I have now performed this operation on twenty cases: Carcinoma 10, Crohn's disease 7, sarcoma 1, volvulus 1, intussusception 1.

There has been no mortality but one post-operative mishap. Here the patient's paramedian incision broke down, a coil of small bowel became lodged in the wound, a small bowel fistula from this coil developed and the wound took three months before it was finally healed.

Comment

I believe this operation has certain advantages and that it is applicable to all but the worst cases. It is a one-stage resection; no second operation to close a fistula is necessary. Though the anastomosis is intraperitoneal it is fixed to the parietal peritoneum beneath an abdominal incision and should sepsis occur within its omental wrappings it has at least an excellent opportunity to reach the exterior. The anastomosis is placed so that it covers the upper part of the "raw" area left by the resection. Not only is decompression drainage provided for the upper part of the alimentary tract by the gastric suction but the lower reaches of the ileum, that danger area in the post-operative case, are also drained and can be emptied considerably at operation. There may be dangers in introducing a rubber tube through an anastomosis, but I have seen no ill-effects. It is perhaps apposite to point out that Wangensteen (1943) has described two cases in which, with a Millar-Abbott tube in the lower ileum, it was yet necessary to put a duodenal tube down the patient's other nostril for post-operative distension. That this can occur once the small bowel has been "swept and garnished" by the passage of a Millar-Abbott tube and with the tube still in position, is surely good evidence of the part played in post-operative distension by aerophagy.

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A Small High-grade Carcinoma of the Rectum with Extensive Lymphatic Spread.—W. B. Gabriel, M.S.

R. B., male, aged 48.

History.—His chief complaint was of piles, with latterly more prolapse and some burning pain at defæcation.

Examination on 12.11.45 at St. Mark's Hospital revealed a curious indurated elongated plaque in the left anterior quadrant of the anal canal and extending up the rectal wall for about ½ in. (1·25 cm.). The condition suggested at first a recent thrombosis or possibly an early squamous-cell carcinoma.

Biopsy.—A month later the condition was unchanged and an examination under low spinal anæsthesia was done. An indurated cord of lymphatic spread was felt running up the mesorectum in the left posterior quadrant which strongly indicated the diagnosis of malignancy. A biopsy was done and Dr. C. E. Dukes reported that the tumour was a very undifferentiated type of carcinoma of a high grade of malignancy.

Operation.—On 17.12.45 a laparotomy was done under a nupercaine spinal, 1·2 c.c., with pentothal, gas, oxygen, ether. The liver was smooth but some palpably enlarged glands were felt in the mesorectum on the left side. A perineo-abdominal excision was carried out and uneventful recovery followed, the patient being discharged home on the twenty-sixth post-operative day, 12.1.46.

Pathological findings (Dr. C. E. Dukes).—*Gross characters*: The specimen measured 15 in. (38 cm.). There was no obvious tumour, the only visible abnormality being a small hard ridge in the anal canal and lower third of the rectum over which the mucous membrane was not ulcerated. This ridge could be felt to be in continuity with a thickening around the hæmorrhoidal vessels lying in the perirectal tissues. A cord of hard tissue extended up the course of the hæmorrhoidal vessels for several inches. No papillomata were present but diverticula were seen in the distal end of the pelvic colon.

Microscopic structure: The tumour is a colloid carcinoma, very undifferentiated in character, consisting chiefly of isolated signet cells or clusters of signet cells embedded in mucoid material.

Methods of spread: (1) *By direct continuity*—The growth had extended by permeation of the lymphatic channels causing a continuous extension along the hæmorrhoidal vessels. (2) *Venous spread*—There was no sign of venous spread. (3) *Lymphatic spread*—Eleven out of fourteen glands removed at dissection contained metastases and so did the gland marked "uppermost" sent separately for examination.

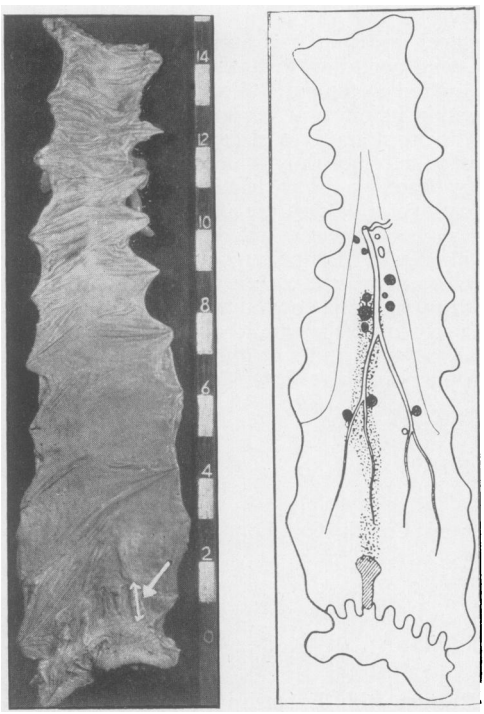

FIG. 1.—A small high-grade carcinoma of the rectum (marked by arrow) with extensive lymphatic spread.

Classification.—Colloid carcinoma of rectum. Extensive lymphatic permeation and twelve glandular metastases. C 2 case.

Subsequent Course.—He remained in fairly good health until 6.5.46, when he reported for examination complaining of some difficulty in micturition. A deep induration in the perineum indicated local recurrence and in addition he presented an enlarged gland in the left groin. He was then referred to St. Bartholomew's Hospital for consideration as to high-voltage X-ray therapy, but when admitted there he was found to have retention with overflow, and cystoscopy showed malignant infiltration of the prostate and bladder. Decompression by an indwelling catheter was required and it was decided that X-ray treatment was contra-indicated.

Re-examination towards the end of June 1946 revealed a very hard irregular fixed mass in the perineum. The patient subsequently went steadily downhill and died of recurrence on 28.8.46, that is, a little over eight months after operation.

Commentary.—The case is of interest from several aspects: (1) The history and clinical findings were anomalous, but the biopsy was of great value in establishing the diagnosis of malignancy; the histological grading rightly indicated a bad prognosis.

(2) The presence of palpable extrarectal spread was revealed by digital examination of the rectum prior to operation and the grave prognosis which accompanies this finding was confirmed by the progress of the case.

(3) Although the primary growth was extremely small, early and extensive lymphatic spread had taken place by the time operation was undertaken and the rapid onset of recurrence shows that even then the growth was surgically inoperable.

Carcinoma of the Paroophoron, invading the Rectum.—A. LAWRENCE ABEL, M.S.

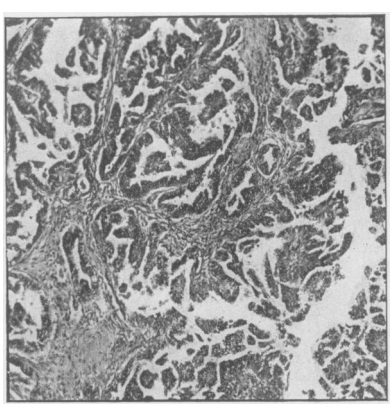

FIG. 1 × 45.

Female, aged 66.

History.—Difficulty in defæcation and occasional slight rectal incontinence for three months, with recent vaginal discharge of blood-stained fluid.

Examination.—*P.V.*: Ulcer crater in the posterior fornix which was closely adherent to the rectum. Biopsy showed a papilliform adenocarcinoma.

Operation.—Wertheim's panhysterectomy and abdomino-perineal resection of the rectum.

Specimen.—The lower sigmoid rectum and anal canal with the attached uterus and its adnexa and vagina (shown at the meeting).

Histology (Dr. L. Woodhouse Price). — Shows the general structure of a malignant ovarian cystadenoma (fig. 1).

Diagnosis.—Carcinoma of the paroophoron, invading the rectum.

(The report of this meeting will be concluded in the December issue of the Proceedings.)