RECURRENT CARCINOMA OF THE RECTUM

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Case Report.—In November, 1924, a male, age 26, was referred to the Johnston-Willis Hospital for study. Two years ago, in 1922, the patient had first noticed blood on defecation. For about a year thereafter his condition showed little change; but, in 1923, he began to feel that there was some obstruction low down in his abdomen, and that his bowel movements were incomplete. Occasional laxatives failed to relieve him. He resorted to enemata about three times a week, which afforded temporary relief. He became nervous, but slept well; had an excellent appetite, no nausea or vomiting, and no abdominal pains except when enemata were not employed. He had lost about ten pounds during the past year.

He consulted his family physician early in the fall of 1924, complaining only of the rectal bleeding and the constipation, which had increased over the past 15 months.

This patient's family history was significant. A brother died of carcinoma of the stomach at age 27; his grandfather died of carcinoma of the rectum. In 1919, the patient had an infected ulcer on his leg which lasted six weeks. No specific treatment was administered.

Laboratory Data.—Repeated Wassermanns were negative; spinal fluid, negative; hemoglobin, 68 per cent.

A barium enema showed an annular filling defect in the rectum, within seven centimeters of the anus. The defect itself was about three centimeters long, and the caliber of the rectum was obliterated to a diameter not much larger than that of a lead pencil.

Complementing the roentgenologist's report, the findings of digital and proctoscopic examinations converged on a diagnosis of carcinoma of the rectum. The diagnosis was confirmed by biopsy.

On November 21, 1924, a Kraske resection of the rectum was performed. The dissection was extended into the peritoneum. The peritoneal cavity was opened anteriorly, and the entire rectum with adjacent nodes was removed. The growth was reported to be a carcinoma Grade II, with involvement of adjacent nodes (Fig. 1).

The patient was discharged from the hospital six weeks after operation. Because of his age, only 26, and the malignant involvement of his nodes, I kept in touch with this case for a number of years. His functional results were reasonably good. He continued in business as a successful architect, was married in 1928, and has a daughter now nine years old.

In November last year, he was referred to me again for treatment of what his surgeon thought to be a liberal redundancy about the stoma. A local examination and biopsy proved this to be a carcinoma of much the same type as previously reported. After the necessary preparations, the patient was operated upon again, December 11, 1930. A combined abdominal and posterior resection was completed in one stage. Some difficulty was encountered because of scar tissue from the former operation. However, the patient stood the operation well.

A troublesome ileus developed during the convalescence, but use of our weighted Miller-Abbott tube saved him from an enterostomy, and enabled the patient to make a complete operative recovery.

This time, the pathologic report showed that both the growth and the nodes were adenocarcinoma, Grade III.

Certainly, the above case report presents nothing original or new in symptoms or surgery. The symptoms are classic, the treatment standard. Instead
of the former operation carried out for resection of the rectum, a combined abdominoperineal resection, for a good surgical risk, would be our choice to-day. The writer feels, however, that an abdominoperineal resection in 1924 would hardly have changed the outcome in this case. Our real interest lies

![Fig. 1.—Photomicrograph of tumor removed November 21, 1924. Diagnosis: Adenocarcinoma of rectum—Grade II.](image1)

![Fig. 2.—Photomicrograph (low power) of the recurrent tumor. Removed December 11, 1939. Diagnosis: Adenocarcinoma of rectum—Grade III.](image2)
in the fact that so young a man remained active and well for more than 15 years after the removal of a carcinoma Grade II with lymph node involvement; but was then found to have an operable recurrence of a similar type of adenocarcinoma with the same lymph node involvement. Although more

![Fig. 3.-Photomicrograph (high power) of Figure 2, showing hyperchromatic nuclei with an abundant cytoplasm, and mitotic figures.](image)

![Fig. 4.-Photomicrograph (low power) showing normal and abnormal sweat glands.](image)
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than 15 years had elapsed since his primary malignancy, we have classed this case as "a recurrence." At his second operation, the patient presented nearly the same type of lesion; the pathologist reported "a striking resemblance in the cell morphology to the previous growth, and that this was probably of similar cell origin."

Not much parallel is to be read, or information had, on this condition. References to operable "recurrence" are scant in cancer literature. Jerome M. Lynch\(^1\) in an interesting case-report says: "I operated upon Mrs. G. in 1926, performing a combined abdominoperineal operation with a perineal stoma. I excised 25 cm. of the lower bowel, including the anus. The growth (Broders Grade II) was found to begin 4 cm. above the anal verge, and to extend 5 cm.

"There was also a chronic inflammation of the lymph nodes. Two years later, there was a recurrence of the disease. It consisted of two separate growths, both of which were Grade III, more malignant than the primary lesion. I must say that it was with some misgivings that I undertook to operate a second time. Seven years have elapsed since the second operation, and the family tells me she is the most cheerful person in the neighborhood and one of the most active."

In Lynch's case, it should be noted that the lymph nodes were inflammatory, not malignant. But within two years there was a recurrence of the carcinoma. It is also notable that this patient had remained well for seven years after her second operation for cancer.

Richard B. Cattel states that in the presence of a recurrence, roentgen ray and radium therapy definitely increase the duration of life and contribute to the patient's comfort. He makes no reference to further surgery. From this and other reports in the literature, the accepted treatment for recurrence in carcinoma is not surgical. The preponderance of evidence is in favor of radium and roentgenotherapy.

We fully realized, at our patient's first operation, that a 26-year-old man, with gross symptoms of more than two years' duration, stood a good chance for a cancer recurrence. We were especially concerned after the lymph nodes about the rectum were found to be of the same grade malignancy. At the end of five years he reported for examination. A thorough check-up failed to show any irregularity. He was married, had one child, was successful in business, and enjoying good health. Ten years passed, and he reported continuing good health. When he reported himself well after 15 years, we really discharged him as a "cancer cure."

We learned, during the sixteenth year of his recovery, that he was having trouble again, but we supposed, of course, that it would be from an irritated, redundant perineal stoma. However, on his arrival for examination, we realized at once that he had a local recurrence of carcinoma of the stoma. Upon further examination we found that, this time, the growth extended about 7 cm. above the stoma.

After removing this growth, we were impressed to learn that the path-
ogy from the bowel and lymph nodes were strikingly similar to that from the former operation, except that these were found slightly more malignant than the tissues removed 15 years previously.

One year has now elapsed since our second operation upon this case of recurrent carcinoma of the rectum. He has been active again in his business; and on examination a few days ago, he seemed to be in good health. But our experience with this patient somewhat dampens any attempt to declare a cure in the case of cancer.

REFERENCE


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