RECURRING TORSION OF THE SPERMATIC CORD: OPERATION.

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In the BRITISH MEDICAL JOURNAL of April 29th, 1905, there was published a paper by me on the subject of "Recurring torsion of the spermatic cord, with an account of five cases."

The second case detailed was that of a lad, aged 16, who had suffered for four years previously from recurring attacks of pain every two or three months, which affected the left testicle. The onset of these attacks was always sudden. The pain, sickening in character, shot up towards the left kidney and caused prostration. In about a quarter of an hour vomiting occurred, and later, some swelling in the scrotum, followed by gradual cessation of the pain and disappearance of the swelling. These attacks passed off completely in a matter of a couple of days.

Mr. C. W. Cathcart, in whose wards the patient was at that time, most kindly asked me to operate for the condition. At the operation there was found the characteristic appearances associated with recurring torsion—clear fluid in the tunica vaginalis, a testicle and cord hanging free in this, and a broad arrangement of the cord with separation of the vas deferens from the vessels. The parietal tunica vaginalis was removed, and a strip of the visceral investment was separated with difficulty from the free aspect of the testicle. Catgut sutures were inserted to unite the surface of the testicle and the scrotal wall.

Since this operation (some nine years ago now) the patient has had no symptoms whatsoever referable to the left testicle. Some three years ago, however, he began to suffer from similar symptoms on the right side. In fact, so strongly did these symptoms imitate his previous condition on the left side that he applied for treatment in February, 1911, having recognized that his condition was similar in character to that which had affected his left side, and for which he was operated on nine years previously. He knew of no cause which precipitated the attack. It might come on while walking, standing, or lying in bed.

State on Examination.—Nothing definite could be made out in any way, and the history of his symptoms had entirely to be relied on. He was anxious to have an operation done, and this was performed in Mr. Cathcart's ward, and I am again indebted to that surgeon for his kindness in permitting me to carry out the second operation.

Operation.—An oblique incision was made over the right external abdominal ring. The tunica vaginalis was found to be large, and contained about 2 drachms of clear yellowish fluid. The testicle and cord hung free in the tunica vaginalis, but did not show the breadth nor the definite demarcation between the vas deferens and vessels which characterized the condition of the left side. The parietal tunica vaginalis was removed and the testicle fixed by catgut sutures to the scrotum.

The subsequent history was that of complete cure.

REMARKS.

The case is of interest on account of the diagnosed and successful treatment on the left side, now nine years since operation, but it is mainly of importance on account of the onset of symptoms affecting the right side, the recognition of the condition by the patient, and his request for operation. I have seen acute torsion of the spermatic cord in a man of 55 coming on for the first time and attributed to a slight injury.

THE Central Public House Trust Association, 15, Dean's Yard, Westminster, S.W., has issued for the use of motorists, cyclists, and other tourists and travellers a list of hotels and inns under the management of the Public House Trusts and the People's Refreshment House Association. General catering is a special feature of these trust houses, and the managers receive a personal profit from the food and non-alcoholic trade. Excellent bedroom accommodation, it is stated, is to be found in the majority of the houses, but in some of the smaller village inns it is of the cottage type. The list is remarkable, inasmuch as it gives the names of inns in many small places in which the motorist or cyclist might not expect to find a comfortable and well-conducted house. The pamphlet is provided with an index.

SIX CASES OF HYDROCELE IN INFANTS TREATED BY OPERATION.

[WITH SPECIAL PLATE.]

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In a paper on the surgery of infancy, read at the Meeting of the British Medical Association in Belfast in August, 1909,¹ and based on an experience of some 9,000 operations up till then performed on children treated as out-patients, I advocated the relegating to the out-patient operating theatre of a much larger number of the cases treated in our children's hospitals, and particularly pleaded that "in children under 2 years of age there are few operations indeed which cannot be as advantageously carried out in the out-patient department as in the wards," with great gain to the hospital's accommodation and efficiency. My views have not been left uncriticized. In particular, operations for hernia were singled out by certain critics as being unsuited for out-patient treatment. As a matter of fact, as our statistics show, operations for hernia in out-patient infants are amongst the safest and most efficient of all our operations. More recently the opinion has been expressed that the operative treatment of hydrocele is unsafe in the out-patient department.

The opinion is as ill-founded as that expressed regarding hernia. My experience has been that the operative treatment of hydrocele in children is as uniformly successful in the out-patient as in the in-patient department.

During November and December I have operated on the following six cases of hydrocele in the out-patient department of the Royal Hospital for Sick Children, Glasgow:

Name.	Age.	Date of Operation.	Result.
John S.	2 months.	Nov. 8th, 1912.	Primary healing.
John L.	2 weeks.	Nov. 8th, 1912.	Primary healing.
James M.	5 months.	Nov. 15th, 1912.	Primary healing.
John W.	4 months.	Nov. 22nd, 1912.	Primary healing.
John L.	3 months.	Dec. 3rd, 1912.	Primary healing.
Allan W.	18 months.	Dec. 27th, 1912.	Primary healing.

All were cases of hydrocele of the ordinary "acquired" type. No local preparation was done till the child was under anaesthetics on the table. The dressing was a small pad of sterile gauze fitted by a strip of adhesive plaster. The children were taken home by their mothers after operation, and brought back in a week for removal of dressing and sutures.

The operation performed in all six is indicated in the drawings made for me by Mr. A. Kirkpatrick Maxwell. A skin incision (1 to 1½ in.) was made just above the groin over the inguinal canal, and the spermatic cord exposed just below the ring. The testicle and hydrocele were pushed up into the wound, and the upper end of the hydrocele sac exposed by a few snips of the scissors (Fig. I). The exposed sac was then emptied by trocar and cannula (Fig. II). The collapsed sac with the testicle was then pulled out of the wound, and the sac dealt with—either by tearing out its internal serous lining, by complete excision, or by bisection and suture of its halves back to back behind the testicle. Replacement of the testicle in the scrotum, and suture of the wound in the groin completed the operation.

(In the comparatively small hydroceles of infancy no drainage is necessary. In operating by this method for large hydroceles in adults, it is advisable to use a drainage tube, reaching from the wound to the bottom of the scrotum, for forty-eight hours.)

¹ BRITISH MEDICAL JOURNAL, vol. ii, p. 753, 1909.

AT the recent examination held by the Sanitary Inspectors' Examination Board for inspectors under the Public Health (London) Act (1891), fifteen candidates passed, all but one of them women.