Clinical and Other Notes.

AMOEBOMA OR CARCINOMA OF THE RECTUM?

BY

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Recent literature has discussed the surgical complications of amœbic dysentery including amœboma (Cropper, Smythe and James). This serves to remind us that we must keep amœbic dysentery in our surgical differential diagnosis. But at the same time we must not hesitate where the physical signs are so clear-cut that another pathology is indicated. This pre-occupation with amœbic dysentery caused a physician and a surgeon to hedge in a patient suffering from a frank carcinoma of the rectum.

James reported that in a series of a thousand cases of amœbic dysentery six cases of adenocarcinoma of the colon (two of which were within reach of the examining finger) were treated as dysentery.

As a routine in this hospital all suspect dysenteries are examined with the sigmoidoscope. In one patient at this examination the attending physician considered he saw either a carcinoma or an amœboma. This examination was repeated and a surgeon agreed but considered that amœboma was more likely because the patient had served abroad where he had had occasional bouts of diarrhœa and because his age was 43.

Before any further investigations were undertaken I asked to see the patient. He stated that twelve months before admission he had had injections for piles. He had not been hospitalized previously for dysentery. His present complaint was looseness of the bowels, the motions being watery, loose and containing blood; previously he had had one firm motion per day. There was no loss of weight. The only physical signs were in the rectum where on digital examination a typically craggy hard tumour was felt in the lateral rectal wall. Its lower edge was raised but the finger could not reach the upper limit. It was not fixed. The prostate and vesicles were normal.

Sigmoidoscopic examination was suggestive of a malignant ulcer whose edges were raised and everted and whose centre was ulcerated, friable and bleeding. It was situated 3½ in. from the anus. The appearances were that of a carcinoma of the rectum and of nothing else. A piece was removed for section and the patient transferred to the Surgical side where his colon was prepared for operation.
Biopsy showed an adenocarcinoma. Perineo-abdominal excision of the rectum was performed under spinal nupercaine plus cyclopropane and oxygen (Major Miss Watson, D.A., R.A.M.C.).

The specimen was sent to the surgical department of the Royal Army Medical College who kindly supplied the photographs. In fig. 1 the specimen is laid open to show the malignant ulcer. In fig. 2 the excised rectum and anal canal is viewed from behind to show the dissected vascular pedicle with the associated pararectal and superior haemorrhoidal lymph glands which have been numbered.

Major H. Spencer, R.A.M.C., of the pathological department of the college reported microscopically that “the rectal growth itself is a tubulo adenocarcinoma. There does not appear to be any deep penetration of the muscular coat. Lymphatic glands 1, 2, 6, 7 and 10 are all free of carcinomatous cells but show a good deal of chronic sinus catarrhal change indicative of chronic inflammatory changes. The growth is classified as a Broder type 2.” According to Dukes classification it belongs to group A, 83.9 per cent of which have a five-year survival rate after combined excision of the rectum.