VII

GONORRHŒA OF THE RECTUM

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I.—INTRODUCTION

THE number of Russian works on gonorrhœa of the rectum is not very large. Escaping the eye of the practitioner, gonorrhœa of the rectum may develop very serious complications, the stricture (*e.g.*, "strictura gonorrhœica recti") playing the most important rôle amongst them.

About forty-six years ago the German gynæcologist, Bumm, recorded the presence of Neisser's gonococcus in the purulent discharge from the rectum.

II.—THE SPREAD OF GONOCOCCAL INFECTION, ETC.

Gonococci may be variously introduced on to the mucous membrane of the rectum. *Primarily*, due to coitus per anum or when using the same pipe for vaginal douches, enemas, and so on. *Secondarily*, it may occur when gonococcal infection of the urinary system is present. In that case girls and women are more liable to infection, as pus flows down from the vulva to the anus, where fissures, scratches and piles may be present. During the act of defecation, especially in patients suffering from constipation, the excrement covered with purulent discharge from the vulva may be drawn back through the external sphincter, carrying the infection with it (virus).

Lang describes a case of rectal gonorrhœa after operation on the glands of Bartholini, as a result of which a recto-fistula may develop.

A possible way of infection is the penetration of gonococci from the bursting of abscesses into the rectum in the cases of purulent prostatitis, vesiculitis, or in the case of gonococcal infection of adnexa (adnexitis), but these are very rare. I have had only two cases.

These authors are greatly mistaken who consider that gonococci in the prostate, seminal vesicles and in infiltrations perish as regards infection; they are really

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weakened, as evidenced by the growth on the culture, but still they are alive and are capable of provoking gonorrhœal inflammation of the rectal mucous membrane, of which I have been a witness myself.

III.—PATHOLOGY

The pathological changes in rectal gonorrhœa are not known very well. As far as we know they are: loss of columnar epithelium and of Lieberkuehn's glands; the presence in some of the spaces left of funnel-shaped abrasions with festoon-like edges, from which develop a typical overgrowth of Lieberkuehn's glands and connective tissue. Also there is a very intensive cellular infiltration, which penetrates into the tunica muscularis; here, and in submucous membrane, may be seen the majority of small cells, but in the mucous membrane mostly cells of the large size are found.

Along the Lieberkuehn's glands are situated the chains of infiltration, where in the big cells, especially in the mucous membrane, in the places covered with columnar epithelium, were found gonococci (Frish, Schneider). Gonococci were also found on the outside of cells in the lumen of Lieberkuehn's glands.

IV.—SIGNS AND SYMPTOMS OF RECTAL GONORRHOEA

The following are the signs which may be associated with the presence of rectal gonorrhœa:—

(1) The purulent drop of whitish-yellowish discharge, containing gonococci, which may be seen after pressing on the rectum through the vagina.

(2) The presence of a fissure in the posterior sector of the anus, and this is, as a rule, narrow and superficial, but concealed in the anal folds.

(3) An outgrowth of the condylomatous type, mostly isolated, soft, oblong and practically painless.

(4) Copious discharge from the anus, and deep ellipsoidal ulcers on the place of transition of the skin into the mucous membrane (Jullien: "Ulceres glennorrhagiques").

V.—DIFFERENTIAL DIAGNOSIS

Differential diagnosis must be instituted in respect to syphilis, tuberculosis, ulcus molle, and the consequences of

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dysentery. At the same time, it is necessary to remember the long-standing inflammatory processes caused by tumours and worms.

VI.—METHOD OF EXAMINATION

Glingar, Buschke and Klopstock suggest examining microscopically the flakes and threads in the water after irrigation. The first-mentioned author manipulates with the catheter (female). Buschke and Klopstock introduce two glass pipes into the rectum—one for irrigation and the other for the collecting of returning water. As regards myself, I use a very thin, soft, elastic catheter with many small holes in it, and collect the water flowing down between the rectal wall and the pipe into a glass basin, from which I catch flakes of pus and threads; the quantity of water being about 400.0 c.c. and t. 96.8° F.

The sphincteroscope or short rectoscope may assist in investigating changes of the mucous membrane of the rectum. In children, an ordinary urethroscope may be very useful, as the external light is more satisfactory than the internal one, owing to the last-named being easily soiled by the fæcal masses.

VII.—COURSE OF THE DISEASE, ETC.

By rectoscopy, Stumpke distinguishes four stages of the disease :—

(1) The mucous membrane is very red and swollen. Owing to this, the central starlike figure disappears, and in place of that there is a transversal one, cleft-like and swollen. The mucous membrane oozes easily, and there is a copious discharge of greenish-yellowish pus, flowing freely. The opening of the anus is very swollen and painful, and around it, for about two inches, the skin is rather hyperæmic.

(2) Œdema and redness is less; the mucous membrane lays in thick folds; the central figure is starlike, but not symmetrical. In some places there are projections like grains, of the same colour as the mucous membrane; pus is thicker, but still flows; around the anus are the same changes as in the first stage.

The third stage comes after one or two days' time.

(3) Redness is moderate, the mucous membrane is still

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swollen, of granular character and covered with a very thick, sticky, viscid pus. After a few days comes the fourth stage.

(4) The mucous membrane is nearly normal, but is covered with purulent deposit, and with threads stretching from one wall of the rectum to another.

In my seventeen cases, the acute period was observed only twice, the second stage six times, and the third one three times.

In two cases the third stage was complicated by superficial ulcerations in some places, and in one case, where there were no changes at all, the patient was very exhausted, owing to bleedings.

The percentage of cases of isolated gonorrhœa of the rectum is not established yet, as not all cases of this disease are diagnosed, and therefore are not included in statistical tables. This fact may thus be explained: not only patients, but even practitioners, are not quite acquainted with this disease, which sometimes runs a very weak and symptomless course, excluding only itchings, burning feeling, discharge from the rectum, and eczema around the anus. In two or three weeks all symptoms may disappear. In some cases, however, the symptoms and signs may be quite the opposite, *i.e.*, very acute; strong tenesmus, pains during the act of defecation, blood, purulent discharge, and fissures around the anus.

The reflexible spasm gives rise to the spasm of sphincters and constipation. Temperature may be normal, or may run between 99.5° to 101.3° F. Very often the symptoms are masked by the presence of piles, and diagnosed as due to hæmorrhoids.

From the rectum the process may spread through Lieberkuehn's glands and solitary follicles on to the external surface of the rectum, and provoke peri-rectitis. Besides the infiltration, an abscess may appear or, if the glands are obstructed, the process may spread into the cavity of the pelvis, where the abscess may burst either into one of the pelvic organs, or near the anus (Jullien, Huber, Baer, Boas, Stühmer, Almkvist).

Sequential fistulæ heal very badly. In abscesses, gonococci are very rarely found; as a rule they are replaced by other microbes. Mixed infection may be met with in the long-standing cases of gonorrheal proctitis;

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it may be the cause of the superficial ulcerations, with resultant strictures.

VIII.—STRICTURES OF THE RECTUM

Strictures here, as in the urethra, do not always appear after gonorrheal infection.

In all my cases I have had five strictures, two central ones, cylindrical and funnel-shaped, which let a No. 23 urethrosopic tube pass, and three eccentric, one of which was funnel-shaped; all of these three allowed No. 21—25 tubes to pass, and were situated 2 to 2½ inches from the anus.

Three of these strictures occurred in women, and two in men. In one case (woman) there was gonorrhœa, but gonococci were not found in the rectum. It was the same in the case of one man, and in another case only a very few gonococci were found.

RECTOSCOPIC VIEW.

Normal condition of
rectum 1 to 1½ in.
from anus.

Normal condition of
rectum about 3 in.
from anus.

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A stricture of eccentric
character.

A stricture, central,
funnel-shaped.

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GONORRHŒA OF RECTUM.

Mucous membrane covered with pus.

Para gonorrhœal process.
Polypus between pelvic colon and rectum.

GONORRHŒA OF RECTUM.

Process of granulation with hæmorrhage, about 6 to 8 in. from anus.

Poliposis at the lower third part of rectum.

Ulcerous process between the third and the lower part of anus.

"MOULAGE."

Tubercular ulcer of anus.

"MOULAGE."

Gonorrhœa of rectum, pus and anus
fissures.

Strictures may be of rectal or of peri-rectal origin, respectively. Some authors emphasise the low situation of strictures in the rectum, but it is not really so: strictures may be situated not only on the lower half of the rectum, but even on the upper third of it.

In one case, in a man (homosexualist), the stricture let a small rectoscopic tube pass, and it was found to be formed of stretched fibrous bundles.

A very characteristic sign of the hard infiltration and of peri-rectitis is the immobility of a certain part of the wall of the rectum.

Stricture of the rectum is due to intensive formation of connective tissue, especially in the submucous membrane.

Exner considers that the presence of plasmatic cells in large quantities is a characteristic sign of gonorrheal stricture. In one case, Langer found not only such an infiltrate consisting mostly of these cells, but also diplococci.

Stricture may lead to very serious consequences, such as the development of dyspepsia and the retention of stools, alternating with a form of diarrhœa, which

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exhausts patients terribly. Some authors (Livy-Weismann), consider that "proctitis gonorrhoeica proliferans" and "rectitis fibrosa" are precursors of stricture, but I cannot verify this.

IX.—HYPERTROPHIED CONDITIONS OF RECTAL MUCOUS MEMBRANE, ETC.

In my practice I saw overgrowth of the mucous membrane of the rectum, but I cannot establish its connection with consequent stricture of the rectum.

This condition is called "rectite blennorrhagique Bensaude," and is characterised by the presence of excoriations and superficial ulcerations. R. Bensaude describes a case of gonorrhoea of the rectum of a woman with a large overgrowth on the mucous membrane quite of the same type as in the vagina.

Another case (with Gosset) was in a patient with an overgrowth about $2\frac{1}{2}$ inches from the anus. The same overgrowth may be seen in syphilis, dysenteric processes and tumours.

Overgrowths may be of papillomatous character, either on a flat basis or associated with a pedicle.

X.—PROGNOSIS

Prognosis, if the treatment is started early, is good; but it is wise to let the patient know that the process may last a very long time, and that relapses cannot be excluded; especially when in peri-rectal infiltrations the glands are involved.

XI.—TREATMENT

A. Acute Stage.—Rest, suppositories, warm baths with potassium, permanganate, and further, washings out of the rectum with astringent and disinfectant solutions. It is better to introduce a thin, soft catheter, with small holes on its upper two to three inches, and to irrigate the rectum for a very long time with hot solutions. Introduction of warm paraffin gives very good results also. Application of ointments, especially the protargol one in a warm state (Bouschke), is also very good.

B.—In chronic cases, where the glands are involved, and infiltrations, overgrowths and ulcers are present,

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local treatment is essential through the rectoscope. In children urethroscope tubes are used.

Diathermy may also be very useful.

Vaccines and proteid shock therapy are used on general principles.

C. Treatment of Strictures.—Strictures are treated by bougies, or by means of small incisions made under careful inspection through the ano-rectoscope.

In cases of a solid, ring-shaped stricture, which cannot be dilated, it is necessary to make a fistula, and through it to apply the local treatment.

XII.—BACTERIOLOGICAL EXAMINATION

It will be found necessary to take three swabs : firstly, from the urethra ; secondly, from the vagina, cervix uteri or prostate ; and thirdly, from the rectum.

It is necessary to prevent the discharge from the vulva from passing into the rectum.

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