

One room, 12 by 12 feet, was used as the urethral irrigating room; and urinals, running water and connected plumbing (which last we now had for the first time) was installed by the Utilities Company under the direction of Lieutenant Bruno. Twelve patients could be irrigated at one time with this equipment. A second room, about 10 by 10 feet, was used to administer arsphenamin and to take blood for Wassermann tests.

The major portion of the equipment came from the Post Hospital, San Juan, which was discontinued. A water still was given on temporary memorandum receipt by the base hospital, San Juan. All in all, we are fairly well off, and have taken advantage of the facilities as fully as our limited personnel allows.

AN OPERATION FOR VARICOCELE

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Varicocele is a frequent cause of disability in the naval service, not really so much because of its local disabling factors but more especially because of the

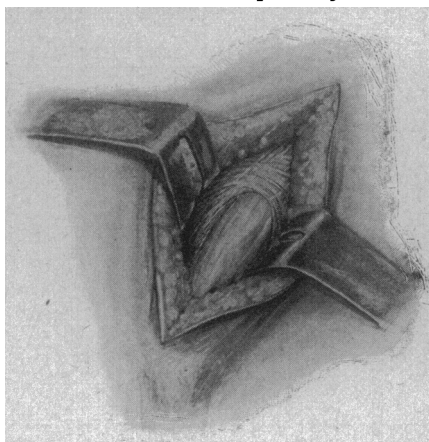


Fig. 1.—Exposure of external ring, cord and coverings by incision of overlying tissues.

complaints of a reflex nervous or psychic nature attributable to it. Occasionally a large varicocele is used as a means of avoiding unpleasant duty. On examination of applicants for enlistment, a large varicocele is considered officially to be sufficient cause for physical rejection. Size alone in varicocele is not necessarily an indication for operation. Some men with extremely large varicocele never have any symptoms referable to it. Others with varicocele of medium or small size have psychic disturbances or local pain far beyond the objective signs. Local pain, bearing down sensations, extremely low hanging testicles, psychic disturbances, anxiety or worry over a possible defective genital condition are sufficient warrant for operative procedure.

OPERATION

Step 1.—After the usual preliminaries and under either local or general anesthesia, an incision of 1 or 1½ inches is made in the skin over and down from the external inguinal ring, parallel to Poupart's ligament. This incision divides the superficial tissues and fascia and exposes the external ring and the cord with

its coverings (Fig. 1). Superficial vessels are caught and ligated.

Step 2.—The cord is not lifted from its bed. The fascial coverings of the cord are lifted between two forceps and incised in the long axis of the cord (Fig. 2). The spermatic veins are thus brought to

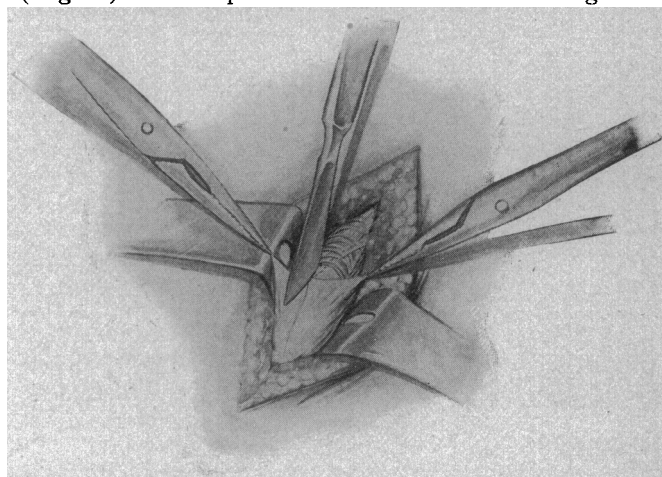


Fig. 2.—Incision of coverings of cord.

view without disturbing the vas and its accompanying vessels (Fig. 3).

Step 3.—The spermatic veins, including the spermatic artery, are gently picked up and cleared for a distance of 1½ or 2 inches. Inspection and gentle palpation will demonstrate the vas lying in its bed undisturbed and entirely separate from the exposed group of veins (Fig. 4). Crushing hemostats are applied about 1½ or 2 inches apart to the exposed spermatic vessels. Plain catgut ligatures are passed by needle through the substance of the cord proximal to the upper hemostat and distal to the lower hemostat, thus securely tying the cord with a nonslipping ligature. The intervening vessels are excised. The ends of these ligatures are left long.

Step 4.—The two ends of the upper ligature are passed through the fascial coverings of the cord, one end through the inner, the other end through the outer

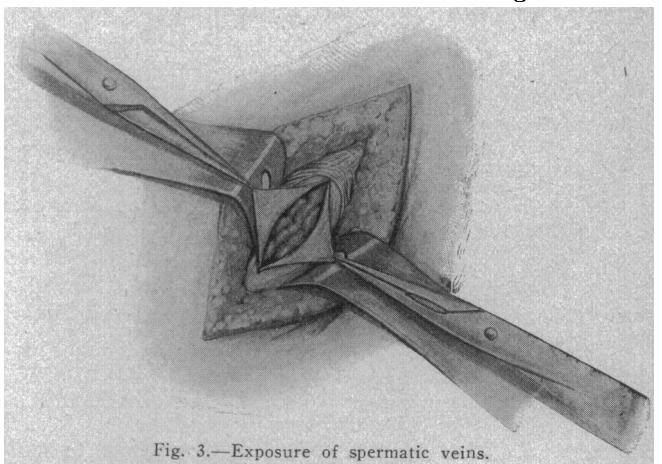


Fig. 3.—Exposure of spermatic veins.

side, and the two ends of the lower ligatures are also passed through but above the ends of the upper ligature, so that when the ends are pulled together, the cut ends of the cord are brought into close apposition (Fig. 5). The coverings of the cord are dropped back and the two upper and the two lower ligatures are tied over the incision (Fig. 6).

Step 5.—The superficial tissues are closed by routine methods, and a small dry dressing is applied.

Step 6.—Care must be taken to provide suspension of the testicles in order to prevent the postoperative swelling and the subsequent induration of the scrotal end of the cord.

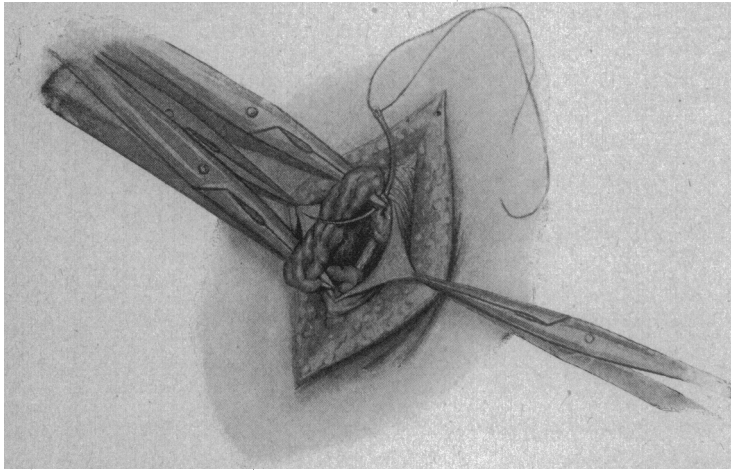


Fig. 4.—Raising up, spermatic veins, disclosing vas lying in bottom of wound.

COMMENT

No priority is claimed for this method. An excellent description of a similar operation is found in Taylor's "Operative Surgery." Very few textbooks pay much attention to the cosmetics of varicocele or to the details of this simple operation.

There is no necessity for subjecting the vas and its accompanying vessels to trauma, yet most operative methods include as a step the lifting of the cord from its bed. This greatly increases the postoperative induration. Induration should be a rare sequela. In this method the tissues are subjected to a minimum of trauma. I have followed the principle of this method for a number of years in operating aboard ship for varicocele under local anesthesia without distress to

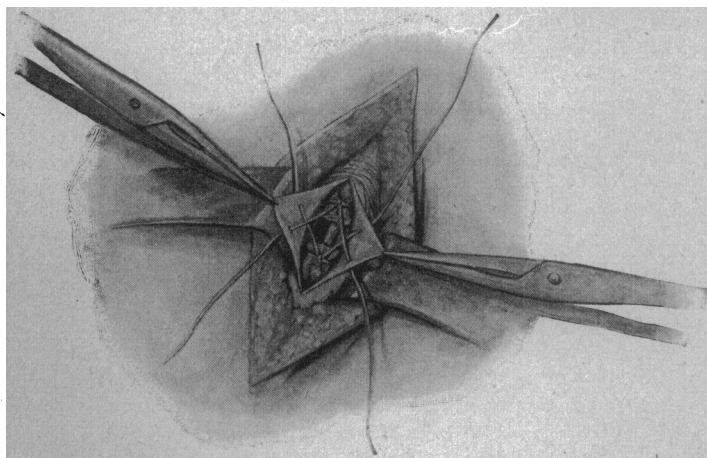


Fig. 5.—Manner of passing ligatures used to tie spermatic veins for closing cord covering.

the patient. Handling the vas is liable to be painful and makes complete anesthesia difficult.

The spermatic artery is excised with the spermatic veins, no attempt being made to separate it. Bevan¹ satisfied himself by a review of his own varicocele work, and by a review of experimental work on dogs

to determine the blood supply of the tests, that there were two distinct and separate sources of blood supply for the testicles, namely, the spermatic vessels, and the other vessels accompanying the vas, either of which were quite sufficient to maintain the nutrition and the function of the organ.

I am indebted to G. V. Schwarz, the artist at Naval Hospital, Philadelphia, for the excellent illustrations of the operative steps.

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HOSPITAL STANDARDIZATION

WITH ESPECIAL REFERENCE TO MEDICAL EDUCATIONAL WORK IN HOSPITALS *

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There are few social institutions progressing and changing so rapidly as hospitals. At the present time, therefore, "standardization," in the sense in which that word is usually used, which would mean the deter-

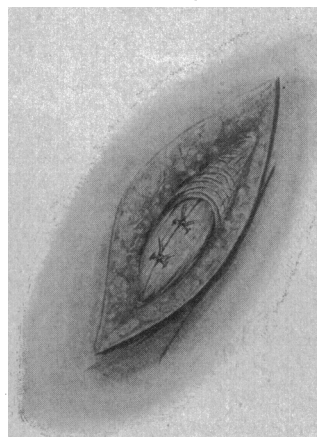


Fig. 6.—Closure of wound by tying of two sutures, as described in article by Dr. Angwin.

mination and use of types of institutions and types of work generally accepted as best, is clearly impossible. Types would be out of date long before they could become established. On the other hand, progress and enthusiasm have made many dissatisfied with conditions which are as yet quite general, and which should unquestionably be replaced by better methods. To those who have thought most about the problem, "hospital standardization" includes the setting of minimum

standards; but this only as a minor feature. The majors are the development of the institution to meet more effectively and more efficiently in every way occasions for work from the front door to the ash pile. In this sense the word "standardization" will hereinafter be used. The hospital is a more complex institution than is commonly understood by trustees, managers and department workers, including the medical staffs. In fact, it is often a question if they have not become too complex to be managed successfully by superintendents now available. It is unusual for men to develop real interest in so many and so different human activities as a modern hospital must include.

MULTIPLE FUNCTIONS OF HOSPITALS

It was not long ago that hospitals were merely institutions for the care of the ill, for the physicians. Then hospitals assumed the responsibility for educating and training professional nurses. We are more or less familiar with the expansion of hospitals as social institutions, not only in the development of the work generally called "social service" work, but also

* Read at the Fifteenth Annual Conference of the Council on Medical Education of the American Medical Association, Chicago, March 3, 1919.

1. Bevan: Surgical Clinics, p. 1103 (Dec.) 1918.