An Address

ON THE VARIETIES OF COLITIS AND THEIR DIAGNOSIS BY SIGMOIDOSCOPIC EXAMINATION.

BY
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COLITIS is at the present time a name which is very loosely used to describe a number of quite distinct conditions.

Ulcerative colitis is a very distinct and definite disease, characterized by severe and intractable diarrhoea, profuse haemorrhage, high temperature, and which seriously threatens life.

Follicular colitis appears to be a complication of other diseases, such as cancer and stricture of the colon.

Tuberculous colitis is generally a late complication of phthisis.

Pericolitis, which causes a tight tubular stricture in some part of the colon, results from a slow fibrous change in the bowel wall.

There are also a number of specific types, peculiar to tropical climates.

Chronic Muco-membranous Colitis.

In addition to these specific forms of colitis, we have the better known and commoner condition usually in this country called "chronic muco-membranous colitis." The chief symptoms are an excess of mucus in the stools, accompanied by abdominal pain, usually of a paroxysmal type and associated with chronic constipation. Up to a few years ago, little was known as to its pathology, and it was studied almost entirely from the clinical aspect. During the last few years, however, we have been able to improve our knowledge of the causes and pathology, partly by a systematic examination of the colon by means of the sigmoidoscope, in all cases presenting themselves for treatment, and partly by the knowledge gained during the performance of operations for the relief of the symptoms.

I have during the last few years seen a large number of these cases, and had numerous opportunities of studying the causes at work, both by a routine sigmoidoscopic examination and during operations. As a result, I have been led inevitably to the conclusion that chronic muco-membranous colitis is not, as usually described, a clinical entity, but, on the other hand, is a collection of symptoms which, owing to want of better knowledge as to the pathology and physiology of the colon, have been placed together and labelled as a disease; whereas, in fact, these symptoms may result from a large number of entirely distinct pathological lesions.

Thus, I have seen cases in which all the characteristic symptoms of chronic muco-membranous colitis were found, on careful investigation to be due to one or other of the following causes:

1. Kinking and partial obstruction of the colon from adhesions or pericolitis.
2. Dilatation of the colon and visceroptosis.
3. Chronic appendicitis.
4. Inflammation or displacement of the uterus or appendages.
5. Previous operations upon the abdomen resulting in adhesions.
6. Cancer of the colon.
7. Fibrous stricture of the colon.
8. Aneurysm of the abdominal aorta.
9. Floating kidney.

Many of these conditions are only an indirect cause of the symptoms in that, by causing accumulation of faecal material in the colon, they set up pain and excessive mucus secretion.

In addition to these cases where a mechanical cause for the symptoms can be found, there are a certain proportion—which I have found in my experience to be about 45 per

cent.—in which there is a definite chronic inflammatory condition of the mucosa of the colon. These are the only true cases of chronic colitis, in that they are the only cases in which a definite inflammatory condition exists.

It is possible to distinguish three distinct types of inflammation of the mucosa.

In the *hypertrophic form* the mucous membrane appears swollen, due to submucous oedema, and of a paler colour than normal, with much sticky mucus.

One of the commonest forms is the *granular variety*, in which there is a markedly granular appearance of the whole visible mucosa, accompanied by considerable inflammation, giving the whole a dusky red colour.

There is a third well-marked variety in which the visible mucosa looks as if it had been sandpapered; the normal glistening appearance has gone and the surface epithelium has apparently been removed, leaving a bright red surface, while here and there patches of yellow membrane can be seen adhering to the surface. The appearance of the mucous membrane in many of these cases of true chronic colitis bears a close and remarkable resemblance to the inflammatory conditions of the throat.

It is, I think, obvious that in dealing with a condition having such a variety of causes and pathology the first essential of treatment and the most important factor is to make a correct diagnosis as to the nature and causation of the symptoms, and that a large percentage of failures must result if we simply class all such cases as colitis and proceed to treat them as such. Such conditions as adhesions, floating kidney, and chronic appendicitis cannot be expected to get well as the result of lavage or the administration of intestinal antiseptics and aperients. So that the all-important factor is the diagnosis.

The diagnosis in many of these cases is very difficult, but much can be done by careful investigation of the stools, examination of the abdomen, and, more especially, by a systematic sigmoidoscopic examination of the pelvic colon. The last-named method of investigation should never be omitted in these cases. With this instrument we can distinguish the different forms of true inflammatory colitis with certainty, and very frequently obtain valuable information in the cases where symptoms are due to some mechanical cause.

In cases of ulcerative colitis a sigmoidoscopic examination affords the only means we have of distinguishing this condition from cancer or villous tumour of the rectum, or from multiple papilloma of the rectum—conditions which exactly simulate ulcerative colitis in symptomatology.

The following cases well illustrate the value of a routine sigmoidoscopic examination in all cases:

CASE I.—A. B., a man aged 34, was sent to me for an opinion with a history that for eight months he had been suffering from chronic muco-membranous colitis. The stools had during that period contained large quantities of mucus and membrane, and there had been chronic abdominal pain of a slight character. No diarrhoea or bleeding. During six months he had been under treatment for colitis, but without benefit. On examination with the sigmoidoscope I discovered a malignant growth high up in the sigmoid flexure. This was subsequently resected, and the patient made a good recovery.

CASE II.—Mrs. X., a lady aged 35, had for twelve years been a chronic invalid, with symptoms of chronic muco-membranous colitis. During that time she had been more or less completely incapacitated with frequent very severe attacks of abdominal pain, which necessitated her staying in bed. A sigmoidoscopic examination showed the pelvic colon to be unduly fixed, and the presence of a kink due to adhesions was diagnosed. I operated upon her, and found several tough adhesions kinking the pelvic colon and obstructing it. These were divided, and she made an excellent recovery and had no further symptoms of colitis.

CASE III.—Mrs. M., aged 34, had for many years been an almost complete invalid from what was thought to be chronic muco-membranous colitis. On examination I found a markedly retroverted uterus pressing upon the rectum, and adhesions involving the pelvic loop. I divided the adhesions and performed ventrifixation of the uterus with complete success, the symptoms entirely disappearing.

CASE IV.—Last year I was called to see a lady who had symptoms of ulcerative colitis. On making a sigmoidoscopic examination I found the entire colon, as far as could be seen, full of polypi; and one of these had already undergone carcinomatous change.

I might easily relate a number of similar cases, but these are sufficient to illustrate the importance of a routine sigmoidoscopic examination. The examination can easily be made without an anaesthetic, as it does not cause pain, when a certain amount of dexterity in passing the instru-

ment has been acquired. In difficult cases, however, I prefer an anaesthetic, as the examination can be more deliberately carried out, and it also affords better facility for palpation of the abdomen. The one important factor for a successful examination, however, is to ensure the pelvic colon being empty at the time.

Recently one or two letters have appeared in the medical papers, in which it has been stated that there is danger in using the instrument, and that accidents may result. There is not, however, the least foundation for any alarm on this account. Naturally the instrument is not safe in inexperienced or incompetent hands any more than the majority of other special instruments, and it takes some time to learn to use it properly. Accidents have resulted from its use, but, so far as my knowledge goes—and I have, as far as was possible, investigated all the cases that have come to my knowledge—always as the result of an entirely illegitimate use of the instrument. I have personally never seen the slightest harm result from its use, and I have on numerous occasions used the instrument in cases in which the bowel was seriously ulcerated, and also in cases where an anastomosis, or other operation, had recently been performed upon the pelvic colon, for the purpose of investigating the line of union. Although the instrument is constantly being used at St. Mark's Hospital, we have no records of any injury caused by it.

In addition to the commoner forms of colitis already mentioned, there are several other varieties which are occasionally met with, and which it is important to be able to distinguish. A rare but important form is haemorrhagic colitis. This is a variety of ulcerative colitis in which the whole mucosa of the colon becomes soft and spongy, and remarkably haemorrhagic in appearance. It results in profuse bleeding and severe diarrhoea. There is also severe toxæmia, with high temperature. Most of the cases I have seen have been due to a primary infection of the colon with the *Diplococcus pneumoniae*, large numbers of these organisms being present in the stools in almost pure culture. The condition somewhat closely resembles enteric fever in symptomatology, but can be distinguished from it by the fact that blood is present in the stools from the first. The disease is very dangerous, but I have had excellent results from appendicostomy.

There is a form of ulcerative colitis sometimes seen in this country which is often described as chronic dysentery. The patient has usually suffered from dysentery while in the tropics, but instead of the diarrhoea stopping after the disease has run its course, it has persisted intermittently—often for several years. At the time when we see such cases over here they are indistinguishable from those of chronic ulcerative colitis, indigenous to this country, and require the same treatment. No specific parasite or micro-organism is to be found, and they do not react to the ordinary antidyenteric treatment, unless amoebæ can be found in the stools, which is seldom the case. I have performed appendicostomy in several such cases with most gratifying results.

Another rare form of colitis is that due to infection by the bilharzia parasite. This parasite finds a lodging in the walls of the colon, and sets up a very severe and intractable colitis. Such cases are very uncommonly met with here, but are fairly common, I believe, in Egypt.

Most of the interest in colitis in this country centres round the cases of chronic muco-membranous colitis; and, in closing my remarks, I should like again to insist on the importance of not considering this condition as a disease but as a symptom, and in the routine examination of all cases by the sigmoidoscope as a preliminary to treatment.

AN exhibition illustrating the materials and methods of construction of economical forms of sanatoriums, schools, hospitals, and other temporary buildings, will be held in the museum of the Royal Sanitary Institute, Buckingham Palace Road, during January. The exhibition will be open free daily, from 9.30 a.m. to 5.30 p.m., and on Mondays till 8 p.m. The following lectures will be given: On January 15th, at 7.30 p.m., Professor Kenwood, on fresh air; on January 19th, at 4 p.m., Dr. T. D. Lister, on problems of after-care of sanatorium patients; on January 24th, at 4 p.m., Dr. M. Paterson, on employment of patients in sanatoriums; and at 4.30 p.m. on the same day, Dr. D. J. Williamson, on antituberculosis dispensaries; and on January 26th, Professor Ralph P. Williams, on open-air schools.

VICIOUS CIRCLES ASSOCIATED WITH DISEASES OF THE SKIN.*

BY

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THE presence of a vicious circle frequently baffles the dermatologist in his efforts to cure disease, for the reciprocally acting morbid processes aid and abet each other, prolong and aggravate the disorder, and tax the resources of the medical armamentarium to the utmost. No wonder, therefore, that such strong epithets as "eternal," "endless," "highly pernicious," "incurable," "of fatal import," have been applied by various writers to so vexatious a complication.

In this inquiry the following classification of circles associated with diseases of the skin will be convenient, although it cannot always be logically adhered to:

1. Circles associated with inflammatory disorders.
2. Circles associated with parasitic disorders.
3. Circles associated with neuroses.
4. Circles associated with the appendages of the skin—hair, nails, sweat and sebaceous glands.

I. CIRCLES ASSOCIATED WITH INFLAMMATORY DISORDERS.

Eczema.

Numerous circles will be met with in the study of so common a dermatitis as eczema, which may serve as a type of pruriginous disorders. The itching and associated scratching aggravate and may indefinitely prolong the lesion that produced them. Thus McCall Anderson, speaking of acute eczema, says:

Scratching always aggravates the disease and tends to bring out fresh crops of eruption. . . . Often, in mild cases, where there is not much infiltration, the disease is kept up by the scratching alone.¹

Similar correlations occur in chronic eczema, as Kaposi points out:

The attendant itching is usually very severe and induces violent scratching. This acts as a cutaneous irritant and may excite a fresh eczema.²

Kaposi has also called attention to the "endless *circulus vitiosus*" associated with varicose veins of the leg. These veins give rise to itching and scratching, as a result of which papules, excoriations, haemorrhages and crusts are produced. The resulting inflammation and itching lead to deeper excoriations and increased inflammation. Kaposi thus describes the process:

Such a condition of the skin predisposes in a high degree, *per se*, to renewed attacks of inflammation on the slightest provocation; and, since the inflammation again tends to maintain and increase the ulceration, we have here an endless *circulus vitiosus*.³

Varicose ulcers may, as Unna points out, also be complicated by that "incurable *circulus vitiosus*" which is established when chronic oedema of the skin has caused a disappearance of elastin.

Owing to the loss of elastin, the oedematous skin gradually loses more and more elasticity; that is, the spontaneous elastic recoil of the collagenous tissue, displaced by pressure or by movements of the body, takes place more and more slowly and incompletely; the muscles of the skin lose a great part of their action on the skin texture. Thus we have an additional factor, favouring the oedematous swelling of the cutis. By the oedema directly attacking the elastin it interferes with the most important factor in the healing of oedema and induces an incurable *circulus vitiosus*, which terminates in complete loss of resistance of the skin, rupture of the epidermis, and lymphorrhoea externa.⁴

This circle is especially obstinate in what Unna calls "callous eczema" with thick and indurated edges:

This variety of eczema is always complicated by a *circulus vitiosus*. The eczema itches; the itching leads to scratching; the scratching produces and perpetuates hyperkeratosis, and the hyperkeratosis in turn keeps up the itching. By this noxious circle very trivial attacks of eczema, such as the erythemato-squamous or pityriasisiform variety, may be transformed into hard callous eczema, which lasts for the rest of life.⁵

Somewhat similar correlations may complicate other forms of chronic ulceration, as, for instance, that met with in the vulva.

* A paper read before the Reading Pathological Society.