PROVINCIAL MEDICAL JOURNAL

And Retrospect of the Medical Sciences.

No. 144.]

LONDON, SATURDAY, JULY 1, 1843.

PRICE SIXPENCE.
[Stamped Edition Sevenpence.

COURSE OF LECTURES ON VENEREAL AFFECTIONS

DELIVERED

AT THE HOPITAL DU MIDI, PARIS.

By Dr. PHILIP RICORD.

Translated and arranged by Daniel McCarthy, Esq.,
Interne of the Hospitals of Paris.

LECTURE VIII.

May 16, 1843.

Epididymitis—Causes—Theory of metastases—Mechanical causes—Symptoms—Causes of error attending the diagnosis—Effusion—Complications and treatment of epididymitis—Edema—Phlegmon—Orchitis—Symptoms—Treatment—Prophylaxis—Therapeutic treatment of the acute stage—Treatment of the chronic stage—Mechanical applications—Bandages, &c.—Treatment by compression.

GENTLEMEN,—The disease which shall this day occupy our attention has been known under the several denominations of “venereal testis,” “tumeur vénérienne des bourses,” “hernia humoralis,” “orchite blennorrhagique,” “orchite urétrale” (Velpeau), “hydroorchite,” “vaginalite blennorrhagique” (Rochoux). Most surgeons call it “venereal inflammation of the testis.”

B. Bell, Sir A. Cooper, and others, have given most lucid descriptions of this malady; and it is truly surprising that, after their labors have thrown so much light on the subject, it still should be misunderstood by men of merit—as, for instance, Dr. Desruelles.

I am, Gentlemen, not fond of changing the generally received denominations of any disease. When, however, an alteration of this kind does not break too suddenly upon the public—when it tends to correct an erroneous impression conveyed to a name improperly applied—when its object is to render the physician more cautious in treatment, more guarded in his prognosis, and more minute in his investigation—then, indeed, I approve highly of a modification of the nomenclature. In no instance is a change of appellation so advantageous as in the present case, and I will, in compliance with what is rapidly becoming the general custom, call the disease, which is the subject of this lecture,

Epididymitis.

Gonorrhœa may be properly looked upon as a special, if not a specific, cause of epididymitis. Most writers believe it is generally induced by the “virulent” form of blennorrhagia; in this I cannot agree. Virulent gonorrhœa is merely “chancere in the urethra,” and, uncomplicated with simple inflammation of the duct, will seldom, if ever, cause epididymitis. In some few cases the discharge appears to

have ceased some time; in most the disease occurs very shortly after clap.

Can epididymitis precede the discharge? We have said that gonorrhœa may begin in the posterior region of the duct; hence, epididymitis may show itself before the blennorrhagic running, but, in point of fact, the urethral irritation must necessarily pre-exist.

This inflammation is generally observed after the second week, and may arise at any time between the second and sixth week of the duration of a discharge. When it complicates at a late period of the existence of clap—i. e., several months—it not unfrequently coincides with organic change in the urethra, and, in such case, stricture is commonly detected.

Dr. Lagneau, and, indeed, most surgical writers, believe epididymitis to be a metastatic result of the imprudent suppression of gonorrhœa. I believe that here the generally received doctrine is at fault. Examine the patients, question them closely yourselves, Gentlemen, and you will find that popular opinion has been, in this matter, strangely misled. You will find that, in three-fourths of the cases, no treatment whatever had been applied to the running (which, therefore, has not been *imprudently stopped*); and again, that, in most instances, the discharge diminishes or ceases only *after* epididymitis has become manifest—a complete demonstration that the testicular inflammation is not due to a supposed metastasis, but merely to extension of the urethral irritation; at the same time, a balance of morbid action takes place between the epididymis and urethra, the more violent inflammation of the two inducing a corresponding diminution in the other, agreeably to the old Hippocratic aphorism,

“*Duobus doloribus simul obortis, vehementior obscurat alterum.*”

Alone, without any accidental circumstance to assist its influence, urethritis may certainly cause epididymitis. In most cases, however, fortuitous occurrences combine with gonorrhœa to bring on the disease. As such, we shall notice intemperance, protracted exercise, riding, muscular efforts of a violent nature, seminal loss, self-pollution, and sexual intercourse during the declining stage of gonorrhœa. Relaxation of the scrotum, varicocele, an unusual length of the spermatic cord, costiveness, a disposition to hæmorrhoids, all interfering more or less with the freedom of venous circulation in the organs, have also a marked share in the production of the disease.

Calculus or stricture, more especially if requiring the introduction of instruments, may give rise to it. Badly made injections, the action of cold air on the scrotum, an external injury on the testis, the pressure of an inguinal truss, may occasion it; and it will be more likely to occur in patients of a lymphatic, tubercular, or scrofulous habit, or in those who have already been affected in the same manner.

In general the disease occupies one side only, but sometimes both; and in such cases the testes are often alternately affected, and present, in turn, remissions and exacerbations of inflammatory symptoms. Both organs may simultaneously, and to the same degree, become the seat of the disorder; it is very rare to see it occupy one side, suddenly disappear, and invade the other. Such an occurrence may, however, be observed when simple congestion, having increased the size of one epididymis, ceases, on true phlogosis being established in its fellow.

The statistical tables, drawn up on a small scale by Gaussail and by Desruelles, have led these gentlemen to the erroneous conclusion that epididymitis is more frequent on the right side than on the left. This conclusion, in contradiction to the experience of all practitioners, is an argument not against statistics in general, but against their imperfect application to particular diseases.

To what circumstance are we, then, to attribute this predilection of inflammation for the left epididymis? I have spared no trouble to discover it, and experience leads me to think that epididymitis occurs mostly on that side on which the organs are generally carried, the testis receiving less support from the trousers than the other.

Symptoms.

A sense of uneasiness extending to the whole scrotum, which seems to the patient more weighty—now and then increased venereal desires—frequent but inefficient wish to void the bladder of its contents, leading to vesical tenesmus—are amongst the first symptoms of the disorder.

Shivering and fever set in at this period, and slight remittences, or even true intermittence, are occasionally observed. The groins are painful; a circular tension around the hypogastric region, together with distressing lumbago, add to the sufferings, and compel the patient to assume a bent posture in the act of walking.

The epididymis is swollen and painful. In some cases the pain suddenly appears on any muscular effort being made, and the affection is often attributed by the patient to this circumstance, to which is due merely the discovery of a disease previously existing. Professor Velpeau erroneously, in my opinion, ascribes the inflammation to the cremasteric fibres impeding the venous circulation of the testis during contraction.

Cullerier was of opinion the disorder always began in the vas deferens; but the case with which he chiefly supported his position turned out to be one of "tubercular or scrofulous testis," in which the spermatic cord is always more or less implicated. In Swediaur's opinion, the malady originated in the epididymis itself. Theoretically speaking, it is very probable the lining of the spermatic duct is inflamed, and thus transmits to the appendage of the testis the affection of the urethra, but, in point of fact, no outward appearance, no symptom, demonstrates this to be actually the case.

The epididymis is increased in size; it is acutely sensible to touch, and this state of things may subsequently extend to the funis.

We should not omit to mention here three causes of error which may lead to fatal consequences, espe-

cially the two last, if the surgeon is not aware of these anatomical anomalies.

The first is a condition very frequently met with, and consists in the epididymis being seated in the front of the testis, instead of occupying its posterior aspect. The question here is one of purely scientific interest, and it is sufficient to be warned of this cause of error to avoid being deceived by it.

In the second anomaly an error may lead to very serious consequences. I allude to cases in which the testis is retained beyond the abdominal ring in the inguinal canal, and there becomes affected with epididymitis. A swelling, presenting sometimes a most deceptive fluctuation—pain, sometimes even a slight blush of the skin covering it, the tumor being seated in a region where bubo constantly occurs and suppurates—all these circumstances put together lead almost inevitably to a mistake, the result of which may be a broad incision made into the testis. Some years ago I was very nearly deceived by a case of the sort; I even called for a knife, and, as I make it a rule to explore a tumor once again immediately before I open it, whatever may have been the degree of minuteness of previous investigations, I examined the parts again, and the scrotum appearing very flat on the side of the inguinal tumor, I sought for the testis, and, not finding it, the possibility of an error at once struck me, and further investigation fully showed the true nature of the case.

A third cause of error is found in the testis being occasionally in the perineum, from lengthening of the cord, perhaps, or other anomalies which have not hitherto been the object of proper anatomical investigation. A gentleman affected with gonorrhœa called upon me about six or seven weeks ago, complaining very much of a perineal tumor. It was exquisitely painful, fluctuating, and about the size of a pigeon's egg; the skin adhered to it. I felt inclined to consider it as one of those abscesses I have described to you, originating from the membranous urethra. I was, therefore, about to open it, when examination of the scrotum led me to the discovery that one testis was absent. I inquired from the patient, who told me that the other testis had always occupied the perineum—a piece of information which came in very good time for his own sake, and which has since led me to the diagnosis of another case of the same kind.

I purposely avoid speaking of epididymitis invading a testis still retained in the abdominal cavity, because, if such cases exist, they must be excessively rare, and, in the present state of science, no one symptom could serve to detect them.

From the frequent presence of effusion in the tunica vaginalis, Dr. Rochoux conceives this disease consists merely in inflammation of that serous cavity, and consequently calls it "vaginalitis." Attentive observation convinces me that this opinion is incorrect. The signs of serous inflammations are absent in this malady. The pain is acute, but seated about the epididymis, and not in front of the testis, where inflammation of the tunica would necessarily induce it. The effusion is transparent, or slightly tinged with blood, a few drops escaping from the puncture. This liquid contains no floculi, nor is it possible to detect in it anything like pus. I, therefore, reject Dr. R.'s interpretation of the symptoms, and consider them as

belonging to passive exhalations, arising not from serous inflammation, but from vascular congestion of the membrane.

The quantity of the effusion varies from a few drops to several ounces. In general it is very trifling, and, in some cases, absent. I have met with it on the healthy side, when the diseased side was free from any dropsical secretion.

The transparency of the liquid, the presence of true fluctuation, and puncture with the lancet, will serve to diagnose and demonstrate its existence.

Complications and Treatment of Epididymitis.

Œdema of the scrotum is commonly met with in cases of epididymitis. The dependant parts are mostly thus affected, and the lateral pressure of the neighbouring thighs flattens the organs, and modifies their shape in a characteristic manner. The skin, on the contrary, is free from alteration, and the contrary occurs when, instead of œdema, the cellular tissue is the seat of purulent infiltration.

Phlegmonous inflammation is more rarely met with than œdema, and may either produce diffused or circumscribed suppuration of the structures.

The most important complication of epididymitis is, in all respects, orchitis. I apply this name exclusively to inflammation of the spermatic gland, in order to avoid the confusion necessarily arising from its indiscriminate application to all acute inflammations of the scrotum. It is quite as irrational, and imparts the same kind of vague and useless information, to give the appellation of orchitis to those various disorders, as to call ophthalmia all the maladies of the organ of vision. The tendency of science is, at present, to localise, with as much accuracy as possible, the seat of disease; and this tendency being most certainly good, when not carried too far, I think much advantage may be derived by following it in the diagnosis of the affections of the sexual organs.

The general as well as the local symptoms are so very distinct as to preclude the possibility of confusion of orchitis with epididymitis. Their progress and termination being altogether different, and their treatment also affording contrary indications, it is clear that the division is not merely scholastic, but one the advantages of which will be chiefly acknowledged at the bed-side of the patient.

The increase of size of the inflamed testicle is checked by its unyielding envelope, the tunica albuginea, severe strangulation, violent pain, and the faintness, or even syncope, commonly observed on compression of the spermatic gland. At this period high fever generally appears.

Cramp, sickness, and obstinate vomiting, results of the sympathy of the digestive system with the testis, have often, by their occurrence in orchitis, imposed upon the surgeon, and made him fear the existence of strangulated hernia. My friend Dr. Despretz, whose surgical attainments are known to most of you, told me this very day of a case of orchitis which caused him much perplexity, from the resemblance of its symptoms with those of strangulated hernia.

In the incipient stage of orchitis particularly, the special functions of the testis become stimulated, and a tendency to pollution is manifested. It is not uninteresting to observe that, in parenchymatous in-

flammations in general, the secretions of the affected organ are mixed with blood—*e. g.*, the rusty sputa of pneumonia; and here, again, the seminal fluid is mixed with blood, and changed in its color.

I will now, Gentlemen, rapidly enumerate the leading characters of epididymitis and orchitis. In the former the epididymis forms a distinct crescentic tumor behind the testis. It is hard, and continuous with the vas deferens. The testis preserves its special elasticity—that semi-fluctuation which is so remarkable; its size is equal on both sides, and the organ is free from adhesion to the skin. In orchitis, on the contrary, the spermatic gland itself is increased in volume; its resiliency is lost, the organ feels, as it were, coagulated, and the skin adheres to it, smooth, and deprived of the folds and wrinkles special to the region. Epididymitis has *always* preceded orchitis when the latter disease results from gonorrhœa.

The termination of epididymitis by delitescence is very rare. Gradual resolution is the common rule. The liquid effused in the tunica vaginalis is first absorbed, and the epididymis returns to its natural condition by slow degrees, and even, in most cases, a hard spot remains in the caudâ.

In some few instances hydrocele persists, and I feel convinced that many serous collections of this nature in the scrotum recognise no other origin.

In some patients suppuration of the cellular structures of the scrotum takes place, but very rarely does the epididymis itself suppurate.

Orchitis, on the other hand, has far different terminations. Resolution seldom occurs; mostly the testis suppurates, or is gradually absorbed. In both cases the organ is destroyed. Should any difficulty exist in distinguishing favorable absorption from atrophy, it need only be remembered that, in favorable absorption, the testis resumes its elastic feel, at the same time that its size decreases, whereas, in atrophy, the hardness persists all over the organ.

In the prognosis of epididymitis the fear of consecutive syphilis should be altogether set aside.

Some authors—Lagneau, amongst others—think that it may occasion syphilitic sarcocele. This is impossible, unless the patient be at the time under the influence of constitutional syphilis, and then, indeed, epididymitis may become a local stimulus, sufficiently powerful to cause the appearance of the syphilitic affections of the testis, so accurately described by Sir A. Cooper.

The existence of epididymitis on both sides, and its persistency in the chronic form, should direct the attention of the physician towards the possibility of tubercular disease of these organs, and point out the propriety of minute investigation of the chest. It must be likewise recollected that tubercular testis invariably is accompanied by an alteration of the spermatic duct, which appears enlarged, and assumes a bead-like form; also, cancerous transformation of the testis may occasionally trace its origin to epididymitis.

Treatment.

We will divide it into the prophylaxis and therapeutic treatment.

I. *Prophylaxis.*—By reference to our list of causes, the prophylaxis of epididymitis can easily be deduced. We shall only say, that we deem of first-rate im-

portance the use of a suspending bandage from the beginning of gonorrhœa. We shall also add, that the inflammation of the epididymis generally occurring after the second week of the existence of clap, the best means to prevent that painful complication will, most undoubtedly, be the timely application of the abortive treatment of gonorrhœa, such as we have described it.

II. *Therapeutic Treatment.*—a. *Acute Stage.*—Rest, strict abstinence from food, diluent drinks, are to be employed from the very first. The greatest attention must be paid to the state of the digestive organs; and this is not one of those common recommendations usually annexed to the treatment of every disease, for, independently of the revulsive action obtained by opening medicines, a mechanical benefit will also be derived from the mere voiding the intestines of a mass of fœces, which, by compressing the spermatic veins, might baffle your efforts to master the disease.

The testis should be elevated, not bent backwards on the abdomen, but merely raised, and not allowed to hang in a dependent position. Discussive applications, such as ice, alum, &c., may be tried, but their use is not wholly unattended with danger. I prefer the antiphlogistic line of treatment. Leeches applied, in numbers proportioned to the strength of the patient, and the intensity of the disease, to the perineum and inguinal regions, will be found far preferable to bleeding the scrotal veins. When the pulse is full and strong, blood will be taken with very great advantage from the arm. Poultices and warm fomentations should be kept constantly applied to the parts.

Should the liquid effused in the tunica vaginalis cause, by its abundance, uneasiness or pain, a puncture with a lancet will suffice to rid the patient of this complication; but, in one-half of the cases, the use of sharp instruments is altogether unnecessary, and the slight effusion may be neglected. In itself, the puncture has no marked influence on the duration of the disease.

b. *Chronic Stage.*—When the violent inflammatory symptoms have in some measure subsided, the greatest advantage will be derived from compression of the testis by Fricke's method.

The acute stage of the disease, inflammation *en masse* of the spermatic cord, supuration of the cellular tissue, or abundant effusion not evacuated from the tunica vaginalis, are so many circumstances which should prevent the application of compression.

I will now apply the bandage before you, in order that the slight practical details, on which may depend the success or failure, should not escape your notice. With a long, narrow strip of adhesive plaster, placed at about an inch from the abdominal ring, I compress circularly the spermatic cord, so as to separate perfectly the diseased testis from the healthy one, and tighten it sufficiently to preclude the possibility of the organ ascending through this ring. Two or three other strips are then placed, in succession, circularly around the testis, so as to compress it equally on all sides; several short strips are then applied in the shape of so many loops, compressing the organ upwards by their concavity, and crossing each other at the summit of the tumor. Circular strips are then applied around the whole, so as to insure the solidity

of the bandage, and the equal distribution of the compressive force.

This operation, in which the testis is handled for some minutes, is productive of some pain; but, should that pain not have subsided within half an hour after the application of the bandage, it must be withdrawn; otherwise the patient is exposed to inflammation, and even gangrene of the scrotum, and all its consequences.

Thin pledgets of lint, placed between the first ring of the bandage and the skin, will prevent excoriations, or even ulcerations, which direct pressure might produce.

The inflamed organs do not diminish in the same ratio in all their parts; some portions of the bandage will, therefore, be soon relaxed, while others will remain tight; and as the upper ring compresses with the same power, accidents of strangulation might supervene if the bandage was not speedily renewed, at least every forty-eight hours.

When Fricke's method cannot be employed, the mere plaster of rigo cum mercurio, ointments containing hydriodate of potash, or ioduret of lead, or equal parts of extract of cicuta with mercurial ointment, or even the ung. merc. fort., will answer as excellent discussives, and hasten the cure.

Gonorrhœal ophthalmia, and gonorrhœa in women, will occupy our next lectures.

CASE OF HYDATIDS IN THE UTERUS.

TO THE EDITORS OF THE PROVINCIAL MEDICAL
JOURNAL.

GENTLEMEN,—Should you consider the following outlines of a case of hydatids in the uterus, which occurred in my practice a short time since, sufficiently interesting for insertion in the Provincial Medical Journal, I shall feel obliged by your giving it a place in an early number.

I am, Gentlemen,
Your obedient servant,
GEORGE KING.

Bath, June 5, 1843.

Mrs. C., a married woman, about forty years of age, and the mother of three children, had, since her last confinement (which took place in July, 1841, of a still-born child), been very much out of health, but not sufficiently so to be under any particular mode of medical treatment, as I considered the cause of her ailments to be more mental than bodily. Some time in November last she was rather more desponding than usual, and I was requested to call on her; the moment she saw me she said, "Doctor, I know now what is the matter with me; I am certainly in the family way, and I must be gone three or four months, for I quickened last night." I listened to all she had to say, but gave no opinion, thinking that a woman who had had four children must know more about the sensation of quickening than I did. From that time she improved in health, and was much more cheerful; she also increased in size. In this way she went on for three or four months, when I was again