ULCERATIVE COLITIS

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184 ILLUSTRATIONS

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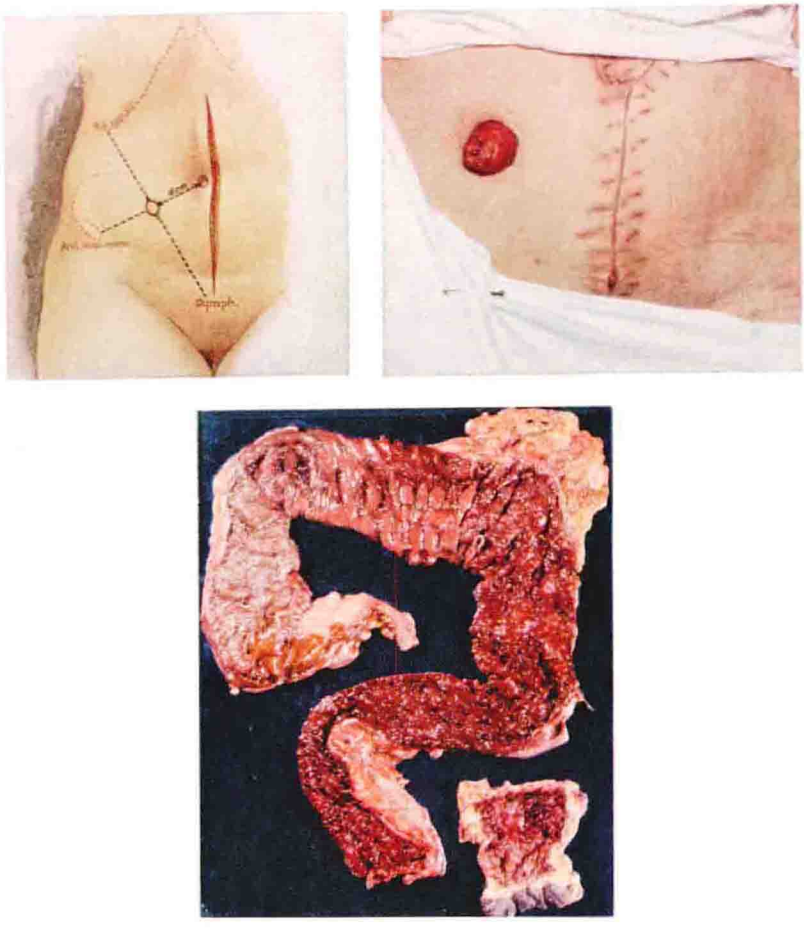

(*Top, left*) Placement of ileostomy determined by intersection of lines drawn from 9th rib to symphysis and from right anterior iliac spine to umbilicus.

(*Top, right*) Appearance of ileostomy on 10th day prior to discharge.

(*Bottom*) Specimen removed by single-stage ileocolo-proctectomy.

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To
ALTON OCHSNER

Distinguished surgeon, teacher, investigator, whose vision in establishing and developing a department of colon and rectal surgery has proved to be an expanding influence, bringing increased knowledge and enhanced skills to those who serve and relief from suffering to those who are served.

Foreword

There are few conditions that have presented greater problems in therapy and more controversy than chronic ulcerative colitis. As succinctly stated by Dr. Bacon: "The fact must be recognized that there is no specific cause and, at the present time, no specific nonsurgical form of treatment." In view of the complete ignorance concerning the etiologic factors involved in the production of chronic ulcerative colitis, it is understandable that there is a lack of uniformity concerning therapy.

Dr. Bacon has made a distinct contribution to a rational understanding of chronic ulcerative colitis. The subject is considered from every possible angle, with an extensive and thorough evaluation of the various theories concerning etiology and a detailed description of the pathologic lesion associated with ulcerative colitis. The clinical picture of chronic ulcerative colitis and the methods of diagnosis, including a complete consideration of differential diagnostic problems, are thoroughly discussed. Complications of ulcerative colitis, which from the standpoint of diagnosis are extremely important, are very carefully considered, and recommendations are made concerning their prevention and correction.

Unquestionably, psychiatric disturbances and emotional instability are prominent factors in many patients with chronic ulcerative colitis; probably it is for these reasons that many physicians believe psychiatric treatment to be all that is necessary in the care of these unfortunate individuals. Though emotional instability can never be disregarded, the organic phases of chronic ulcerative colitis are equally as important as the emotional factors, if not more so. Regarding this, Dr. Bacon says: "The psychiatrist should not be permitted to imprison a patient in a special department or even compartment for hourly intervals, three to five times a week for months or even for years, while the patient suffers continuing, intractable diarrhea or pseudopolyps abound, recurrent abscesses develop, fistulas drain and carcinoma tends to develop."

Because many cases of chronic ulcerative colitis can be treated adequately by conservative measures and because many physicians have the misconception that ulcerative colitis should be treated only by nonsurgical measures, Dr. Bacon discusses with considerable detail the nonsurgical treatment. He states: "There is perhaps no illness the treatment of which has so completely defied all efforts at standardization as nonspecific colitis. Indeed, it is this nonconformity and departure from the usual among diseases that has so greatly engendered and nourished the many biases and misconceptions that even today prevail in no small number." The nonsurgical methods of therapy are considered, presented and carefully evaluated in an extremely complete manner as only one with such extensive experience could do. Dr. Bacon's experience embraces over 400 cases of chronic ulcerative colitis in a period of 16 years. He emphasizes that approximately 60 per cent of patients can be fairly well controlled by general medical care, but that they must be followed carefully because of the danger of recurrence and exacerbation.

Unfortunately, in too many cases, progression to the severe form of chronic ulcerative colitis is permitted by continu-

ation of nonsurgical treatment in patients who do not respond to the therapy, and, according to Dr. Bacon, surgery is required in from 20 to 30 per cent of all cases. To quote Dr. Bacon: "The danger of procrastination to these patients who do not respond to a conservative regimen is all too evident. In fact, if we are to see substantial reduction in morbidity and mortality, counsel with the surgeon, whether or not operation is elected, should be obtained early. Even before diagnostic studies are complete, the surgeon should have the liberty of supervising all decisions." The indications and the contraindications for surgical intervention are carefully considered and evaluated. The various operative procedures employed, colectomy and ileostomy, are discussed, a critical analysis of the results obtained from each procedure being given. Colectomy is employed at times as a life-saving procedure in acute fulminating toxic ulcerative colitis. Surgical procedures are used to correct and prevent disabling and fatal complications, and they are used as well in patients in whom the lesion becomes intractable. Technics of the various surgical procedures are excellently described. Although the author decries procrastination in the use of surgical procedures when they are indicated, he is certainly not "knife happy," as shown by the fact that of the 440 cases with chronic ulcerative colitis treated by him and his colleagues, only 108 patients had colectomies. Undoubtedly, the cases seen by the author and his associates represent the most severe types of chronic ulcerative colitis. Because of Dr. Bacon's tremendous experience in the treatment of bowel conditions, a large number of cases are referred to him, and, therefore, the cases seen by him and his group are much more severe than those seen by most surgeons.

A chapter, written by Dr. LeRoy W. Krumperman, is devoted to anesthetic management in surgery for ulcerative colitis. There is also an excellent chapter on preoperative and postoperative treatment of patients with chronic ulcerative colitis.

Dr. Bacon's contribution on chronic ulcerative colitis is the most complete consideration of the subject that has ever been prepared. It is so well done and so authoritative that physicians who might come in contact with the disease cannot afford to be without the book. The pathologist, the internist, the gastroenterologist, even the pediatrician (because the disease does occur, although infrequently, in patients under 15 years of age) and the surgeon need this monograph in their libraries. There is no other place where so much factual information and critical evaluation of chronic ulcerative colitis can be obtained so readily and so easily.

ALTON OCHSNER

Preface

Nonspecific ulcerative colitis is a debilitating and devastating disease, the many facets of which often are viewed with little concern. In fact, there is probably no other clinical entity in which the extensiveness is so frequently undetermined, the ramifications so definitely unappreciated and the treatment so often futile. While the disease in its incipient form generally responds to conservative measures, it is in its more severe manifestations, limited to approximately 20 to 30 per cent, that surgery is required, yet so belatedly instituted.

The clinical problem of nonspecific colitis is one of magnitude and infinite complexity that has challenged the acumen and skills of the medical profession for decades. The disease has been the testing ground of well-based as well as half-hatched theories, and the patients have been subjected to clinical methods not thoroughly thought through. More unfortunate is the fact that these sick have been the birds that have been batted back and forth across the net of argument in the clinical game of badminton. On one side of the net have stood those clinicians who obstinately persist in medical treatment when all signs point to failure and deterioration. On the other side is the psychiatric fraternity, many members of which display an unenlightened propensity to toss all colitis patients into an unqualified psychotic group with an unchastened disregard of common sense and pathologic facts. Is it any wonder that pseudopolyps abound, cancer develops, abscesses and fistulas appear, ileal invasion progresses and hepatic as well as pancreatic disease becomes manifest? This is a situation fraught with disaster for the patient, and the tables in the following text lend support to this statement.

From the welter of theory and practice certain facts emerge—facts that one would suppose even the narrowest mind could not discount: procrastination spells doom for the patient; the high rate of cancer is more than coincidental; organic manifestations differ from functional syndromes; through surgery complete rehabilitation can be obtained in over 90 per cent of cases and with low mortality and decreased morbidity.

The mortality rate would drop materially if clinicians were quicker and more willing to recognize the line where their methods no longer benefit the patient, where colectomy could save and rehabilitate many who now reach the operating table too advanced for salvage either for life or for the resumption of the useful duties of the living. Such clinical procrastination dooms the patient, not the physician. Many psychiatrists rate criticism because they assume an unjustified authority over the life and being of these patients, often isolating them from access to the gastroenterologist and the surgeon, in complete disregard of organic lesions that, for want of surgical care, continue an unobstructed course of deterioration.

In the past, any type of surgical intervention ran the gamut of criticism, perhaps rightly so. Largely because patients were referred when nearly moribund, the operative mortality was extremely high and paralleled closely the mortality from a medical regimen. Many who were fortunate enough to survive their ileostomy required repeated hospitalizations for revisions; those who submitted to segmental colectomy usually experienced protracted morbidity, and many who had

not been colectomized developed malignancy. A new era was initiated through the advocacy of colectomy by such pioneers as Cave, Strauss, Lahey and Stone. Particularly through refinements in technic, improvements in anesthetic management, enhanced knowledge of biochemistry and more exacting preoperative and postoperative care, surgical extirpation is being performed in two stages and even in one stage, and patients are able to return to their former work, raise families and serve their community as useful citizens.

There must be a middle ground on which the several branches of medicine can meet in the interest of patients afflicted with this disorganizing disease. It is for such co-ordination of thought and effort that the author makes this plea. To forget oneself in the patient is the highest ethic of the physician—forget a theory, forget the "perhaps" of another therapeutic idea that will prove to be fruitless, forget a personal failure that carries no blame once one has done all that is possible, to remember that no physician is God and that where one man fails because of the peculiarity of a case, another, given the chance in time, may be more fortunate, again because of the same peculiarity. By pooling opinions, experience and skills in a spirit of humility the ultimate good for these patients can be accomplished.

HARRY E. BACON

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The writer is indebted to Mr. Melford D. Diedrick, Director of Medical Illustration at the University of Buffalo, to Mr. Yun Yong, Head of the Department of Medical Art at Temple University Medical Center, and to Tetsuo Yajima, Head of the Department of Medical Art at the University of Chiba, Japan, for the excellence of their illustrative material. A large measure of credit must be accorded to Mr. William J. Taylor, Head of the Department of Photography at Temple University Medical Center, for permission to use his prints and photomicrographs.

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Contents