A SURGICAL WEEK-END IN THE SIERRA LEONE PROTECTORATE.

By Major F. J. W. Porter, D.S.O.
Royal Army Medical Corps.

On August 12th I received a wire from Dr. Jackson-Moore, W.A.M.S., asking me to spend a couple of days with him at Moyamba. This is the headquarters of a district, and is 76 miles north-east of Freetown.

I left at 7 a.m. on the 14th, and reached my destination at 1 p.m. Travelling at a higher speed on this line is not possible owing to the narrow gauge, sharp curves, and utter disregard of keeping or making up time, which is exhibited by the Sierra Leone creole.

After lunch we went to the hospital. It is a very small wood and iron building and very roughly put together. A number of cases had been collected for operation, chiefly scrotal elephantiasis and inguinal hernia; in several, both conditions were present.

Many of the men were under 30 years of age, and had been carrying scrotal swelling ranging from 20 lb. to 50 lb. for several years. The penis was completely buried, and (what is to the African native a tremendous drawback) quite useless for the purpose intended by Nature.

The operating table consisted of a wide deal table covered with tin, and perforated by a couple of holes for drainage. Originally it had been intended for post mortems.

The anaesthetist, dresser, and nursing staff were combined in the person of a Sierra Leone creole dispenser, very willing, but not possessing a very deep knowledge of the art of giving anaesthesia. Frequent pauses were necessary, either to rescue the patient from an over-dose of chloroform or to get him more deeply under. His instructions, Mr. — give him another pennerth (sometimes two pennerth), answered the purpose fairly well—and with a couple of men to hold on to the feet and wrists, we got on as well as could be expected.

On Saturday afternoon, two elephantiasis cases were operated on.

The usual procedure in these cases is as follows:—

After the application of a rubber tourniquet to the root of the tumour, a deep incision is made about 2 inches to one side of the middle line, commencing about 2 inches from the tourniquet and extending downwards for a distance varying with the size of the tumour. The tunica vaginalis is opened and exit is usually given to a large quantity of fluid. The gubernaculum is divided, and the testis in its tunic drawn out. The latter is invariably much thickened, and it is freely removed. The testicle is dropped back into the cavity for protection. A similar procedure is adopted on the other side. A median incision is made at about the same level as the first two, and the penis dissected out. A curved skin incision is then made from about the centres of the first
two, and drawn round the back of the tumour, the skin dissected towards the perineum and the mass removed.

The penis is covered by flaps taken from those which were first cut. Thinking it possible to improve on this method, we devised the following:

The skin immediately round the preputial orifice is usually quite thin and easily detached. It is, therefore, very suitable for covering the penis after it has been dissected out. It also seemed much easier to fashion the new scrotum before the tumour had become collapsed from evacuation of the hydroceles. A superficial incision was made in the middle line from 2 to 3, fig. 1. From 3, a racquet-shaped incision (also superficial and shaped as in diagram) was made, about 1½ inches all round from 1, which represents the preputial orifice.

Fig. 1.  

This skin was dissected towards 1, and the penis with the reflected skin attached, dissected out of the tumour as far as the root. The attached skin is found to be capable of covering in nearly the whole of the penis, and it fits as accurately as the finger of a glove. From 3, the incision is carried in a curved direction outwards on each side, and round the back of the tumour as indicated by the dotted line, taking care to leave sufficient flap to form the new scrotum, but not too much. It is, perhaps, more easy to err on the side of too little flap. This skin flap is dissected well towards the perineum and outwards in front as in 2, 3, 8, and 2, 3, 9. The incisions are then made to release the testis as before, and the tumour is cut away from before backwards. Each large group of vessels is better transfixed and tied before division. This results in a very much smaller loss of blood than by cutting away first and picking up the vessels afterwards. After removal of the tourniquet and ligature of the remaining vessels, the pointed process of skin at 3 is sutured to 2, and accurately closes that angle.

The edges of the scrotum behind are rolled together and sutured from below upwards as far as 7 (fig. 2) by continuous catgut suture. An occasional supporting suture of wire is very useful. The testes are now
replaced, and point 4 (fig. 1) is secured to 7 (fig. 2), and the edges 5-4
to 10-7 and 6-4 to 11-7. On the upper surface, 3-5 and 3-6 are sutured
to 2-8 and 2-9. Four cases (two complicated by inguinal hernia) were
done on Sunday. The ligature and suture material ran out after the
fourth or fifth case. This was a serious position. Some of the patients
had come from long distances.

Search disclosed a skein of ordinary pack thread. This was quickly
wound on glass slides and boiled; by its aid we were able to carry on.

On Monday morning another case of scrotal elephantiasis, complicated
by a large hernia, and a big “scrotal hernia,” arrived; both very anxious
to be operated on. They were not disappointed, and one was able to
catch the 11.20 train back to Freetown.

In forty-eight hours, seven cases of elephantiasis and four cases of
inguinal hernia were operated on.

I believe that many of these so-called elephantiasises are really enormous
hydroceles. In these cases the skin is not infiltrated by the dense
material which one meets with in genuine elephantiasis. It is quite soft
and strips easily. In some, however, there is a quantity of gelatinous
material in the connective tissue, which may possibly be early elephantiasis.
The operation which is required in these cases is, however, identical with
that which is necessary in elephantiasis scroti, but is much easier. The
after results were quite as good as is usual in these cases.

Preparation of the skin consisted in freely painting the whole tumour
with 10 per cent. spirit iodine, but only one coat should be given in case
the skin is thin; probably 3 per cent. would be strong enough. A couple
of coats may be given to the skin of the thighs and lower part of the
abdomen. Such luxuries as operating towels and gowns were not avail­
able. One’s theatre kit consisted of a pair of mosquito boots, short
drawers, and cotton shirt.

It is to be hoped that the Colonial Government will soon establish a
large central hospital in the Protectorate. Elephantiasis is everywhere
prevalent. Such an institution would do an enormous amount of good
in relieving large numbers of unfortunate and grateful people from the
discomfort (amounting in bad cases to a living death) attendant on this
problem.

BROMIDROSIS OF THE FEET.

By Major C. H. Hale.

Royal Army Medical Corps.

My apology for writing this short article on the treatment of the above
disease is as follows: A short time ago the subject cropped up in con­
versation with a certain Lieutenant-Colonel of our Corps, and when I
explained to him the treatment which I have used for a good many years,
always with complete success, he replied that he had never heard of it,
and suggested that I should send it to the Journal.