it was found that owing to a stenosis at the opening, the ileum was drawn in with separation of the graft and, finally, the tube of the graft was also in the abdominal wall.

Mr. A. DICKSON WRIGHT.

(1) **Plastic Carcinoma of Cæcum Complicating Chronic Colitis** of twelve years' standing (man of 26) complicated by nephrosis and anasarca. The colon though greatly fibrosed was not polyposed or ulcerated, although mucosa was completely changed in character and appearance. (2) **Plastic Carcinoma of Rectum** from man of 84, resembled plastic linitis of the stomach and mucosa. Membrane was normal and unulcerated. Recovered well after abdomino-perineal resection. (3) **Ileostomy and Subtotal Colectomy for Ulcerative Colitis.**—The patient (female of 23), after nine months' illness, had lost half her weight at time of operation (4 st. 7 lb.). A total colectomy, with spout ileostomy carried out in one operation in spite of emaciation, had a remarkable effect and she now weighs after two months, 7 st. 10 lb.

Mr. LIONEL E. C. NORBURY.

Perforated Diverticulum of the Descending Colon Simulating a Carcinoma in a Man Aged 44 Years.

Mr. W. B. GABRIEL.

(1) **Rectum Showing a Carcinoma and Lymphosarcoma at the Same Level.** (2) **Squamous-cell Carcinoma of the Rectal Ampulla.**

Mr. H. E. LOCKHART-MUMMERY.

Squamous-cell Carcinoma of Recto-Vaginal Septum.

Dr. JAMES EARLE.

(1) **Malignant Growth of Rectum of Indeterminate Origin.** (2) **Unusual Spread of Mucoid Carcinoma of Sigmoid Colon.**

Mr. STANLEY AYLETT.

Anus, Rectum and Lower Colon from a Patient Suffering from Non-specific Ulceration of These Regions.

[*February* 27, 1952]

The Use of Bradosol Solution (1 in 2,000) as a Wound Dressing in Rectal Surgery

By W. B. GABRIEL, M.S., F.R.C.S.

BRADOSOL is a new antiseptic, a quaternary ammonium compound, produced by the Ciba Research Laboratories. It is described as a cationic bactericide and detergent, readily soluble in water and giving a neutral solution which lathers copiously. Bradosol is stated to be effective in very low concentrations and to have a Rideal-Walker coefficient of 450. Bacteriological tests have shown that it has a high degree of activity against *Staphylococcus aureus* and *Streptococcus pyogenes*, and that it is also active against Gram-negative organisms.

In 1950 I thought it might prove valuable in dilute solution as a primary dressing for rectal wounds and, by virtue of its soapy characteristics, would be an efficient and kindly solution for the patient: Having in mind that dreaded third-day dressing which so often is tightly wedged into the anal canal, very adherent and only capable of being shifted little by little, with great care, under a stream of several pints of peroxide lotion, or else with the aid of intravenous Pentothal given in the patient's bed (a practice which I believe is not altogether without risk), I hoped that Bradosol might be the means of introducing an improvement in our routine. I accordingly agreed with the makers to give Bradosol an extended trial in rectal cases and I can say at once that my hopes have been realized.

This report covers a consecutive series of 310 minor operation cases under my care at St. Mark's Hospital from August 1950 to February 1952, inclusive. These were all in-patient cases in which open wounds were left at the anus following operations for cure of hæmorrhoids, fissures and fistulæ (either alone or in various combinations), partial prolapse, fibrous polypi, anal skin tags and abscesses. In all of these cases one or more flat open wounds were left at the anus. In the case of the fissure and fistula wounds a surface coagulant in the form of 20% tannic acid in flavine was dabbed on for a few seconds at the conclusion of the operation prior to application of the final dressing. This dressing, in all the cases now reported on, has been 1 in 2,000 aqueous Bradosol applied as usual on flat folded gauze with a corner of the moistened dressing tucked into the anal canal.

Post-operatively for the next two days the original gauze dressing has been damped each morning and evening with the Bradosol solution, and on the third morning the routine olive oil and gruel enema has been given.

This brings me to the crux of this report. Previously the third-day dressing has been a painful and sometimes a distressing session, but recently I attended at St. Mark's Hospital one morning with the intention of seeing what exactly happened to 6 patients operated upon three days previously—4 of these were fissures (surely the test of any rectal routine), and 2 were straight hæmorrhoids. In all of these cases I found that the original gauze dressing had been passed spontaneously, definitely without any traction by the nurse or sister, in 5 cases after the enema and in 1 case before it. The third-day dressing then merely consisted in irrigating the wound with peroxide lotion and tucking in a fresh dressing. I feel quite sure that these patients had a very comfortable passage with their third-day dressing compared with the average. Since making this observation a careful note has been kept regarding the third-day dressing in a total of 43 rectal cases, and it has been found that in 37 (or 86%) the original dressing came out spontaneously; in only 6 cases was it slightly adherent so that some traction under a stream of lotion was required.

Subsequently the dressings have been carried out on routine lines by irrigation morning and evening with dilute peroxide lotion, and a fresh gauze dressing moistened with 1 in 2,000 Bradosol has been laid on the wounds.

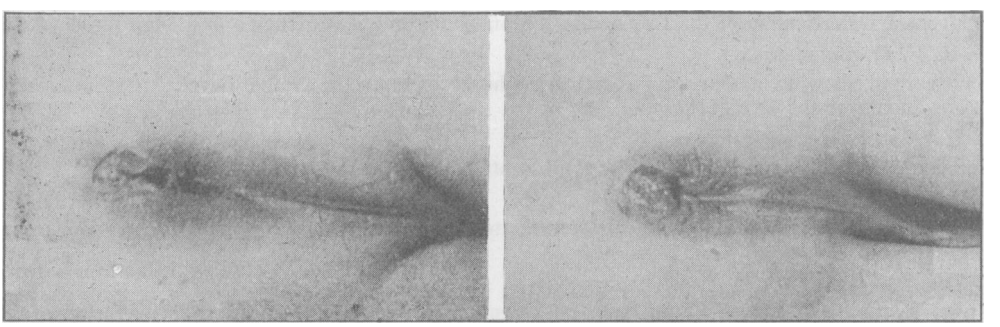

FIG. 1

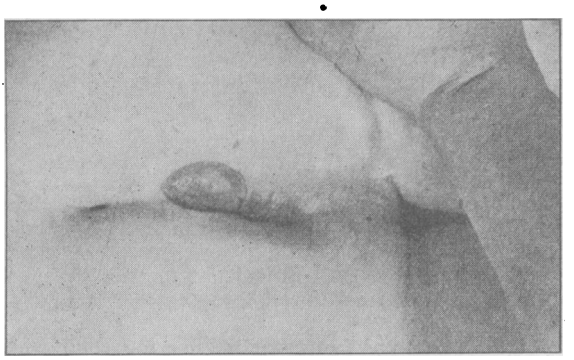

FIG. 2.

FIG. 1. — Two fissure wounds on the fourth post-operative day, showing the clean wound surfaces, the clear-cut edges and absence of skin irritation after dressing with Bradosol lotion.

FIG. 2.—Fistula wound on sixth post-operative day showing remarkably clean surface and margins on Bradosol dressings.

Later results.—I have no hesitation in saying that the state of these anal wounds, on and after the third day, has been superb, as will be seen in Figs. 1 and 2. There has been no skin irritation, and on the third day the skin margins have been clean cut, without the least sign of inflammation, and the surfaces of the wounds, particularly in the fissure cases, have been amazingly bright, clean and relatively free from evidence of the tannic acid coagulation.

The subsequent course has been equally satisfactory and when inspected on the sixth post-operative day the wounds have been flat, clean, and in my estimate several days in advance of the average. In the early days of this series, while the Bradosol solution was still under trial, the dressings were usually changed to lotio rubra on the sixth or seventh post-operative day, but now the wounds seem to go so well if kept exclusively on Bradosol that I seldom see any indication for making a change. Many fissure cases have been discharged on the sixteenth post-operative day and have only needed one subsequent visit to the Out-Patient Clinic.

The hæmorrhoid cases constitute slightly over half of the total number treated with Bradosol (162 out of 310 cases) and have done extremely well; the anal wounds have kept remarkably clean and healing has now become very even and rapid, without any evidence of that initial period of local sepsis and discharge which used to be quite common after hæmorrhoidectomy, in old subjects especially.

Bradosol solution has been particularly effective in cleaning up big fistula wounds. In 2 recent cases of infected pilonidal sinuses with secondary discharging openings which were excised and left open, the wounds were dressed with Bradosol on and after the third day when the original zinc peroxide gauze was removed. Although these wounds were rather large and deep at first, they are healing very quickly and present ideally bright red clean surfaces. The patients are very comfortable and have had very little pain.

Conclusion.—I can without hesitation recommend 1 in 2,000 Bradosol as a primary dressing for rectal wounds and its soapy characteristics provide many advantages: it is a good antiseptic and seems to inaugurate rapid wound healing by granulation. In the series of 310 cases now reported I know of no instance in which the skin has become inflamed or irritated, or in which the use of Bradosol has had to be discontinued or changed for this reason.

As a postscript to the above I might add that Bradosol is equally satisfactory for a perineal dressing after excision of the rectum and it is also being used for the subsequent dressings after that common out-patient operation of excision of an anal hæmatoma.

Alcohol Injections in the Treatment of Pruritus Ani

By J. H. Lees Ferguson, M.B.E., M.A., M.B., B.Chir., F.R.C.S.

It is generally recognized that the majority of patients suffering from pruritus ani have a local pathological condition or infection causing the irritation, which is susceptible to treatment (Gabriel, 1949).

In this short paper a residual number of 28 cases of essential, idiopathic, intractable or chronic pruritus ani are presented, in which no direct cause was discoverable, or in whom symptoms persisted after any probable causes were removed, and who eventually came to alcohol injection (Table I).

Table I.—Intractable Pruritus Ani
St. Mark's and Middlesex Hospitals. 1947–1951

Total cases reviewed	31
Too recent for follow-up	3
Total analysed	28
Ages: 24–70, majority of middle age	
Sex: Men 10, women 18	
Duration of Symptoms 1–22 years	
Average 7·7 years	

Table II.—Treatment of Associated Rectal Conditions

Hæmorrhoids injected	9
Hæmorrhoids excised	3
Fissure excised	2
Mucosal prolapse ligated	1

The multitudinous varieties of treatment advocated for this disease are sufficient proof of its unresponsiveness.

All of these patients received, for long periods, the basic general treatment accorded to all cases of pruritus, consisting of instructions as to careful hygiene, the application of simple preparations such as lot. mag. carbol. and prohibitions regarding diet and raiment. This resulted in slight improvement in individuals, but in no cures.

Local rectal conditions were treated in 15 patients (Table II).

No improvement resulted save in the patient with mucosal prolapse.

Other treatments of the pruritus are given in Table III.

Table III.—Direct Treatment of Pruritus

Hygiene and lotions (lot. mag. carbol.,* antimycotics, &c.)	28 patients
Ball's operation	3
Deep X-ray therapy	6 (10 courses)
Antihistamines	11
Psychotherapy	6
Proctocaine	7

* It consists of Phenol gr. xv; Zinc oxide gr. xxx; Prep. calamine gr. xv; Glycerine ℥ xxx; Rose water ℥ lx; Mixt. of mag. hyd. to 1 ℥.