

THE SURGICAL TREATMENT OF ACUTE GONORRHOEAL EPIDIDYMITIS BY EPIDIDYMYTOMY.

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ALTHOUGH in the hands of a few genito-urinary surgeons epididymotomy has become the treatment of choice in acute gonorrhœal epididymitis, it has not as yet reached as full an appreciation as the operation seems to warrant. It is an axiom of surgery to-day, that when the function of an organ is threatened by the invasion of pus-producing organisms, prompt incision and drainage are indicated.

During the past five or six years, I have been doing this operation as described by Hagnar, of Washington, on only such of those cases as have come under my care, having unusually severe pain, with considerable swelling and high temperature. In all of these cases the results were so satisfactory that I was led to the idea of applying this treatment consecutively to all the acute cases during two and a half months last summer, when I had the care of the service at Bellevue Hospital, with which I am connected.

The astonishingly happy outcome of this experiment, as far as immediate results were concerned, seems to justify a short review of the methods employed in this small collection of twenty-one successive cases. It gives me pleasure to acknowledge the assistance and valuable suggestions of Dr. George F. Cahill, of the house staff, who did this work with me, and who deserves much of the credit for putting this small operation on a technically simpler basis than it has, I think, previously enjoyed. It is on account of the simplicity of this operation and its apparent freedom from risk, also the firm conviction that the course of the disease is shortened and the liability of sterility is lessened, that I am here adding a record of my experience to the list.

The frequency with which this complication of a gonococcus infection occurs, its obvious diagnosis, the distracting character of the pain, the attending fever, its debilitating and often protracted course, the unsatisfactory nature of medical treatment and the considerable percentage of following sterility are all so well known and so well described in standard text-books, that there is no need for repetition here. The simple method we employed was as follows:

The patient was prepared for an ether anæsthesia. Just as soon as the patient was lightly under, the operative field was sterilized with 2½ per cent. tincture of iodine, and an oblique incision, 1½ inches long, was made downward and forward over the epididymal swelling, which in our series of cases occurred uniformly in the globus minor. With the oblique course of our incision it was possible to avoid most of the small vessels in the skin and thus get very little bleeding.

The incision was carried down to the tunic vaginalis, which was opened to the length of the skin incision and the fluid, which was usually present, drained off. The edge of the tunic was picked up on both sides with hæmostats, which acting as retractors bared the swollen and congested epididymis; its thickened fibrous covering was incised for one-half inch over the prominence of the swelling and a probe gently passed into the substance of the epididymis, in several directions. If suppuration had occurred, the pus was in this way easily found and drained off. In all cases relief of tension was effected and drainage established.

The most important element in this operation is the lack of traumatism, as the testicle is not delivered or the parts bruised from handling. In that smaller percentage of cases where the body of the epididymitis or the globus major is involved, a freer incision and possibly a turning out of the testicle will be found to be best, but the special point of this paper is to show how little of an operation is necessary in the great majority of cases, and the little excuse there is to allow these patients to suffer the pain, the slow convalescence and possibly sterility for want of a prompt decision in draining this dependent point of infection.

A wick made of rubber dam was gently placed in the substance of the epididymis, where the probe found least resistance, or into the cavity made by the accumulation of pus, if pus was present.

In 33 per cent. of the cases pus was present. The gonococcus was the only organism found. One or two catgut sutures were then used to draw the deeper structures together, and two or three silk-worm sutures closed the skin except for about a half inch opening through which the drain emerged. The time of operation was usually from five to ten minutes. A generous dressing was held in place by an Alexander suspensory.

The immediate relief from pain and the decline in temperature was the pleasing aftermath of each operation. In forty-eight hours the drain was removed and the parts so exquisitely tender before operation could be handled without discomfort.

On the fourth or fifth day the patients were allowed up, and on the fifth or sixth day the stitches were removed and the patient allowed to go out.

This form of treatment is indeed in striking contrast with the older methods, where the patient lies in bed with his scrotum resting on a supporting bridge, stretched between the thighs and surmounted by heat, cold or chemicals, wincing at the approach of attending hands and patiently waiting, while the severity of pain was dulled by anodynes, the slow restitution of the swollen gland.

It is difficult as yet to tell the end value of this little surgical procedure, which secures such immediate relief. What is radical to-day often becomes conservative to-morrow. We may hope as much for this way of dealing with acute epididymitis, for with practically no risk, it saves a deal of suffering and lost time in tedious convalescence.

It is impossible with the class of patients dealt with at Bellevue Hospital to hope for co-operation in the after-study of these cases.

The pathology of the condition as it exists and as it is dealt with expectantly is well known and equally unsatisfactory. To get the relative value of the newer way of dealing with this complication, must needs take patient and scientific study over a period of subsequent years.

In a paper read by Cunningham, of Boston, before the American Association of Genito-Urinary Surgeons in Wash-

ington, last spring, of his series of cases he reported having operated bilaterally on six. Two of these patients have married and each of them has had two children. This is interesting as not only showing potency, but the fact of their having had two children is evidence that they probably did not infect their wives. Two others of these six cases showed numerous living spermatozoa in condom specimens collected at coitus; but no spermatozoa were seen in specimens collected by massage of the seminal vesicles and prostate. The remaining two had had no sexual intercourse and the specimens collected by massaging the seminal vesicles showed no spermatozoa.

With the knowledge we have at hand it seems unlikely that this operation, when properly done, that is without further destruction of the tissue than the disease has already effected, cannot but shorten the course of the pathological process and bring to the organ a better chance of ultimate recovery. Whether the organisms are recovered from the exudate which nature has produced by her processes and which we release by the knife, is of very little moment.

The real question is, do we lessen or obviate by epididymotomy that sequel of the disease, which so often leaves the testicle with the pathways of its spermatozoa blocked—in permanent bondage?