REPORTS
ON
MEDICAL & SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN, IRELAND, AND THE COLONIES.

SOUTH DEVON AND EAST CORNWALL HOSPITAL, PLYMOUTH.

STRANGULATED EPIDIDYMIS OF INCOMPLETELY DESCENDED TESTIS PRODUCING SYMPTOMS LIKE THOSE OF STRANGULATED HERNIA: CASTRATION: CURE.

(Under care of Mr. CONNELL WHIPPLE.)

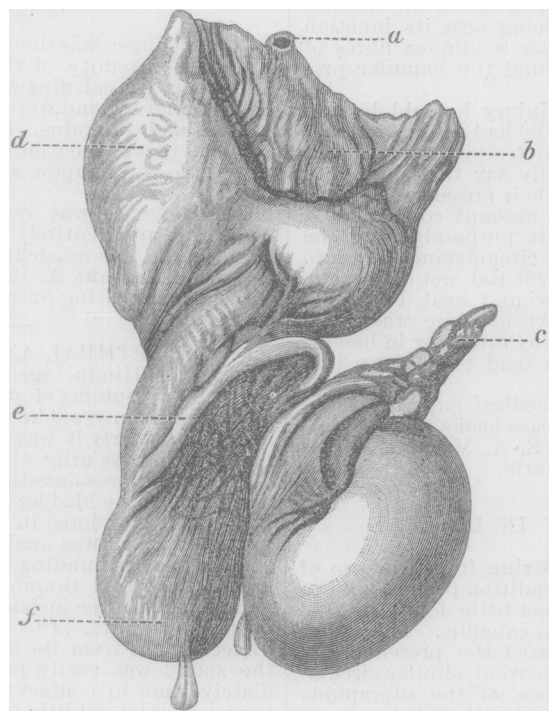
[Notes by W. GIFFORD NASH, House Surgeon.]

A. H., aged 16, was admitted on January 21st, 1891, at 4.45 P.M. He stated that for seven or eight years he had noticed a lump in his left groin, which occasionally disappeared within his abdomen. This he believed to be his left testicle. The day before, at 4 P.M., he strained himself, and felt something give way in the left groin. At 2 A.M., on the 21st, he noticed a lump in the groin, and at 8 A.M. began to vomit. He consulted a medical man, who diagnosed a strangulated hernia, and sent him to the hospital with a note to say he had had stercoraceous vomiting. Bowels acted slightly, at 2 P.M. to-day, before that two days ago.

On Examination.—In the left groin is an hour-glass shaped swelling. The lower half of this is the left testicle, lying in the upper part of the scrotum. The upper, lying over the external abdominal ring, about the size of a hen's egg, is very tense, quite dull on percussion, and gives no impulse on coughing.

The pubes was shaved and washed, and at 5.15 P.M. methylene was given. Mr. Whipple made an incision over the upper swelling, and a dark-coloured tense sac was exposed. This was opened, and some blood-stained fluid gushed out. A dark claret-coloured coiled mass presented, and after careful examination this was made out to be a much-enlarged strangulated epididymis. Lying in the lower half of the sac was the body of the testis, about normal size, and attached to it and forming a circle round its hilum was a band of omentum. This tag was torn through, and the proximal part of the omentum, which was unaltered in appearance, was returned within the abdomen through a large inguinal canal. The epididymis appeared to be twisted twice on its own axis. This was pulled down and untwisted. The epididymis was ligatured as high up as possible, and it and the testis were removed. The pedicle was dropped back into the abdomen. The sac was ligatured in two halves, and cut away, and the pillars of the external abdominal ring sutured. A small tube was inserted, and the wound sutured. On January 24th the tube was omitted, and on January 27th the sutures removed. The patient got up on February 2nd, and was discharged on February 7th.

The specimen removed was sent to the museum of the Royal College of Surgeons of England, where Mr. J. H. Targett very kindly examined it and reported as follows: "The preparation consists of the body and epididymis of the left testis, and the adjacent portion of the mesorchium. The relations of these parts are well illustrated in the accompanying woodcut. The body of the testis is normal. Between it and the globus major *(f)* there is a deep groove, at the bottom of which lies a loop of omentum, which completely, but not tightly, encircles the attachment of the body of the testis to the epididymis. The torn end of this loop of omentum is marked (*c*). The mesorchium (*b*) measures nearly two inches across, and is irregularly swollen on either side from distension of the vessels and extravasation of blood between the layers of the peritoneum (*d*). The position of the vas deferens is indicated at (*a*). At the junction of the mesorchium and epididymis, in the position of the globus minor, there is a well marked constriction, which appears to have resulted from a severe twisting of the epididymis upon the mesorchium. To this torsion the acute strangulation of the epididymis was probably due, as well as the hæmorrhage into the fatty tissue of the mesorchium."



a, Vas deferens; *b*, mesorchium; *c*, tag of omentum; *d*, hæmorrhage into mesorchium; *e*, digital fossa; *f*, globus major.

REMARKS BY W. GIFFORD NASH.—There seems to be no doubt that this was a case of strangulation of the epididymis, and not traumatic or gonorrhœal inflammation. The strangulation was caused by swelling, due to twisting of the epididymis (mesorchium). The seat of strangulation was the external abdominal ring. The epididymis, as is usually the case in these misplaced testes, did not assume the usual canoe shape or bear its usual relations to the testis. The body of the testis itself was not altered in appearance. The cause of the incomplete descent of the testis, no doubt, was the band of omentum which surrounded the hilum of the testis. I have looked through the *Surgeries* of Gross, Ashhurst, Holmes and Hulke, Erichsen, Bryant, and Heath, and cannot find any similar case of strangulation by torsion of the epididymis; but several instances of inflammation of misplaced testes are recorded, one or two of which gave rise to very similar symptoms. Curling[1] mentions a case in which a testis in the groin became inflamed, was mistaken for a strangulated hernia, and operated on. When the nature of the case was discovered castration was performed. Jacobson[2] relates two cases of inflamed testes in groin, one of which proved fatal from peritonitis. With regard to the diagnosis of strangulated hernia in our case, the existence of an hour-glass shaped swelling in the groin, the lower half of which was the testis and the upper a tense, elastic swelling, giving no impulse on coughing, lying over the external abdominal ring, and extending along the inguinal canal, taken with the general symptoms of strangulated hernia, pointed very strongly to this being the nature of the swelling.

[1] *Diseases of Testis*, p. 88.
[2] Holmes and Hulke, *System of Surgery*, vol. iii, p. 470.

MEDICINE AND MUNICIPALITIES IN SPAIN.—At the municipal elections, held in Spain on May 10th, members of the medical profession were among the successful candidates in some of the most important centres of population. In Madrid Dr. Esquerdo, the distinguished alienist; Dr. Menendez Tego, a well known balneologist; Drs. Novellas and Díaz Argüelles, and several other medical men were elected. It is of good augury for the future of sanitary progress in Spain that medicine should be so well represented in the public bodies in whose hands is the guardianship of the public health.

GUY'S HOSPITAL.

TWO CASES OF ANGULAR CURVATURE: PARAPLEGIA: LAMINECTOMY: RECOVERY.

(Under the care of W. ARBUTHNOT LANE, M.S., F.R.C.S., Assistant-Surgeon to Guy's Hospital and to the Hospital for Sick Children, Great Ormond Street.)

CASES of paraplegia consequent upon spinal disease which have been treated by operative measures, and with success, are still of sufficient rarity to merit being put on record, since it is only by a considerable familiarity with the varying symptoms presented by each that one can hope to separate clinically those cases that are likely to be benefited by prolonged rest in the recumbent posture from those demanding more or less urgent surgical interference.

In one of two[1] successful cases I recently published, a very brief delay would probably have been followed by a rapidly fatal result. The cases that form the subject of this brief communication form a suitable pendant to the other two. It is interesting to note that the mode in which the cord is compressed in consequence of disease of the spinal column varies widely; in two of these cases the cord was jammed between fixed bony points, while of the others, in one it was crushed by a caseating tuberculous mass of granulation tissue, and in the other by the wall of a large abscess.

CASE I.—W. S., aged 16, was admitted on August 29th, 1890. He had been under the care of Dr. Hugh Stott, to whom I am indebted for the earlier history and progress of the case. The boy's family history was very good. Three years ago he fell from a window 20 feet from the ground, striking his side. He was not much hurt, and was able to continue his work on the following day. A year ago he noticed a pain in his back. It was at times very severe, but did not prevent him following his occupation. In November, 1889, he found that there was a projection in his back. He was treated with a Sayre's jacket, which he wore for three months. It was not reapplied, and he managed to get about with difficulty. In March, 1890, he began to lose power in his legs, especially the left. This gradually increased, till he was able to perform no voluntary movement of his lower extremities, and sensation in the legs and abdomen was very much impaired. He had occasional trouble with the sphincter of the rectum. From March till his admission he was treated by rest in the recumbent posture.

On admission the boy had no power of voluntary movement over his legs. His abdomen was distended, and when he coughed the abdominal muscles did not contract. The abdominal reflexes were absent. Knee- and ankle-clonus were very marked. There was no plantar reflex. Sensation up to the level of the sixth rib was much impaired, but not absent, except around the left knee. The spinous process of the fifth dorsal vertebra formed the apex of a rather abrupt angular curve.

On September 1st the spines and laminæ of the fourth, fifth, and sixth dorsal vertebræ were exposed and removed. The cord was then found to be splayed out over the firm wall of a tense abscess cavity, which came into relation with its anterior surface. On opening this abscess a large quantity of curdy material welled out, and on introducing a sharp spoon it passed into a cavity in and about the bodies of the dorsal vertebræ as large as a tangerine orange. It contained caseous matter and comparatively large fragments of necrosed bone. These were removed, and the cavity was filled with glycerine and iodoform. A drainage tube was left in the skin wound for thirty-six hours, and when the second dressing was removed on the eighth day the wound was found to have healed perfectly. Sensation and movement returned very rapidly, a marked improvement being observed within forty-eight hours of the operation.

The amount of movement and sensation increased steadily up to a certain point, the patient being able to move the legs with ease. After a time, however, the amount of voluntary power diminished, and finally almost disappeared, though sensation remained but little impaired.

A second operation showed that the cord was surrounded by abundance of caseous material, which had extended into the muscles and parts in the vicinity for a considerable distance. As much as possible of this material was removed, but with little benefit, the patient leaving the hospital in a condition only a little better than that which existed before admission.

CASE II.—The second case was sent to me by Dr. Bernard Scott, of Bournemouth, as he considered the condition to be one only likely to be benefited by operative treatment. It resembled the first of my four cases, in that the cord was compressed between two bony points, the existence of the possibility of which is denied by most pathologists. Another point of great interest about the case is the fact that, though the cord seemed to be very much reduced in its antero-posterior diameter at the seat of compression, yet the patient recovered movement with greater rapidity than did the others. K. B., aged 21 years, was healthy till four years ago, when she had a large gland in the neck. About this time she fell downstairs hurting her back. Two months later she had pain in her back, and could not sit up in a chair. After some weeks' rest in bed she was able to walk about without pain. About two and a-half years ago she noticed a prominence of the back. At the same time time her right knee-joint became swollen and painful. About Christmas, 1889, she first lost power in the left leg, and later sensation became much impaired in it. After the same changes had developed in the left leg as in the right, she was placed in the recumbent posture for about seven weeks without benefit. She was admitted on October 28th, 1890. She was a very delicate-looking girl, and had pulpy change in her right knee-joint, the knee being dislocated backwards a little. There was a distinct projection just below the centre of the dorsal spine. It was peculiar in that the spine of the tenth dorsal, with those of the subjacent vertebræ, was displaced forwards, lying in a plane which was considerably in front of that occupied by the spine of the ninth dorsal vertebra. The feet were blue and cold. She was able to perform no movement of the legs; and, with the exception of some slight vague sensation on sticking a pin into the sole of the foot, she could not feel in her lower extremities. She had no consciousness of the position of her legs. There was plantar reflex, ankle-clonus, and depressed patellar reflex on the left side. No ankle-clonus or plantar reflex was present on the right side. Sensation of an imperfect character was observed over the abdomen. There was no line of hyperæsthesia. The abdominal reflexes were fairly marked.

On November 5th the spinous processes and laminæ of the ninth, tenth, and eleventh dorsal vertebræ were exposed and removed. It was found that the cord was compressed very forcibly between the body of the tenth and the lamina of the eleventh dorsal vertebræ, a very abrupt and considerable change in its antero-posterior diameter being observed in consequence. A drainage tube was left in for forty-eight hours.

On the day following the operation, though there was no perceptible improvement in sensation, the patient insisted that her legs felt different to what they did before.

On November 12th she could distinguish between hot and cold, but could not localise the place touched with any certainty. Painful spasms in the legs commenced, and her pulpy knee gave her pain when it was flexed.

On November 20th she made movements with the muscles of the left leg, and the sensation in both limbs had improved.

On November 30th she could move the muscles of both legs freely, but was unable to move the right knee, as it was very painful. The left she could flex and extend without any difficulty. Sensation was apparently normal in both legs. The right knee-joint, which was completely disorganised, was excised with an excellent result.

About five months after the first operation complete paraplegia again developed with much rapidity, and was accompanied by cystitis. The cord was exposed without delay, and was found to be splayed out over a tense abscess. This was freely opened; much pus, curdy material, and carious bone were removed from the bodies of three vertebræ, and daily injections of iodoform and glycerine were introduced into the cavity through metal drainage tubes, which were removed after several weeks. The girl recovered complete voluntary control over her legs. I am now waiting for the diseased bones to ankylose firmly before sending her home.

[1] BRITISH MEDICAL JOURNAL, April 20th, 1889; *Lancet*, July 30th, 1890.

I have now operated on 8 cases, all of which were very bad subjects for operation, since they were very feeble, some having tuberculous disease in other parts as well. Of these, 1 died from hæmorrhage from a polypus in the rectum while the spinal condition was progressing in a most satisfactory manner; 1 (W. S.) relapsed, and was only slightly benefited by operation; 1 has up to the present shown no improvement; while 5 are at this moment apparently permanently relieved of their paraplegic symptoms. Not one of these cases could have derived anything but harm from prolonged rest in bed, and the indiscriminate adoption of such treatment is obviously most iniquitous and unscientific.

REPORTS OF SOCIETIES.

GLASGOW PATHOLOGICAL AND CLINICAL SOCIETY.

MONDAY, MAY 11TH, 1891.

DAVID NEWMAN, M.D., President, in the Chair.

Cholecystotomy.—Dr. E. DUNCAN, for himself and Mr. PARRY, gave an account of a case in which jaundice of six weeks' standing, with complete absence of bile from the stools and a distended gall bladder, had given occasion for the performance of this operation. Cancer of the pancreas was found, and there was a secondary nodule obstructing the common bile duct. Mr. Parry referred to the difficulty which existed in some cases in determining the cause of obstruction, even when the distended bladder had been opened. The nodule, in this case at the orifice of the common bile duct, might easily have been mistaken for a stone.—Dr. HECTOR CAMERON expressed the opinion that the long-continued presence of gall stones was apt, when the cancer age was reached, to set up cancerous growth.—Dr. HUGH THOMSON could not understand the object of the operation in the absence of distinct symptoms of gall stones.—The PRESIDENT was of opinion that where cancer and gall stones were found together the gall-stone formation was secondary to the catarrhal state produced by the obstruction.—Dr. FINLAYSON considered it open to question whether it was wise to open a gall bladder unless there was a fair chance of getting gall stones or unless there were symptoms in the neighbourhood of the gall bladder suggesting the possibility of its rupturing.—Dr. DUNCAN, in reply, pointed out that, while there was no clear evidence of gall stones, there was no tumour beyond that of the gall bladder itself to suggest malignant disease. Rupture of the gall bladder was itself a danger sufficient in such case to justify an exploratory operation.

Specimens.—Dr. JOSEPH COATS showed a specimen of Horseshoe Kidney, and called attention to the fact that the ureters came off forwards and downwards, not inwards, as commonly represented. Dr. Coats also showed a specimen of Fracture and Dislocation of the Cervical Spine, in which it seemed to him that an immediate attempt at reduction, as by suspension, might have been beneficial. In reply to Mr. MAYLARD, he admitted that here, as probably in most cases, the most serious injury to the cord was inflicted at the time of the injury, but he still thought some relief might have been obtained by stretching.—Dr. HECTOR CAMERON showed: (1) A Multilocular Colloid Ovarian Cystoma, one compartment of which was lined by epidermis, and contained hair and teeth set in a mass of bone; (2) A Dermoid of One Ovary, the size of a turkey's egg, from a case in which the other ovary was the seat of a multilocular colloid cystoma. Mr. H. RUTHERFURD directed attention to the analogy of the colloid ovarian tumour and the dermoid. The colloid often contained well-formed mucous glands. It seemed unjustifiable to assume that the dermoid was specially, and in all cases, of congenital formation. On the inclusive theory, all tumours might be of congenital origin.

Card Specimens.—Dr. COATS showed: (1) Aneurysm of a Renal Artery; (2) An Autoclave Steriliser, for sterilising by steam under pressure; (3) Some Cultures.—Mr. H. RUTHERFURD showed specimens, with microscopic sections of (1) Squamous-celled Epithelioma of the Leg; (2) Epitheliomata of the Dorsal Surface of the Fingers of the type of rodent ulcer.—Mr. MAYLARD showed an Epithelioma of the Hand, with microscopic sections.

GENERAL COUNCIL
OF
MEDICAL EDUCATION AND REGISTRATION.

SPRING SESSION, 1891.

Friday, May 29th.

Sir RICHARD QUAIN, President, in the Chair.

ON the reading of the minutes, Mr. B. CARTER objected to the record that the report of the Education Committee was ordered to be received and entered on the minutes.—The PRESIDENT pointed out that receiving a report was a mere formality, and did not involve its adoption.

Dental Business.—A report from the Dental Committee on the case of Henry Louis Goodman was received and entered on the minutes. Mr. Goodman was in attendance to answer the charge:

That he had issued and published, and caused to be issued and published, advertisements and other public announcements falsely describing himself in them as Surgeon Dentist to the Queen's Household, and Surgeon Dentist to the Household of Her Majesty the Queen and His Royal Highness the Prince of Wales, the effect of such advertisements and public announcements being to convey to the public the false idea that he held an appointment in the Queen's and Prince of Wales's households, and that, after being repeatedly warned against continuing to issue and publish the said false and misleading descriptions, he had persisted in issuing and publishing the same, and had not withdrawn them.

Mr. FARRER (Solicitor to the Council) pointed out that the report was conclusive as to the facts of the case; the duty of the Council was, therefore, limited to considering what was to be done under the circumstances. He read *inter alia* a statement from the defendant explaining why he had used these titles. He, however, said he had abstained from repeating the offence since his attention had been called to it by the Council, and he claimed to have honestly complied with the wishes of the Council in the matter. He read part of the summing up of the Recorder of London, in a compensation for disturbance case in which he was concerned, who stated that "he was not to blame," that "he was probably right" in using this title. At the same time, he was prepared to give an undertaking never to use it again. In response to the President, he said he unequivocally withdrew any claim to the title. In response to Sir Dyce Duckworth, he declined to say when he had begun to practise dentistry. He was 38 years of age. He did not believe that he had gained anything by the use of the title. The Council then proceeded to deliberate in private on the case, strangers being ordered to withdraw. On the readmission of strangers, including the defendant, the PRESIDENT informed him that the Council had come to the conclusion under the circumstances, and in view of his promise, to treat him with leniency, and not to remove his name from the *Dental Register*.

Case of John Keys.—This adjourned case came on for further consideration, and Mr. Corrigan on this occasion produced the original letter, an allusion to which was embodied in his previous statement.—Counsel for defendant obtained permission to address the Council in reference to Mr. Corrigan's further evidence and animadverted on Mr. Corrigan's statements and past conduct.—The Council then proceeded to deliberate *in camerâ*, strangers being ordered to withdraw. After a prolonged deliberation the defendant was recalled, and the PRESIDENT stated that it was his painful duty to have to inform him that the Council had arrived at the conclusion that he, John Keys, had committed the offence charged against him, and that that, in the opinion of the Council, constituted "infamous conduct in a professional respect," and that his name had been ordered to be erased from the *Register*.

Destination of Penalties under the Medical Acts.—Dr. GLOVER brought forward a motion:

That the Council represent to H.M. Government: That the appropriation which is claimed in London under the Metropolitan Police Acts, for fines imposed within the metropolitan area, differs, in regard of fines under the Medical Acts, from the appropriation in force in other parts of the United Kingdom, and is practically such as to prevent within the metropolitan area prosecutions, which for the protection of the public ought from time to time to be undertaken in respect of offences committed against the Medical Acts; and that, in the opinion of the Council, it is urgently to be desired, either that the metropolitan appropriation of fines under the Medical Acts should be assimilated to the appropriation of such fines in other parts of the United Kingdom, or else that, for the metropolitan area, the Government, as appropriating the fines, should