INDICATIONS FOR INFANT CIRCUMCISION WITH NOTES OF A SIMPLER OPERATION

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In out-patient practice sepsis is so common after circumcision that my attention has been drawn to defining the criteria for operation and to devising a procedure which will minimize post-operative infection. The latter is most certainly due to the necessity of applying dressings in the child's home, and of the consequent lack of surgical cleanliness.

Aesthetically one may affirm that the natural appearance of the prepuce is at least as good as, if not better than, that after the most perfectly performed circumcision. What, then, are the characteristics of a satisfactory prepuce which requires no improvement at the hands of the surgeon? It should be possible to dislocate it behind the glans penis with simple pressure of the thumb and forefinger without causing pain; if a constriction is so caused one must estimate if it is likely to produce any degree of paraphimosis; reduction should be possible with the same ease; the end of the prepuce should be in a healthy condition, not habitually oedematous or inflamed. If these desiderata are fulfilled there is no reason for performing a mutilating operation, nor indeed for any operation at all.

The next type of prepuce cannot be dislocated on account of adhesions to the glans. These can be separated easily with a probe while the thumb and forefinger gently press back the foreskin. The application of liquid paraffin and subsequent dislocation will prevent their re-formation. Next comes the type where hard pressure is required to perform the dislocation, perhaps also with separation of adhesions. Here paraphimosis with swelling of the glans and pain will follow if the dislocation is not reduced. This and the next class, where dislocation is impossible without tearing or forcibly stretching the prepuce with an instrument, should be classed as cases of phimosis and require operation.

Operative Technique

The operation necessary in most cases is a very simple one, requires no dressing, and can be performed usually without haemorrhage. A general anaesthetic is given to

FIG. 1.

FIG. 2.

FIG. 3.

all children over a fortnight old. The procedure is a simple plastic one for widening the calibre of the prepuce, and consists in making three longitudinal slits in its folded edge. One blade of a pair of sharp-pointed scissors is inserted between the glans and foreskin, and after the loose skin has been pushed back as far as it will go with simple pressure, the three slits are made, avoiding the dorsal arteries and vein. They are three-sixteenths to one-quarter of an inch long, and are placed one dorsally and two laterally. Complete dislocation is then possible, and unless a big vessel has been cut there is very little

bleeding. The slits open out into diamond-shaped spaces, in each of which the proximal and distal corners are then sutured together with fine catgut. The operation is completed by reducing the dislocation, when it will be found that the loose skin behind the incisions comes forward and completely covers the wounds. Thus no dressing is necessary, and the parents are told not to meddle with the part at all. The child may have its daily bath. Post-operative care consists in repeating the dislocation on the second, sixth, and tenth days after operation, by which time healing will have taken place. The figures are self-explanatory.

The operation is an elaboration of the well-known dorsal slit, but differs from it in that it produces an aesthetically perfect result without the untidy apron-like effect of the long dorsal slit.

All cases are not suitable for this operation. Where the prepuce is very long or constricted for any length in front of the glans, the incisions have to be made so long that the wounds are not automatically covered by skin, and in these cases a formal circumcision is preferable.

Clinical Memoranda

Age Incidence in Epilepsy

A recent reference in the Press to the notorious "Brides in the Bath" murder trial recalls to mind an important point which was discussed during the proceedings. The murderer claimed in each case that his bride had had an epileptic seizure on the day before her death. His defence was that she must have had another fit while in the bath and as a consequence been drowned. None of the women had been known to have fits previously, and all three were over thirty years of age. The prosecution pointed out that epilepsy is rarely manifested for the first time in a person over thirty. The coincidence of such an occurrence in three wives of the same man imposed an insupportable strain on the credulity of the jury.

An analysis of three hundred cases of epilepsy, almost all idiopathic, examined during the past nine months in St. David's Hospital (for male epileptics) reveals the following facts as regards age incidence:

Onset under								Over
1	2	5	10	15	20	25	30	30
18 =6%	8 =2.6%	23 =7.6%	41 =13.6%	81 =27%	44 =14.6%	24 =8%	24 =8%	37 =12.3%

It will be seen that 12.3 per cent. of the cases were over thirty years of age when epileptic fits first began. Talbot (*Treatment of Epilepsy*) reproduces a table from the thirty-second annual report of Craig Colony giving particulars of 6,595 patients admitted there. In 520 cases the age at onset was unknown; of the remaining 6,075 cases, 447 were over thirty when epilepsy began—that is to say, 7.35 per cent.

The large discrepancy between 12.3 and 7.35 per cent. may possibly be accounted for in two ways. First, the table reproduced above concerns a relatively small number of cases. Secondly, of the 6,595 patients in Craig Colony, no fewer than 1,830 were under five years of age, or 28 per cent. Such children have a high mortality. Of the 300 cases at St. David's Hospital all when admitted were over fifteen years of age, and their history showed that in only 6 per cent. of cases had epilepsy developed before the age of five. All patients at St. David's Hospital are sane and are capable of some work in the hospital and its grounds and workshops. Indeed, it is a condition of suitability for admission that they should be capable of