Medical Memoranda

Torsion of the Spermatic Cord: A Plea for Manipulative Reduction

The accepted treatment of torsion of the spermatic cord is operative reduction. That this is a comparatively rare surgical emergency all surgeons will readily admit. As O'Connor (1933) pointed out, however, the condition is probably much commoner than is generally realized, most cases never reaching a surgeon, and, in fact, never being diagnosed at all. They are looked upon by their doctor as cases of simple orchitis, and treated conservatively. If no attempt is made to reduce the torsion the pain will disappear after two to five days, and the swelling will disappear by the end of 10 days or a fortnight. Only if the doctor sees the case a long time afterwards, and notices that the patient has one atrophic testicle, will he have a chance of recognizing his mistake. One wonders whether it is impressed strongly enough on the young doctor that orchitis is extremely rare, while torsion of the testis is comparatively common in the young subject.

The results of operative reduction are unfortunately extremely bad, and most figures go to show that approximately 50% develop subsequent atrophy of the testis.

The reason for this is presumably the testicle's intolerance to ischaemia, and it is therefore of the utmost importance that reduction should be carried out at the earliest possible moment. The period elapsing between the consultation in the doctor's surgery and the operating table may be just sufficient to make the difference between a lost and a saved testis. If the patient has the normal complement of two testes, this may be of small importance, but it is very different if only one is present, and there is always the danger of mumps striking down the other later. Where the testis is fully descended non-operative reduction is often an exceedingly simple manoeuvre, which can be carried out by any doctor in his surgery or in the patient's home.

This non-operative treatment has not been advocated in this country on the grounds that failure to fix the testis may result in recurrence. This seems a most inadequate argument, as orchidopexy can always be performed at a later date if necessary, and, if immediate manual reduction may save the patient from a 50% chance of losing his testis, surely it is something which must be attempted.

CASE REPORT

A man aged 21 was admitted to hospital at 9.30 a.m. on April 2, 1955, with the diagnosis, by his private doctor, of torsion of the left testicle. Sudden pain had developed in the left testicle 1½ hours before admission, and had persisted. On examination there was a tender swelling in the lower end of the left inguinal canal, about the size of a grape, and the left testis was retracted up to the top of the scrotum. This appeared to be an early case of torsion of the spermatic cord in a patient with a normal scrotal testis and the ideal subject for non-operative reduction. The testis was gently rocked to see which way the torsion had occurred, and then rotated in an anti-clockwise manner. The swelling in the cord became smaller, and the pain diminished. A further untwisting, and the lump disappeared altogether, and the testis dropped down to the bottom of the scrotum. There was no further pain, and no swelling of the testis occurred, the patient being discharged from hospital the next morning. One cannot, of course, say for certain whether or not atrophy will develop in this case, but as there had been no swelling of the testis and no hydrocele one feels that there is little doubt but that reduction was performed before any serious vascular changes had taken place.

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REFERENCE

O'Connor, V. J. (1933). *Surg. Gynec. Obstet.*, 57, 242.

Acute Bilateral Retrobulbar Neuritis

In June, 1954, a clergyman aged 42 complained of dimness of vision of the left eye and neuralgia over the left frontal region. Within 48 hours the left vision was limited to counting fingers. Ocular movements were full but painful, and there was tenderness on palpation over the insertion of the superior rectus muscle. The pupil reaction to light was of the typical Marcus Gunn type. The optic disk was normal. Acute retrobulbar neuritis was diagnosed. Five days later there was blurring of the disk margin, with no perception of light. Ten days later the optic disk was definitely pale. Throughout these events the right vision was 6/6 and the right eye normal.

In view of the severity of the left visual loss he was admitted to hospital. The Wassermann reaction, E.N.T. examination, blood count, x-ray film of the skull, and examination of the teeth all showed no abnormality; neurological examination revealed, apart from the ocular changes, no abnormality in the central nervous system. Eleven days after the onset of symptoms in the left eye he suddenly found that the smaller newspaper print could not be seen by the right eye. The right ocular movements were full, with no pain on movement or tenderness on palpation. The reaction of the right pupil to direct light was poorly sustained. The right optic disk and the fundus appeared normal. Within 24 hours the right vision had fallen to 6/18. The right peripheral field was temporally contracted midway to fixation point. A considerable scotoma extending to 30 degrees above and below and to the temporal side of the fixation point was present.

Corticotrophin, 10 units six-hourly, was given. After three injections the right vision recovered to 6/9. The right optic disk was slightly paler than normal, but there was no oedema of the disk or fullness of the veins. There was pallor of the left optic disk—a rather surprising finding in view of the brief history. The right visual field was full to 3/330, but on the Bjerrum screen there was a small scotoma on the temporal side only, partial to 2/1000 in a semicircle up to 6 degrees from the fixation point and complete in a further 2 degrees semicircle external to this. It was considered that the only possible diagnosis was bilateral retrobulbar neuritis of the nature of Devic's disease.

Corticotrophin, 10 units six-hourly, was continued for 10 days, after which the vision began to fail again and a further scotoma developed. Corticotrophin was increased to 50 units in 24 hours and continued at this level for 17 days. Then 20 units in 24 hours was given, and this amount was gradually lowered until corticotrophin was discontinued altogether 10 days later. By that time the right vision had recovered to 6/6 and Jaeger 1. The peripheral field was full. Only a minute partial scotoma remained in the lower temporal area. Twenty months later these findings for the right eye were unchanged. With the left eye hand movements are seen in the upper nasal field; there is no projection of light elsewhere.

At no time has there been any associated myelitis, but the two classical components of Devic's disease are by no means invariably associated. The severity of the attacks of bilateral retrobulbar neuritis, their close association in time, the response to corticotrophin therapy, and the complete absence, then or subsequently, of any other abnormal signs in the central nervous system are very strongly suggestive that this was, in fact, an incomplete form of neuromyelitis optica rather than a manifestation of other demyelinating diseases of the central nervous system, such as a multiple sclerosis.

I thank Dr. Mark Lester for watching this case and Mr. A. J. B. Goldsmith for kindly confirming the ophthalmic findings.

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