THE OPERATION FOR VARICOCELE,

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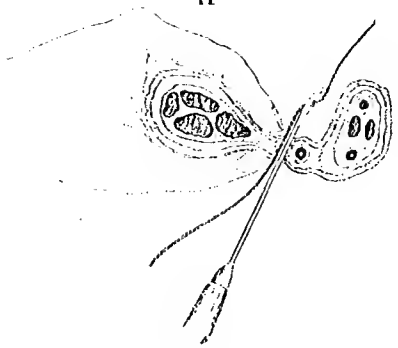
Nowhere has the introduction of the antiseptic method into surgery exercised a more marked influence than in the encouragement it has given to the performance of such operations of convenience as that for Varicocele. Formerly looked upon with disfavor, if not actually considered unjustifiable, this operation has since the antiseptic days been again taken up by surgeons everywhere, and modified or improved in accordance with antiseptic principles. Where this has happened, it is now part of the daily routine of practice, and is recommended with as much confidence, and performed with the same security, as tenotomies and subcutaneous operations. Improved varicocele operations are continually appearing in our surgical literature, and various plans are being advanced as claiming both safety and success.

That the operative treatment is sound and justifiable surgery can scarcely be denied, for advanced cases of the disease are so frequently found to produce distress and disablement to a great degree, that a reasonably safe and certain cure is welcome both to the sufferer and the surgeon. Palliative methods of treatment, such as Wormald's ring, trusses, suspensory bandages, are seldom of any use.

The method of operation I have employed during the last eight years excels in simplicity, safety and certainty the various proceedings that I have seen recommended by operators. It is indeed so simple that I have no doubt many others besides myself have had recourse to it, although I have not observed in medical periodicals any statement of its having been adopted or recommended.

It consists in an aseptic subcutaneous deligation of the vein by means of a needle and disinfected thread.

II

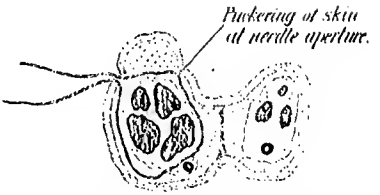


Thread passed through between Vas and Veins

I

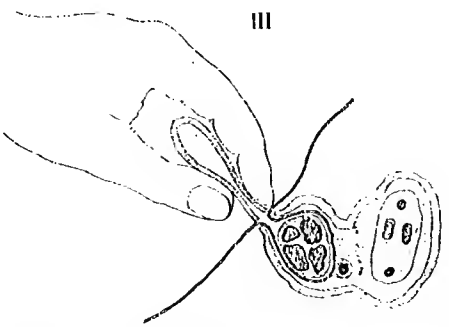
Horizontal section of Scrotum in Varicocele.

IV



Position of Thread and Veins before tying

III



Position of Thread and Veins before the second insertion of the needle.

I have preserved notes of six patients so operated on, the earliest in January, 1878. They were all young men, the subjects of advanced varicocele on the left side, and there existed softening of the testicle in two of them. In all the operation was confined to the left side, and was done in the same manner save that in one of them anæsthesia was not employed. They suffered from no fever or constitutional disturbance after the operation, the local reaction was confined to the formation of a firm induration at the site of operation, which in the course of a few months slowly disappeared. The result was in every instance satisfactory at the time, and most of them I have seen or heard from long after the operation, and they have found the cure complete and permanent.

The operation was carried out as follows: The patient was, in all cases save one, put under the influence of chloroform or ether in bed, and the scrotum disinfected by a 5 per cent. solution of carbolic acid. The patient, who was not anæsthetized, was operated while sitting on a chair. After disinfection the left half of the scrotum was, by the usual manœuvre, seized three-quarters of an inch above the testicle, between the forefinger and thumb of the left hand and its contents allowed to slip back and escape until the cord-like vas deferens had slipped out of grasp. At this point the finger and thumb squeezed the skin of the two sides of the scrotum together, to squeeze the veins away from the just escaped vas, and a threaded needle was thrust through the scrotum at this spot (Fig. II). A handled needle with a large eye at its point was employed, and its thread was the strongest surgeons' silk, disinfected either by having been boiled in 5 per cent. carbolic solution, or by Kocher's method of twenty-four hours soaking in German oil of juniper, the thread being afterwards kept in absolute alcohol. The needle was disinfected by being washed, first with oil of turpentine, and then with carbolic lotion. Care was had, in thrusting the needle through the scrotum, to avoid, at the points both of entrance and emergence of the needle, the tubular sebaceous serotal glands from which the hairs emerge, as they are always full of bacteria and their disinfection is an impossibility. The needle was then unthreaded and withdrawn leaving the thread in its track. The skin of the front of the

scrotum was then seized by the left forefinger and thumb and drawn forwards in a fold between them until the punctures from which the thread emerged were drawn forward over the dilated veins to the base of the folds (Fig. III). They were there squeezed together and steadied by the finger and thumb, and the needle, this time without any thread, was once more passed through the scrotum, entering and emerging by the same points as before. The end of the thread emerging beside the needle point was threaded into its eye and the needle was withdrawn, carrying the thread with it, so that both ends of the thread emerged by the same point where the needle was first entered (Fig. IV). The needle having been detached the long ends of the thread were tied by a surgical knot and tightened upon the veins and tissues they embraced with the utmost strength that could be applied. A triple knot was made, the ends of the silk were cut off short and the knot permitted to sink into the depth of the scrotum. The puckerings inward of the needle apertures, due to the first and second needle tracks not quite coinciding in the subcutaneous tissues, (see Fig. IV.) were freed by pulling the skin outwards at these spots until the included fibres gave way and allowed the skin to fall into its natural position entirely unconnected with the knot.

Another exactly similar operation was made an inch (or two finger breadths, as the case required) higher up the veins, and the operation was then complete.

The scrotum was again disinfected, surrounded by a sheet of salicylic wool, and the patient laid in bed with the testes elevated.

One of my patients submitted to the operation without anæsthesia, but as a rule, it is sufficiently painful to demand the administration of an anæsthetic, and the careful carrying out of the disinfection and necessary steps are much facilitated thereby.

A knot of the size of the point of the thumb appears between and around the ligatured points, and a slight degree of scrotal œdema can be detected, lasting for a few days. The patient suffers little pain, and as the needle punctures are agglutinated at once frequent dressing is needless.

A daily renewal of the salicylic wool during the first three days is desirable, after that no further dressing is required. The knot at the site of the operation slowly disappears, and at the end of three weeks the patient can safely walk about, using, however, a suspensory bandage, and being careful to avoid strain, pressure, or fatigue of the part.

The disappearance of the last traces of the knot demands a month or two for its accomplishment, but eventually no trace remains of the operation having been performed.

THE TRETAMENT OF FRACTURES OF THE LOWER END OF THE RADIUS.[1]

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AT the outdoor department of the Roosevelt Hospital, a not inconsiderable number of fractures of the lower end of the radius present themselves, which have already been seen by physicians in private practice, and after the reduction of the deformity and the application of an apparatus, have been referred to us for treatment, because the patients are impecunious; or which have received the first care at some other hospital or dispensary, and are sent to us because the patients reside in the neighborhood. In this way, and through conversation with various surgeons and physicians in the city, I have had opportunity to note the different modes of treatment adopted by a great number of surgeons, and in a number of the hospitals in the city.

In the claim of a particular apparatus, and the treatment of the fracture, two ideas seem to me to have special weight with

[1] Read before the New York Surgical society March 23, 1886.