TORSION OF THE SPERMATIC CORD WITH GANGRENE

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THE first case of torsion of the spermatic cord was described in 1840 by Delassiuave. Wallenstein reports 150 cases in the Journal of Urology, for February, 1929, which he has summarized from the literature, including one case of his own. Sixteen additional cases have been found in the literature by us, which are not referred to by Wallenstein.

In this group of cases it was found that torsion is especially prevalent in undescended testis. Of 150 cases, 60 per cent were on the right side and 40 per cent on the left side; eight cases of intra-abdominal testis have been reported. There are acute and occasionally recurring cases.

The onset has been associated with violent exertion, sudden strain, straining at stool, trauma, sudden crossing of the leg, coughing, rapid walking, squeezing, reduction of strangulated hernia. Several have been reported as occurring during sleep.

The symptoms associated with the onset of this condition are sudden and very sharp pain, nausea and vomiting, fever, leukocytosis, plus the local symptoms of swelling and extreme tenderness.

The recurrent type is described in which the symptoms are more mild and there is spontaneous untwisting. Under etiology, abnormal mobility is considered a cause. A portion of these cases have occurred at puberty and it has been suggested that venous congestion at this time might be a factor.

Necrosis of Spermatic Cord and Testicle from Torsion.

Uffreduzzi has found that a normally attached testis could not undergo torsion. He felt that the contraction of the cremasteric muscle is responsible for the rotation of the cord. Venous congestion, be it at the time of puberty, or at other times, due to varicocele, plus abnormal mobility, plus sudden exertion, appears to be the most logical explanation of the pathological physiology involved in causing torsion.

Differential Diagnosis: The chief points to be differentiated are epidydimitis, orchitis, strangulated hernia.

Case report of patient treated at the Good Samaritan Hospital: L. B. L. Chart No. 0, 7806.

History: A white, adult male, married, who is 40 years of age. He had been in good health, except for several days prior to the onset of the present illness when he had been very constipated and had complained of vague generalized abdominal pain. The evening before the onset of his acute pain the patient had given himself an enema, and while straining excessively at stool had a very sudden, sharp pain in the right testicle. This pain was excruciating in character, and was not relieved. The patient applied very hot compresses and certain essential oils to relieve the pain, but only succeeded in burning the skin of the parts. Although the pain was unrelieved, the patient did not call for medical aid until 5:30 A. M., some nine hours after the onset of the acute pain. At this time he described the pain by saying that he felt as though someone was "kicking him there all the time." There was a venereal history of gonorrhea and chancre some 15 years previous to this illness. The pain had been so severe that the patient had vomited clear fluid three or four times.

Physical Examination: A thin, but well nourished male, apparently in great distress, writhing in agony from the pain. Examination is negative except for the local condition. The right testicle is two and one-half times normal size, extremely tender and very painful. The spermatic cord is hard as high up as it can be felt. The external inguinal ring is small and there is no bulging on coughing. No hernia is present. The skin over the scrotum and lower inguinal region is burned from the patient's applications; 1/4 gr. morphine-sulphate did not relieve the pain and it took another 1/6 grain to give relief. The patient was operated on at 8:30 A. M., three hours after first being seen. Diagnosis: Torsion of spermatic cord.

Operative Record: Orchidectomy with excision of three inches of spermatic cord.

A three-inch right inguinal incision made. Tumor of scrotal sac delivered, found to be a testicle which had become twisted on its cord, twist extending all the way to the internal inguinal ring. The testicle was already partly gangrenous. Cord was also gangrenous to the level of the internal ring. The veins of the cord were very tortuous and full. Testicle and cord were removed at the level of the internal ring. Veins, arteries and cord were ligated separately. Repair of the muscle and fascia were done just as for inguinal hernia. Dermal sutures for skin.

Pathological Report (by Dr. Manlove)

Gross: The specimen is a much enlarged spermatic cord and testicle. The external surfaces are hemorrhagic. The cord when cut shows diffuse necrotic process throughout with hemorrhage into the tissue. The testicle is brown with a red tinge. The entire testicle shows disintegration from strangulation of the blood supply.

Diagnosis: Necrosis of spermatic cord with associated disintegration of testicle from strangulation of blood supply. Torsion of spermatic cord.

Clinical Course: The patient was discharged, well, from the hospital two weeks after the operation.

The pathological physiology in this reported case seems to be the one we have suggested, for there was abnormal mobility, plus varicocele, plus sudden straining.

Treatment, unless spontaneous untwisting occurs at once, incision should be made, and if in the early hours, untwisting may be sufficient to relieve the condition.

If gangrene is present or imminent, orchidectomy is necessary.

This case was of 12 hours duration

and probably the necrosis and gangrene existing at operation, had so existed for several hours.

Summary

(1) A case of Torsion of the Spermatic cord is reported.

(2) The important features of such cases are summarized from the literature.

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