Diseases of the Colon & Rectum

THE FIRST FIFTY YEARS
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The First Fifty Years

With the publication of this special booklet, *Diseases of the Colon & Rectum* celebrates the 50th anniversary of its inaugural issue. Congratulations are in order. *DCR* has flourished in ways that have certainly exceeded its founders' most optimistic hopes.

*DCR* was conceived as “The Official Journal of the American Proctologic Society.” During its early days, there were realistic concerns about its ability to sustain itself both financially and scientifically. This rather sickly child was nurtured—no other word will do—by the tireless ministrations of its first Editor-in-Chief, Louis A. Butie, M.D. With time, the journal gained bulk, self-confidence, and financial security. More importantly, it has gained international respect as an authoritative voice in colorectal disease. The child has become a thriving adult. Its parents deserve to be proud.

With this publication, we hope to remind *DCR*’s readers about its origins and history. We also wish to pay tribute to those whose devoted work led to the journal’s success—a success that was far from a foregone conclusion 50 years ago.

Publication of this booklet would not have been possible without the energetic efforts of Tracy Hull, M.D., to whom all editorial credit is due, and to the dedicated editorial staff in the *DCR* office: Pat Oldenburg, Nancy Truax, and Irene Seabright. To each of these, my profound personal thanks.

Robert D. Madoff, M.D.
Editor-in-Chief
*Diseases of the Colon & Rectum*
Introduction

Congratulations to Diseases of the Colon & Rectum on your 50th anniversary. When I was “volunteered” to lead this project, I never realized the fascinating things I would learn about the Journal. Doctor Buie invested his heart and soul to make the Journal successful. He essentially rewrote or at least heavily edited all articles. He solicited leading surgeons for articles. From reading his correspondence, I think at times he almost “begged” for manuscripts, quite different than it is today. The Journal was published every other month at that time, and the process sounded like nearly a fulltime job.

Doctor Hill took over in 1966 and served until 1986. He initiated the editorial board to provide a peer review of manuscripts. A list of past reviewers since 1978 is copied in this publication. I listened to an hour-long interview between Doctors Hill, Beart, and Fazio from 1996. The ideas and changes they reminisced about were fascinating.

During Doctor Beart’s tenure from 1986 to 1996, the editorial office started using computers. It is hard to remember what we did prior to the computer. Therefore, in this publication we have included copies of the 3 by 5 index cards that tracked Journal manuscripts from submission to publication.

Doctor Fazio assumed leadership in 1997. Having an office down the hall from him at the Cleveland Clinic, I remember seeing piles of orange bags of manuscripts delivered regularly. His secretary would organize them as he read and assigned them to be reviewed. They were sent to reviewers for critique. Then they would be sent back to the editorial office in Minnesota where the ladies would organize them in those orange bags and send them back to Cleveland and Doctor Fazio to review these critiques. In the early 2000’s the review process became fully computerized. However, before that Doctor Fazio always had one of those orange bags on his arm.

Now the Journal is published monthly. Everything is done via the computer and Internet, but there is still an important office of women in Rochester, Minnesota that add the personal touch to the needs of our Journal: Pat Oldenburg, Nancy Truax, and Irene Seabright. What you may not know (but can read about in this publication), is that the Truax women chronicle the start from Doctor Buie’s assistant, Mildred Truax, to the present representative, Nancy Truax.

Included in this publication is a timeline that chronicles world, medical, and selected colorectal events over the past 50 years. Using my editorial privilege I chose things that I felt were interesting or important. Therefore, if your favorite event was not cited, I apologize.

Finally, I would like to thank Pat Oldenburg and Nancy Truax for their tremendous assistance in selecting and preparing this information.

TRACY HULL, M.D.
Associate Editor
Diseases of the Colon & Rectum
As most readers will know, 2008 is the Golden Anniversary of the Journal that first saw the light of day with the combined January/February edition in 1958. A few months ago, the Editor-in-Chief, Dr. Robert Madoff, asked me to write an article which would gaze into the future by reflecting on the past. Easy then!

Fifty years of academic activity in the field of colorectal diseases—where to start? I thought it might be useful to commence this exercise by producing a list of major advances in colorectal surgery over that half century. These would have to be advances that have had a significant impact on patient care around the world.

Clearly, on the face of it, that would rule out such initiatives as minimally invasive surgery because very few patients have their operations performed laparoscopically even in the so-called developed world, never mind globally. However, I think I can safely predict that in the next 50 years the march of the minimalists will prove irresistible. In another half century there seems little doubt that the overwhelming majority of surgeons will be carrying most of their operations using some form of laparoscopic technique. I would also suggest that they will be doing this without the aid of a robot because this technology—exciting though it may be—certainly fails the global applicability test.

Now before you say that laparoscopic colorectal surgery has been around for almost 20 years and yet is still a niche activity, let me remind you about open surgery for a moment. I know that all of us good surgeons have always used high quality surgical techniques such as total mesorectal excision (TME) and these days it would be a struggle to find anyone bold enough to admit that levering a rectum out of the pelvis with a gloved hand was their preferred approach. But let’s not forget that somebody, somewhere, was producing local recurrence rates approaching 30 to 40 percent for the best part of a century. In other words, it has taken the profession about 100 years to work out how to remove rectal cancer properly using full-length abdominal incisions—and there is still a ways to go. So let’s not get too depressed about the apparently slow dissemination rate of laparoscopy after less than 20 years.

The reason to jump straight in and predict the dominance of minimally invasive techniques is simply because that is what has been happening over the last 50 years already. Mobile phones, MP3 players, etc.—they are all getting smaller not bigger. No more do we regularly undertake speculative and exploratory laparotomies—they are still used, but very rarely in the 21st century. Also virtually consigned to the history books are operations to drain subphrenic collections of pus. Nearly all of these techniques have been rendered out of date by one of the genuine advances we have all experienced: sophisticated imaging.

The advent of accurate cross-sectional imaging—CT, MRI, PET/CT—has truly revolutionized colorectal surgery almost everywhere in the world. CT scanners are within the financial reach of the most modest budgets and surgeons have had to learn a more collaborative approach to their practice as the radiologists hold an increasing amount of information that is of real use. Hardly any patients are allowed to undergo a modern operation of any form—appendicectomy up to pelvic exenteration—without having some form of imaging. Unquestionably, this has benefited patient care with the correct operation now almost always being performed in the least adverse circumstances. In addition, unnecessary operations are largely prevented by better diagnostics—largely the accurate identification of both the nature and location of pathology—and therapies.

Interventional radiology has changed the surgeon’s world. These days a quick call to a good radiologist will set up a remote-controlled procedure that will suck out, bite off, block up or inject into almost any organ or space. Younger surgeons will know nothing different, but less than 30 years ago simple diagnostic ultrasound was still pretty sexy stuff. This technology has made a real difference to surgeons and patients alike.

So what else have we changed in 50 years? The year 1958 was the birth year of such luminaries as Madonna, Prince, and Michael Jackson from the world of music. Orel Hershiser and Willy McGee from baseball, footballer Anthony Munoz, actors Drew Carey and Michelle Pfeiffer, and boxer Azumah Nelson. The USA gained Alaska as a
state, Pope Pius XII died, TV became color for the first time, and the Munich air disaster killed the heart of a gifted Manchester United team on a snowy night.

Back then, we knew very little of the physiology of the bodies we operated on every day. Because we knew nothing about it we didn’t even measure it during surgery. Talk to your senior anesthetic colleagues and they will all recall the days before pulse oximeters and cardiac monitoring—never mind invasive techniques. All surgeons—and relatives—were familiar with the concept of the operation being a success but the patient not being fit enough to survive. Acute tubular necrosis was unpredictable and frequently fatal, cardiac arrhythmias were the equivalent of Russian roulette—never mind the consequences of systemic sepsis. Lest we forget, in 1958 we had never heard of cytokines and were only just getting our heads around hormones. Antibiotics were limited in scope and availability and the understanding of critical care physiology was still in its infancy. The mortality rate of single organ failure in an ITU setting was very high indeed. Patients with gram-negative sepsis were in big trouble and surgery was only starting to emerge from the era where most outcomes were dependent on nature rather than medical intervention. Monoclonal antibodies were not even faintly glimmering in the eyes of either Kohler or Milstein whose discoveries didn’t appear until 1975.

So this is another major advance we have witnessed in surgery over the last 50 years: the understanding of human physiology and pathology. This has allowed increasingly ill patients to be subjected to even more major operations with previously unheard of prospects of survival. Now that the babies of 1958 are celebrating their own golden anniversaries, it is gratifying to know that their chances of living many more decades should they require major colorectal surgery, have never been better.

I am only going to offer one more major change in the last 50 years. Please do not take this to mean that there have been no others. There have, but this is a personal list after all, based on my current practice in colorectal surgery (and after asking a series of colleagues their views in a very unscientific survey.) I would propose that the third big development has unquestionably been flexible endoscopy. It might actually be suggested that this technology is too recent to make the podium of winners. However, it has been around for several decades at this stage and covers the period quite nicely.

In 1958, the endoscopist had access to very little of the GI tract. Only with the use of truly frightening looking instruments was the stomach entered under general anesthetic. As for the journey up the colon, it was effectively over before it really started, in most cases using the rigid sigmoidoscope. In 2008, only a part of the small intestine remains out of bounds to the talented "scope jockey." The mucosa can be examined microscopically, sprayed with dye, biopsied, lasered, burnt and even resected by the brave. All of this can be done as a day case under light sedation—or without any at all for the more resilient patient. This development of fiberoptic and then digital imaging technology has truly revolutionized colorectal surgical practice. There is little high quality evidence to support this suggestion, but I would contend that countless lives have been saved over those decades when we add up the number of cancers prevented by prophylactic polypectomy and the number of patients who avoided formal resections to those who had a timely diagnosis of treatable colitis or cancer.

For the colorectal surgeon, it seems that the ingenuity of endoscopy technology is only getting into its stride. The next 50 years will undoubtedly see the further development of new approaches (see earlier comments about minimally invasive approaches) using newer more efficient instruments or new routes of access such as natural orifice surgery (NOTES).

I would also like to comment on one area of development that I did not include as a major change or development: nonsurgical oncology. By this I mean the use of radiotherapy and chemotherapy. There is no doubt that in both areas much has changed, mainly in the area of reducing toxicity. Radiotherapy has always worked somewhat, but at least these days it is much safer than before and can readily be offered to many patients without fear of the consequences. However, the colorectal community cannot agree on the right approach and the radiation oncology community has done nothing to resolve the debates.

With respect to chemotherapy, the situation is really not much better. No, that is wrong—it’s worse than radiotherapy in some ways. The mainstay of treatment after all these years is still 5FU, and in several decades we have changed very little else. There is a baseline efficacy that has indeed been improved with the use of more modern agents but overall the overwhelming majority of patients gain no benefit from adjuvant therapy following surgical resection. We still face two big problems. First, which patients should get adjuvant therapy and second where is the really effective treatment? The search for the colorectal version of the leukemia/lymphoma advances of the last 50 years is not over by a long way.

Now, any review of this nature might be expected to pay tribute to the contributions made by advances in molecular biology and genetics. I have not included this for the following reasons: despite many false dawns and candidate molecules none has really stood the test of time
(remember S-Phase fraction, ploidy, CEA, DCC, et al. for example). In addition, the overwhelming majority of patients worldwide undergo their cancer operations without any reference to predictive or diagnostic molecules. As an amateur molecular biologist myself, I would have to conclude that the day of the molecule is not quite here yet and, I suspect it will take the best part of the next 50 years to truly arrive.

Perhaps it would be more important to know how long it will take to sort out the dilemma of surgical site specialization in reference to colorectal surgery. In 1958 the generalist ruled unquestioned. By 1983, a small number of colorectal giants had changed things forever. Leaders such as John Goligher and Rupert Turnbull had established colorectal specialization as a valid entity even though the generalist still dominated. In 2008, I would contend that in some respects the argument has been decided at least intellectually if not in practical terms. In other words, despite the intellectual arguments one way or another, wherever one looks internationally the anatomical specialist has won the day—witness the rise of the subspecialist societies as evidence.

The only caveat to this contention is that statistically, colorectal surgery is still provided to the majority of patients by general surgeons. Whatever the arguments say, we should be able to agree that after 50 years of experience, we can say that good quality surgical technique does make a difference and that expert specialist surgeons do the best job.

But now we must return to the 50 years of DCeR as it is universally known. To paraphrase a famous comment of Churchill, we should look at history to try and learn for the future.

To assist in this venture, I want to look at the start (1958), the middle (1983), and the end (2007-2008) of the period in question and see what progress we have made—either as a Journal or as a profession.

The first thing that has changed is the volume size. In 1958 the output was 67 papers in six editions. By 1983 the number of papers had jumped to 191, and this number had further risen to 313 in the last full year of monthly publication (2007). Undoubtedly therefore, the Journal has reached out to a wider audience and has provided a forum for many more authors to spread their knowledge. Actually that is quite true when one looks at the numbers. In 1958 the average number of authors of each paper was less than 2—1.38 to be exact. In fact most papers were single authored opinion articles or details of personal experiences. By 1983 the number of authors had almost doubled—2.8 per paper—and very few articles were by single authors. Contrast that to 2007 when the average number of authors per offering exceeded five with many papers listing in excess of 10 authors for a single study.

Now one might ask what is behind this phenomenon. I would venture that it is simply a reflection of publication in a peer-reviewed journal being a real and surrogate marker for professional success. It has ever been thus, of course, but in truth in the 50 years of the Journal’s existence the need for publication has become ever more important for surgeons in training and their mentors. Publication supports career development and is frequently used by institutions to gauge continuing performance—and thereby determine remuneration. Yes indeed folks—publish in DCeR and bring home the bacon! Of course most scientific journals understand this issue and many have responded by requiring statements of intellectual input and endeavor for each submission. A good idea with high ideals but in reality it simply means that the authors sign up on the dotted line as required.

What about the content over 50 years? There seems little doubt that things have changed quite dramatically in that time frame. The world of clinical science has changed in the last fifty years starting with the development of the randomized clinical trial (RCT). Surgery was for many decades based on experiential teaching and mentorship—what the boss said went. If the boss was an enthusiastic writer, then the world believed as well as a result of papers and textbooks. In the 1958 volume, the majority of the papers were simple examples of expert opinion—level 5 of the hierarchy of evidence base. By 2007 things had changed a lot.

Well-designed RCT’s are still rare items but the level of evidence has indeed improved by several grades. Level 5 opinion articles essentially do not exist. Single author papers are either editorial comment in relation to a specific paper or more likely a meta-analysis or systematic review. This is because in the 21st century opinion has to be based on evidence that can be produced to defend a position. Never before has the contention that “multiple anecdotes are not the same as data” been more relevant for debate! The Journal still contains a large proportion of case controlled studies, cohort series and retrospective audit—these remain the bread and butter of most clinical journals. These days, though the sample size is bigger and the analysis somewhat more rigorous using properly applied statistics.

I have kept the best for last—namely what has not changed—in order to reinforce our humility! In the last few years there was a concerted effort to make the Journal more “international.” The very first paper published in the
Journal came from England, and what is more from a surgeon who genuinely made a difference! No sensible surgeon or patient would refute that Sir Brian Brooke deserves his place at the top table having sorted out the ileostomy! After that, there were only a few more overseas contributions in the first year, but in the years since DCe-R can genuinely lay claim to being a truly international colorectal journal—approaching 50 percent of published papers are from outside the US.

The really humbling experience, however, comes when the list of topics from 1958 is examined and then compared to 2008. What exactly have we been doing in the last 50 years? Not a lot would appear to be the answer!

In the first year there were articles telling the readership about the recent developments in the following clinical problems:

- Ileostomy dysfunction
- Steroids in ulcerative colitis
- Surgery for colorectal cancer
- Malignant colonic polyps
- Rectal prolapse
- Management of diverticular disease
- Villous tumors of the rectum
- Sigmoid volvulus
- Bowel preparation
- Abdominal incisions

- Surgical technique for rectal cancer
- Hemorrhoids

The briefest of trips through either the 1983 or 2007/8 volumes will show the reader that little has changed in some respects. Without exception, all of these topics are covered again! In 1958, the leading surgeons were pretty sure they knew how to manage or treat these conditions. In that respect the top people in 1983 and 2008 are no different—they still think they know how to treat these conditions. However, bearing in mind that the current treatments in 2008 are very different in many cases to those used 50 years ago, it seems more than likely that time will prove us just as deluded as our heroes.

Perhaps I could conclude with two final light hearted comments from the 1958 volume. Perianal larval migrans sounds really unpleasant to me and I am pleased to say it does not feature too much in 1983 and 2008. Finally, I am like most surgeons struggling to cure pruritis ani. In 1958 we are told by the Cleveland Clinic that malt soup would do the business for most patients—yeah right!

Congratulations to the Journal for the first 50 years, and let's all make the next half century even better.

JOHN MONSON, M.D.
Associate Editor
Diseases of the Colon & Rectum
The First Decade
1958-1967
1958
Nikita Khrushchev becomes premier of Soviet Union
Charles de Gaulle becomes French Prime Minister
World's first artificial heart valve implanted
First coronary artery catheterization
Rupert Turnbull developed the concept of enterostomal therapy (ET nursing)

1959
Fidel Castro takes over Cuba
Alaska and Hawaii become states

1960
John F. Kennedy elected 35th president
U.S. scientists discover laser
Birth control pill introduced

1961
Soviet Union and United States put first men in orbit
East Germans erect the Berlin wall
Structure of DNA molecule determined
First total hip replacement
Bryan Brooke first performs strictureplasty in Birmingham UK (described but not published)

1962
John Glenn, Jr. orbits earth
First oral polio vaccine (alternative to injected vaccine)
Cuban missile crisis
United Ostomy Association founded

1963
Michael DeBakey implants first artificial heart
Martin Luther King delivers “I have a dream” speech
John F. Kennedy assassinated
Thomas Fogarty invented the Fogarty balloon embolectomy catheter

1964
Nelson Mandela sentenced to life in prison
Beatles appear on The Ed Sullivan Show in USA
First vaccine for measles

1965
Medicare, senior citizens government medical assistance program begins
Congress passes law requiring cigarette package labeling “Warning: cigarette smoking may be hazardous to your health”
W. A. Altemeier and W. R. Culbertson describe their modification of the perineal resection for rectal prolapse
Hirohumi Niwa introduces the first prototype colonoscope

1966
World's first pancreas transplant

1967
Christiaan N. Barnard and team of South African surgeons perform world's first successful heart transplant
First coronary bypass grafting
First combined kidney-pancreas transplant
First vaccine for mumps
THE FIRST DECADE
1958 -1967

The American Society of Colorectal Surgeons was founded under the name of the American Proctologic Society in 1899. In an effort to promote knowledge, which was a stipulated goal in the Constitution, the proceedings were published under the title Transactions. This was sporadically published until 1956 and a stenographer was employed to transcribe all presentations at the official meetings. Additionally during several years in the 1940's, papers were published in the American Journal of Surgery.

Almost from the inception of the Society, there was discussion regarding the need for an official journal. In the 1950's serious bids were obtained, but most publishing companies were not enthused. The concerns were the ability to provide 50 to 60 papers per year which would be required to sustain a bimonthly publication; competition from other journals for top rated proctologic papers; and the need for funds from the Society to subsidize the Journal for at least 3 years (estimated to be at least $10,000 yearly plus editorial office expenses).

After considerable work by Drs. Stuart Ross and Harry Bacon, in 1957 a contract was reached with J.B. Lippincott Company to publish the first issue in January of 1958. A committee was appointed to determine a name for the Journal and the choice was narrowed down to "Surgery of the Colon and Rectum" or "Diseases of the Colon & Rectum" with the latter being chosen.

One thing that has always set this Journal apart from many others is that it is owned and administered by a society, now called The American Society of Colon and Rectal Surgeons.


Most of the burden for getting the Journal started and maintaining the quality rested on Dr. Louis A. Buie, the editor. As his criteria for choosing articles, Dr. Buie would ask "Will this article help the Journal?" He was legendary for offering extensive revisions for articles that he did not feel met his standards. When Dr. Buie accepted this position, he was 67 years old and retired from the Mayo Clinic.

Initially there was concern about filling the 96 pages of each bimonthly publication. However with the dedicated work of Dr. Buie, this was never a problem.

In 1967, Dr. John R. Hill was chosen to succeed Dr. Buie.
Dr. Buie Edits Medical Journal

Bimonthly Publication Issues First Number

The first number of a new bimonthly medical journal, "Diseases of the Colon and Rectum," of which Dr. Louis A. Buie of Rochester is editor in chief, was issued this week by the J. B. Lippincott Co. of Philadelphia, which publishes the journal for the American Proctologic Society.

Dr. Harry E. Bacon of Philadelphia is executive editor of the new publication. Members of the editorial board are Dr. Garnet W. Ault of Washington, D.C.; Dr. Walter A. Fansler of Minneapolis; Dr. Wendell Green of Toledo, Ohio; Dr. Merrill O. Hanes of New Orleans; Dr. A. W. Martin of Brooklyn; Dr. J. P. Nesselrod of Evanston; Dr. H. R. Reichman of Hotel.

Salt Lake City; Dr. Stuart T. Ros of Garden City, Long Island; Dr. Robert J. Rowe of Dallas; Dr. Robert A. Scarborough of San Francisco; and Dr. Neil W. Swinton of Boston.

Three members of the staff of the Mayo Clinic, Dr. J. Arnold Bargen, a specialist in internal medicine; and Dr. C. W. Mayo and Dr. John M. Waugh, are members of the advisory board of the journal.

"Within the pages of this journal will be collected authentic communications pertaining to diseases of the colon and rectum and anal canal," Dr. Buie writes. "In these pages will be found papers devoted to basic research in metabolism, pathology, virology, radiology and the clinical practice of medicine and surgery. We submit that this journal will not only lighten the toil of the overburdened reader as he seeks information about diseases of the colon, but will also assure authors in this field of a commanding place in the forum with an audience that is pre-eminently interested in their presentation."

The first number of the journal presents a paper, "Perianal Pseudomembranous Suppurative: A Clinical and Pathologic Study," by Dr. Markham J. Anderson Jr. of the Section of Proctology, and Dr. Malcolm B. Dockerty of the Section of Surgical Pathology, both of the Mayo Clinic.

Dr. Buie, who has twice served as president of the American Proctologic Society and who founded the Section of Proctology of the Mayo Clinic, was chosen editor of the new journal in 1957. Editorial offices of the publication are on the mezzanine floor of the Kahler Hotel.


RIGHT: Dr. Louis A. Buie, First Editor-in-Chief of DC&R.
J. B. Lippincott Company
is pleased to present
an important new journal,
Diseases of the Colon and Rectum,
beginning with the issue of
January-February
1958
sponsored by
American Proctologic Society

annual subscription, $12

Announcement of the new Journal by publisher.
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Colon and Rectal Pathology
(Clinicopathologic Conference)

Selected Abstracts

Review of Literature on diseases of the colon and rectum

Robert A. Scarborough, M.D.
San Francisco, Calif.

Charles E. Dunlap, M.D.
New Orleans, La.

Compiled by Robert J. Rowe, M.D.
Dallas, Texas

**NOTICE TO CONTRIBUTORS**

*DISEASES OF THE COLON AND RECTUM* is designed for the publication of original papers which constitute significant contributions to the advancement of knowledge within the special field designated by the name of this journal.

**CONTRIBUTIONS**

Original typed manuscripts, not carbon copies, and illustrations, exchanges and book reviews, should be forwarded prepaid, at the author's risk, to the Editor-in-Chief of *DISEASES OF THE COLON AND RECTUM*:

Louis A. Butte, Sr., M.D.
Mezzanine Floor
Room 1, Kahler Hotel
Rochester, Minnesota

Manuscripts should be typed double spaced on one side of the paper, with wide margins. Although every effort will be made to guard against loss, it is advised that authors make and retain copies of manuscripts which they submit to this journal. All pages should be numbered. In the text, numbers one to ten should be spelled out, except when they are used to denote percentages, doses, degrees or when decimals are involved; for numbers above ten, numerals should be used, except at the beginning of sentences. Dorland's *Illustrated Medical Dictionary* and Webster's *New International Dictionary* are used as standard reference works. Scientific, meaning nonproprietary, names for drugs should be used whenever possible. If copyrighted or trade names of drugs are used, they should be capitalized. Units of measurement, such as doses and weights, should be expressed in the metric system. Temperature should be expressed in degrees centigrade. Contributions written in a foreign language, when accepted, will be translated and published in English.

**ILLUSTRATIONS**

Black-and-white illustrations will be reproduced free of charge, but the publisher reserves the right to establish a reasonable limit to the number which will be printed. Colored illustrations will be published only at the author's expense. Black-and-white photographs should be in the form of glossy prints. Line and wash drawings should be black on white paper, with lettering in black India ink, which should be large enough to be legible after whatever reduction may be necessary. Large or bulky illustrations should be accompanied by smaller glossy reproductions of the same, to facilitate their circulation among the judging members of the editorial board. Illustrations should be designated as to figure numbers; the top aspects should be indicated, and the author's name and the title of the paper in question should appear on the back of each print. A separate typewritten sheet of legends for the illustrations should accompany the manuscript.

**REFERENCES**

A list of numbered references, prepared in alphabetical order, should appear on a separate sheet at the end of the manuscript, with corresponding numbering in the text. References should conform to the style of the *Quarterly Cumulative Index Medicus*, with the exception that the last page number of the source cited should be omitted; thus, author's name, title of paper or book, name of journal or publisher of book, volume number, first page number (or specific page or pages in the case of a book) and year of publication, in the order named.

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Philadelphia 5, Pa.
New ideas and discoveries possess an importance quite apart from the intrinsic value ascribed to them. They liberate a series of far-reaching reactions which excite the minds of many, and stimulate fresh inquiry and discussion. Yet, unless such ideas are displayed and such discoveries described, they can exercise but small influence and bring little benefit to anyone. If a philosophy is suppressed, it is of service to no one; conversely, if it is disseminated far and wide, its benefits, measured by the effects on the minds of those who are ready for its reception, may be untold. A new opinion, embraced in solitude by the one who originated it, may come to nothing; but the same opinion, adopted and advanced with vigor by many, may change the destinies of half the world.

It is obvious, then, that the mere acquisition of knowledge in itself can accomplish little and influence few. Experience alone very often effects no improvement at all, but once its meaning has been analyzed, demonstrated and then wisely applied, observations which once seemed empty of meaning acquire significance which sometimes is of great moment. Every seasoned worker in the sciences recognizes such a sequence as a prelude to discovery.

Therefore, knowledge and the interpreted consequence of experience must be recorded before they can become widely available not only to those who seek their own improvement but also to the progenitors of new ideas and the protagonists of untried notions. In this manner experience itself can be made to undergo useful scrutiny and appraisal and further interpretation. Fundamental to this grand scheme of wide dissemination of information is the concept of freedom of thought and expression which most of us probably consider to be among our greatest strengths and greatest blessings. Thus, the importance of medical journals in such a vast plan can scarcely be exaggerated. They can serve as repositories in which the treasures of the intellect can be safely kept and conveniently located.

In a somewhat more confined province, material on diseases of the colon is being accumulated to an imposing degree, but it is not readily available in convenient form. The inquisitive reader must search through innumerable files and indexes before he finally arrives at a unified acquaintance with current literature on diseases of the colon. Even if he is willing to make such a search, in the absence of a modern medical library or the services of experts experienced in searching through countless medical journals, he will be defeated before his objective is sighted.

Within the pages of this journal will be collected authentic communications pertaining to diseases of the colon, rectum and anal canal. In these pages will be
found papers devoted to basic research in metabolism, pathology, virology, radiology and the clinical practice of medicine and surgery. We propose, moreover, to present comprehensive abstracts of medical literature. We submit that this journal will not only lighten the toil of the overburdened reader as he seeks information about diseases of the colon, but will also assure authors in this field of a commanding place in the forum with an audience that is pre-eminently interested in their presentations.

LOUIS A. BUIE, SR., M.D.
Ileostomy Chemistry *

B. N. BROOKE, M.D.
Birmingham, England

The creation of a permanent ileal stoma is accompanied by especial problems anatomically, physiologically and psychologically. Intimately associated with the physiologic problem is the matter of changes in gastroenterologic chemistry, particularly as these changes relate to protein metabolism and electrolyte balance.

For these reasons, this study of the output of nitrogen, sodium, potassium and calcium from permanent ileal stomas is important. It provides a sound basis for protein and electrolyte therapy after the performance of ileostomy.—(Ed.)

With one exception, material was collected from patients with ulcerative colitis; in one of whom secondary ileitis was observed. One patient was operated upon for familial polyposis of the colon; the observations in this case agreed with those made among the patients who had ulcerative colitis.

**Methods**

Twenty-four hour samples of fluid from ileal stomas were collected from midnight to midnight in enamel cans. The volume of each daily sample was measured and adjusted to a suitable quantity for homogenization by the addition of distilled water. Samples were thoroughly homogenized and the aliquots were taken for analysis. Two 2-ml. samples were placed directly into Kjeldahl flasks for the estimation of nitrogen by a micro-Kjeldahl method. To a 10-ml. aliquot in a conical flask was added 2 ml. of concentrated nitric acid; then the mixture was allowed to stand for at least ten minutes. Next, the mixture was brought slowly to boiling, and was allowed to boil for a few seconds. It was cooled, made up to 50 ml. and filtered through a Whatman 544 filter paper. Quantities of the filtrate were suitably diluted, and the content of sodium and potassium was estimated by means of the E.E.I. flame photometer.

For the estimation of calcium 20 ml. of the nitric acid digest was used, and after neutralization with ammonia and acidification with concentrated hydrochloric acid had been done, the calcium was precipitated with 2.5 per cent oxalic acid and 20 per cent sodium acetate. The sample was allowed to stand overnight to ensure complete precipitation of the calcium.

To remove sodium oxalate, the precipitate was centrifuged and washed three times; the calcium content of the precipitate was then determined by titration in an acid solution with 0.01N potassium permanganate.

It was neither practicable nor advisable to maintain for all patients an identical routine for the intake of fluids after operation, nor to follow a strict schedule for a return to normal diet, since the general condition of these patients allowed little latitude as to treatment. Rather, each patient had to be treated according to the indications in respect to the restoration of fluids and electrolytes. In general, however, fluids alone were administered intravenously.

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* Read at the meeting of the American Proctologic Society, New Orleans, Louisiana, April 21 to 27, 1957.
until the ileal stoma began to function, usually about 24 to 48 hours after operation. The taking of fluids by mouth was then permitted, in quantities of 30 ml. hourly, for the first 12 hours, with an increase to 60 ml. and then 120 ml. at intervals of 12 hours. From approximately the fifth postoperative day a light diet was taken, and this was increased to a full diet within a week to ten days. It is not possible, therefore, to present standardized figures from these investigations, but only to reveal general trends under the circumstances pertaining during routine treatment, the purpose being to reveal therapeutic necessity rather than physiologic certitude.

**Results**

**Nitrogen:** Studies of total balance were undertaken; these revealed that patients with an ileal stoma remain in negative balance after operation no longer than do patients who undergo operations which do not produce a fistula of the small bowel (Fig. 1). Thereafter, these patients remain in positive nitrogen balance. When ulcerative colitis is present more nitrogen may be lost preoperatively in the stools than subsequently occurs from the ileal stoma. Figure 2 is an example in point, up to 7 Gm. of nitrogen (equivalent to approximately 44 Gm. of protein) having been excreted daily in the stools by a man who later lost only 1 to 2 Gm. of nitrogen each day from his ileal stoma.

Figure 3 gives a general picture of the excretion of nitrogen immediately after ileostomy in 7 patients, and from ileal stomas established for ten, 18 and 30 months in three cases, respectively (the operation referred to in the figure as "established" cases indicates a subsequent excision procedure and is incidental). The high peak of excretion at 8 Gm. on the eighth day after ileostomy in one patient was associated with severe ileostomy diarrhea caused by what clinically appeared to be pseudomenbra-

**Fig. 1. Nitrogen balance after operations associated with ileostomy.**

uous enteritis, which responded rapidly to erythromycin.

Excluding complications, it therefore seems that 3 to 4 Gm. of nitrogen is the maximum lost each day immediately after ileostomy, and that this declines to 1 to 2 Gm. when the stoma is long established. The loss of nitrogen therefore is of little significance from the therapeutic aspect, since 1 Gm. is the average daily amount in a normal stool. Chromatograms made on
Fig. 2. Graphic representation of the correction, by means of ileostomy of the loss of nitrogen and potassium caused by ulcerative colitis. The study was started 3 days before primary colectomy.

Exudates from two patients indicated that the following amino acids were excreted: glycine, alanine, valine, leucine and arginine. Since the total daily loss of nitrogen is only 1 to 2 Gm., it seems improbable that the amount of each individual amino acid excreted is significant. The abundant increases in weight after ileostomy performed for ulcerative colitis supports this contention.

Volume Output: A characteristic feature of most ileal stomas is the considerable

First article published in the first issue of DCER.
NITROGEN

NEW ILEOSTOMY

ESTABLISHED ILEOSTOMY

Fig. 3. Composite graphs to show the loss of nitrogen. The operation listed under "established ileostomy" indicates a procedure performed ten, 18 or 30 months subsequent to ileostomy.

The volume of fluid excreted immediately after creation of the stoma (Fig. 4). This volume reaches two liters or more per diem during the first postoperative week, and then decreases to approximately 500 ml. each day, by the time the excreta thicken. The average output remains at 250 to 500 ml. from the established ileal stoma, although this may increase after subsequent operations. The quantity seldom increases to more than one liter daily, however, provided complications at the stoma, such as partial obstruction, do not arise. The mechanism whereby this diminution in output is brought about cannot be explained, although alteration in the activity of the small bowel and even perhaps in the powers of absorption of the bowel may be factors. These figures represent only the average, for on occasion the output may be higher. Sometimes it is lower (Fig. 5).

A direct correlation exists between the volume of fluid excreted and the quantity of the substances contained in the excreta.
this being more clearly pronounced in the case of nitrogen and sodium (Figs. 5, 6). This cannot be accounted for by the assumption that the ileum can excrete the various electrolytes only at constant concentrations. Sodium, for example, becomes less concentrated in the established ileostoma, whereas calcium is less dependent on volume output and varies more according to the intake of calcium, as might be expected.

**Sodium:** At first the sodium loss is considerable (Fig. 7), perhaps of the order of 200 to 400 mEq. per liter, with no clear evidence of conservation in the urine. The total quantities lost at this stage are almost invariably greater than was the previous loss in stools, resulting from diarrhea, before ileostomy was performed. As the exudates from the ileostoma thicken, the rate of loss decreases to approximately 150 mEq. per liter. The greater concentration of sodium in the exudates, together with the greater volume excreted, combines to produce a state of depletion of sodium which may induce a sudden clinical collapse—salt-depletion crisis. This is best treated prophylactically by routine intravenous therapy within the first four or five postoperative days; for rule-of-thumb calculations of the requirements of sodium it is only necessary to know the daily volume of output from the ileostoma (a simple ward procedure), and to assume that 300 mEq. of salt has been lost with each liter.

Should sudden collapse occur, with no obvious surgical complication to account for it, and in particular if the rate of excretion has been persistently high, then the collapse probably is due to depletion of salt, and should be treated urgently and rapidly with double-strength saline solution given intravenously. This measure will quickly correct the situation, often within half an hour.
It should also be borne in mind that an increase in output from the ileal stoma at a later stage, from any cause, will be accompanied by an increase in loss of salt; patients should therefore be advised to take extra salt should they at any time have an attack of ileostomy diarrhea.

Potassium: Whereas loss of sodium is aggravated by the performance of ileostomy, the loss of potassium is a more urgent preoperative problem, and usually it is corrected by ileostomy (Fig. 2). The two preoperative estimations recorded in Figure 8 show high losses of 35 and 85 mEq. daily by way of the stools. In five of seven patients studied immediately after ileostomy, none of whom received corticoid compounds.
ILEOSTOMY CHEMISTRY

**SODIUM**

**NEW ILEOSTOMY**

**ESTABLISHED ILEOSTOMY**

Fig. 7. The output of sodium.

**POTASSIUM**

**NEW ILEOSTOMY**

**ESTABLISHED ILEOSTOMY**

Fig. 8. The output of potassium.

First article published in the first issue of DC&O.
excretion scarcely exceeded 20 mEq. daily as a maximum. It was approximately 10 mEq. per liter, a rate which is maintained after the stoma becomes established. In one patient, previously referred to, severe ileostomy diarrhea developed as a result of pseudomembranous enteritis, and this diarrhea was accompanied by considerable loss of potassium and nitrogen (Fig. 9).

In another patient who had ileocolitis marked loss of potassium developed (Fig. 10), although convalescence after primary colectomy was entirely uneventful. In this case no attempt at conservation of potas
Fig. 9. Study undertaken from the fourth day after primary colectomy. Pseudomembranous enteritis developed on the ninth postoperative day, causing considerable increase in the loss of nitrogen and potassium.

Excretion scarcely exceeded 20 mEq. daily as a maximum. It was approximately 10 mEq. per liter, a rate which is maintained after the stoma becomes established. In one patient, previously referred to, severe ileostomy diarrhea developed as a result of pseudomembranous enteritis, and this diarrhea was accompanied by considerable loss of potassium and nitrogen (Fig. 9).

In another patient who had ileocolitis marked loss of potassium developed (Fig 10), although convalescence after primary colectomy was entirely uneventful. In this case no attempt at conservation of potas-
liter, and this figure should be borne in mind when replacement therapy is calculated for patients in whom excessive loss of potassium is suspected. These losses are summarized in Table 1.

The effects of cortisone on the concentration of sodium and potassium in the output from ileal stomas have been studied in three patients, and compared with a similar output from three patients who received no corticoid compounds (Table 2). Cortisone has the effect of reducing the volume of the output both of excreta from the ileal stoma and of urine. At the same time, the concentration of sodium from the ileal stoma is lower, and approximates the concentration obtained from an established ileal stoma, while the concentration of sodium in the urine is higher. The concentration of potassium is markedly higher in the output from the ileal stomas among patients who received cortisone. In case 6, however, in which no cortisone was used, the concentration of potassium was high, and the patient was the one who had ileitis (Fig. 10). The reciprocal lowering of the output of sodium is to be noted in this case. The concentration of potassium in the urine is the same in both groups. When these figures are translated to total daily output (Table 3), it can be seen that the total loss of sodium by way of the ileal stoma and in the urine is considerably reduced among patients receiving cortisone. Moreover, despite the higher concentrations of potassium in the output from ileal stomas among patients receiving cortisone, the total loss of potassium actually is less than among those not receiving corticoids because the volume of fluid excreted in the urine and feces is less. The lower loss of potassium among patients receiving cortisone is contrary to expectations, but possibly may be accounted for by the fact that the patients in this group were depleted of potassium before operation—more than members of the control group. There may be a case for the administration of corti-

First article published in the first issue of DC&R.
ILEOSTOMY CHEMISTRY

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Recent Ileostomy Output</th>
<th>Established Ileostomy Output</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24 hrs.</td>
<td>mEq/Liter</td>
</tr>
<tr>
<td>Volume</td>
<td>1000-3000 mls.</td>
<td>—</td>
</tr>
<tr>
<td>Nitrogen</td>
<td>2-4 g.</td>
<td>—</td>
</tr>
<tr>
<td>Sodium</td>
<td>200-600 mEq.</td>
<td>200-400</td>
</tr>
<tr>
<td>(1-1.1 g)</td>
<td>(1-1 g)</td>
<td>—</td>
</tr>
<tr>
<td>Potassium</td>
<td>10-20 mEq.</td>
<td>5-10</td>
</tr>
<tr>
<td>(0.3-0.8 g)</td>
<td>(0.2-0.4 g)</td>
<td>—</td>
</tr>
<tr>
<td>Calcium</td>
<td>40-100 mEq.</td>
<td>20-50</td>
</tr>
<tr>
<td>(1-2 g)</td>
<td>(0.5-1 g)</td>
<td>—</td>
</tr>
</tbody>
</table>

sone to patients who lose large volumes and therefore much sodium by way of the ileal stoma after operation. Cortisone will check the loss of both fluid and sodium without unduly upsetting the potassium balance.

**Calcium**: Such are the body's reserves of calcium that the loss of this element by way of an ileal stoma causes no immediate concern postoperatively. Although the loss of calcium is relatively high during the period of an output of high volume (fig. 1), there is no decrease corresponding to that in the case of sodium in association with a lower volume of excretion; at this later stage the intake of calcium increases with widening of the diet, and thus output is affected. More important is the daily output in patients with an established ileal stoma, since continued loss of calcium over a considerable period might lead to decalcification of bone. The last part of the graph for an established ileal stoma in figure 11 gives an indication of the loss usually seen by the time a patient is taking a normal average diet: approximately 50 to 60 mEq. daily, or just over 1 gm. In three cases daily analyses of the exudates for the content of fat also were done; no direct correlation was present between the output of calcium and that of fat.

The loss of rather more than 1 gm. of calcium daily raises two points, one physiologic, one clinical. Such a quantity is more than a normal person on an average diet loses daily in the stools (0.4 to 0.8 gm.). Is the large bowel in man inert in respect to calcium metabolism, as is supposed, or may it play some part in absorption? It is difficult to believe that the last two to three inches of ileum, removed for technical rea-

Table 2. Average Daily Concentration of Electrolyte Excretion over Ten Days Following Ileostomy, Together with Average Volume Output

<table>
<thead>
<tr>
<th>Case</th>
<th>Ileostomy NA mEq/Liter</th>
<th>Urine NA mEq/Liter</th>
<th>Total Daily Vol. MLS.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>K Vol. MLS.</td>
<td>K Vol. MLS.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>120 500</td>
<td>50 500</td>
<td>1100</td>
</tr>
<tr>
<td>2</td>
<td>150 100</td>
<td>100 100</td>
<td>1400</td>
</tr>
<tr>
<td>3</td>
<td>150 100</td>
<td>150 100</td>
<td>1700</td>
</tr>
<tr>
<td>4</td>
<td>300 300</td>
<td>30 45</td>
<td>2800</td>
</tr>
<tr>
<td>5</td>
<td>400 700</td>
<td>50 65</td>
<td>1700</td>
</tr>
<tr>
<td>6</td>
<td>150 1500</td>
<td>25 70</td>
<td>3000</td>
</tr>
</tbody>
</table>

First article published in the first issue of DCE&R.
TABLE 5. Average Daily Excretion of Electrolytes over Ten Days Following Ileostomy

<table>
<thead>
<tr>
<th>Case</th>
<th>Ileostomy</th>
<th>Urine</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NA mEq</td>
<td>NA mEq</td>
<td>NA mEq</td>
</tr>
<tr>
<td></td>
<td>K</td>
<td>K</td>
<td>K</td>
</tr>
<tr>
<td>1</td>
<td>60 9</td>
<td>30 30</td>
<td>90 30</td>
</tr>
<tr>
<td>2</td>
<td>60 9.2</td>
<td>100 70</td>
<td>160 70</td>
</tr>
<tr>
<td>3</td>
<td>60 7</td>
<td>195 78</td>
<td>255 78</td>
</tr>
<tr>
<td>Cortisone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>90 1</td>
<td>125 113</td>
<td>215 113</td>
</tr>
<tr>
<td>5</td>
<td>280 3.5</td>
<td>50 65</td>
<td>330 68.5</td>
</tr>
<tr>
<td>6</td>
<td>225 45</td>
<td>38 105</td>
<td>263 150</td>
</tr>
<tr>
<td>No Cortisone</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Some when ileostomy is performed, could account for such a difference. The clinical significance of this constant loss of calcium can be judged only when studies of calcium balance, at present under way, have been completed; four studies undertaken to date, including one late in pregnancy, show positive balance.

Summary

The effects of the creation of an ileal stoma on the loss of nitrogen, sodium, potassium, and calcium have been studied mostly among patients who had ulcerative colitis. In such patients the loss of nitrogen is reduced by creation of the stoma: the average daily loss of 1 to 2 Gm. from an established ileal stoma is not significant for patients on a normal diet. The loss of potassium is checked: the postoperative loss usually is insignificant. The loss of sodium is increased by the performance of ileostomy, and may be severe in the immediate postoperative period. For those concerned in the treatment of such patients, the establishment of an ileal stoma switches the electrolyte problem from one involving potassium to one involving sodium, for the ileal stoma halts the loss of potassium, but creates a sodium imbalance. Up to 300 mEq. of sodium can be lost per liter of exudate from a recently established stoma, and 150 mEq. per liter is lost from a fully established stoma. The amount of sodium required for restoration may be calculated from the volume of the output on this average. The administration of cortisone reduces the total loss of fluids and sodium, without increasing the total output of potassium.

From the established ileal stoma calcium is excreted at a little more than 1 Gm. daily by patients on a normal average diet; nevertheless, positive calcium balance appears to be maintained.

First article published in the first issue of DCe-R.
QUOTES FROM THE FIRST DECADE

1959 — “I must mention that repeatedly I hear very flattering remarks regarding the Journal. It is a publication for which we are justly proud, and this is due to none other than L.A.B.”

Letter to Louis A. Buie from Harry E. Bacon

“I am glad you hear good things about the Journal. Although I have not ‘let up’ one bit in the amount of time and work that I spend on it, my task is not as difficult as it was at first because I have become familiar with many things which were quite difficult then. The more excellence we can provide now and the longer we can continue to provide it, the more certain we can be that the Journal will live. I doubt that we can ever lessen our insistence on the highest quality of material which we publish and I intend to ‘carry the ball’ as long as possible on that account.…”

“I have several things in mind—additions and changes which can be made at the appropriate time which will make it a better Journal.”

Letter to Harry E. Bacon from Louis A. Buie, 1959

“…asked me to deliver the Mathews Oration in May, … which, of course, is a distinct honor. I have thought and planned this for many months and I have it finished but it is lousy. It misses the point. It is a conglomeration of data poorly presented. What I wanted to impart was from a philosophical standpoint—calling attention that while we are physicians of an honored profession, we are becoming indoctrinated into a machine. We have lost the appreciation of the patient; in yesteryear, the doctor was like a minister of the gospel—he was revered and respected, but not a doctor—is spoken of in turns of an expensive car, country club affiliation, and a spouse bedecked in a mink coat. I wanted to relate, impersonally, my own experience that a great Physician directs our destiny. For a number of years, I pleaded with … to make a place for a Chapel for all religions—Catholic, Jew, Protestant, etc., in our hospital. With the new one he did and I have used it to advantage. When I have a bad case, one I am worried about, I kneel for a minute or two and his His guidance. Believe me, … my results have been better and all I have to do is look at my records to prove it. I would like the privilege of mailing this lousy paper on to you for your wise counsel whereby you can help me separate the wheat from the chaff. I know I have missed what I wished to convey.”

Letter to Louis A. Buie from Harry E. Bacon, 1952

“Do you realize that I have been at work on this job for two years? …what an imponderable task it has been. I have been spurred on by my desire that the Journal shall succeed. I am encouraged by its favorable acceptance and laudatory comments which I have received from many authoritative sources. Nevertheless, I am not deluded into believing that because of this the success of the Journal is assured. I am confident that anything that would provoke adverse criticism (justifiably) would do irreparable harm. Therefore, I shall continue to study all contributions thoroughly. I shall attempt to select the best material and prepare it in the most perfect form of which I am capable. With some exceptions, mine is a thankless task. I can brush this aside easily in my enthusiasm to see the Journal succeed, but many individuals … believe that I am well paid for my work. …If they only knew the ceaseless hours I spend at my desk. If they only knew that I receive no compensation … except that which comes with the knowledge that thus far the integrity of the Journal is acknowledged and the quality of the material which has been published is responsible for this integrity. …Although I am not an editor and never will be, I ‘will have to do until one comes along’. …The manner in which I edit papers has been accepted in a friendly manner and in the spirit in which I perform this duty. When I submit suggestions editorially, I insist that they be approved by the author only if they are correct. In this manner I have learned to enjoy my duties and I am hopeful that some day someone else with a similar attitude and dedication will be willing to assume my responsibilities. I am sure that under no other circumstances can the successful continuance of our Journal be assured.”

Letter to Harry E. Bacon from Louis A. Buie, 1959

“…There is little doubt but that your task has been an imponderable one but realize that you can face all with pride; that this has been an achievement and just another feather in your cap although you do not need one. The Journal is excellent, very representative.”

Letter to Louis A. Buie from Harry E. Bacon, 1959

“Certainly no one will deny that there never would have been a journal if it had not been for you.”

Letter to Harry E. Bacon from Louis A. Buie, 1960

“…It is difficult enough for a participant to speak his piece in 20 minutes; of course, some could never get it said if they had 20 hours. There is an old saying, the origin of which I am unaware, that goes like this: ‘He that thinketh by the inch and speaketh by the yard should be kicketh by the foot.’ To this I say ‘amen’!”

Letter to Harry E. Bacon from Louis A. Buie, 1962
Announcement by Dr. James A. Ferguson, Secretary of the American Proctologic Society

Journal Editor

Our journal, Diseases of the Colon & Rectum, since its conception in 1957 by Dr. Harry Bacon, has been developed, nurtured, and directed under the dedicated and skillful management of its first Editor, Dr. Louis A. Buie, Sr., of Rochester, Minnesota. Due almost entirely to his Editorship, the journal is today one of the finest surgical specialty journals in existence and is the pride of our Society and of its publishers. Papers from all over the world are continuously coming in to Dr. Buie's office in hope of expression through this organ.

Inevitably, the time has come when Dr. Buie can no longer carry the great load of detail necessary to continue the high quality of the journal, and at his instigation the Council began a search for a suitable successor. Dr. John Hill, also of Rochester, Minnesota, one of Dr. Buie's protégés, has been appointed Editor effective April 1, 1967. Dr. Buie is very pleased with this arrangement and, as Editor Emeritus will assist Dr. Hill in his new duties. We are fortunate to have Dr. Buie's invaluable experience and selfless devotion available to Dr. Hill in preserving the high quality of our journal.

On behalf of the American Proctologic Society, we wish to express our gratitude to Dr. Buie for a job superbly done, and to Dr. Hill for assuming this responsibility.
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**specify...**

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soft pads of cotton flannel, moistened with witch hazel, 50%, and glycerin, 10%; per sheet 4s.

**You'll find TUCKS**
wonderfully convenient in—
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- episiotomies
- pruritus ani et vulvae
- after anorectal surgery
- whenever a soothing wipe or wet dressing is needed for irritated surfaces

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- **Hydrocil**
  - Refined psyllium mucilloid: 40%
  - Gum karaya: 10%
  - Dextrose: q.s.
  - 4 oz. and 1 lb. canisters

- **Hydrocil Fortified**
  - Hydrocil plus 2 mg. acetylsalicyl per 5 Gm.
  - 4 oz. and 1 lb. canisters

- **Hydrocil Fortified Capsules**
  - Each capsule contains—
    - Refined psyllium mucilloid: 1.925 gr.
    - Methylcellulose: 5.775 gr.
    - Acetylsalicyl: 3,000 mg.
  - Bottles of 30 and 100

This is a reproduction of the ad that appeared in 1958—Volume 1, Issue 1 of DCe-R