TRANSACTIONS OF THE PHILADELPHIA ACADEMY OF SURGERY.

Stated Meeting, March 6, 1899.

The President, J. EWING MEARS, M.D., in the Chair.

PANCREATIC CYST.

DR. THOMAS S. K. MORTON reported the following case: A woman, thirty years of age, had noted thirteen months before coming under his observation a swelling in her epigastrium, as a lump behind her stomach, which had arisen after an experience of colicky pains in the epigastrium, with occasional violent exacerbations, making in all a period of two years from the first observation of the pains up to the time of her coming to Philadelphia. Eight months before operation the mass in her epigastrium had become as large as a cocoanut, and she consulted a surgeon in Cleveland, who, finding that it fluctuated, aspirated the fluid, and proved, on analysis, that it changed starch into glucose and emulsified fat. She returned to her home subsequently, and remained comparatively comfortable for a short time, the swelling, of course, having temporarily disappeared. Something over a pint of fluid was withdrawn. It was colorless and watery and had the chemical properties before mentioned. Recurrence of swelling, however, promptly came about, with an amplification of her former colicky pains. Occasionally she had an exacerbation, which amounted to agony. This history made diagnosis easy. The tumor presented immediately beneath the ensiform cartilage and apparently displaced the stomach and colon downward. A small median incision, not more than an inch and a half, was made in the epigastrium. The tumor, which then was the size of a canteloupe, was opened and the edges of the sac were united with the skin of the abdominal wall. About three pints of fluid were withdrawn, having the same properties

as the fluid first drawn from the cyst.—namely, that it was of neutral reaction, colorless, watery, not thick, emulsified fat to a slight degree, and to a greater extent converted starch into sugar. There was a moderate discharge of fluid from the sac for several days subsequently. The method of draining was a large rubber tube, which was in turn surrounded by a spirally wrapped rope of iodoform gauze. No hardening or other trouble with the pancreas could be detected. On the fourth day the gauze wicking was withdrawn, and at the end of ten days the tube was left out. She returned to her home three weeks after the operation. The sinus continued to discharge for two months more, when it closed spontaneously. She has been perfectly well ever since, now a period of nineteen months.

MOVABLE KIDNEY.

DR. JOHN B. DEAVER read a paper with the above title.

MOVABLE KIDNEY.

By JOHN B. DEAVER, M.D.,

SURGEON-IN-CHIEF TO THE GERMAN HOSPITAL.

In the present paper movable kidney will be discussed entirely from a practical stand-point. It is a well-known fact that movable kidney is more common in women than in men; that the right kidney is the organ more commonly at fault, and that both kidneys may be movable. It is asserted that most women who are affected with this condition have borne children, or had an abdominal tumor removed; but this is not in accord with my personal experience. In fact, the greater number of cases coming under the writer's observation have been in unmarried women of a markedly nervous temperament. The question of the cause or causes of movable kidney is debatable, and one which is not by any means definitely settled. The determination of the cause is not a practical point; but the practical considerations are the detection and correction of the abnormality, the method of treatment for alleviation of the symptoms, and the operation which is safest and least likely to be followed by a return of the deformity. I will therefore speak of the symptoms of movable kidney,—the differential diagnosis between this condition and those affections which may be mistaken for it, and the operative treatment which has given the best results in the writer's experience.

Movable kidney may be indicated by the presence of an abnormal depression in the flank; but this I regard as of little moment in the diagnosis of a movable kidney, a movable tumor characteristic in shape, which, by properly directed pressure, can be restored to its normal position. The best position of the patient in which to detect and re-

place a movable kidney is lying upon the side opposite to that of the organ supposed to be affected. The legs should be flexed upon the thighs, the thighs strongly flexed upon the abdomen, and the spinal column flexed so as to bend the trunk as far forward as possible. The patient is now requested to take one or two deep inspirations, so that, if the kidney is movable, displacement of the organ will be assured. In this position the kidney is readily detected and returned to its normal position.

Auscultation over or in the immediate neighborhood of the displaced organ may elicit a bruit, the result of twists of the renal vessels. The bruit as well as perceptible pulsation of the abdominal aorta, due to traction on it by the renal artery of the affected kidney, disappears when the kidney is pushed back into its natural position. Throbbing of the aorta is frequently felt and seen in these cases, and should not be mistaken for aneurism. Slight catarrhal jaundice is present in a small percentage of cases, the result, I believe, of the general catarrhal condition of the lower alimentary tract, from which so many of these patients suffer, and not to parietal obstruction of the common or the hepatic duct by traction of the displaced organ.

In discussing the symptoms it must not be forgotten that, in a large percentage of cases, the condition gives rise to no trouble. The more common symptoms are a sense of dragging and discomfort, pain in the lumbar region of the affected side or pain referred to other regions, as the chest-wall in the line of the intercostal spaces. In the majority of cases the symptoms are those of neurasthenia with dyspeptic derangement, flatulence; and more particularly attacks of mucous diarrhœa. In movable kidney, but more especially when the organ has a more or less wide range of motion, the patient may be suddenly attacked with excruciating abdominal pain, paroxysmal in character, attended by nausea, vomiting, chills, a subnormal temperature, or it may be that the temperature is elevated to the degree of fever. Associated with these acute symptoms are marked rigidity and tender-

ness of the part of the abdominal wall overlying the displaced organ and for some distance beyond; and pressure upon the organ causes a sickening pain,—"fainting pain." Coincident with the above condition is frequent desire to urinate and pain referred in the line of the ureter. I have in occasional instances seen hæmaturia. In some cases the patient describes the sensation of a moving body within the abdomen, and others claim to be able to feel and locate it. The variability of the pain, referred here, there, and yonder, is understood when we recall the rich net-work of sympathetic ganglia and nerves in relation with the kidneys and suprarenal capsules. The pain in movable kidney is aggravated by assuming the erect posture. The pain may resemble that in nephritic colic. Paroxysmal attacks of pain are most likely to be excited by unusual exertion of any kind, such as dancing, etc. In females they not uncommonly occur during menstruation. The attacks of pain are frequently preceded by diminution in the quantity of urine passed.

The conditions between which and movable kidney we have especially to distinguish are a displaced spleen, an enlargement of the gall-bladder, a growth of the pylorus, of the head of the pancreas, or, of the ascending or descending colon, mesenteric or omental growths, an elongated lobule, circumscribed abscess or echinococcus cyst of the liver, an ovarian tumor with a long pedicle, a pedunculated uterine fibroid, appendicitis, and nephritic colic. The differential diagnosis between a movable kidney and the above conditions is, in the absence of acute symptoms, usually not difficult. Movable kidney attended by acute exacerbations of pain, vomiting, and circumscribed rigidity of the overlying belly wall, may be very difficult to distinguish from acute appendicitis, or an elongated lobule of the liver, the site of a circumscribed abscess.

The points of difference between a displaced spleen and a movable kidney are that in the former the shape of the organ, the recognition of the hilum, the greater range of motion, the difference in the location of the organ, the absence

of splenic dulness over the normal site of the spleen, the absence of urinary symptoms, which are present to a more or less degree in a greater number of cases of movable kidney, and the ability to return the organ to its natural position, where it can be located by percussion.

Between an enlarged gall-bladder and a movable kidney the points of difference are—the position which the gall-bladder occupies, the fact that in enlarged gall-bladder the lower part of the tumor is more freely movable than the upper; that the lower end of the gall-bladder enlargement is more rounded and less resistant on pressure, the absence of jaundice, and of a cholelithiatic history. In some cases of gall-bladder enlargement a sense of fluctuation is elicited. However that the lower end of the tumor formed by enlargement of the gall-bladder can at times be carried into the loin-space, to the extent of making the latter prominent, and thus simulate a replaced movable kidney, I have demonstrated upon more than one occasion. When the patient is in the supine position and the lower end of an enlarged gall-bladder is sufficiently movable to permit of its displacement into the loin-space, that organ returns to its normal position after removal of the pressure, while this is not the case with a reposited movable kidney, if the patient observe strict quiet and does not breathe deeply. The conditions under which this is impossible are when the gall-bladder is tied and matted to the adjoining viscera by exudate or strong adhesions.

Between a growth of the pylorus and a movable kidney there is some resemblance, in that the growth of the pylorus may be very movable and that in size it may resemble a kidney. Differentiation of the two, however, should not be difficult. The pyloric growth differs in shape, is ordinarily of stony hardness, and has an irregular surface, and in the majority of instances is felt in the immediate neighborhood of the umbilicus, and is flat upon percussion. Further, the age of the patient, about middle life, loss of flesh, cachexia, in some instances gastric symptoms, which may arouse sus-

picion, and which, upon careful examination of stomach contents, etc., may shed light upon the diagnosis.

Between a growth of the head of the pancreas and movable kidney there should be little difficulty in arriving at a correct conclusion. A growth involving the head of the pancreas, which in the majority of instances is malignant and, like retroperitoneal growths, is immovable, irregular in outline, and presents to the educated examining finger a sense which is not communicated by a movable kidney. Further, the time of life at which these growths are most likely to occur, the condition of the patient, and their frequently associated symptoms of gastric or hepatic disturbances, so often accompanying malignant disease of this gland, should not be overlooked. Again, if the growth trespass upon the common bile-duct, where it occupies the pancreatico-duodenal sulcus, jaundice will be a symptom.

Between movable kidney and a growth of the ascending, transverse, or descending colon, a growth of the mesentery or of the omentum, or a fæcal mass in the colon, there should, ordinarily, not be much difficulty in arriving at a correct conclusion. These growths are dull upon percussion, and seldom can they be displaced into the lumbar region. They are more commonly located near the middle line of the abdomen, are malignant in nature, do not present the sensation to the finger which is so characteristic of a movable kidney when it slips away from the palpating hand, are irregular in outline, and communicate to the examining finger a peculiar hardness characteristic of a carcinoma. Further, evidence of dyscrasia and of bowel-disturbance, such as diarrhœa with tenesmus, or constipation, the presence of mucus or blood in the stools, loss of flesh and perhaps a cachexia, family history, etc. The time of life at which these growths are most commonly seen may influence the diagnosis. A sarcoma of the wall of the large bowel is more likely to cause an error in diagnosis, particularly, if it is present, as a pedunculated growth. If a fæcal mass is suspected, the administration of purgatives, high injections, etc., will clear up any doubt.

Between a movable kidney and an elongated lobule of the liver, a circumscribed abscess occupying an elongated lobule of the liver, or an echinococcus cyst of the liver, the diagnosis should be made by observing that, in the presence of an elongated lobule of the liver the dulness upon percussion is continuous with that of the liver; that the lower end of the tumor is more rounded; that it is smooth in outline, and that in forcing it into the loin-space much more pressure is required than in restoring a movable kidney.

Between movable kidney and a circumscribed abscess occupying the site of an elongated lobule of the liver there should be but little, if any, difficulty in differentiating, when it is borne in mind that a movable kidney, except during an exacerbation of acute pain attended by vomiting, rigidity of the overlying abdominal wall, etc., presents no symptoms of an inflammatory affection. The absence of deep fluctuation, of the characteristic hectic temperature of liver abscess, of increased pulse-rate, of chills, of pain referred to right shoulder, and of constant tenderness over the affected area, whereas immobility of the growth and leucocytosis, detected by examination of the blood, indicate abscess.

A movable kidney may be distinguished from an echinococcus cyst of the liver occupying the epigastric or right hypochondriac region by observing the following points: An echinococcus cyst of the liver is an immovable, painless enlargement, either regular or irregular in outline, and presents a smooth surface, fluctuation, and possibly the hydatid tremor. It has existed for some time, grew downward from the liver, and has caused no disturbance of the health.

Between a movable kidney and a small cystic or a solid ovarian tumor and a pedunculated uterine fibroid the diagnosis is ordinarily not difficult. The points to be considered in the differentiation are the size and form of the movable tumor, the direction in which it is most readily displaced, if a kidney into the loin-space, if ovarian or uterine in the direction of its attachment to the latter, the tendency to increase in size, the absence of urinary symptoms which attend many

cases of movable kidney, and the presence of fluctuation, if it be a cystoma of the ovary. The diagnosis may, however, be attended with difficulty.

The symptoms occasioned by the ovarian or uterine condition are usually not present until the growth is of considerable size, which would mark it from movable kidney.

Movable kidney is differentiated from appendicitis by observing the following points: in arriving at a correct diagnosis between movable kidney and appendicitis, first in importance is the fact that movable kidney is most commonly seen in neurasthenic women who have gastro-intestinal disturbance. The attacks of pain in movable kidney are associated with nausea and vomiting, fever, and often chills. In the majority of instances the urinary function is disturbed, as instanced by the frequent desire to urinate, the act of which may be painful and the urine large in amount, particularly if the patient is of a nervous disposition. The urine may contain blood, and, as I have seen in some attacks, pus, but the high color of the urine is more likely to be due to the presence of an excess of uric acid or oxalates. The differentiation between the local disturbance during an attack of pain in a movable kidney which is dragging upon its pedicle, and appendicitis is, to say the least, highly important. From the history can be learned the frequency of the attacks of pain, its nature, the part of the abdomen to which the pain is referred; whether it is confined to one point or shifts; whether or not it occurred after the ingestion of a heavy meal, exposure to cold, or during the period of digestion, or after unusual movement or position or indirect violence. The degree of illness following must be ascertained as well as the tendency of the patient to constipation or diarrhœa. During or following an acute exacerbation of pain due to movable kidney, occurring in either a nervous or robust individual, local examination will show pronounced rigidity of the overlying abdominal wall, with tenderness, the degree of which is in direct proportion to the muscular rigidity.

The important differential points between appendicitis

and movable kidney are these: in appendicitis we have the sudden onset of acute abdominal pain, most commonly following the partaking of indigestible foods, and which, at first, is referred to the epigastrium or to the region of the umbilicus, and later becomes localized in the right iliac fossa. The presence of fever and an increased pulse-rate are more indicative of appendicitis. Also in appendicitis, the rigidity of the lower portion of the right rectus muscle, and the flat muscles of the abdominal wall immediately overlying the infiamed organ, differs from the rigidity present in movable kidney in that it does not involve so much area. The presence of a most acute tender point, which corresponds to the position of the inflamed appendix, is, at least early in the inflammation, more circumscribed than the tenderness in movable kidney. The tender area over a movable kidney is not so painful to slight pressure and extends over a greater area. The pain which, as a rule, is not so intense is at once referred to the site of the kidney or is reflected along the course of the ureter. Movable kidney, attended by both pain and rigidity, requires very delicate manipulation to detect it. By having the patient breathe with the mouth open, and with the thighs slightly flexed upon the abdomen, gentle pressure enables us to detect the kidney slipping away from the examining finger. There are cases, however, where nothing short of anæsthesia will clear up the question of a movable kidney. The presence of nausea, extending over days, is one of the most prominent symptoms in certain cases of movable kidney.

The operator may be thrown off his guard by acute indigestion occurring in a nervous individual suffering at the same time from acute paroxysms of pain due to a movable kidney, which was previously not known to the patient or to the physician. Under these circumstances the kidney may become temporarily anchored in its abnormal position. Under the foregoing conditions I have been called to operate for acute appendicitis, but could not say definitely that the case was not acute appendicitis until the patient was fully anæs-

thetized; then upon palpation the diagnosis at once became clear. Again, in the presence of both conditions—*i.e.,* movable kidney with acute symptoms and an enlarged appendix due to chronic inflammation—examination under ether will disclose not only the abnormal condition of the kidney, but also the presence of a palpably enlarged appendix. If under these circumstances the patient has been suitably prepared, an appendical operation should be performed. The operator, whose experience in appendical work has been rich, can usually say, upon what to the by-stander seems to be a superficial examination of the belly wall, whether the case is one of movable kidney or appendicitis. On the same principle, in the presence of a peritonitis, the result of appendicitis, the every-day operator can often separate the operative from the non-operative cases merely by palpation of the belly wall.

That movable kidney is mistaken for nephritic colic is evidenced by reports of cases. The subsequent symptoms of the two conditions bear some resemblance to one another, I admit; yet, after careful examination, that they should be confounded, I confess, I cannot quite understand. The presence of a calculus in a movable kidney is a different matter entirely. A properly taken X-ray picture would settle this question. The point which clinches the diagnosis in the case of movable kidney is its detection; that this is possible there is no doubt. In very stout persons difficulty in detecting the movable organ is increased, but in my experience is made certain by the administration of an anæsthetic.

The author has not included the various types of movable kidney in this paper, as he believes it simplifies the subject to describe them *in toto,* as he has done.

The treatment of movable kidney resolves itself into palliative and curative.

Palliative treatment consists of attention to the general health, attention to digestion, the administration of tonics, hydrotherapeutic baths, general massage, and the adjustment of some form of support which will retain the organ in its normal position. As to the question of the proper form of

support or of retaining appliance, I confess that I have yet to see one which is satisfactory; in fact, it is my experience that these appliances are more harmful than useful, therefore, if the patient is a great sufferer, particularly from frequent attacks of paroxysmal pain attended by vomiting, rigidity of the overlying abdominal wall, etc., which I am constantly seeing confounded with appendicitis, I believe that operative treatment of a radical character is indicated, certainly in at least the majority of these cases. Many different operative procedures are advised for the correction of this deformity, among the most important of which are stitching the kidney fast by carrying sutures through its capsule and substance, by dividing its capsule and stitching capsule fast, and by transplanting the kidney, as it were, an operation which has been recently advocated. As I have operated upon several cases of movable kidney and have seen the disastrous results of some of the forms of operation, I unhesitatingly put myself on record in favor of anchoring the kidney by gauze packing, as I will describe, and against suturing, particularly when the kidney substance is trespassed upon. Unfortunately, I have seen treated one case of movable kidney by suture, and in this case subsequent abscess-formation resulted consequent upon urinary infiltration into the substance of the organ through puncture of the uriniferous tubules with the needle. In this case it was finally necessary to perform nephrectomy. I would, therefore, raise my voice against any operative procedure which punctures the substance of the organ, and with more substantial reason, since I can bear witness to good results obtained by the gauze-packing method. The operation which the writer invariably performs was suggested to him two years ago by Dr. Nicholas Senn, but does not in detail correspond with the Senn operation.

The kidney is reposited in the loin-space and held *in situ* by an assistant.

A vertical incision, three to four inches in length, is carried through the loin-space of the affected side and the perirenal fat exposed. This consists of two layers, the adipose

layer proper and the fibrous layer, which closely resemble the parietal peritoneum. The outer layer of the fat is carefully dissected off. To accomplish this I frequently entirely deliver the organ. All of the posterior part of the fatty capsule is cut away and that of the anterior part as far as the hilus. The capsule proper of the kidney is next carefully scarified with the scalpel, not trespassing upon the kidney substance. Two long pieces of gauze are now selected, one is passed beneath each pole of the kidney, and the organ is reposited. With the organ *in situ* and the pieces of gauze carried beneath the poles protruding from the wound, more gauze is gently packed around and over the kidney, between it and the pieces of gauze first introduced. Over the gauze packing the first or long strips of gauze are tied, and a large gauze pad is placed upon the anterior abdominal wall over the site of the kidney. The wound is dressed and the dressing and anterior gauze pad are securely held in place by a strip of adhesive plaster carried around the abdomen. Over the pad of gauze and the gauze covering the wound an additional dressing is applied, and retained by a few circular turns of a bandage. This operation is not difficult, and requires but ten to fifteen minutes. The patient is made to assume the supine position. At the end of a week or ten days the gauze is removed, and the bed of the kidney and the surface of the organ will be found to be studded with healthy granulation. The wound is washed out with sterile water or a weak solution of bichloride, to which is added carbolic acid. The wound is gently repacked and dressed after the usual manner. The wound heals completely in from four to five weeks. I commend this operation as I have had a number of cases, a large percentage of which I have seen frequently since the day of operation, and the result in all is most satisfactory.

I have had the opportunity of a still better test than that of inspection and questioning the patient,—namely, that of palpating the organ from within the abdominal cavity when performing a subsequent operation for an entirely different condition. Here I found the kidney occupying its bed, which

proved to me that the ultimate results from this procedure would be good.

Relative to the question of suture of the kidney or its divided capsule, I do not for one instant think that the sutures play any part in the retention of the organ, other than through resulting inflammation and the inflammatory deposit consequent upon their introduction. In other words, I believe that the manner in which the kidney is permanently fixed in its bed in the few instances of relief which follow these procedures, is the same as that following the operation recommended,—namely, inflammation, granulation, etc. I believe, further, that the manipulation to which the organ is exposed in carrying out the suture process is more responsible for the ultimate anchoring than is the introduction of sutures. Again, the operation recommended in this paper does not expose the organ to the injurious effects of urinary extravasations, which occurred in the experience of the author, and also in that of Mr. Christopher Heath, who, Dr. Keen tells me, has discarded the operation of suturing the kidney for these reasons.

That the presence of sutures in themselves play no part in retaining the kidney can be demonstrated by carrying two or more of these through the kidney and holding the organ up by either end of the suture, when it will be seen that the weight of the organ is sufficient to cut the sutures out. Again, those of us who see a large number of these cases know too well that a recurrence of the deformity after the suturing operation is not uncommon. One of the first cases that the writer has seen was in the care of the late D. Hayes Agnew. Six months after the operation of nephrorrhaphy I saw this distinguished surgeon remove the organ for displacement, because of return of the symptoms for which the first operation was performed.

The report of cases of movable kidney herewith appended include only those which have been treated after the method advocated by the writer in the paper under discussion.

CASE I.—Miss N., aged twenty-four years; neurasthenic. Has had attacks of kidney colic. Right kidney affected. Operation, March 3, 1898. Packing removed and redressed. On sixth day, subsequent dressing at intervals for three days, until wound closed. Discharged cured.

CASE II.—Mrs. C. K., aged fifty-seven years. Admitted to the German Hospital February 10, 1898. Had complained of pain in left side and loin for two years, when lying down, standing, and walking. The pain came on suddenly after lifting a heavy burden. For some weeks noticed a movable mass in left iliac fosssa, moving with diaphragm, also on standing up. On examination the mass can be felt falling downward and forward on assuming the upright position. Tender to touch. During the last two years has had trouble with her bladder; frequent urination, alternating with attacks of retention. Operation February 12, 1898. Packing removed on the sixth day. Redressed every third day. Discharged cured.

CASE III.—J. M., aged twenty-six years. Admitted to the German Hospital February 7, 1898. For three months had complained of considerable pain in epigastrium, shifting to right loin and liver area. Had been quite nervous during this period. Examination revealed a mass moving downward with inspiration, and which could be reposited in loin-space. Operation February 9, 1898. Outside dressings changed on third day. Under ether the gauze packing was removed on seventh day. Redressed every third or fourth day. Discharged cured.

CASE IV.—M. B., aged thirty years. Admitted to the German Hospital June 1, 1897. Examination: Kidney palpated; tender and distinctly movable. Disappears entirely when patient assumes position on left side. Operation June 6, 1897. Gauze removed on seventh day. Kidney in good position in bottom of wound, apparently well anchored.

CASE V.—L. A., aged twenty-four years. Admitted to the German Hospital July 1, 1897. At the age of fourteen she first felt a pain in right side below costal border. Has had it on and off ever since then, accompanied by backache and pains in thighs. Had little nausea or vomiting. Three months ago a movable kidney was discovered. Patient had lost flesh and strength. Operation July 6, 1897. Gauze removed on sixth day. Redressed. Kidney in good position. On thirteenth day kidney

well anchored. On thirty-second day discharged. Kidney in good position, firm.

CASE VI.—A. L., aged thirty-four years. Admitted to the German Hospital February 11, 1898. When a child was injured in the right side, and ever since then has had dragging pain in right loin-space and right iliac fossa, increasing as the years passed. During the last four or five years it has been quite severe, giving rise to digestive disturbances, nausea, vomiting, constipation, and loss of appetite. Has become emaciated. A movable tumor can be felt in right iliac fossa and reposited in right loin-space. Tender to touch. Palpation produces nausea. February 24: Operation. February 26: Dressed. Outside dressings only removed. March 24: Patient has been redressed every three or four days. March 26: Patient allowed to get out of bed. April 4: Wound completely healed. Recovery.

CASE VII.—W. W., aged twenty years. Admitted to the German Hospital October 30, 1897. Has been sickly all her life. Had a severe fall five years ago. Two years later noticed a movable mass in right side of abdomen, tender to touch. Has had nausea and vomiting since the mass made its appearance. Stomach was very irritable; could retain little food. November 2: Operation. November 7: Gauze removed. Another piece packed under kidney and around it. Granulating well. November14: Dressed again, the same done as at first dressing. Wound filling in. Kidney apparently well anchored. December 9: Discharged after repeated dressings. Wound now almost closed. Kidney firm in place.

CASE VIII.—C. H., aged twenty-four years. Admitted to the German Hospital December 3, 1898. Present condition: One of four months' duration, when she had a dull pain on the right side below the ribs, this gradually increased in severity. She felt a swelling in the same position, which was movable. About two months ago had another attack, which lasted about a week. She says she remembers having several atttacks of pain before she discovered the swelling, but always attributed them to dyspepsia. When she turns from one side to another she feels the kidney moving, which gives a dull pain. She has never had any sharp pain and has never vomited with an attack. There has been no vesical disturbance. The kidney is distinctly felt on the right

side and is freely movable. It is tender to touch. Operation: Kidney anchored in position. Discharged cured.

CASE IX.—E. P. C., aged thirty years. Admitted to the German Hospital October 31, 1898. A week ago the patient's attention was drawn to the abdomen, when he noticed a movable mass in right loin-space and iliac fossa. Tumor was freely movable, and could be pushed back into the loin-space and retained there. The mass was quite tender to touch.. Numbness was felt by the patient in right kidney-space when on his feet a long time, also a sensation of weight and dragging in right side of abdomen on standing up. November 1, 1897: Operation. November 5: Gauze removed. Repacked. Dressed every week. December 1: Wound granulating nicely. December 14: Wound about half inch deep, two inches long. Nitrate of silver, 10-per-cent. solution, applied. December 18: Patient feeling very well.

DISCUSSION.

DR. HARTE referred to the practice of Mr. Morris, who was very strongly in favor of using the suture for fixing the kidney in the loin. Regarding the operation described by Dr. Deaver, the speaker had a number of times done practically the same operation, varying slightly in details only. The operation was not original with Dr. Senn, but had been taken from the German. He had followed up these cases, and he agreed with Dr. Deaver that it is the most satisfactory means we have of fixing the kidney in its normal place. He had tried suturing, and did not think that to be a rational operation, because it exposes the kidney to certain dangers. If the operation under discussion is done in a half-hearted sort of way one is bound to have a failure, just as in a hernia operation; but if one cleans out all the perirenal fat, getting good fresh surfaces in the kidney and loin, and then incises the surface of the kidney—the capsule—so that in the course of forty-eight hours a certain number of granulations will start up, and then does the same thing with the posterior wall of the loin, the surgeon will surely have a condition in which the kidney is moored firmly in position. He had followed up the cases that he had done, and his results had been satisfactory. He thought this to be the most rational operation of fixing the kidney.

DR. TAYLOR said that in many cases that he had seen, where

the kidneys had been sutured in place, there had been a persistent pain for a number of weeks, sometimes for months, a presumable pinching of a nerve. He inquired whether in the cases that Dr. Deaver had had he had ever met that condition.

DR. J. CHALMERS DA COSTA said that a clearer distinction should be made between the two sorts of movable kidney. The mere fact that a kidney is movable should not be considered as ample justification for interference, and yet he thought the idea had gone abroad that, if a movable kidney is found in an individual, some sort of an operation must be done. On several occasions he operated in individuals who had been very neurasthenic, and at the same time suffered from a slight degree of movable kidney. It is not to be conceived that mere fixation of a kidney is going to benefit neurasthenia. The fact that a normal kidney is movable to a certain degree is generally recognized, and the question should be, Is this movability sufficient either to endanger the functions of the kidney or interfere greatly with health or with the comfort of the individual.

In regard to the operation of suture, he had been much dissatisfied with it. He had tried several methods, but had been so dissatisfied in anchoring the kidney by sutures that he had not resorted to it in the past year. He had heard Watson Cheyne say that one may anchor kidneys ever so carefully, but they are apt to get loose again. He had read articles in which it was said that the kidney does not get loose, but whenever he talked to individual operators he found that a very considerable percentage of kidneys do get loose.

DR. T. S. K. MORTON said that until surgeons learn something more in the way of treating another condition of which "loose" kidney is usually but one part, they will not get uniform results from any operation on the displaced kidney. The contributions to literature during the last two or three years have shown pretty clearly that "loose" kidneys, as a rule, are simply a part of a more or less general loosening of the abdominal organs (ptosis), and that while a certain proportion would be benefited by anchoring the kidney, the signs and symptoms springing from a disordered position of the abdominal viscera not rarely recur after the rest-cure involved in the after-treatment incident to anchoring of the kidney has lost its temporary beneficial effect. In the treatment of this ptosis of the abdominal viscera will be

found the secret, if there is any, for the getting of uniformly good results in floating kidney.

DR. DEAVER, in answer to Dr. Taylor's question, replied that, with one exception among twelve or fifteen of these operations, he had never seen pain except as the result of dressing the wound. This pain is but temporary, and it so happened in that case he had tried to hasten the process; for two or three days the girl had some pain with a little elevation of temperature. He naturally thought there was a focus of suppuration, but, upon examination of the wound, could not find any. At the end of two or three days the temperature reached normal, and the patient ceased to have pain.

The pain to which Dr. Taylor referred he believed to be due to traumatic neuritis consequent upon injury of nerves at time of operation. In the dissection for the exposure of the kidney he was careful to avoid nerve injury.

Relative to Dr. Da Costa's remark, he had avoided speaking of the different varieties of movable kidney, because he had not wanted to make a distinction between floating kidney and movable kidney, as he thought that the fewer terms were used the more practical the subject would be made. He specifically stated in his paper that movable kidney, which causes symptoms of acute abdominal pain, rigidity of the overlying abdominal muscles, etc., were the only cases in which he advised operation.

He had also borne in mind the likelihood of general dropping of the viscera. He had invariably examined his patients for this condition.

CARCINOMA OF THE FUNDUS UTERI.

DR. CHARLES B. PENROSE read a paper with the above title.

NOTES ON CANCER OF THE FUNDUS UTERI.

By CHARLES B. PENROSE, M.D.,

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During the four years 1894, 1895, 1896, and 1897 I have had an opportunity of observing eleven cases of cancer of the fundus uteri.

It is said in some of the works on gynæcology, such as Hart and Barbour, that cancer of the fundus uteri occurs in a proportion of 2 per cent. of cancer of the cervix. This I have never found to be the case, and I believe that the observers who made such records must have failed to recognize many cases of cancer of the fundus. In my experience at the Gynécéan Hospital, and at the University Hospital, the percentage of cases of cancer of the fundus is very much greater than 2 per cent. In the period during which I have observed the eleven cases of cancer of the fundus here reported I have records of sixty-seven cases of cancer of the cervix, therefore, in my experience, cancer of the fundus has occurred in the proportion of 16 per cent.

In looking over my case-books, in order to determine the total number of cases of cancer of the fundus uteri, I have been forcibly struck by one fact of great interest, and that is, the rapid diminution, in my experience at both the University and the Gynécéan Hospitals, of cancer of the cervix. In my last case-book, in which the records of 250 patients are kept, I find only eleven cases of cancer of the cervix. In the case-book immediately preceding this, containing also 250 patients, I find twenty-seven cases of cancer of the cervix. Many of my friends in gynæcological practice have spoken to me of a similar diminution in the number of cases of cancer of the cervix which now come under their observation. As

I believe that the total number of cases of cancer of all kinds is increasing at a rather rapid rate, I think that we must attribute this diminution in the number of cases of cancer of the cervix to the fact of the very wide use of the operation of trachelorrhaphy.

My cases of cancer of the fundus uteri may be briefly recorded as follows:

CASE I.—W. R., complete abdominal hysterectomy, March 13, 1894. Now in good health with no signs of recurrence.

CASE II.—D. H., complete abdominal hysterectomy, October 25, 1895. No recurrence.

CASE III.—A. P., abdominal hysterectomy complete, March 24, 1896. No recurrence.

CASE IV.—L. H., complete abdominal hysterectomy, May 24, 1896. No recurrence.

CASE V.—Mrs. S., complete abdominal hysterectomy, February 13, 1897. No recurrence.

CASE VI.—R. R., complete abdominal hysterectomy, March 10, 1897. No recurrence.

CASE VII.—E. B., complete abdominal hysterectomy (operation by Dr. Braldy), January 5, 1897. No recurrence.

CASE VIII.—S. S., refused operation, September 11, 1895. Died of exhaustion several months later.

CASE IX.—M. F., cœliotomy, October 13, 1893. Case found to be inoperable on account of intestinal involvement. Died of exhaustion several months later.

CASE X.—R. D., cœliotomy, inoperable. Died of exhaustion in few months.

CASE XI.—D. B., October 1, 1897, incurably insane. No operation considered advisable. Still living.

It will be observed that seven of the eleven cases were submitted to operation. The first operation was performed five years ago, and the last operation was performed about two years ago. All the patients recovered from operation. I have, during the past two weeks, heard from all of these women and from the attending physicians of most of them. They are all in good health, with no indications whatever of a recurrence of the disease.

The ultimate results in operation for cancer of the fundus, as illustrated by the cases which I have reported, are certainly very much more favorable than the results of operation in cancer of the cervix, and I think that these results in cancer of the fundus are superior to the results in operation for malignant disease in any other part of the body.

In my experience with hysterectomy for cancer of the cervix, the results have been most unsatisfactory. I have the record of one patient, where the disease primarily affected the mucous membrane of the cervical canal and had not extended through the body of the cervix, on whom hysterectomy was performed, and no recurrence had taken place at the end of two and one-half years. In another case of cancer affecting the vaginal aspect of the cervix and a portion of the anterior vaginal wall, in which the uterus and part of the bladder was removed, there was no recurrence of the disease at the end of three years, when I closed by plastic operation the opening of the bladder. With the exception of these two cases, I can recall no other patient in whom recurrence has not taken place.

OPERATIONS FOR HARELIP.

DR. J. EWING MEARS presented a series of photographs (Figs. 1, 2, and 3) showing double harelip, with protrusion of the intermaxillary bone, occurring in a lad of eight years of age, and also the results obtained by operation. In this case he removed a small wedge-shaped piece from the posterior surface of the protruding intermaxillary bone, and forced the bone back into

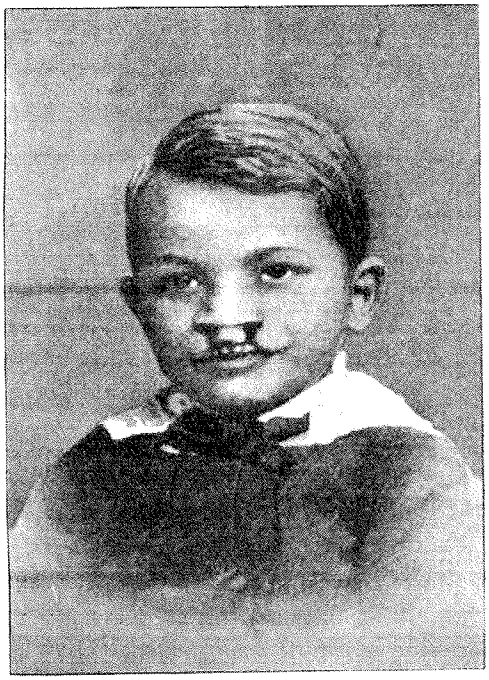

FIG. 1.—Showing double harelip, with protrusion of the intermaxillary bone. Front view.

position in the cleft which existed in the alveolar process, having previously freshened the edges of the bone and of the process. He then wired the bone in position and completed the operation by closing the double cleft in the lip.

He called attention to the method of operation which avoids excision of the protruding intermaxillary bone. Excision of the bone was recommended by Sir Wm. Ferguson and practised by

FIG. 3.—Showing ultimate results after operation.

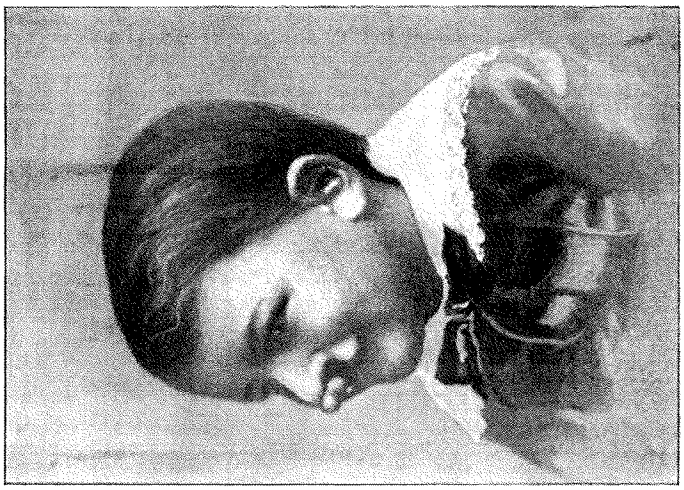

FIG. 2.—Showing side of the same case.

him in his operations, the reason being given for this method that the incisor teeth will grow backward into the mouth, and thus prove a source of annoyance. In the cases which have come under his observation he had not found this to be the fact, and, further, he had gained what he considered decided advantages in perfecting the operation upon the lip as well as upon the hard palate, which is involved in these cases. If the projecting intermaxillary bone is rudimentary, of course it is desirable to remove it.

Several cases had been sent to him for operation upon the palate in which the protruding intermaxillary bone had been removed. He had observed, in these cases, a failure to secure as good results in repair of the cleft of the lip as when the bone is permitted to remain in position, and he had also encountered difficulties in obtaining closure of the cleft in the hard palate by reason of the absence of the bone.

DR. WHARTON said that he had formerly employed the method of excising the maxillary bone, but recently had given it up. He had found that it left a very large gap and made it difficult to close the palate, and closure of the lip is interfered with. In cases which had come under his care recently, he had freshened the edges of the intermaxillary bone and that of the alveolus, and wired them. In some cases the intermaxillary bone is broken, in others he divided it partially with an osteotome, and then bent it into place. He had generally succeeded in wiring the intermaxillary bone in a fair position, with the result that the deformity of the lip was much improved. He thought that when these cases come to operation for cleft palate, it will be found that the correction of the deformity is very much improved by this procedure.