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A CLASSIFICATION OF RECTAL STRICTURES DUE TO LYMPHOGRANULOMA VENEREUM

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THE great majority of inflammatory strictures of the rectum are now agreed to be a result of lymphogranuloma venereum. This fascinating disease seems to take its origin in a trivial and transitory initial lesion which may occur on the penis, vulva, vagina, or in the rectum itself. The virus spreads by way of the lymphatics to the inguinal or pelvic lymph nodes. These become enlarged, and may suppurate and discharge, or they may subside in a few weeks with or without treatment. Later on, the lymphatics of the rectum and anus may be involved in the process, with first the development of proctitis, and later stricture of the rectum. Sufferers complain of long-standing constipation, the passage of ribbon-like or small stools, discharge of bloody mucus or mucopus, and loss of weight, energy, and appetite. Upon examination, these patients are below physical par; there is rectal or anal stricture with varying degrees of stenosis, often with accompanying fistulas, proctitis, or colitis.

A classification of these rectal strictures is desirable, since surgical interference may be necessary, and the type and extent of the surgical procedure depend on the findings above and below the stricture and the condition, position, and extent of the stricture itself. The following types may be observed: (1) anal stricture, (2) rectal annular (also linear) stricture, (3) rectal tubular stricture, and (4) rectal communicating stricture.

Anal Stricture.—This type is more commonly found in women, where the original site of infection is on the vulva or posterior vaginal wall, and the communicating lymph channels provide a convenient pathway via the perineum to the perianal skin and lymphatics. Subsequently, the related subcutaneous and superficial external sphincter muscles are involved, with resultant fibrosis and stricture at the anal canal. There is often an associated esthiomene. It is probable that the next area invaded is the subsphincteric (internal sphincter) lymph spaces, the intramuscular and perirectal

lymph nodes respectively. There may also be lateral spread into the ischioirectal space or along the levator ani muscles. Surgical resection is impossible.

Rectal Annular Strictures.—These are found in the rectum proper. The examining finger is grasped by the fibrous ring of the stricture, located two to three inches above the anus in the rectal ampulla.



Fig. 1.—Photograph taken about one week after dilatation of rectal stricture under general anesthetic. Shows rupture of rectal wall and presence of barium perirectally. Colitis of descending colon and narrowing of sigmoid probably due to fibrosis are noted.

This type of stricture, if discovered early enough, may respond well to radical surgical operation for removal. It is fairly limited in its early stages, and the obstacles of diffuse lymphatic involvement or marked colitis above are lacking.

Rectal Tubular Strictures.—These are the markedly fibrosed and extensive types which are apparently the result of an extension of

lymphatic involvement to peri- and postrectal lymphatics, encroaching en masse upon the rectal lumen from all sides. If a proctoscope is used (with the greatest caution), the rectal mucosa is pale, fibrotic, friable, with many bleeding points and mucopurulent or bloody discharge from above. These stenotic areas may involve the recto-



Fig. 2.—Photograph of same patient as shown in Fig. 1, taken at later date (three weeks) showing further extension of barium into perirectal tissues as well as more advanced colitis. Rectal tube seen in rectum.

sigmoid junction. They are difficult for rectal resection not only because of their relation to the peritoneum, but also because of the friability of the surrounding tissue and the predisposition to multiple fistulas.

Rectal Communicating Strictures.—Here marked ulceration has occurred to produce communicating fistulas to the vagina, bladder, prostate, or seminal vesicles. Surgical resection is contraindicated.

In all types of stricture instances colostomy must be considered unless the patients are seen early enough to permit adequate drainage by frequent dilatation. If sufficient drainage can be obtained by dilatation without injury to the surrounding tissue, and if there are no communicating fistulas, colostomy should be avoided or post-



Fig. 3.—Photograph taken almost one year later. Still further extension and involvement of perirectal tissues. More advanced colitis. Rectal tube in rectum.

poned. That dilatation of a dense rectal stricture may be dangerous, is, however, illustrated by Figs. 1, 2, and 3, all representing barium enemas taken at various intervals after this procedure.

SUMMARY

There is presented a brief discussion of rectal stricture due to lymphogranuloma venereum.