

side, in testicles where there has been no previous clinical evidence of torsion.

While we try to reinforce Dr. Sparks's valuable message that manipulation is an invaluable organ-saving procedure, we believe it is equally important to make it clear that, having apparently untwisted the testicle, the untwisting should be confirmed by operation.—Ed., *B.M.J.*

Torsion of Testis

SIR,—Your leader and the article by Dr. R. H. Chapman and Mr. A. J. Walton on torsion of the testis (15 January, p. 164) advise fixation of the contralateral testis in this condition. Two recent cases at our hospital, one of atrophy and the other of recurrent pain in the originally unaffected testicles, have emphasized the importance of this practice, as does the work of Johnson¹ in demonstrating the frequency of bilateral anatomical abnormalities predisposing to torsion.

I would like to describe a technique which enables the fixation of the opposite testicle to be performed simply at the initial exploration. Through a transverse scrotal incision on the affected side, the testicle is delivered, untwisted, and surrounded by a warm pack. The contralateral testicle is now pressed against the scrotal septum, which then comes up into the wound, and is transfixed through the septum with interrupted sutures. The other testicle is examined for viability and fixation or orchidectomy carried out.

This method has been used in twelve cases, including one of the neonatal variety. It is interesting that of these, six were not viable at the time of operation.—I am, etc.,

D. N. L. RALPHS

Central Middlesex Hospital,
London N.W.10

¹ Johnson, N., *Medical Journal of Australia*, 1960, 1, 653.

SIR,—The following comments have been prompted by the article by Dr. R. H. Chapman and Mr. A. J. Walton (15 January, p. 164) and your leading article (p. 128) on this subject. Both appear to oversimplify the diagnostic problem in patients presenting with a painful scrotal swelling, and both may encourage over-hasty surgical exploration of the scrotum.

I have never seen a case of torsion and have been surprised to read that this is a common emergency. I have, however, dealt with a fairly large number of patients with epididymitis where there has been no associated urinary infection—a situation which you and your correspondents state hardly ever occurs. The so-called "idiopathic" epididymitis became of such importance during the war that the Army Medical Department issued a bulletin on it.

Dr. Chapman and Mr. Walton do not describe the operation findings in the cases they report. It would have been of interest to know if in those cases operated on during a symptom-free interval the congenital anomaly which permits torsion to occur was present. Neither the follow-up study nor the criteria on which they separate "saved" from "wasted" testes are described. Complications of the operation receive no mention.

It is unlikely that a testis will remain fixed to the dartos muscle, particularly in young

people with active cremasteric reflexes. If the organ does remain fixed the consequent lack of testicular mobility may constitute as great a hazard as would further torsion.

A few days ago I read the hospital notes of a patient who had an exploration of scrotum so that a small translucent cyst situated above the testis might be obliterated or removed. Wound infection was followed by sloughing and finally orchidectomy was performed. Haemorrhage and infection continue to be important complications of intrascrotal surgery.—I am, etc.,

JOHN K. MCCOLLUM

Newcastle General Hospital,
Newcastle upon Tyne,
Northumberland

SIR,—In the interesting paper by Dr. R. H. Chapman and Mr. A. J. Walton (15 January, p. 164) and in your apt leading article, "Castration by Neglect" (p. 128), a very important fact in the clinical presentation of torsion of the testis was not even mentioned. The original pain in torsion is not in the scrotum at all. The pain is felt in the lower abdomen in the inguinal region just above the internal inguinal ring, because of the nature of the nerve supply to the testis. It is only when the coverings of the testis become involved that the pain is felt in the scrotum.

I remember well a young boy who was sent from school to an outpatient department of a large hospital, where he was seen by the resident surgical officer (an F.R.C.S.) as a query appendicitis. The child was sent back to school, as there was no evidence of appendicitis. The testis at that time was not suspected. When the child was seen the next morning he had a typical torsion of the right testis, which had to be removed.

I believe, Sir, that this fact of the site of onset of the pain is a very important one which is not generally recognized; it requires emphasis just as much as does the very common occurrence of torsion of the testis and the advisability of treatment by early exploration and fixation.—I am, etc.,

THOMAS MOORE

Manchester M13 0EZ

Haemophilus Epiglottitis

SIR,—The report by Dr. G. M. Addy and his colleagues of epiglottitis in Oxford (1 January, p. 40) prompts me to draw attention to other observations on the condition in North America during the last 20 years.

There was a steady increase in its incidence at Montreal Children's Hospital¹ over a number of years and there were some endemic aspects. Endotracheal intubation was always undertaken before tracheostomy and the anaesthetic considerations were vitally important.² Though the glottic opening is obscured it is not difficult for a trained person to pass a tube into the trachea. Any child with upper airway obstruction arriving in hospital alive should not die. A cricothyrotomy or passage of a bronchoscope should always be undertaken when breathing stops if an endotracheal tube cannot be passed immediately.

More recently mild cases have been treated with antibiotics, constant humidification, and sedation, when experts in respiratory care can remain with the patient at all times. Experienced paediatric intensive

nursing and blood gas measurements are essential in the management. Lateral x-ray examination^{3,4} of the soft tissues can be invaluable, but while the films are being taken intensive observation must not be relaxed. Acute epiglottitis has also been treated successfully by prolonged endotracheal intubation⁵ or intermittent positive pressure breathing with adrenaline aerosol,⁴ provided continuous expert care is available.

There may well be local variants of the pathogenesis and natural history of this condition, and as it is an emergency which any doctor may face all methods of treatment should be widely publicized.—I am, etc.,

HAROLD T. DAVENPORT

Rotterdam 4,
Holland

¹ Baxter, J. D., *Laryngoscope*, 1967, 77, 1358.

² Rosales, J. K., and Davenport, H. T., *Canadian Anaesthetists Society Journal*, 1962, 9, 467.

³ Dunbar, J. S., *Journal of the Canadian Association of Radiologists*, 1961, 12, 86.

⁴ Poole, C. A., and Altman, D. H., *Radiology*, 1963, 80, 798.

⁵ Geraci, R. P., *Pediatrics*, 1968, 41, 143.

⁶ McNally, G. F., and Lorhan, P. H., *Anesthesiology*, 1969, 31, 581.

SIR,—I fully support Dr. J. A. Kuzemko's statement (15 January, p. 180) that endotracheal intubation is preferable to tracheostomy in children with acute epiglottitis. Corticosteroids and ampicillin should be given parenterally and chloramphenicol substituted for ampicillin if there is no improvement after 48 hours' therapy. On this treatment the nasotracheal tube can be dispensed with in the majority on the third or fourth day. Tracheostomy is reserved for those who continue to have airway obstruction after five days' treatment. On the above regimen not more than 5% will require tracheostomy.—I am, etc.,

W. J. NEWLANDS

Royal Aberdeen Children's Hospital,
Aberdeen

SIR,—I was very interested to read Dr. M. G. Addy and others on haemophilus epiglottitis (1 January, p. 40) and also Dr. Jennifer M. Edwards and Mr. Keith D. Roberts (22 January, p. 246). I agree with a great deal with what was said, but I do not agree with the suggestion that epiglottitis is eminently suitable for treatment by intubation with a plastic nasotracheal tube.

Of 26 cases recently reported by me to the Section of Laryngology of the Royal Society of Medicine, the first two patients, both children aged 2½ years, died. One had been treated by the insertion of a nasotracheal tube. Both these cases came to coroner's postmortem which was carried out by Professor F. E. Camps. He demonstrated to me the deeply swollen tissue of the larynx and epiglottis and how the oedema stopped at the level of the vocal cords and the trachea and glottis were unaffected. He suggested that to prevent further deaths from this condition an early tracheotomy was the treatment of choice.

This I have done since with no further deaths among those patients who had been admitted to hospital and who had come under my care. A nasotracheal tube may get blocked much more easily than a tracheotomy. Further, it is more difficult to replace if it becomes blocked whereas a tracheotomy completely bypasses the site of the obstruct-