the harsh truths pointing to the inevitability of the need to ration human life, at least within the context of American medicine, Lundberg¹⁸ concludes with a remark which is equally relevant to the need for Kuhse's "quality of life ethic"¹⁹: "One thing is certain. Reality cannot be delayed. Not to decide is to decide."

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Lesson of the Week

Hirschsprung's disease as a cause of chronic constipation in the elderly

A J RICH, T W J LENNARD, J B WILSDON

Several large series of congenital megacolon have been described in infants.¹ Severe cases do not survive infancy without surgery, but milder forms may remain undetected and present only in adult life,² occasionally as a cause of chronic constipation. The number of histologically proved adult cases is small, and we describe here what is probably the oldest patient so far reported.

Case report

A 74 year old man was admitted for investigation of an abdominal mass, constipation, and weight loss. He gave a history of difficulty in defecation and abdominal distension since birth, and he had always had to use laxatives and enemas. Apart from this he had been healthy, moving his bowels with difficulty two or three times a week.

On examination, he was a thin man of average height in good general condition. His abdomen was distended with visibly dilated bowel and palpable stercoral masses. The rectum was of normal calibre and contained hard faecal pellets. Radiological examination confirmed a grossly dilated colon with faecal residues on plain radiographs and a barium follow through confirmed faecal obstruction of the colon. The mediastinum was shifted to the right. The possibility of adult Hirschsprung's disease was raised.

No spontaneous bowel action occurred, and enemas were administered to ease evacuation. Good results were obtained, but four days after admission he complained of sudden severe generalised abdominal

Hirschsprung's disease should be considered in cases of chronic constipation, irrespective of the patient's age

pain and presented obvious signs of a perforated viscus. An emergency laparotomy was carried out. The whole of the colon was enormously dilated (figure) and thickened above a rectum of apparently normal calibre. The sigmoid loop lay under the left hemidiaphragm and had a stercoral perforation at its apex. At several points in the left and right colon longitudinal splitting of the muscle coats had occurred.

Sigmoid loop of colon presenting through incision.

Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP

A J RICH, MD, FRCS, lecturer in surgery
T W J LENNARD, FRCS, lecturer in surgical science
J B WILSDON, DMRD, senior registrar in radiology

Correspondence to: Mr A J Rich.

The rectum was divided 5 cm distal to the rectosigmoid junction through apparently normal bowel and a total colectomy with a Hartmann's procedure carried out. Histological examination confirmed the absence of ganglion cells and abnormal collections of unmyelinated nerve trunks in the distal 35 mm of rectum, the rest of the colon being normal.

His immediate postoperative recovery was complicated by cardio-respiratory instability resulting from return of the mediastinum to its normal position. After 24 hours' ventilation, however, he made an uneventful and complete recovery. At review a year after surgery he remained extremely well. His comment on his ileostomy was "I don't know why I didn't have this done 50 years ago."

Comment

Hirschsprung described the condition of congenital megacolon in 1888,³ but the true cause of the condition was obscure until Tittel described degenerate ganglion cells in the segment of bowel distal to the megacolon.⁴ This enabled true aganglionosis to be distinguished from other causes of acquired megacolon. Although originally recognised in children, it was suggested that mild cases of Hirschsprung's disease might survive to adult life. Several adult series have been reported where elective surgery has been carried out for longstanding constipation.^{2,4}

Many of the reported cases are in their second or third decade and it seems exceptional for patients to present over

50 years of age. Maglietta described a 69 year old woman with evidence of aganglionosis,⁵ but the patient died before surgery could be performed.

The case we report here showed many of the features of adult Hirschsprung's disease, including stercoral perforation⁶ and respiratory failure,⁷ and is, we believe, the oldest case so far recorded. In cases of severe constipation Hirschsprung's disease should be considered irrespective of the patient's age and can be confirmed by elective full thickness rectal biopsy.

We thank Mr R M R Taylor for permission to report this case.

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For Debate . . .

Surgical oncology—40 years behind

R DAVID ROSIN

The James Ewing Society was founded in the United States in 1940 to further the knowledge of cancer. Its founder members were mostly surgeons from the Memorial Sloan Kettering Hospital in New York and they moulded the future for surgical oncology to become a recognised specialty. In the United Kingdom today, though we have had a British Association of Surgical Oncology for nearly a decade, surgical oncology is probably at the same stage now as it was at the time of James Ewing's death 40 years ago.

There are numerous reasons for the slow progress of surgical oncology as a recognised specialty. Traditionally, subspecialties in surgery have had difficulty becoming recognised, and some specialists are still having problems breaking away from the title "general surgeon with a special interest in. . ." The overriding factor holding back surgical oncology in Britain is simply that there is not the same wealth poured into prevention, research, and treatment of cancer here as there is in the United States. The reticence of many general surgeons, however, not to accept the need for surgical oncologists and the lack of training programmes are also pertinent factors. Indeed, if one looks for academic posts one finds that the only specialist hospital in London does not have

a professor of surgical oncology but a professor of surgery, and this chair was created only during this decade. And if one analyses the professors in London teaching hospitals there is only one whose major interest in research and clinical commitment is surgical oncology, though there are a number outside London.

What is surgical oncology?

One must address two questions before debating the art or lack of it in surgical oncology in Britain. Firstly, what is a surgical oncologist? Secondly, is surgical oncology a necessary subspecialty in surgery? A surgical oncologist should be a highly trained general surgeon interested in the treatment of cancer and knowledgeable in current techniques and treatments in radiotherapy, chemotherapy, and immunotherapy. He or she must be concerned with prevention of, and research into, cancer. The approach to the patient with cancer should be a "combined" one so that all modalities of treatment and their combinations can be discussed from the outset and the proposed treatment agreed from the start. This means, too, that should further treatment be necessary at a later stage the patient already knows and has rapport with the other specialists. I believe the surgical oncologist should and must be the "leader" of this team as he or she will either have made the diagnosis already or need to make it by providing material for histological proof of the disease. The patient too must have one person with whom he or she can

St Mary's Hospital, London W2

R DAVID ROSIN, MS, FRCS, consultant surgical oncologist, and member, National Executive Committee, British Association of Oncologists.