THE RESULT OF A PRETENDED OPERATION UPON A PATIENT SUFFERING FROM A DELUSION OF A SEXUAL CHARACTER; OPERATION FOR THE CURE OF EPISPADIAS; CASE OF PERINEAL SECTION FOR TRAUMATIC STRICTURE, WITH A DESCRIPTION OF A NEW FORM OF PERINEAL STAFF; NEW METHOD OF TREATING A RESILENT AND NODULAR STRICTURE OF THE PENILE PORTION OF THE URETHRA.

CLINICAL LECTURE DELIVERED AT THE JEFFERSON MEDICAL COLLEGE HOSPITAL.

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GENTLEMEN,—The first case that I bring before the class to-day is that of an individual who applied for relief at this institution five years ago. At that time he was suffering with spermatorrhœa dormientium, or nocturnal pollution, accompanied by well-marked neurasthenia. I call your attention to the case not only because it is one of great interest from a psychological point of view, but also because it illustrates what I have so frequently insisted upon when lecturing upon the treatment of individuals whose condition was similar to that of this person now before you; that is, that in order to benefit these cases every effort should be made to gain the confidence of the patient, and all your tact must be employed to allay his fears until the disordered nervous system regains its tone. You must ever be ready to meet all complications which from time to time will arise.

This individual is twenty-eight years old. He is a carpenter. When he applied to the surgical department of this hospital he asked to have his testicles removed, believing that it was the only way whereby the seminal discharges might be stopped, and saying that their continual recurrence was undermining his health, and that his reason would be

destroyed unless he was relieved. He stated that the various methods of treatment resorted to by numerous practitioners had all failed to benefit him. His condition had preyed upon his mind to such an extent that he declared that unless he could find some one who would be willing to castrate him, he would himself perform the operation. Six months previously he had attempted excision of the scrotum, but after making an incision his courage failed him. You may readily observe the scar resulting from this attempt at emasculation. The scars that you see on the body of the penis are the results of ulcerations produced by acids employed to render the organ sore, so as to make masturbation impossible. At the age of sixteen he had contracted the habit of self-pollution, which he had continued until the time of his application for treatment. He attributed his condition to this unfortunate practice.

His nocturnal emissions occurred as often as three times weekly; he occasionally experienced pain along the course of the urethra, extending into the spermatic cords and testicles. He urinated with abnormal frequency.

He stated that his appetite was poor; that he had a feeling of gastric depression; that his sleep was neither sound nor refreshing. He was oppressed by heavy pains in the groin, lumbar region, and back of the head; there was great mental hebetude; he was easily fatigued; his hand was unsteady; he had an anxious look; was markedly anæmic. When a seminal discharge took place it was followed by unusual depression and lassitude, with increased pains.

The urethra was intensely hyperæsthetic, especially the prostatic portion. The meatus was contracted; there was no stricture. The prepuce was elongated.

The individual was placed upon full doses of bromide of potassium and fluid extract of ergot, atropine being given at bedtime; hot douches were applied to the spine, and a bougie was passed every third day.

Under this treatment the emissions lessened in frequency, and, in fact, became normal; that is, they occurred about once in two weeks.

The patient's mental condition remained unimproved, and whenever a seminal discharge took place he was plunged into the depths of despondency.

Observing that he was not improving mentally, and fearing that, unless some means was resorted to that would make a strong impression upon him, he would either become insane or do himself bodily injury, I resolved to perform upon him a pretended or bogus operation. Both

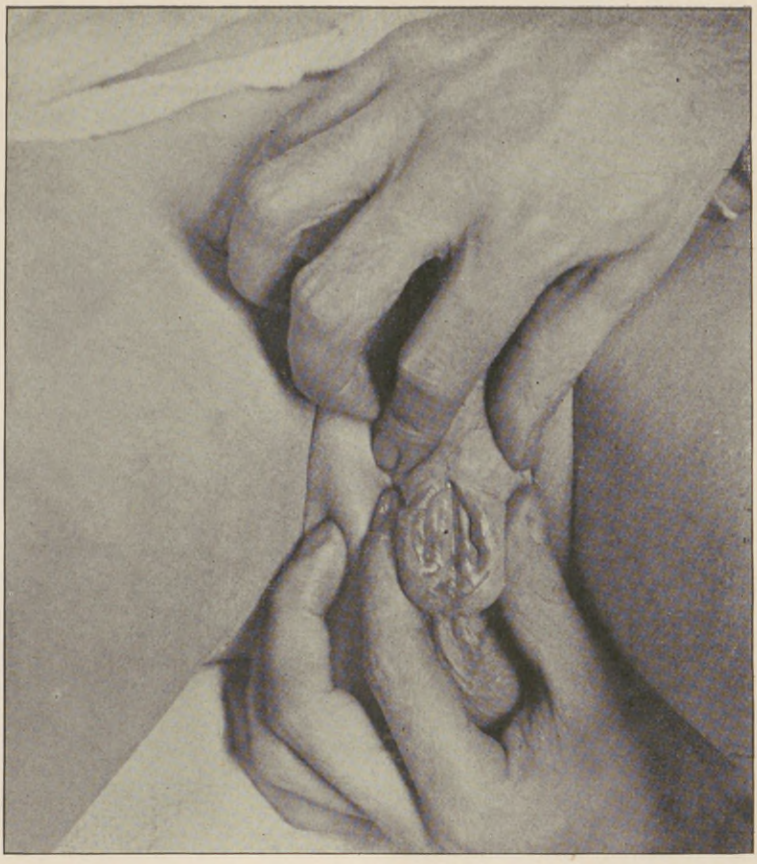


FIG. 1.—Epispadias, before operation.

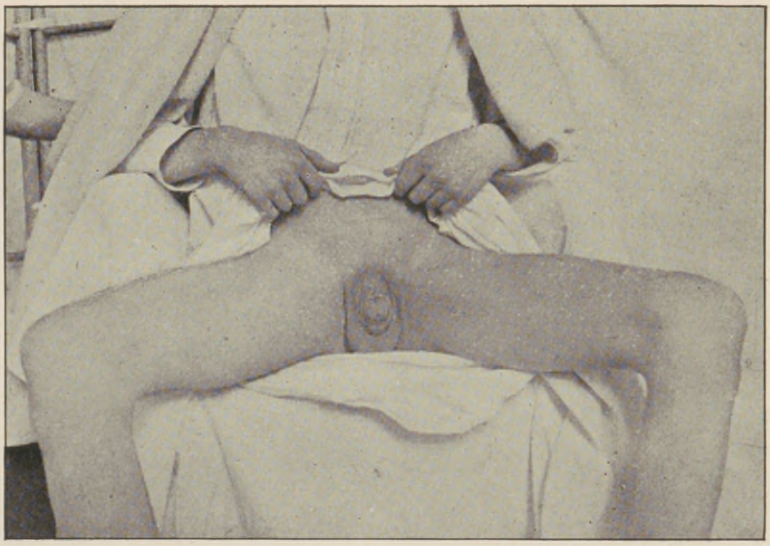


FIG. 2.—Perfect union, nine days after operation.

the mother and the patient had frequently begged me to remove his testicles.

By means of anatomical plates, he was made to understand that absolute removal of the testicles was not necessary, but that the object sought for would be accomplished if the vasa deferentia were divided. It was furthermore explained to him, so that the delusion might be carried out, that after the operation he must expect that emissions would, from time to time, take place, which, however, would be only mucoid in character, and that whilst this discharge would simulate a nocturnal emission, it could contain no semen.

He was much pleased with the suggestion, and was glad to believe that the functions of the testicles could be destroyed without marked mutilation.

The parts having been properly prepared, he was etherized, and an incision three and a half inches in length was made over each abdominal ring, care being taken not to cut deeper than through the skin and superficial fascia. The wound was closed with sutures, and properly dressed. To produce greater mental effect, he was circumcised, and to control nocturnal pollutions, if possible, an application of a few drops of a solution of twenty grains of nitrate of silver to an ounce of water was made to the prostatic urethra.

He was kept in bed for the space of two weeks, that he might be fully impressed with the gravity of the operation. Doses of bromide of sodium and atropine were administered at bedtime.

After leaving the hospital he remained under my care for the space of four months. A full-size bougie was passed twice a week. He was placed upon the use of strychnine and the chlorides of gold and sodium, and an ice-bag was applied over the lower portion of the spine for one hour every night before retiring.

His neurasthenic condition rapidly improved. He gained in weight and in strength, and finally resumed his occupation, perfectly cured.

A year after all treatment had been discontinued, he called at my office in apparently perfect health, but looking very sheepish. After talking around the subject for some time, he stated that he had fallen in love with a young woman and wished to marry her, provided I could put him in proper condition by cutting down and fastening together the severed ends of the vasa deferentia. The exhibition of his inordinate joy, together with his astonishment, was very amusing when he understood that the ducts had never been cut, and that he could become a married man whenever he saw fit. He is now the father of two children and enjoys perfect health.

This patient suffered from intense hyperæsthesia of the urethra, brought on by excessive masturbation; the hyperæsthetic condition of the canal in time caused an irritable condition of the ejaculatory centre and an anæmic state of the lumbar portion of the cord, known as neurasthenia.

Now, as regards the treatment pursued. The first point was to remove the cause of trouble, by restoring the urethra to its normal condition. It will be observed that whilst the patient steadily improved physically, his mind remained in a morbid state: hence the necessity for producing a strong mental impression by the means already described.

After the operation had been performed and the discharges had been reduced to normal frequency, the condition of the nervous system was improved by the use of strong tonics. Castration in this case would have been not only barbarous, but criminal; the effect of the operation would not only have still further impaired his mental condition, but in all probability, from constant brooding over his mutilation, he would have either committed suicide or become insane.

EPISPADIAS.

The case that I next bring before you is of especial interest because of its great rarity. It is one of epispadias, the urethral opening being at the middle of the dorsum of the penis.

This patient is about seventeen years old. The penis is well developed, but the opening of the urethra is situated at the upper middle portion of the organ, instead of terminating at the end of the glans.

When he first applied for relief the glans was well-nigh solid, with only a urethral trough, covered with mucous membrane, marking the natural site of the urethra, besides which there was a marked upward curve of the organ. There are many theories advanced by writers as to the cause of this abnormal condition. I shall not take up your time by recounting them, but shall go immediately on with the case before us.

This individual has already had two operations performed on him before the class; the object of the first was to straighten the membrum virile; the second was to endeavor to form a canal from the epispastic opening to the extremity of the glans. To-day I bring him before you to complete the cure by changing the urethral furrow into a tube. The parts have been made aseptic in the usual manner. The patient has been given ten grains of boric acid three times daily for the last three days, so that the urethra may be as nearly as possible in an aseptic condition.

For the purpose of denuding the skin and mucous membrane you will observe that I make use of an iris forceps and scissors. The forceps have the advantage of being light, and at the same time taking firm hold of the tissue which is about to be removed, without the possibility of slipping. I now freely denude both sides of the canal, and I wash the wound with 1 to 20,000 corrosive sublimate solution. Waiting a few minutes, until all hemorrhage has ceased, the abraded surfaces are brought together by means of a silkworm-gut suture, and the operation is completed by inserting a new thoroughly aseptic Nélaton catheter, which will effectually prevent the urine from gaining access to the wounded surface. The catheter and sutures will be removed on the eighth day. The wound will be dressed with sterilized iodoform and dry bichloride gauze.

To prevent erections, as far as possible, which would naturally have a tendency to impede union, full doses of bromide of potassium will be administered.

TRAUMATIC STRICTURE.

You will recall the case which I next present as one which I brought before you at the last clinic.

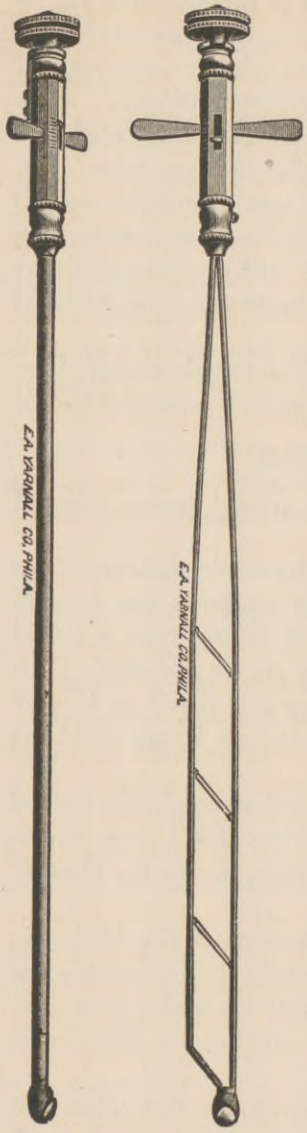
The individual is affected with a tight traumatic stricture of the membranous portion of the urethra. This condition was brought about, some seven years ago, by the patient falling from a height astride of a wood-horse and violently striking on the perineum. You will recollect that the calibre of the urethra was found to be very small, and that the stricture was tortuous: a filiform bougie could not be made to pass through.

I propose this morning to perform a perineal section by the method known as the Wheelhouse operation,—modifying and, I hope, simplifying it by substituting a staff of my own device, to take the place of that recommended by Mr. Wheelhouse.

You will observe that this instrument consists of two blades, in close apposition, which together form a smooth staff, with a thumb-screw at one end, by means of which the blades may be readily separated. The other end terminates in a hook, similar to that on the Wheelhouse staff.

The advantages claimed for this instrument are, that when it is placed in position, and the blades separated, the urethra is firmly fixed, and that the operator, after having made an incision through the skin, can open the canal with as much ease as he would an ordinary abscess. The fixation of the urethra prevents it from sliding from one side of the staff to the other, which is the objection to the Wheelhouse instrument;

especially is this slipping apt to take place when the tissues of the perineum are dense and fibrous.



Closed. Open.
Newly devised perineal staff.

As soon as the canal is fairly opened, the blades must be brought into contact by turning the thumb-screw at the handle. The instrument is then adjusted, so that the hook presents in the perineal wound, and is to be clasped to the upper edge of the incision. The sides of the canal are now to be caught by means of a pair of hæmostatic forceps, and given to an assistant to hold. Thus, by tension made above and at the two sides of the open urethra, the strictured portion is drawn forward, so that it presents directly towards the face of the operator, who now attempts to pass through it a probe-pointed director; if he succeed, he incises the stricture on the floor of the urethra by means of a probe-pointed bistoury. The director having been removed, the instrument which I here exhibit, known as a Teale gorget, is inserted through the wound into the bladder, and serves as a guide for the passage of the catheter.

This patient having been etherized, he is placed in a lithotomy position; the staff, with the hook turned away from the operator, is passed gently down to the seat of the stricture, then withdrawn for the length of a quarter of an inch, so that I may open the urethra at a healthy point. My assistant now separates the blades, by means of the thumb-screw; this dilates, fixes the urethra, and at the same time makes it evident to the touch.

You will observe that I have incised the skin, and without the slightest difficulty carry the knife directly onward through the centre line, being very careful not to cut too far forward, lest I wound the artery of the bulb, nor too far backward, for fear of wounding the rectum.

The urethra has thus been opened between the separated blades, which are now closed and turned until the hook presents in the wound, and by elevating it in the manner here exhibited I catch the upper angle, and by means of two hæmostatic forceps fix the sides of the urethra. You will observe that the grooved director has found the opening of the stricture and has passed through it. I now divide the seat of coarctation by means of this probe-pointed knife.

The next step is to pass the gorget into the bladder; this being accomplished, a full-sized silver catheter is inserted and the gorget removed. The catheter will be left *in situ* until the perineal wound is closed, which will take place in from three to four weeks.

The incision will be irrigated with 1 to 20,000 bichloride of mercury solution, and the urethra will be washed out twice a day with warm water to which has been added boric acid. The catheter will be removed every third day, disinfected, and replaced. The incision will be dressed with iodoform and dry bichloride gauze.

[This patient made an excellent recovery, leaving the hospital on the twenty-sixth day, the wound being entirely healed. He was enabled to pass a 35 French bougie without difficulty.]

RESILIENT AND NODULAR STRICTURE.

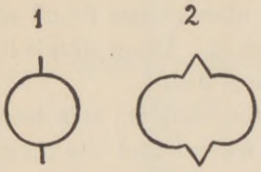
The next case that I bring before you is an individual thirty-two years old, apparently in good health. He is suffering from a resilient and nodular stricture situated three and a half inches from the meatus. Dr. Fleming, to whom I am indebted for this patient, tells me that he has repeatedly dilated the stricture so as to admit of the passage of a 32 French bougie, but that within forty-eight hours contraction takes place to so marked a degree that it is with great difficulty that an 18 French can be passed.

On examining the parts you will observe that a little in front of the peno-scrotal junction there is an indurated mass. This marks the site of the stricture. From what you have heretofore been told, when I have lectured on this subject, you will readily understand that the case before you is one upon which to perform internal and external urethrotomy.

With this operation you are already familiar. The indication for surgical interference in these cases of stricture is their irritable, resilient, or nodular condition.

Internal urethrotomy is primarily performed; then a perineal puncture is made, so as to put the parts at perfect rest and thus allow the indurated tissue to undergo fatty degeneration and absorption. Some

time since it occurred to me that this result might be produced by cutting the stricture on the roof and on the floor of the canal so as to produce a condition illustrated in these figures:



I conceived that instead of performing the perineal section the same effect might be produced by passing a full-size silver catheter and allowing it to remain in position for the space of at least two weeks, thus putting the parts at rest, and at the same time allowing them to receive the benefit of continual pressure on the nodular mass surrounding the urethra.

I have twice performed the operation in this manner with perfect success, and I propose to repeat it before you to-day.

The urethra has been rendered as nearly aseptic as possible.

As I can only pass a filiform through the constriction, I will first, by means of Maisonneuve's urethrotome, proceed to cut the coarctation on the roof of the urethra. Having done this, I readily pass an Otis's urethrotome, by which means the stricture is divided on its floor. The canal is now to be irrigated with 1 to 20,000 corrosive sublimate solution, and a full-size silver catheter, which has been rendered aseptic by heat, will be passed into the bladder, there to remain for two weeks, removing it for a few minutes every day, so that it may be cleansed.

[At the end of two weeks the patient left the hospital, being able with ease to pass a 33 French bougie. The induration at the seat of stricture had almost completely disappeared.]