Die operative Chirurgie

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(Google translation)

page 721 **Die Operation der Phimose**

This surgical method for phimosis is so named because the foreskin is cut away all around, although in practice this is usually done only partially. It is this partial circumcision that is discussed here first.

Circumcision is indicated for a constricted foreskin—otherwise healthy—when that foreskin is unusually long and thick. An incision performed under these circumstances results in significant deformity: if the incision is shorter, two large flaps hang down at the sides of the glans; if the incision extends beyond the corona of the glans, the entire foreskin forms a walnut-sized edematous swelling or a flaccid pouch at the base of the penis, upon which the exposed glans rests. This condition interferes with sexual intercourse and exposes the swelling to frequent irritation. Circumcision is also indicated when the foreskin is hypertrophic—whether due to inflammation or otherwise—and its length and thickness exceed that of the entire penis (a common occurrence), particularly when ulcers are also present, as in cases of elephantiasis of the scrotum and prepuce. Furthermore, circumcision is indicated for a very long and thick foreskin—even without constriction—that interferes with intercourse and leads to excoriation of the glans and the inner layer of the foreskin; finally, it is indicated in cases of pathological conditions, tissue induration, extensive scarring, and cancer, where total excision may even become necessary.

During the operation, the patient sits or stands—as previously described for the incision—in such a way that he cannot pull his pelvis back. Using a clamp with blades at least three inches long, the foreskin is grasped and compressed into a vertical fold in front of the glans, with the ends of the blades pointing upwards and downwards. The handles of the clamp are then handed to an assistant. Next, the thumb and index finger of the left hand are placed on the posterior part of the foreskin above the glans—partly to push the glans back and protect it from injury, and partly to stretch the outer skin. Then, a narrow, straight knife with a long, rounded-tip blade is placed against the upper, sharp edge of the compressed foreskin; the tissue is cut through in a single stroke, sliding the knife along the clamp's blades as if along a ruler. Scissors are then quickly taken up to slit the inner layer—which still covers the glans—down its center as far as the corona. Bleeding is staunched by pouring cold water over the area; the outer layer is then pulled forward, and its circular wound edge is brought into gentle contact with that of the inner layer. Cold compresses are then applied. Healing occurs without deformity.
In cases of complete degeneration of the foreskin—affecting both the inner and outer layers—both layers must first be slit open, and all diseased tissue removed. The affected tissue is then grasped with a fine-jawed clamp—whose grooved jaws measure only three-quarters of an inch in length—and severed with a small knife; care is taken to spare the healthy skin so that the loss of tissue is not excessive and the penis is not constricted during erection by skin that has become too short, following generally the principles established for plastic surgery. (See Vol. I).

Alternative Methods.

Other surgeons proceed differently. Most simply have an assistant pull the foreskin forward, protect the glans by pushing it back with their own fingers, and cut through the skin between the two with a single stroke of the knife. The inner layer is then split from front to back using scissors. This method is recommended, for instance, by Blasius. However, considering that the foreskin is extremely tough and difficult to cut cleanly unless held taut and evenly compressed, there is a risk–when the assistant gathers the anterior portion–that the incision will result in a zigzag cut, even with the most skillful handling, or even leave a projecting flap of skin at the bottom. Only the clamp ensures consistently clean, straight wound edges while allowing for an easy cut. – While one surgeon might always have the outer layer pulled forward during the operation and another always pulled back, the specific case dictates which approach to take. In cases of significant excess skin, the skin is pulled forward; if the excess is minimal, it is pulled back; or, as previously described, it is simply cut off in front of the glans without pulling it in either direction. – Abdul-Qasim used a specialized pair of scissors for the operation. Special instruments were recommended early on to secure the part to be removed; Bernstein devised a specific clamp for this purpose, while S. Cooper proposed a special pair of forceps. The latter united the wound edges using fine sutures–a practice against which I have already cautioned due to the risk of inflammatory irritation. – Lisfranc has the edge of the foreskin grasped and pulled forward with three pairs of forceps, then applies a dressing forceps transversely in front of the glans, cutting off the foreskin (which has been drawn forward by the forceps) just in front of the instrument. This is evidently far more cumbersome than using a bar clamp, as it requires the active involvement of three people and five instruments. In cases of inflammatory phimosis, he inserts one blade of a pair of curved scissors beneath the foreskin to make a circumferential incision in the inner layer. This method is not recommended. – Wattmann has the edge of the foreskin pulled forward using two small hooks while a second assistant pushes the glans back; he then passes three threaded needles through the entire thickness of the foreskin from top to bottom in front of the glans, folds back the thread ends, and uses scissors to cut off the prepuce in front of them. Next, he pulls out the middle sections of the threads sufficiently, cuts them, and ties the ends of the resulting six sutures individually. Placing sutures–specifically enough of them to precisely join the layers of the foreskin, a result already achieved simply by apposition–is unnecessary; certainly, six stitches are not required, and in most cases, they would provoke severe post-operative inflammation. This method, which is far too complicated overall, also requires three people–the surgeon and two assistants–whereas a single person is always sufficient.

Practitioners generally excise the foreskin between two ligatures applied in front of the glans. This procedure is very rapid and superior to some of the more recent, contrived techniques; unfortunately, however, the wound edges are rarely perfectly clean, as the skin becomes puckered due to the ligation. It is said that the Arabs performed the operation in this manner.

Post-operative care following surgery for phimosis–whether by incision or circumcision–is always anti-inflammatory. The regimen begins with cold compresses to arrest bleeding and reduce inflammation, followed by lukewarm elderflower tea mixed with lead water, and finally lukewarm lead water alone; in cases of edematous swelling, chamomile tea with lead water is used. Compresses are applied using charpie (surgical lint); the use of dry charpie should be avoided. Once the tissue layers have separated and suppuration has set in, smooth charpie soaked in a mixture of white wax and almond oil is applied to the area.

Bleeding during the operation is rarely profuse, though I have occasionally had to tamponade spurting arteries–a method preferable to ligation in this instance. I have sometimes observed severe, dangerous post-operative hemorrhaging–occurring after an operation that involved little initial bleeding–triggered by erections, particularly at night; ice compresses and torsion served to arrest the bleeding.

Addenda and Remarks.

The religious rite of circumcision among Jewish children is performed in a most cruel manner; despite numerous reform proposals recently voiced in Paris–most notably the recommendation that the procedure be performed by qualified surgeons–the practice persists in its old, hazardous form. After the child has been securely swaddled, a man takes him onto his lap. Thereupon, the circumciser pulls the prepuce forward and places a silver clamp upon it; he stretches the protruding tip with his fingers and cuts it off–using a specially shaped knife–in the space between his fingers and the clamp. Next, he inserts the long, sharp thumbnails beneath the inner layer and tears it open as far as the corona of the glans. After taking a mouthful of water and spraying it onto the area, he sucks out the blood with his mouth. The penis is then wrapped in a strip of fine linen, a styptic powder having first been sprinkled onto the foreskin. Rust recounts an incident where all the Jewish children in a certain region contracted syphilis because the rabbi had a mouth full of chancres. – The Egyptians first evert the foreskin, place a small round wooden rod behind the glans, pull the foreskin forward again, press it firmly against the rod, pull it further forward still, and then insert a pair of forceps between the rod and the glans, using them to hold the skin while cutting it off with a razor. By everting the inner, unsplit layer–bringing its edges into contact with those of the outer layer–an artificial paraphimosis is created. It is safe to assume that this condition is often accompanied by inflammatory and edematous swelling.

The operation for phimosis is one of those surgical procedures that appear so simple that the entire medical community believes itself capable of performing them; yet, it is by no means an easy procedure, as evidenced by the frequent errors committed during it. "What?" says the novice surgeon. "Two people for such a trifle? I am sufficient unto myself–just me and my scissors." [He uses almost nothing but scissors.] Sit down. The patient sits down, inserts one blade of the scissors, and makes an incision. The foreskin is now sufficiently wide–or perhaps he realizes the cut was not large enough–but the patient recoils, the penis retracts into the skin, bleeding begins, and the patient refuses to allow further cutting. However, since the incision was usually not made far enough back, the wound edges grow back together, and the phimosis becomes even more severe due to the resulting scar. I have seen and performed corrective surgery on countless patients who had undergone such procedures. A yet more audacious beginner might use a pointed Pott's fistula knife. I witnessed one such case that could have ended very badly. A young doctor–otherwise skilled–asked me and another acquaintance to be present during the operation of an anxious young man with congenital phimosis. After the pointed fistula knife had been boldly inserted along a probe, I noticed the knife being pushed in too deeply–just as the patient pulled back his pelvis and penis–and discovered that the tip of the knife (the blade of which lay above the penis) had penetrated beneath the skin far back, past the pubic hair line. Had the surgeon not been quickly interrupted, he would have split all the soft tissues from the foreskin up to the pubic arch and ruined his reputation forever. I believe this story serves as a useful warning for young, inexperienced surgeons. Anyone can easily imagine the risk of accidentally splitting the entire skin on the dorsum of the penis when

making an incision with a fistula knife, if they recall how patients react during the operation ...involuntarily retract the penis.

In the course of my life, I have observed a number of rare cases of degeneration of the prepuce that necessitated circumcision—often a total one. I found the patients wretched and emaciated. The penis was as elongated as in a state of maximum erection and showed signs of phlegmonous inflammation, with patches of gangrene appearing here and there. A foul-smelling ichor oozed from the foreskin, and dangerous hemorrhages had set in. In other instances, I saw the glans protruding from the middle of the penile shaft—through skin perforated by ulceration or gangrene—much like a button through a buttonhole, with the edges of the opening constricting it; at times, the glans was also partially eroded by chancres. In other cases—where perforation of the urethra had precipitated urinary infiltration—the entire cellular tissue between the skin and the penis was necrotic, and the scrotum was a glistening blood-red and the size of a child's head.

Under these circumstances, while general treatment is of primary importance, surgery is the immediate priority, as it halts the spread of gangrene, arrests hemorrhage, and reduces the threat to life. The procedure involves excising the entire foreskin from the glans and freeing the glans from entrapment; in cases of extensive necrosis of the cellular tissue, two additional lateral incisions are made at the base of the penis to allow for the free drainage of purulent fluid and the removal of detached tissue. It would be a serious error to extend the incision from the circumcision wound along the dorsum of the penis to its base, as this often fails to preserve the skin, which may subsequently rupture inferiorly; the scarring process then draws the skin downward, leaving the penis exposed. In cases of elephantiasis affecting the scrotum and penile skin, I have occasionally found it necessary to excise large portions of the degenerated skin—along with the foreskin, which may weigh as much as an ounce—and to reconstruct the area according to the principles of plastic surgery.